Australian Government

Department of Health and Ageing

HOME CARE PACKAGES PROGRAM GUIDELINES

CONSULTATION DRAFT

APRIL 2013

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PURPOSE OF THIS CONSULTATION DRAFT

These draft Guidelines for the Home Care Packages Program are being released as a consultation draft to assist stakeholders in understanding the upcoming changes to home care, and to provide an opportunity for stakeholders to provide comments and feedback on the proposed implementation arrangements.

The development of the draft Guidelines has been informed by preliminary advice from the National Aged Care Alliance, but does not necessarily represent the views of all stakeholders.

Comments and feedback from stakeholders on the consultation draft, as well as final advice from the National Aged Care Alliance, will inform the final Guidelines for the program and the relevant subordinate legislation.

The proposed commencement date for the Home Care Packages Program (1 July 2013) is subject to the passage of the amending legislation.

Any legislative references in the consultation draft, including changes to existing legal arrangements, are indicative only.

The final Guidelines will be available once the legislative framework for the program is in place.

PART A – INTRODUCTION

Covered in this part

- Aged Care Reforms
- New Home Care Packages Program
  - Package levels
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1. *Living Longer Living Better* Aged Care Reforms

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

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

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

The Government will provide $880.1 million over five years to increase the total number of Home Care Packages from around 60,000 packages (in 2012) to around 100,000 packages (by 2016-17). More than 40,000 additional packages are expected to be available over the following five year period, from 2017-18 to 2021-22.

2. A New Home Care Packages Program

2.1 Package levels

From July 2013, there will be four levels of Home Care Packages, including two new levels:

- Home Care Level 1 – a new package to support people with basic care needs.
- Home Care Level 2 – a package to support people with low level care needs, similar to the existing Community Aged Care Package (CACP).
- Home Care Level 3 – a new package to support people with intermediate care needs.
- Home Care Level 4 – a package to support people with high care needs, similar to the existing Extended Aged Care at Home (EACH) package.

These packages form a new Home Care Packages Program commencing 1 July 2013.

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

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

The first group of new Home Care Packages (around 5,800 packages) will be allocated through the 2012-13 Aged Care Approvals Round (ACAR).

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

2.2 Program Objectives

The objectives of the Home Care Packages Program are:

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

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

2.3 Target Population

The Home Care Packages Program is targeted at frail older people who are assessed as having needs that can only be met by a coordinated package of care services on an ongoing basis.

There is not a minimum age requirement for eligibility purposes.[1]

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

A younger person can be assessed by an ACAT as eligible for a Home Care Package only where there are no other more appropriate services or care facilities available.

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

2.4 Special Needs Groups

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

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

Packages are sometimes allocated to an approved provider on the condition that priority of access is given to people who belong to defined special needs groups. However, all approved providers are expected to have policies and practices in place to ensure services are accessible to people with special needs. Providers should have regard to consumer diversity, taking into account their individual interests, customs, beliefs and backgrounds.

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

[1] During the 2011-12 financial year, the average age of admission into a CACP, EACH or EACHD package was 81 years. For Aboriginal and Torres Strait Islander people, the average age of admission into a CACP, EACH or EACHD package was 66 years.

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

2.5 People with Dementia

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

3. Consumer Directed Care (CDC)

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

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

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

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

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

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

CDC models were trialled in around 1,000 home-based packages, as part of a pilot program funded by the Australian Government from 2010 to 2012. A copy of the final report of the evaluation is available at the Consumer Directed Care Pilot Evaluation Report website.

3.2 CDC Principles

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

3.2.1 Consumer Choice and Control

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

3.2.2 Rights

CDC should acknowledge older people's right (based on their assessed need) to the individualised services and support that will assist them.

3.2.3 Respectful and Balanced Partnerships

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

Consumers should have an opportunity to work with the approved provider in the design, implementation, and monitoring of a CDC approach and cultural change in the approved provider organisation.

3.2.4 Participation

Community and civic participation are important aspects for wellbeing. CDC in Home Care Packages should support the removal of barriers to participation for older people.

3.2.5 Wellness and Re-ablement

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

Many people enter the aged care system at a point of crisis. Such situations may require the initial provision of services designed to address the immediate crisis. However, there should always be an assumption that the older person can regain

their previous level of function and independence with re-ablement services being offered at a time that suits/supports the individual circumstances.

3.2.6 Transparency

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

4. Use of innovative and digital technology

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

5. Evaluation

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

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

- consumer experience and outcomes;
- provider operations;
- Aged Care Assessment Team processes;
- the interface between the Home Care Packages Program and other elements of the aged care system such as the Home and Community Care Program; and
- the effectiveness of the new arrangements in delivering a graduated continuum of care.

The evaluation will also consider whether CDC has supported increased access to digital technology by consumers and providers.

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

6. Legal Framework

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

- the *Aged Care Act 1997* (as amended in 2013);
- Principles made under the Act;
- Determinations made under the Act (for example, setting out relevant subsidy levels); and
- conditions of allocation made under the Act (for example, conditions applying to all packages and/or specific conditions applying to individual providers or services such as CDC).

7. Using these Guidelines

7.1 Purpose of the Guidelines

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

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

Much of the information in these Guidelines is relevant to all types of packages, whether delivered on a CDC basis or not. In some cases, the Guidelines relate specifically to the packages delivered on a CDC basis, particularly the information in Part D.

The Guidelines are primarily for use by home care providers, although they have been written with a broader audience in mind. The Guidelines will be complemented by other resources, including Frequently Asked Questions and a separate consumer information kit.

7.2 Terminology

In the Guidelines, the term “consumer” refers to the person for whom a subsidy is paid. In the *Aged Care Act 1997*, this person is described as the “care recipient” and this term is sometimes used in the Guidelines when referring to matters directly governed by the legislation.

While not referring specifically to other individuals who may be supporting the consumer, it is assumed that others may be present at various meetings and discussions, at the request of the consumer or acting on behalf of the consumer. Often this will involve the primary carer (generally a spouse, partner or an adult child). Where a formal action is required (for example, correspondence from an

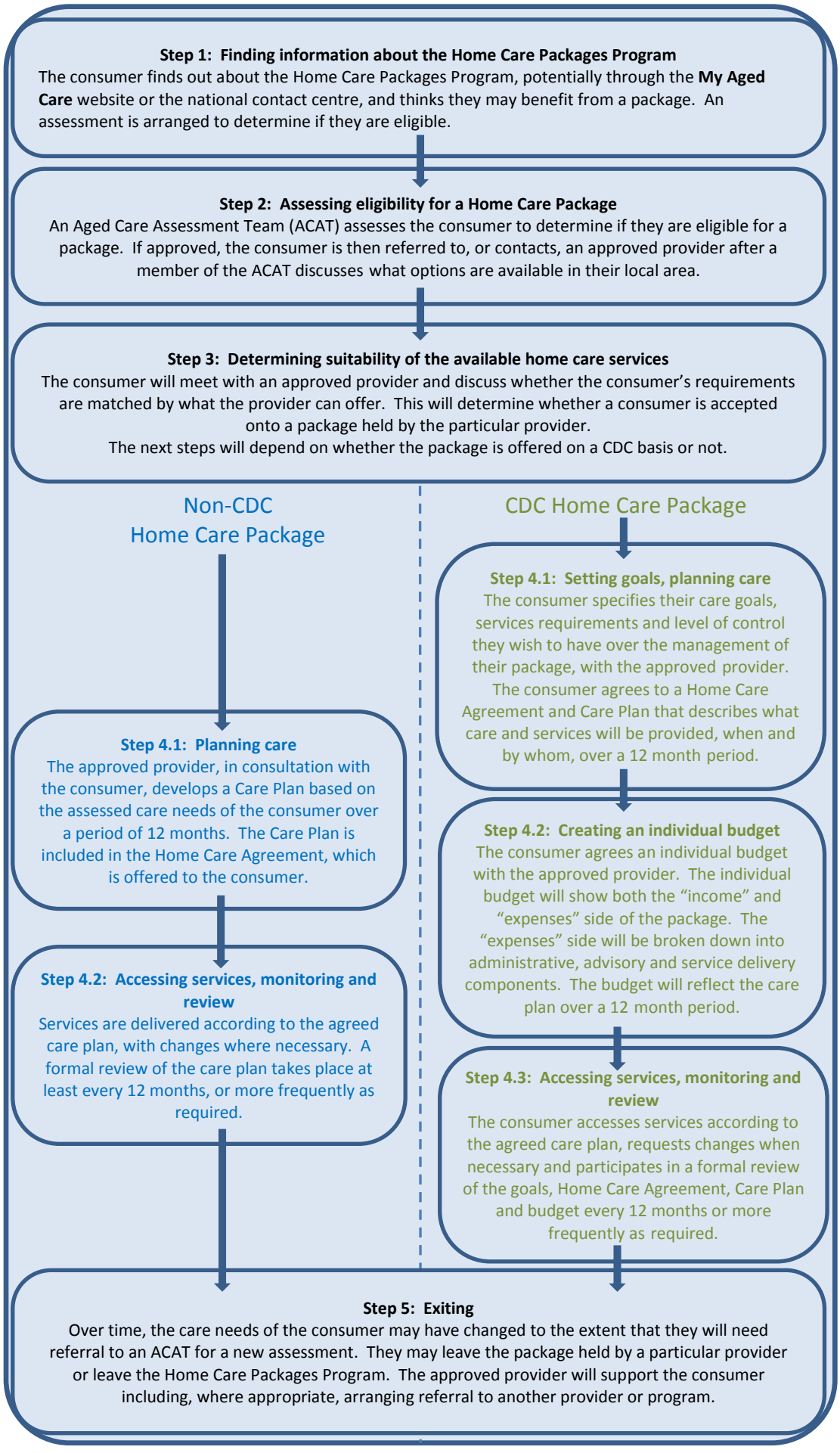
Aged Care Assessment Team or signing a Home Care Agreement with an approved provider) the consumer or the consumer's legal representative will need to be involved.

8. Pathway for the Consumer

The pathway for the consumer involves a series of steps from finding information about the Home Care Packages Program, assessment by an Aged Care Assessment Team, engagement with an approved provider, care planning and budget setting, service delivery, monitoring and review, and exiting the program.

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

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


Step 1: Finding information about the Home Care Packages Program
The consumer finds out about the Home Care Packages Program, potentially through the My Aged Care website or the national contact centre, and thinks they may benefit from a package. An assessment is arranged to determine if they are eligible.
Step 2: Assessing eligibility for a Home Care Package
An Aged Care Assessment Team (ACAT) assesses the consumer to determine if they are eligible for a package. If approved, the consumer is then referred to, or contacts, an approved provider after a member of the ACAT discusses what options are available in their local area.
Step 3: Determining suitability of the available home care services
The consumer will meet with an approved provider and discuss whether the consumer's requirements are matched by what the provider can offer. This will determine whether a consumer is accepted onto a package held by the particular provider.
The next steps will depend on whether the package is offered on a CDC basis or not.
Non-CDC Home Care Package
Step 4.1: Planning care
The approved provider, in consultation with the consumer, develops a Care Plan based on the assessed care needs of the consumer over a period of 12 months. The Care Plan is included in the Home Care Agreement, which is offered to the consumer.
Step 4.2: Accessing services, monitoring and review
Services are delivered according to the agreed care plan, with changes where necessary. A formal review of the care plan takes place at least every 12 months, or more frequently as required.
CDC Home Care Package
Step 4.1: Setting goals, planning care
The consumer specifies their care goals, services requirements and level of control they wish to have over the management of their package, with the approved provider. The consumer agrees to a Home Care Agreement and Care Plan that describes what care and services will be provided, when and by whom, over a 12 month period.
Step 4.2: Creating an individual budget
The consumer agrees an individual budget with the approved provider. The individual budget will show both the "income" and "expenses" side of the package. The "expenses" side will be broken down into administrative, advisory and service delivery components. The budget will reflect the care plan over a 12 month period.
Step 4.3: Accessing services, monitoring and review
The consumer accesses services according to the agreed care plan, requests changes when necessary and participates in a formal review of the goals, Home Care Agreement, Care Plan and budget every 12 months or more frequently as required.
Step 5: Exiting
Over time, the care needs of the consumer may have changed to the extent that they will need referral to an ACAT for a new assessment. They may leave the package held by a particular provider or leave the Home Care Packages Program. The approved provider will support the consumer including, where appropriate, arranging referral to another provider or program.

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

Covered in this part

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

1. Summary of Changes

Item	Up until 30 June 2013	After 1 July 2013
Program name	Community Packaged Care Programs – comprising the CACP, EACH and EACHD Programs	Home Care Packages Program
Package levels	3 levels: – CACP – EACH – EACHD	4 levels : – Home Care Level 1 – Home Care Level 2 – Home Care Level 3 – Home Care Level 4
Supplements	Viability Supplement applies to all package levels Oxygen Supplement and Enteral Feeding Supplement apply to EACH and EACHD packages, but not CACPs	Existing supplements will continue New Dementia/Veterans' Supplements apply to all package levels[2] New Aged Care Workforce Supplement applies to all package levels[3]
Consumer Directed Care (CDC)	Limited application[4]	Applies to all new Home Care Packages from July 2013, and to all packages (including existing packages) from July 2015 Option to convert existing packages to CDC earlier

[2] Payable where the consumer meets the relevant eligibility requirements for the Supplement
[3] Payable where the provider meets the relevant eligibility requirements for the Supplement
[4] Applies to 1,000 packages from the former CDC trial (converted to mainstream packages in July 2012)

Item	Up until 30 June 2013	After 1 July 2013
		than July 2015 if the provider wants to
Care and services	CACP: – does not include nursing and allied health, or aids and equipment in the range of care and services EACH/EACHD: – include nursing and allied health, as well as some aids and equipment in specified care and services – contain exclusions such as motorised wheelchairs and custom-made aids	Broadbanded care and services: – Level 1 and 2 similar to former CACP – Level 3 and 4 similar to former EACH All package levels, regardless of whether delivered on a CDC basis or not, will have: – greater flexibility in the range of care and services through an "other services required to maintain a person at home" category – access to nursing and allied health – access to a wider range of aids and equipment – limited number of specified exclusions
Standards	Community Care Common Standards	Home Care Standards
Charter	Charter of Rights and Responsibilities for Community Care	Charter of Rights and Responsibilities for Home Care
ACAT approval	Separate approval required for each package level	Broadbanded approval – two assessment points (Level 1 / 2, Level 3 / 4)
Lapsing ACAT approvals	CACP approvals automatically lapse after 12 months	Approvals do not automatically lapse at any level
Agreement between the approved provider and the consumer	Care Recipient Agreement	Home Care Agreement
Care recipient (consumer) contribution fees	Consumers can be asked to pay a care recipient contribution fee of: – Up to 17.5% of basic	From 1 July 2013 – no changes from previous arrangements From 1 July 2014 – new

Item	Up until 30 June 2013	After 1 July 2013
	pension, plus up to 50% of income above the basic pension	income testing arrangements will apply
Approved provider status	Approved provider of Community Care required for CACP packages Approved provider of Flexible Care required for EACH/EACHD packages	Approved provider of Home Care required for all packages levels
Agreements between the Commonwealth and approved providers	Requirement to enter into a Deed for Agreement for CACPs, and separate Payment Agreements for EACH and EACHD packages	No new agreements from 1 July 2013. Existing agreements will also cease – replaced by expanded Principles and conditions of allocation.

2. Transitional Arrangements

2.1 Existing allocations of packages

From 1 July 2013, all existing allocations of:

- CACP packages will become Home Care Level 2;
- EACH packages will become Home Care Level 4; and
- EACHD packages will become Home Care Level 4 (plus a Dementia Supplement will be paid in respect of all existing care recipients, ie those receiving care under an EACHD package on 30 June 2013).

The change from the former CACP, EACH and EACHD packages to new Home Care Packages will take effect from 1 July 2013, once the transitional provisions in the *Aged Care Act 1997* and the relevant Aged Care Principles commence.

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

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

2.2 Existing Consumers

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

- a CACP will receive services under a Home Care Level 2 package;
- an EACH package will receive services under a Home Care Level 4 package;
- an EACHD package will receive services under a Home Care Level 4 package plus a Dementia Supplement will be paid automatically to the approved provider.

Care Recipient Agreements (which, after 1 July 2013, will become Home Care Agreements) will continue to remain in force.

2.3 Existing ACAT Approvals

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

Previously, CACP approvals lapsed after 12 months. From 1 July 2013, ACAT assessments will not automatically lapse after 12 months across any of the four package levels.

Further details are in Part C, Section 4.

2.4. Changes to Approved Provider Arrangements

From 1 July 2013, the arrangements for obtaining approved provider status have been simplified for home care.

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

From 1 July 2013, there is a single level of approved provider status for **home care**. This enables an approved provider to deliver services at any of the four levels of Home Care Packages (as long as they have been allocated packages through the ACAR).

For existing approved providers (ie those who have approved provider status on 30 June 2013):

- an approved provider of community care is deemed to be an approved provider of home care; and
- an approved provider of flexible care is deemed to be an approved provider of home care. They also retain their status as an approved provider of flexible care, which is still relevant to the Multi-Purpose Services Program and the Transition Care Program.

For new providers (applying for approved provider status after 1 July 2013):

- providers wanting to deliver services at any of the four levels of Home Care Packages need to be approved as an approved provider of home care; and
- providers wishing to provide services under the flexible care programs (eg Multi-Purpose Services or Transition Care) need to apply to become an approved provider of flexible care.

PART C – ACCESSING A HOME CARE PACKAGE

Covered in this part

- Finding out information about packages
- Eligibility for a package
  - Age
  - Residency or citizenship
  - Assessment by an ACAT
  - Broadbanded assessments
- Issues to be considered by ACATs in determining eligibility
  - Eligibility criteria
  - When a package may not be appropriate
  - Aged care client record and information about the ACAT decision
- ACAT approvals
  - Existing approvals (valid on 1 July 2013) will not lapse
  - Removal of automatic lapsing of approvals
- Referral from an ACAT to an approved provider
- Being offered a package by an approved provider
  - Moving between package levels or bands
  - Waiting lists

1. Finding information about Home Care Packages

From 1 July 2013, older people, their families and carers will be able to access the **My Aged Care** website at www.myagedcare.gov.au and the national contact centre on **1800 200 422**, for information about the aged care system and services including Home Care Packages.

2. Eligibility for a Home Care Package

2.1 Age

The Home Care Packages Program is targeted at frail older people who are assessed as having needs that can only be met by a coordinated package of care services on an ongoing basis.

There is not a minimum age requirement for eligibility purposes.[5]

In some cases, younger people with disabilities, dementia or special care needs may be able to access a Home Care Package – if the person has been assessed and

[5]During the 2011-12 financial year, the average age of admission into a CACP, EACH or EACHD package was 81 years. For Aboriginal and Torres Strait Islander people, the average age of admission into a CACP, EACH or EACHD package was 66 years.

approved by an ACAT, and an approved provider is able to offer an appropriate package for the person.

A younger person can be assessed by an ACAT as eligible for a Home Care Package only where there are no other more appropriate services or care facilities available.

2.2 Residency or citizenship

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

2.3 Assessment by an Aged Care Assessment Team

A consumer will access a Home Care Package in a similar way to the previous CACP, EACH and EACHD packages. People will need to be assessed and approved as eligible for Home Care by an ACAT (or known as Aged Care Assessment Service in Victoria), and then offered a Home Care Package by an approved provider.

2.4 Broadbanded assessments

ACAT assessment requirements for Home Care will be "broad-banded".

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

- *Home Care Levels 1 and 2* – to be eligible to access either a Level 1 or 2 package, a person must be approved by an ACAT as eligible for low level residential care; and
- *Home Care Levels 3 and 4* – to be eligible to access either a Level 3 or 4 package, a person must be approved by an ACAT as eligible for high level residential care.

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

However, the definitions used to describe the eligibility bands (above) will be reviewed during the first year of the program, to take effect from 1 July 2014, noting that there will no longer be a distinction between low level and high level residential care from 1 July 2014.

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

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

The decision to offer an eligible person a package, including at what level the package is offered (within the band for which the person has been approved by the ACAT) is made by the approved provider.

3. Issues to be considered by ACATs in determining eligibility

3.1 Eligibility criteria

An ACAT will conduct a multidisciplinary and comprehensive assessment, taking account of a person's physical, medical, psychological, cultural, social and restorative care needs. The ACAT will then need to determine that a person meets all the eligibility criteria before approving the person to receive a Home Care Package.

The requirements of the legislation[6] mean that, for a person to be eligible for a Home Care Package, the person must:

- be assessed as eligible for residential care;
- have expressed a preference to live at home (including as a resident of a retirement village); and
- be able to remain living at home with the support of a Home Care Package.

3.2 When a package may not be appropriate

Packages are a long-term care option for frail older people who want to remain living at home. Packages should not be used as a crisis management tool for people requiring temporary care or short-term care.

3.3 Aged Care Client Record and information about the ACAT decision

Part of the ACAT approval process involves the creation of an Aged Care Client Record (ACCR) for each person who is approved as eligible for a Home Care Package. The onus is on an approved provider to check that a consumer's approval is valid before arranging for services to commence.

The consumer should be advised promptly in writing of the outcome of their ACAT assessment and receive contact details for further advice if required. The ACAT delegate must provide sufficient information in the letter to allow a person to understand why a decision has been made.

[6] Include updated references to legislation

An ACAT approval to receive a Home Care Package takes effect from the day the approval is given, but a subsidy is not payable to the provider until the consumer has been offered a package by an approved provider and the Home Care Agreement is in place.

4. ACAT approvals

4.1 Existing approvals (valid on 1 July 2013) will not lapse

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

This means that:

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

4.2 Removal of automatic lapsing of approvals

Previously, CACP approvals automatically lapsed after 12 months.

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

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

5. Referral from an ACAT to an approved provider

Once a person is approved as eligible for a Home Care Package, the ACAT assessor may make a direct referral to an approved provider or provide information to the person on how to contact local providers.

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

6. Being offered a package by an approved provider

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

The decision to offer an eligible person a package, including at what level the package is offered (within the band for which the person has been approved by the ACAT) is made by the approved provider.

People on a waiting list do not necessarily access care purely on a "first come, first serve" basis. Approved providers are encouraged to assess each individual's care needs relative to others also waiting for home care.

If a person has been approved by an ACAT as eligible for a higher level/band of package (eg Level 3 or 4), but none is available, the person can be offered a lower level package (eg Level 1 or 2) as an interim measure until a higher level package is available. No additional ACAT approval is required in this case.

6.1 Moving between package levels or bands

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

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

6.2 Waiting lists

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

If a package is not available immediately following the ACAT approval, the ACAT may refer the consumer to more than one provider. The consumer can also contact providers directly.

Approved providers manage their own waiting lists, giving access and priority according to each individual's need and the provider's capacity to meet that need. As explained above, people on a waiting list do not necessarily access care purely on a "first come, first serve" basis.

PART D – MAKING USE OF A HOME CARE PACKAGE

Covered in this part

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

1. Being offered a package by an approved provider

Once a person has been assessed and approved by an ACAT as eligible for a Home Care Package, the consumer may be referred to local approved providers – either by the ACAT or through the consumer making direct contact with individual providers.

The approved provider will determine whether they are able to offer a package suitable for the consumer.

The ACAT assessment supplies the approved provider with important information about the characteristics, needs and circumstances of the prospective consumer. The approved provider should always review the consumer's Aged Care Client Record (ACCR). This should be considered, together with other information provided by the consumer, in determining whether a package can be offered and if so, at what level (within the band approved by the ACAT).

2. Home Care Agreement

2.1 Overview

For all Home Care Packages, whether delivered on a CDC basis or not, a Home Care Agreement (previously known as a Care Recipient Agreement) must be offered to the consumer before the package commences. This is a legal requirement.[7]

[7] Reference legislative provisions.

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

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

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

Once signed, the Home Care Agreement establishes security of tenure for the consumer (see Part E, Section 3), care and services can formally commence under the package, and the approved provider is able to commence claiming the government subsidy for the package (see Part I, Section 4).

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

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

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

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

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

2.2 Items to be included in the Home Care Agreement

Under the legislation[8], the following information must be included in the Home Care Agreement:

[8] Refer to updated legislative provisions

Check	Item
☐	start date for the care
☐	details outlining how the consumer can suspend care
☐	an explanation of security of tenure
☐	conditions under which either party may terminate care
☐	an explanation that any variation must be by mutual consent, following consultation between the consumer and the approved provider, and may only be made after the provider has given reasonable notice in writing to the consumer
☐	a copy of the consumer's care plan
☐	details of the consumer's rights about the service they are to receive. A copy of the *Charter of Rights and Responsibilities for Home Care* must also be provided to the consumer
☐	a statement that the consumer is entitled to make, without fear of reprisal, any complaint about the Home Care Package, and an explanation of how to make a complaint. This refers to both internal complaint mechanisms and the Aged Care Complaints Scheme
☐	a guarantee of the confidentiality, as far as legally permissible, of information provided by the consumer and the use to be made of the information
☐	a clear itemised statement of the fees payable (if any) by the consumer and how they were calculated
☐	other financial information relevant to the care and services provided to the consumer
☐	an explanation that a consumer is entitled to request a statement of the home care service's financial position, including a copy of the most recent version of the approved provider's audited accounts. This must be provided within seven days of the request

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

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

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

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

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

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

The approved provider should always be ready to provide evidence that an "in-principle" agreement is in place.

3. Packages delivered on a CDC basis

3.1 Care planning

3.1.1 Overview

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

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

- consumer choice and control;
- support for consumer decision-making;
- wellness and re-ablement; and
- maintenance of independence and continuation of participation in the community.

3.1.2 Goal setting

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

The objectives of the program – to assist people to remain living at home for as long as possible and to enable consumers to have choice and flexibility in the way that

care, services and support is provided at home – establish an overall framework for goal setting.

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

Individual goals will be shaped by the consumer's own circumstances, including the amount of support available from family, friends and carers, the consumer's level of health and well-being, and cultural and personal values.

3.1.3 Level of consumer control over the management of the package

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

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

In some cases, this will mean that the approved provider's role will undergo very little change, but in other cases, the approved provider's role will be to support and facilitate access to services rather than to directly deliver all of what the consumer requires.

The level of consumer control may also vary over time, which should be discussed during the formal reassessment of the consumer's care plan.

The consumer's involvement in managing their package could include making contact with service providers, negotiating fees, scheduling appointments to provide services required by the consumer, and monitoring the quality of services provided. Administration activities could include record keeping and managing invoices.

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

The extent to which the consumer is able to be involved in the management of the package will partly depend on what services are to be provided, and the way in which service providers or workers are engaged to deliver the services.

For example, a consumer may have more scope to be involved in the ongoing management of the package where services are being provided by way of brokered services or sub-contracted services, but less involvement where services are being provided directly by the approved provider.

3.1.4 Determining who has authority to make decisions

The determination of who has the authority to make decisions (eg the individual consumer, a guardian, or a person with power of attorney) will be a crucial part of this process. Approved providers will need to have a formal system to determine who has the authority to make decisions consistently and fairly. Such a system should also enable and support shared decision-making and duty of care between the consumer, their appointed representative (if they have one) and the approved provider. This will be particularly important in situations where the older person has a cognitive impairment.

3.1.5 Case management

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

- the initial assessment by the provider;
- identification of the consumer's goals;
- development of the Home Care Agreement, care plan and individualised budget;
- ongoing monitoring and informal reviews of the consumer;
- formal reassessment of the consumer's needs, and adjustment of the Home Care Agreement, care plan and individualised budget if required; and
- referral to an ACAT (eg if a reassessment is needed to move to a higher broadbanded level of package).

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

In some cases, a consumer may wish to have a specific person as a case manager. This can be negotiated between the consumer and the approved provider. If agreed, the approved provider would need to establish a contractual or employment relationship with the case manager suggested by the consumer.

It is not expected that a consumer would take-on the functions of a case manager.

3.1.6 Choosing care and services

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

In a CDC environment, the consumer should not be limited by a "standard" menu of services or service providers. Providers and consumers should be thinking about

innovative ways to meet the consumer's goals and care needs. This may involve the use of sub-contracted or brokered services if the approved provider is unable to provide the service/s itself or where the consumer would prefer the service be delivered by a particular worker.

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

3.1.7 Care plan

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

- the consumer's goals – what it is the consumer would like to achieve through their package;
- the care and services to be provided to support the identified goals;
- who will provide the care and services;
- when care and services will be provided, including the frequency of services and days/times when regular services are expected to be provided;
- the level of control the consumer will exercise over the management of the package; and
- case management arrangements, including how ongoing monitoring and informal reviews will be managed and the frequency of formal reassessments.

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

3.1.8 Giving effect to the consumer's choices and preferences

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

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

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

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

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

- The proposed service may cause harm or pose a threat to the health and/or safety of the consumer or staff.
- The proposed service is outside the scope of the Home Care Packages Program (see Part E, Section 2.3).
- The approved provider would not be able to comply with its responsibilities under aged care legislation or other Commonwealth or state/territory laws.
- The consumer's choice of service provider is outside the approved provider's preferred list of service providers and all reasonable effort has been made to broker an acceptable sub-contracting arrangement.
- The requested service provider will not enter into a contract with the approved provider.
- There have been previous difficulties or negative experiences with the consumer's suggested service provider.
- Situations in which a consumer may want to go without necessary clinical services (resulting in a possible compromise of their health and/or wellbeing) in order to "save" for a more expensive non-clinical service.
- The cost of the service/item is beyond the scope of the available funds for the package.

An approved provider may also consider declining a request from a consumer where the requested services do not have a strong evidence base or have been shown to be ineffective. However, there could be circumstances where a type of service or support activity is accepted within a particular community or special needs group even though there may not be a broad evidence base for the service.

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

3.1.9 Sub-contracted or brokered services

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

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

Approved providers are encouraged to develop a list of "preferred service providers" to support consumers' needs and choices.

Approved providers should also endeavour to build relationships with other organisations that specialise in providing services to people from special needs

groups. Some consumers may request or prefer service providers that work with, or are from, the same special needs group.

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

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

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

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

In such cases, the approved provider is still responsible for obtaining the necessary police checks, where required, and for ensuring that the worker is appropriately qualified and trained for the service being provided. Police check requirements are set out in Part F, Section 4.

3.1.11 Contracting to informal carers, family members or friends

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

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

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

- elder abuse safeguards;
- the approved provider's responsibility for service quality, including the need to include the person providing the service in the provider's employee, volunteer or sub-contractor systems;
- legal responsibilities, including the requirement to obtain police checks;
- industrial implications;
- insurance requirements;
- workplace health and safety; and

- qualifications and training required to provide certain types of care.

3.2 Individualised budget

3.2.1 Overview

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

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

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

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

3.2.2 What is an individualised budget?

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

The budget should be developed in partnership between the consumer and the provider, based on the agreed care plan.

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

Income

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

- the full amount of the government subsidy for the package level;
- all funding from relevant government supplements[9], eg Dementia, Veterans', Oxygen and Enteral Feeding Supplements (where applicable); and

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

- any consumer contribution/fee.

Planned expenditure

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

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

These categories are explained below.

- *Administration costs* – reflect the establishment and set up costs for the package and would also include the costs of meeting government quality and accountability requirements. Administrative costs include:
  - insurance and government reporting;
  - corporate overheads;
  - capital costs;
  - ongoing research and service improvement;
  - advocacy;
  - CDC administrative overheads including staff and IT;
  - developing statements and other consumer communication;
  - establishing contracts with sub-contracted providers; and
  - setting up and cancelling appointments.

- *Core advisory and care coordination services* – this category will include the costs of:
  - initial assessment;
  - set up costs for new consumers;
  - case co-ordination or management;
  - provision of support to consumers that elect to manage their package themselves;
  - ongoing monitoring and informal reviews; and
  - formal reassessments.

- *Service and support provision and/or purchasing* – to cover the costs of service delivery as defined in the care plan.
  - the provider should describe and quantify what tangible services will be provided to the consumer, eg costs are based on personal and phone contact of X hours per week at $Y per hour (or appropriate service unit).

3.2.3 Contingency

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

If a contingency is used, it must be no more than 10% of the total budget for the package, and the contingency amount must be clearly identified in the individualised budget and in the regular statement of income and expenditure provided to the consumer.

3.2.4 Regular statement to the consumer

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

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

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

3.2.5 Unspent funds when a consumer leaves a package

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

- If the consumer continues to receive a package from the approved provider (at a different package level), any unspent funds from the previous package must continue to be available under the consumer's new package.

- If the consumer moves to a different approved provider (eg to take up a package with another approved provider or to enter residential care), any unspent funds can be retained by the previous approved provider to support service delivery for other consumers, or for infrastructure purposes.

  - However, if the consumer returns to a package after a short period of time (eg within 28 days), there is discretion for the approved provider to make available the unspent funds in a future package offered to the consumer.

  - There is also the discretion for an approved provider to agree to transfer unspent funds to another approved provider to support the ongoing care

needs of the consumer. This would need to be negotiated and agreed between the relevant approved providers, in consultation with the consumer.

- Any unspent funds remain with the approved provider on the cessation of the Home Care Package where the consumer is deceased. These funds should be used to support service delivery for other consumers, or for infrastructure purposes.

3.3 Monitoring, Review and Reassessment

3.3.1 Ongoing monitoring and review

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

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

3.3.2 Reassessment

Reassessment is a more formal process that involves assessing the consumer's needs, goals and preferences in order to update their care plan and what services they receive, if necessary. This may also result in changes to the Home Care Agreement and the individualised budget.

There should be a formal reassessment every 12 months, at a minimum. The cost of the reassessment/s should be included in the individualised budget.

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

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

- a request by the consumer;
- a health crisis or episode;
- a change in care need;
- a change in living or carer arrangements;
- ongoing or increasing use of clinical services by a consumer; or
- the use of a large amount (or all) of the contingency funds in the budget.

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

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

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

3.3.3 Support for the consumer following reassessment and review of the care plan

A review of the care plan could lead to significant changes in the nature of support being provided to a consumer. The approved provider should support the consumer, as much as possible, in any changes resulting from the review of the care plan. This could include changes to care and services under the consumer's current package, moving to a different level of package (sometimes with a different approved provider), re-assessment by an ACAT, or moving to residential care.

4. Packages not being delivered on a CDC basis

4.1 Overview

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

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

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

- After the ACAT assessment and approval, the next step is for the consumer to be offered a package by an approved provider. The provider will determine whether they are able to offer a package suitable for the consumer

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

4.2 Level of consumer control over the management of the package

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

4.3 Giving effect to the consumer's choices and preferences

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

4.4 Individualised budget

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

While there is no requirement for an individualised budget in a non-CDC package, all providers are expected to deliver all Home Care Packages in an open and transparent manner, so that the consumer is aware of the budget/funding available and how funds are being spent. An individualised budget (or elements of the budget) can be

incorporated into an existing package at any time, even if the package is not formally being delivered on a CDC basis.

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

A consumer may choose to "top up" their package by purchasing an extension of care and services through their approved provider. This would need to be negotiated and agreed between the consumer and the approved provider.

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

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

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

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

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

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

Once the Home Care Packages Program commences, the Department will provide further advice about how approved providers can apply to convert existing packages to a CDC basis.

PART E – WHAT HOME CARE PACKAGES PROVIDE

Covered in this part

- Subsidies
- Care and services
  - Home Care Levels 1 and 2 Inclusions
  - Home Care Levels 3 and 4 Inclusions
  - Exclusions
- Security of tenure
  - Consumers moving locality
  - Other reasons for terminating a package
- Leave provisions
  - Overview

1. Subsidies

The government subsidy for the Home Care Package is paid to the approved provider, not directly to the consumer.

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

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

Indicative subsidy amounts are set out below.[10]

Home Care Package level	Subsidy per day	Subsidy per annum
Level 4	$...	$45,500
Level 3	$...	$30,000
Level 2	$...	$13,600
Level 1	$...	$7,500

2. Care and Services

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

While there will continue to be a list of specified care and services after 1 July 2013 (broadly based on the former CACP and EACH packages), consumers and providers will be able to negotiate "other services required to maintain a person at home"

[10] Subsidy levels for 2013-14 are not yet available. Changes to subsidy levels usually take effect from 1 July each year. Rates are published on the Department of Health and Ageing's website.

where this will assist the consumer to achieve his/her goals,[11] consistent with the consumer's care needs and the scope of the Home Care Packages Program.

This increased flexibility will apply to all Home Care Packages, whether delivered on a CDC basis or not.

2.1 Home Care Levels 1 and 2

2.1.2 Overview

Home Care Levels 1 and 2 cover the same types of care - largely based on the services previously available under a CACP, plus additional flexibility to provide other services required to maintain a person at home.

These packages are not intended to provide comprehensive clinical services, but some nursing and allied health services may also be provided as part of Home Care Level 1 and 2 packages. This is a change from the former CACPs, which did not include nursing and allied health services.

The key difference between Level 1 and Level 2 will be the amount or quantum of services that can be provided, ie more services under the Level 2 package, reflecting the higher subsidy for that level.

2.1.2 Relevant legislation

Quality of Care Principles 1997

2.1.3 Inclusions

For Home Care Levels 1 and 2, the range of care and services that may be provided to a consumer includes, but is not limited to, the following:

A. Care Services

Service	Description
Personal care	• Bathing, showering, or personal hygiene • Toileting • Dressing or undressing • Mobility • Transfer (eg in and out of bed, shower, etc) • Preparing and eating meals (but not including the purchase of food) • Sensory communication, or fitting sensory

[11] The consumer's goals may be specified in the care plan, particularly for packages being delivered on a CDC basis.

Service	Description
	communication aids

B. Support Services

Service	Description
Support services	• Assistance with a special diet • Medication management • Laundry • Home help • Gardening • Rehabilitative support • Emotional support • Support for consumers with cognitive impairment • Having at least one responsible person or agency, approved by the organisation providing the Home Care Package, reasonably near and continuously on call to give emergency assistance when needed • Transport to help the person shop, visit a health practitioner or attend social activities • Respite care • Home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security • Minor modifications to the home, if required, such as easy access taps, shower hose or bath rails. Approved providers will assist the consumer and homeowner, if the home owner is not the consumer, in accessing further technical advice on more comprehensive home modifications • Arranging social activities, providing or coordinating transport to social functions at a reasonable frequency and other out-of-home services that help prevent social isolation • Advocacy services to help protect the person's interests • Support services to maintain personal affairs

C. Clinical Services

Service	Description
Clinical care	Nursing, allied health and other clinical services (where required). Examples of other clinical services could include hearing and vision services.
Access to other health and related services	Referral to health practitioners or other service providers (where required).

D. Other Services

Service	Description
Other services required to maintain the person at home	This is a general category that provides flexibility for the consumer and the approved provider to agree on other services required to support the consumer to live at home. This category includes, but is not limited to: • the use of telehealth, video conferencing and digital technology (including remote monitoring) where appropriate, to increase access to timely and appropriate care; and • assistive technology, such as aids and equipment (particularly those that assist a person to perform daily living tasks), as well as devices that assist mobility, communication and personal safety. The agreed services must be consistent with the consumer's care needs, the consumer's goals (where these are identified in the care plan) and be within the scope of the Home Care Packages Program. Services that outside the scope of the program are listed at Section 2.3 in this Part.

2.2 Home Care Levels 3 and 4

2.2.1 Overview

Home Care Levels 3 and 4 cover the same types of care – largely based on the services previously available under an EACH package, plus additional flexibility to provide other services required to maintain a person at home.

Compared to Levels 1 and 2, the Level 3 and 4 packages have a greater emphasis on delivering complex care in the home, including clinical care where required.

The key difference between Level 3 and Level 4 is the amount or quantum of services that can be provided, ie more services under the Level 4 package, reflecting the higher subsidy for that level.

2.2.2 Relevant legislation

Quality of Care Principles 1997

2.2.3 Inclusions

For Home Care Package Levels 3 and 4, the range of care and services that may be provided to a consumer includes, but is not limited to, the following:

A. Clinical Services

Service	Description
Clinical care	Nursing, allied health and other clinical services (where required). Examples of other clinical services could include hearing and vision services. Where nursing services are provided, the provider must also provide 24-hour on-call access to care by, or under the supervision of, a registered nurse.
Access to other health and related services	Referral to health practitioners or other service providers (where required).

B. Care Services

Service	Description
Activities of daily living	Personal assistance, including individual attention, support, supervision and physical assistance with: • bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids; • communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance in using the telephone; and • assistance with shopping and transport to and from appointments and support with performing household tasks including house cleaning, removal of household waste, ironing, personal laundry services including laundering of clothing and bedding that can be machine-washed.
Nutrition, hydration and meal preparation	Includes: • assistance, as necessary, in preparing meals and special diets for health, religious or cultural reasons; • providing enteral feeding formula and equipment, as required; and • assistance using eating utensils and eating aids and assistance with actual feeding if necessary.

Service	Description
Management of skin integrity	Providing bandages, dressings, and skin emollients.
Continence management	Includes: • assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas; and • assistance in using continence aids and appliances and managing continence.
Support for consumers with cognitive impairment	Individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance the quality of life and provide ongoing support.
Mobility and dexterity	Includes: • providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs where needed and the consumer does not already have them; • providing, where assessed as required, mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses; and • assistance in using the above aids.

C. Support Services

Service	Description
Leisure, interests and activities	Includes: • encouragement to take part in social and community activities that promote and protect the consumer's lifestyle, interests and wellbeing; and • assistance to access support services to maintain personal affairs.
Emotional support	Ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the consumer and carer if appropriate.
Respite	Respite care
Therapy services	Includes: • maintenance therapy, such as diversional, recreational or speech therapy, podiatry, occupational or physiotherapy services designed to minimise deterioration in function.
On-call access	24-hour on-call access to at least one responsible person

Service	Description
	or agency located reasonably close to the consumer who will organise emergency assistance when required. This includes access to an emergency call system if the consumer is assessed as requiring it.
Home safety	Advice for the consumer, on areas of concern in their home that is a risk to the provider's staff, the consumer or carer.
Home maintenance	Home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security.
Home modification	Minor modifications to the home, if required, such as easy access taps, shower hose or bath rails. More extensive home modifications can be considered if they are related to the consumer's care needs (but the costs must be within the limits of the funding available for the package).

D. Other Services

Service	Description
Other services required to maintain the person at home	This is a general category that provides flexibility for the consumer and the approved provider to agree on other services required to support the consumer to live at home. This category includes, but is not limited to: • the use of telehealth, video conferencing and digital technology (including remote monitoring) where appropriate, to increase access to timely and appropriate care; and • assistive technology, such as aids and equipment (particularly those that assist a person to perform daily living tasks), as well as devices that assist mobility, communication and personal safety. The agreed services must be consistent with the consumer's care needs, the consumer's goals (where these are identified in the care plan) and be within the scope of the Home Care Packages Program. Services that outside the scope of the program are listed at Section 2.3 in this Part.

Note – the former "General" category under the EACH and EACHD packages, which included *Administration* and *Care Planning and Management services*, is no longer included as a separate category of services. As explained in Part D, administration,

care planning and management activities are elements of the delivery of Home Care Packages across all four levels.

2.3 Excluded services and items

The following services and items are outside the scope of the Home Care Packages Program. The Government subsidy for the Home Care Package and supplements cannot be used for these purposes across any of the four package levels:

- use of the package funds as a source of general income to the consumer, including adding to other government income payments;
- purchase of food (except as part of enteral feeding requirements);
- paying for permanent accommodation, including assistance with home purchases, mortgage payments or rental assistance;
- payment of consumer fees/contributions for Home Care Packages or other programs;
- home modifications that are not related to care needs;
- non-care related capital items;
- purchase of motorised wheelchairs, although these may be leased or hired;
- customised aids;
- travel and accommodation for holidays;
- entertainment activities, such as club memberships or tickets to sporting events (assistance to access these activities, such as transport costs, can be supported through the package);
- payments for services and items covered under the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS); and
- gambling activities; and
- illegal activities.

3. Security of Tenure

Under the legislation, approved providers are responsible for ensuring a consumer's security of tenure.[12]

At present, an approved provider may cease to provide a package to a consumer under the circumstances described in sections 3.1 and 3.2 (below).

During the consultations to date, some stakeholders have identified the need for greater consistency of security of tenure provisions across residential care and home care. Security of tenure provisions for the Home Care Packages Program are currently being considered.

[12] Section 56-2 of the *Aged Care Act 1997* and Part 3 of the *User Rights Principles 1997*

3.1 Consumers moving locality

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

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

3.2 Other reasons for terminating a package

The Home Care Agreement must specify how either party may terminate the agreement and must not contradict the security of tenure provisions in the Act.

When a consumer commences on Home Care Package, the approved provider should explain that, at some time in the future, the consumer may no longer be able to continue on the package. This may occur for various reasons, including:

- the consumer cannot be cared for at home with the resources available to the approved provider;
- the consumer tells the approved provider, in writing, that they wish to move to a location where home care is not available through the approved provider;
- the consumer tells the approved provider, in writing, that they no longer wish to receive the care; or
- the consumer's condition changes so that:
  - they no longer need home care; or
  - the consumer's needs, as assessed by the ACAT, can be more appropriately met by other types of services or care.

When an approved provider seeks to terminate an agreement, the consumer must be provided with reasonable written notice and assistance to make other suitable arrangements.

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

4. Leave Provisions

4.1 Overview

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

There are currently different leave provisions between CACP and EACH/EACHD packages, with subsidies paid for varying periods depending on the type of leave taken.

During the consultations to date, stakeholders have identified the need for greater consistency of leave provisions. Future leave provisions for the Home Care Packages Program are currently being considered.

PART F – RIGHTS AND RESPONSIBILITIES

Covered in this part

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

1. Context

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

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

2. Consumers

2.1 Rights and responsibilities

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

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

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

2.2 Advocacy

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

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

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

Under section 23.23 of the *User Rights Principles 1997*, the approved provider must allow an authorised advocate access to the home care service if the consumer or their representative has requested the assistance of such a person.

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

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

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

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

2.3 Complaints

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

Approved providers must have appropriate processes in place to receive, record and resolve complaints (section 56.4 of the Act). These processes are to include consideration of people with special needs such as people with vision of hearing impairments and people from culturally and linguistically diverse backgrounds. Approved providers are required to inform consumers about these mechanisms and they must be identified in the Home Care Agreement.

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

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

Consumers should be actively encouraged to provide feedback about the services they receive. Approved Providers must also make available information about the

Aged Care Complaints Scheme, including information about how to make contact with the Scheme.

2.4 Aged Care Complaints Scheme

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

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

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

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

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

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

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

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

More information can be found on the Aged Care Complaints Scheme website.

3. Approved Providers

3.1 Responsibilities

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

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

Sanctions may be imposed under Part 4.4 of the Act on approved providers who do not meet their responsibilities.

3.1.1 Quality of care

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

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

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

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

3.1.2 User rights

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

In summary, the responsibilities of approved providers include:

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

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

3.1.3 Accountability

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

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

4. Police check/certificate requirements

4.1 Key Personnel

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

The approved provider must:

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

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

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

- all staff members who are reasonably likely to have access to care recipients, whether supervised or unsupervised; and
- volunteers who have unsupervised access to care recipients.

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

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

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

4.2 Staff member

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

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

4.3 Volunteer

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

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

4.4 Contractors

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

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

4.5 Independent contractors

Police check requirements are not intended to extend to people engaged on an ad hoc basis. For example, trades people engaged as independent contractors generally do not require police checks. Visiting medical practitioners, pharmacists and other health professionals who have been requested by, or on behalf of, a care recipient but are not under contract to the approved provider also do not require police checks. The policy intention is to allow for reasonable judgments to be made.

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

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

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

The difference between a contractor and an independent contractor is generally decided on the basis of the degree of control that is exercised over the person's work. A precise determination of whether a contractor is under the control of an approved provider can be difficult, and whether someone is a staff member or an independent contractor is a matter that might ultimately be determined by the courts.

To assist employers to determine whether an individual is a staff member or an independent contractor, a Contractor Decision Tool is available at the business.gov.au website.

Further information about police checks is available:

- by phone: **1800 200 422**
- in writing to:
  - the Department's inbox "Police Checks@health.gov.au"
  - Police Checks MDP 452
    Department of Health and Ageing
    GPO Box 9848
    Canberra ACT 2601
- online: at the Police Certificate Guidelines for Aged Care Providers website.

5. Quality Reporting Program

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

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

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

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

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

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

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

6. Qualifications of staff and workers

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

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

With the introduction of CDC in new Home Care Packages from July 2013, and in all packages from July 2015, it is important for all staff and workers to understand what

CDC means, including how care and services should be delivered on a CDC basis. In many cases, this will require additional training and support for staff and workers.

PART G – CONSUMER FEES

Covered in this part

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

1. Overview

1.1 Arrangements from 1 July 2013

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

These arrangements will continue to apply from 1 July 2013 under the Home Care Packages Program – as set out in this Part.

1.2 Arrangements from 1 July 2014

As part of the *Living Longer Living Better* aged care reforms, from 1 July 2014 (subject to the passage of legislation), new arrangements will apply to the way that the Home Care subsidy and fees are calculated.

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

Further information about these changes will be available prior to the introduction of the new subsidy and fee arrangements in July 2014. The Home Care Packages Guidelines will be updated in the future to explain the new income testing and care subsidy reduction arrangements.

2. Determining consumer fees

The maximum fee that a consumer can be asked to pay in care recipient contribution is determined by the legislation[13].

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

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

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

The maximum amount that can be levied depends on the consumer's income and unavoidable expenses such as pharmaceutical bills, rent, utilities and other living expenses. The maximum amount payable is updated twice a year and published on the Department's website.

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

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

The legislation[14] also requires that information about fees, including how fees are calculated and the fees payable, is included in the Home Care Agreement between the consumer and the approved provider.

[13] Include updated references to legislation – currently paragraphs 56.2(b) and 56.3(b) of the Act referring to the User Rights Principles

[14] Updated references to legislation will be added at a later date – currently paragraph 23.95(a) of the *User Rights Principles*

3. Payment of consumer fees in advance

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

4. Review of consumer fees

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

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

5. What constitutes income?

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

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

PART H – SUPPLEMENTS

Covered in this part

- Eligibility for supplements
  - Dementia and Veterans' supplements
  - Oxygen supplement
  - Enteral Feeding supplement
  - Viability supplement
  - Aged Care Workforce supplement

1. Eligibility for Supplements

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

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

1.1 Dementia and Veterans' Supplements

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

There will also be a new funding supplement for veterans with an accepted mental health condition. Like the Dementia Supplement, the Veterans' Supplement will provide an extra 10% funding on top of the basic subsidy level for the relevant Home Care Package level for eligible consumers. Veterans with a Department of Veterans' Affairs accepted mental health condition will be eligible for the supplement and providers will automatically receive the supplement for eligible consumers from 1 July 2013. An approved provider can receive either the Dementia Supplement or the Veterans' Supplement in respect of an eligible consumer.

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

A Dementia and Veterans' Supplement Working Group comprising clinicians, service providers, consumers and the Department of Veterans' Affairs is providing advice to the Department on the implementation arrangements for these supplements.

A discussion paper on the proposed implementation arrangements, including the eligibility requirements, will be available on the *Living Longer Living Better* website in April/May 2013.

1.2 Oxygen supplement

An oxygen supplement is currently available to eligible consumers receiving an EACH or EACHD package, if clinically required. During consultations to date, stakeholders have suggested that eligibility for the oxygen supplement, which is based on clinical need, should be the same across all Home Care Package levels. Future arrangements are currently being considered.

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

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

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

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

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

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

The rates for the oxygen supplement are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the Department of Health and Ageing website.

1.3 Enteral feeding supplement

An enteral feeding supplement is currently available to eligible consumers receiving an EACH or EACHD package, if clinically required. During consultations to date, stakeholders have suggested that eligibility for the enteral feeding supplement, which is based on clinical need, should be the same across all Home Care Package levels. Future arrangements are currently being considered.

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

A higher supplement may be approved when, for example:

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

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

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

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

The rates for the enteral feeding supplements are the same as the Residential Aged Care Supplements (Care Related) rates. The rates are available on the Department of Health and Ageing website.

1.4 Viability supplement

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

The viability supplement is dependent on the consumer's location according to their Accessibility Remoteness Index of Australia (ARIA) score. The amount of the supplement varies depending on the remoteness of the consumer's location. ARIA scores for geographical locations in Australia can be found on the Department of Human Services website.

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

Information about the viability supplement including the subsidy rates is available on the Department of Health and Ageing website.

1.5 Aged Care Workforce Supplement

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

Home care providers will receive more information on the requirements of the Aged Care Workforce Compact and Aged Care Workforce Supplement in the lead up to the commencement of the Aged Care Workforce Supplement on 1 July 2013. Organisations will need to consider this information when deciding whether to elect to receive the Aged Care Workforce Supplement.

Further information is also available on the *Living Longer Living Better* website.

PART I – ADMINISTRATIVE ARRANGEMENTS FOR APPROVED PROVIDERS

Covered in this part

- Conditions of allocations to replace agreements
  - Conditions of allocation
  - Commencement of packages
- Variation and transfer of places (packages)
  - Variations provisional places
  - Exchange of Care Type (Variations operational places)
  - Transfer of places
  - Surrender or relinquishment of places
- Financial reporting to the Department
- Claims process
  - Home care subsidy payments
  - Home care subsidies are GST free
  - Other taxation requirements

1. Conditions of allocation to replace agreements

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

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

From 1 July 2013, there will no longer be a requirement for approved providers to enter into an agreement with Commonwealth in respect of allocations of new Home Care Packages. This change will take effect once the transitional provisions in the *Aged Care Act 1997* and the relevant Aged Care Principles commence.

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

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

1.1 Conditions of allocation

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

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

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

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

1.2 Commencement of packages

An allocation of packages to an approved provider takes effect when the Secretary of the Department (or delegate) determines that the approved provider is in a position to provide care in respect of those packages.

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

If the package has been allocated on a provisional basis, the approved provider must advise the Department in writing when they are able to commence providing services. Providers have two years to make packages operational. An approved provider may apply in writing to the Secretary under sections 15-1 and 15-3 of the Act using the form titled, *Application for a Determination that an Approved Provider is in a Position to Provide Care – Home Care*. An application form will be available on the Department's website.

Once this information has been considered by the Department, the delegate will make a determination under section 15.1 of the Act, and once approved this will

enable the approved provider to commence claiming a subsidy for the package. Such determinations cannot be backdated.

2. Variations and transfer of places (packages)

The Act provides that an approved provider can apply to the Department to vary or transfer places (Home Care Packages) in certain circumstances.[15]

2.1 Variations – provisional places

An approved provider who has been granted a provisional allocation of places may apply to the Secretary for a variation of the provisional allocation.

Further information is available on the application form titled, *Application for a Variation of a Provisional Allocation of Places*. This form will be available on the Department's website.

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

2.2 Exchange of Care Type (Variations – operational places)

Where a package is operational, an approved provider may apply in writing to the Secretary to exchange the type of care to which the allocation is subject under sections 18-2 to 18-4 and Division 14 of the Act.

Further information is contained in the application form titled, *Application to Exchange Care Type*. The application form will be available on the Department's website.

The exchange cannot take effect unless it has been approved by the Secretary.

2.3 Transfer of places

An approved provider may apply in writing to the Secretary of the Department to transfer operational Home Care Packages under sections 16-1 and 16-2 of the Act. A transfer of a package cannot take effect unless it has been approved by the Secretary.

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

[15] Refer to legislative provisions

Further information, including the application form titled, *Application to Transfer Aged Care Places other than Provisionally Allocated Places to Another Provider* will be available on the Department's website.

2.4 Surrender or relinquishment of places

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

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

3. Financial reporting to the Department

Approved providers are required to provide an audited Financial Accountability Report (FAR) and Statement of Compliance to the Department each financial year. These requirements are currently specified in the relevant agreements for the CACP, EACH and EACHD packages.

While these agreements will no longer have effect from 1 July 2013, providers must continue to provide financial reporting information to the Department. The requirements will be included in the new legislative framework which will apply from 1 July 2013.

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

The Aged Care Financing Authority (ACFA) has been asked to provide advice to the Minister for Mental Health and Ageing by 30 June 2013 on cost effective options for improving the collection of appropriate financial data from aged care providers, including residential care and home care providers.

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

4. Claims Process

4.1 Home care subsidy payments

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

There is information on the subsidy amounts for the Home Care Packages at Part E, Section 1 and on the Department of Health and Ageing's website.

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

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

To enable initial payments, or to change bank details to enable ongoing payments, approved providers must supply their aged care service's bank details to the Department of Human Services via a form. The form is available on the Department of Human Services website at: Department of Human Services —For Health Professionals>Aged Care>Forms. The form is titled *Add or Change Approved Aged Care Service's Bank Details*.

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

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

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

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

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

To register to use the ACOC website to view eACCRs, approved providers need to complete a registration form. The registration form is available on the Department

of Human Services website at: Department of Human Services —For Health Professionals>Aged Care>Forms.

The form is titled *Register or Amend Access for Aged Care Online Claiming Viewing electronic Aged Care Client Records*. Further information about claiming for Home Care Packages is available at: Department of Human Services —For Health Professionals>Aged Care.

Additionally, information about online claiming is available at: Department of Human Services —For Health Professionals>Aged Care>Online-claiming.

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

4.2 Home care subsidies are GST free

Home Care subsidies are considered to be "GST free" under section 38.30 and 38.35 of the *A New Tax System (Goods and Services Tax) Act 1999*.

4.3 Other taxation matters

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

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

PART J – INTERFACE WITH OTHER PROGRAMS

Covered in this part

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

1. Interface with other programs

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

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

More detailed information about the individual programs will be available from the **My Aged Care** website from 1 July 2013.

2. Commonwealth Home Support Program

2.1 Overview of program

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

The Home Support Program will incorporate the existing Commonwealth HACC Program, the National Respite for Carers Program (NRCP), the Day Therapy Centres

(DTC) Program, and the Assistance with Care and Housing for the Aged (ACHA) Program.

2.2 Interface with the Home Care Packages Program

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

3. Home and Community Care (HACC)

3.1 Overview of program

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

The Commonwealth HACC program does not apply in Western Australia and Victoria. In these states, HACC services for consumers of all ages are delivered via a jointly funded Commonwealth/State program which is administered by state governments. Providers in these states should refer to the relevant HACC program guidelines, which should be broadly consistent with guidance in the Commonwealth HACC Program Manual.

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

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

3.2 Interface with the Home Care Packages Program

Generally, HACC services should not be provided to people who are already receiving services under their Home Care Package that are similar to service types funded through the HACC Program.

3.2.1 Accessing services from HACC service providers as part of a Home Care Package

HACC services may be provided to people in receipt of Home Care Package services if the services are being delivered by a HACC service provider on behalf of the home

care provider, for example, personal care, social activities, or respite. In these cases, the full cost for providing the service will be paid out of the Home Care Package budget.

3.2.2 Accessing HACC services in addition to a Home Care Package

As much as possible, consumers' care needs should be addressed through their Home Care Package.

Access to additional HACC services may also be considered in the following circumstances:

- In an emergency, or when a carer is not able to maintain their caring role. These instances should be time limited, monitored and reviewed.
- For the provision of specific items, including:
  - home modifications that allow the consumer to live and move safely about the house; and/or
  - goods and equipment that assist a consumer to cope with a functional limitation and to maintain their independence.

Where Home Care Package funds have been fully allocated to address priority care needs, access to additional HACC support and maintenance services may be also considered. This may include:

- social support;
- centre-based day care;
- respite;
- meals;
- home maintenance; or
- transport.

These arrangements should not unfairly disadvantage other members of the HACC target population (either the Commonwealth HACC target population or the HACC Program target population in Western Australia and Victoria).

The consumer would be expected to pay the fees for the HACC service as applicable.

4. National Respite for Carers Program (NRCP)

4.1 Overview of program

The Australian Government funds a range of home support services and programs for carers of frail older people. The National Respite for Carers Program (NRCP) is designed to contribute to the support and maintenance of caring relationships between carers and their dependent family members. The NRCP respite services

provide community based respite care in a variety of settings, including in carers' homes, day centres, host families and overnight cottages.

4.2 Interface with the Home Care Packages Program

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

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

5. Residential respite

5.1 Overview of program

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

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

5.2 Interface with the Home Care Packages Program

A consumer receiving services under a Home Care Package (at any level) can access residential respite care if they have been assessed as eligible for residential respite care by an ACAT, and a respite place is available. A residential respite subsidy will be paid to the respite facility to support this care. The home care subsidy cannot be used to pay consumer fees/contributions for respite care.

6. Day Therapy Centres program

6.1 Overview of program

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

6.1.1 Therapy and Services

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

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

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

6.2 Interface with the Home Care Packages Program

As much as possible, it is expected that consumers' care needs will be addressed through their Home Care Package. However, where day therapy services have been identified in the consumer's care plan, and package funds have been fully allocated to priority care needs, services may be provided through the DTC program.

DTC service providers should give priority to those consumers who do not receive Home Care Packages.

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

7. Assistance with Care and Housing for the Aged (ACHA) program

7.1 Overview of program

The Assistance with Care and Housing for the Aged (ACHA) program supports older people who are not in secure housing arrangements, or who are homeless. The program helps consumers live in, participate, and feel included in the community of their choice, by facilitating access to sustainable and affordable housing.
This includes activities such as locating suitable accommodation, providing advice on housing applications, coordinating removals and assisting access to accommodation-related legal and financial services.

The type of assistance provided for ACHA consumers varies to suit the needs of the individual. ACHA is also a program that links consumers to appropriate community care and welfare services, not a program that provides ongoing care.

Consumers may be referred to ACHA from a range of sources, including:

- general practitioners;
- Aged Care Assessment Teams;
- social workers;
- geriatricians;
- hospitals; and
- community health workers.

Consumers do not need a written referral. Consumers may also self-refer or be referred by a carer or family member.

Further information about accessing ACHA is available at the Department of Health and Ageing ACHA website.

7.2 Interface with the Home Care Packages Program

ACHA is a guided referral program to support people facing homelessness in the community. The home care subsidy cannot be used to provide permanent accommodation, assistance with home purchases, mortgage payments or rental assistance independently or as part of the ACHA program (see Part E, Section 2.3).

8. Transition Care program

8.1 Overview of program

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

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

8.2 Interface with the Home Care Packages Program

A Home Care Package consumer is able to access transition care if they have been assessed as eligible for transition care by an ACAT. This will involve the consumer taking leave from their Home Care Package.

Consumer fees must not be charged by the home care provider where the consumer takes transition care leave, as the transition care provider may ask the consumer to pay a care fee as a contribution to the cost of their care.

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

9. Community Visitors Scheme

9.1 Overview

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

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

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

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

The Community Visitors Scheme is funded by the Australian Government and operates in every State and Territory.

9.2 Interface with the Home Care Packages Program

From 1 July 2013, the Community Visitors Scheme will be expanded to Home Care Packages. The expansion will also provide opportunities to use innovative technology in home care environments to encourage social networking and help reduce social isolation.

10. Disability programs

10.1 Overview of program

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

The Australian Government provides funding for these services for people who are aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) to access specialist disability services provided by state and territory

governments. This enables older people who have been receiving state and territory disability services to choose whether they wish to continue to access these disability services, or receive aged care services instead, in order to receive care most appropriate to their needs.

These arrangements came into place on 1 July 2012.

10.2 DisabilityCare Australia

From 1 July 2013, DisabilityCare Australia (the national disability insurance scheme) will commence initially in South Australia, Tasmania, the Hunter region in New South Wales, and the Barwon region in Victoria. The Australian Capital Territory will join DisabilityCare Australia on 1 July 2014.

DisabilityCare Australia will provide reasonable and necessary supports to participants as per section 34 of the *National Disability Insurance Scheme Act 2012*. To become a participant of DisabilityCare Australia, a person must meet:

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

Each of these requirements is specified in Part 1 of the *National Disability Scheme Act 2012*.

10.3 Interface with the Home Care Packages Program

A person cannot be a participant of DisabilityCare Australia or receive disability services at the same time as they receive aged care services (including a Home Care Package).

Younger people with a disability (including those with younger onset dementia) are not excluded from Home Care Packages, if they are assessed by the ACAT as eligible. However, all other care options of appropriate care should be explored and exhausted in the first instance.

The final decision to accept a younger person on a Home Care Package is with the approved provider, as they evaluate the appropriateness of their service to meet the care needs of the younger person.

11. Aids and equipment schemes

11.1 Overview of program

State and territory governments operate specialised aids and equipment schemes to assist people with disabilities, including older people. There are sometimes different

eligibility and access policies between the schemes. For more information, refer to the individual state or territory government scheme.

11.2 Interface with the Home Care Packages Program

The Home Care Packages Program is not intended to be an aids and equipment scheme. While some aids and equipment can be provided to a consumer where this is identified in their care plan (within the limit of the package funding), it is expected that consumers will continue to be able to access specialised aids and equipment schemes where there is a need for support.

12. Palliative Care

12.1 Overview of palliative care

A person receiving palliative care will have an active, progressive and far-advanced disease, with little or no prospect of cure. The aim of palliative care is to achieve the best possible quality of life for the individual patient, their carers and family. Palliative care may involve coordination of the skills and disciplines of many services.

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

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

As part of the aged care reform package, the Government will also provide access to specialist palliative care and advance care planning expertise for aged care providers and GPs caring for recipients of aged care services, through innovative advisory services. The Government has also funded the development of an online education and training package to assist health workers, including general practitioners, nurses and care workers to implement the principles of the *Guidelines for a Palliative Approach for Aged Care in the Community Setting.* The online training will be available from June 2013 on the Palliative Care Online website.

This aligns with the *National Palliative Care Strategy*, which aims to raise awareness of and information about palliative care and its benefits, and help build a skilled workforce across the health system to deliver quality palliative care. This will help aged care recipients to remain in familiar surroundings as their care needs change.

12.2 Interface with the Home Care Packages Program

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

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

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

13. Hospital in the Home

13.1 Overview of program

Hospital in the Home (HITH) is the delivery of acute and post-acute care in the patient's home as a substitute for being in hospital. HITH care is provided by clinicians from many specialties, eg infectious diseases, gerontology, general practice, emergency medicine, orthopaedics, cardiology, paediatrics, rehabilitation, respiratory, surgery and haematology.

13.2 Interface with the Home Care Packages Program

A person can continue to access services under a Home Care Package while an inpatient on the HITH program. However, where clinical services are being provided to the person through the HITH Program, these services should not be provided under the person's Home Care Package.

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

14. Department of Veterans' Affairs Programs

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

Through DVA, eligible veterans and war widows/widowers may also access a range of other services, for example the Coordinated Veterans' Care Program, Veterans'

Home Care, community nursing, allied health services such as physiotherapy and podiatry, counseling services and transport for health care. For further information on these programs, including guidelines and fact sheets, refer to the Department of Veterans' Affairs website.

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

14.1 Veterans' Home Care program

14.1.1 Overview of program

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

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

14.1.2 Interface with the Home Care Packages Program

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

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

The veteran or war widow/widower should not be accessing the same service tasks simultaneously from VHC and the Home Care Package, eg showering. In some instances, however, the veteran or war widow/widower may supplement the care

provided under a Home Care Package with some VHC services, such as additional respite care, if the Home Care Package is not sufficient to meet the veteran's or war widow/widower's needs.

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

Any approval for additional services through the VHC program must be negotiated between the veteran or war widow/widower, the VHC Assessment Agency and the approved provider of the Home Care Package.

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

14.2 Coordinated Veterans' Care Program

14.2.1 Overview of program

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

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

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

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

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

14.2.2 Interface with the Home Care Packages Program

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

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

In some instances, the veteran or war widow/widower may supplement the care provided under a Home Care Package with other DVA services (see Section 14.1 of this Part – Veterans' Home Care Program).

14.3 Department of Veterans' Affairs Community Nursing Program

14.3.1 Overview of program

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

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

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

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

14.3.2 Interface with the Home Care Packages Program

Although not intended to provide comprehensive clinical services, some nursing and allied health services may be provided as part of Home Care Level 1 and 2 packages. Where there is an assessed clinical need, and these services are not being provided

under a Home Care Level 1 or 2 package, a DVA-contracted community nursing provider may deliver clinical nursing services.

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

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

14.4 Department of Veterans' Affairs Rehabilitation Appliances Program

14.4.1 Overview of program

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

The program provides aids and appliances:

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

The equipment should be:

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

14.4.2 Interface with the Home Care Packages Program

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

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

14.5 Veterans' Transport for Treatment

14.5.1 Overview

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

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

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

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

Reimbursement (D800) – Eligible persons can arrange and pay for their own transport and seek reimbursement from DVA. Travel, meals and accommodation may be payable for the entitled person and their attendant (if medically required). Entitled persons are able to arrange taxi travel themselves by contacting their local taxi company. Reimbursement of a taxi fare will only be approved if the age criterion or any one of the medical criteria is met or public, community or private transport are unavailable.

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

- are aged 80 years or older; or
- are legally blind; or
- have any specific medical conditions (refer to DVA Fact Sheet); or
- were unable to use public, community or private transport due to lack of availability.

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

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

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

14.5.2 Interface with the Home Care Packages Program

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

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

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

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

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

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

PART K – APPENDICES

Appendix A – Glossary of Terms

Term	Meaning
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team. ACATs are known as Aged Care Assessment Services (ACAS) in Victoria
ACFA	Aged Care Financing Authority
Act	*Aged Care Act 1997*
approved provider	A person or organisation approved by the Department to operate Australian Government funded aged care services
CACP	Community Aged Care Package
consumer/care recipient	A person who is a receiving a Home Care Package funded by the Australian Government. In the *Aged Care Act 1997*, this person is described as a "care recipient". In these Guidelines, the term "consumer" is used more broadly to also include people acting on behalf of the consumer, eg carers, spouses or partners.
claim form	The Department of Human Services form used by approved providers to claim home care subsidy payments
Commonwealth HACC program	Provides home and community care services for frail older people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over. The Commonwealth HACC program does not apply in Victoria and Western Australia
CDC	Consumer Directed Care
Department	Department of Health and Ageing
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home package
EACHD	Extended Aged Care at Home Dementia package
Home and Community Care (HACC) Program	In all jurisdictions except Victoria and Western Australia, the state governments provide basic maintenance and support services for younger people with a disability and their carers who live in the community and whose capacity for independent living is at risk. In Victoria and Western Australia, HACC services for consumers of all ages are

Term	Meaning
	delivered via a jointly funded Commonwealth/State program which is administered by the state governments
home care	A type of aged care for which a home care subsidy is payable under Part 3.2 of the Act
Home Care Agreement (previously a Care Recipient Agreement)	An agreement signed by a consumer and an approved provider outlining rights and responsibilities and what services will be provided to the consumer under the Home Care Package
Home Care Standards (previously the Community Care Common Standards)	The Standards are set out in the *Quality of Care Principles 1997*
Home Care Packages Program	The Australian Government program that provides subsidies for Home Care Packages aimed at supporting people to remain living at home for as long as possible
home care subsidy	The subsidy payable by the Australian Government for providing home care under Part 3.2 of the Act
NRCP	National Respite for Carers Program
Principles	Aged Care Principles made under subsection 96.1(1) of the *Aged Care Act 1997*
re-ablement	The use of timely assessment and targeted interventions to assist people to maximise their independence, choice and quality of life and minimise support required – to enable people to actively participate and remain engaged in their communities
VHC	Veterans' Home Care