The Residential Care Manual
TABLE OF CONTENTS

CHAPTER 1
INTRODUCTION 1

CHAPTER 2 9
BECOMING AN APPROVED PROVIDER 9
EXTRA SERVICE PLACES 32
FEES AND PAYMENTS 37
ACCREDITATION AND QUALITY OF CARE 45
CERTIFICATION 52

CHAPTER 3 63
APPROVAL OF RESIDENTS 63
CLASSIFICATION OF RESIDENTS 71

CHAPTER 4 89
FUNDING FOR PERMANENT RESIDENTIAL AGED CARE 89
RESIDENTIAL RESPITE CARE 154
CAPITAL GRANTS FOR RESIDENTIAL AGED CARE 168

CHAPTER 5 174
RESIDENTS’ RIGHTS 174
PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS 191
SPECIFIED CARE AND SERVICES 235
PROVIDERS’ RESPONSIBILITIES AND NON-COMPLIANCE 253
COMPULSORY REPORTING 267
CHAPTER 1

From 18 September 2013, the *Aged Care Act 1997* is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services.

To reflect these changes, all references in this Manual to the former Department of Health and Ageing have been changed to the Department of Social Services.

However, it will take some time for the practical application of these changes to flow through. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at [www.health.gov.au](http://www.health.gov.au).

The *Australian Aged Care Quality Agency Act 2013* provides for the establishment of a new Australian Aged Care Quality Agency (the Quality Agency) on 1 January 2014. This new body is the sole agency providers of Australian Government funded aged care will deal with in relation to quality assurance of the aged care services they deliver. The new Quality Agency replaced the Aged Care Standards and Accreditation Agency Ltd (ACSAA Ltd). The Quality Agency commenced carrying out functions relating to residential aged care services on 1 January 2014 and will commence functions relating to home care services on 1 July 2014.

INTRODUCTION

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

**Welcome to the Residential Care Manual 2013**

*This Manual has been updated and revised to help approved providers comply with their responsibilities under the Aged Care Act 1997 (the Act), and to assist staff of aged care services to understand the regulation of residential aged care.*
Australian Government-subsidised residential aged care is governed by the Act and the Aged Care Principles and is administered by the Department of Social Services (DSS). The Act covers a number of types of aged care including residential care, home care (Levels 1 to 4) and flexible care (Multi-Purpose Services, Innovative Care and Transition Care). However, the purpose of this Manual is to provide a plain English guide to Government-subsidised residential aged care only.

Government-subsidised residential aged care provides a range of supported accommodation services for older people who are unable to continue living independently in their own homes and is based on a set of objectives outlined in the Act. See legislative reference – section 2-1, Aged Care Act 1997.

These objectives include:

- promoting high quality care and accommodation
- protecting the health and well-being of residents
- helping residents enjoy the same rights as all other people in Australia
- ensuring that care is accessible and affordable for all residents
- planning effectively for the delivery of aged care services
- ensuring that aged care services and funding are targeted towards people and areas with the greatest needs
- encouraging services that are diverse, flexible and responsive to individual needs
- providing funding that takes account of the quality, type and level of care
- providing respite for families and others who care for older people
- promoting ‘ageing in place’ - that is, help older people stay where they want to live, by linking care and support services.

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

Australian Government subsidies can only be paid for a resident:

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

While most of the funding comes via DSS, residential aged care for veterans is also funded by the Department of Veterans’ Affairs. Although the Government funds the majority of approved residential aged care services, residents are asked to make a contribution to the cost of their care and accommodation where they can, by paying fees directly to an approved provider. The legislation regulates the maximum fees an approved provider can ask a resident to pay. All residents in Government-subsidised residential aged care can be asked to pay a basic daily fee as a contribution towards living expenses, such as meals, cleaning, laundry, heating and cooling in the service.

Residents with sufficient assets may be asked to pay an accommodation payment. Accommodation payments include accommodation bonds for low-care residents or
residents who receive high-care on an extra service basis and accommodation charges for residents with high-care needs. Residents can only be asked for an accommodation payment if the aged care service is certified. Residents who have the means will also make a contribution towards their costs of care, through an income tested fee.

The Government can assist older people experiencing genuine financial hardship by stepping in and paying the shortfall in fees these residents would normally pay an approved provider. Hardship provisions also ensure that these residents have equal access to residential aged care and are not discriminated against in favour of residents who can afford to pay fees themselves.

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

In order to meet the objectives of the Act, approved aged care providers must meet building requirements for certification (where they have applied for certification) and for accreditation, as overseen by the Quality Agency. They must also adhere to prudential regulation requirements. Under Government-subsidised residential aged care, protections are also afforded to residents by the Aged Care Commissioner and the Aged Care Complaints Scheme.
Structure of the Aged Care Act 1997

Chapter 1 - Introduction

Chapter 2 - Preliminary matters relating to subsidies
Part 2.1 Approval of providers
Part 2.2 Allocation of places
Part 2.3 Approval of care recipients
Part 2.4 Classification of care recipients
Part 2.5 Extra service places
Part 2.6 Certification of residential care services

Chapter 3 - Subsidies
Part 3.1 Residential care subsidy
Part 3.2 Home care subsidy
Part 3.3 Flexible care subsidy

Chapter 4 - Responsibilities of approved providers
Part 4.1 Quality of care
Part 4.2 User rights
Part 4.3 Accountability etc.
Part 4.4 Consequences of non-compliance

Chapter 5 - Grants
Part 5.1 Residential care grants
Part 5.4 Accreditation grants
Part 5.5 Advocacy grants
Part 5.6 Community visitors grants
Part 5.7 Other grants

Chapter 6 - Administration
Part 6.1 Reconsideration and review of decisions
Part 6.2 Protection of information
Part 6.3 Record keeping
Part 6.4 Powers of officers
Part 6.4A Complaints
Part 6.5 Recovery of overpayments
Part 6.6 Aged Care Commissioner
Part 6.7 Aged Care Pricing Commissioner

Chapter 7 - Miscellaneous

Schedule 1 - Dictionary
Structure of the Residential Care Manual 2013

- Table of contents

Chapter 1 - Executive summary
- Executive summary

Chapter 2 - Approved provider, allocations, accreditation and certification
- Becoming an approved provider
- Allocated places
- Extra service places
- Accreditation and quality of care
- Certification

Chapter 3 - Approval and classification of residents
- Approval of residents
- Classification of residents

Chapter 4 - Funding for residential aged care, residential respite and capital grants
- Funding for permanent residential aged care
- Residential respite care
- Capital grants for residential aged care

Chapter 5 - Caring for residents, and providers’ responsibilities
- Residents’ rights
- Protection and responsibilities relating to accommodation bonds
- Specified care and services
- Providers’ responsibilities and non-compliance
- Compulsory reporting
- Record keeping

References
All references to websites are hyperlinked. Addresses, contact numbers, website links and all other reference information in the Manual are correct as at 1 August 2013.

Guide to Terms
The following list includes some of the terms used throughout the Manual and explains the way in which they are used. A list of definitions is also included in the Dictionary at the end of the Act. Where terms used in the Manual are not defined, they have their plain English meaning. See legislative reference – Schedule 1 - Dictionary, Aged Care Act 1997.

Aged care service
In this Manual, this is the term used to describe a residential aged care service operated by an approved provider. It replaces the older terms “nursing home” and “hostel”.
Approved provider
An approved provider is a person or body who is approved by the Department of Social Services to provide Government-subsidised residential, home or flexible aged care. An approved provider may be approved for a single care type or may be approved for a combination of these care types. In this Manual, it is assumed that an approved provider is approved to provide residential aged care. An approved provider is referred to either in full, as an approved provider, or in some instances as a provider.

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

A resident is someone living in a residential aged care service. All references to resident also cover resident and/or their representative as appropriate. A resident’s representative may be:
- a guardian appointed by a tribunal
- a person to whom the resident has formally delegated decision-making power (‘power of attorney’)
- a person nominated by the care recipient as his or her representative.

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

DSS
All references to the acronym DSS mean the Department of Social Services.

DHS
All references to the acronym DHS mean the Department of Human Services.

DVA
All references to the acronym DVA mean the Department of Veterans’ Affairs.

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

Minister
All references to the Minister mean the Minister with responsibility for ageing.
Operational places
Within an aged care service, an operational place is a place that is either occupied by a resident, or if not occupied, is available to be occupied.

Penalty unit
In a law of the Commonwealth or a Territory Ordinance, unless the contrary intention appears, one penalty unit means $170. See legislative reference – section 4AA, Crimes Act 1914.

Resident
Refer to the definition of care recipient for this definition.

Secretary
All references to the Secretary mean the Secretary of the Department of Social Services, unless stated otherwise - e.g. Secretary of the Department of Human Services. References to the Secretary may include an officer of the Department of Social Services holding, or performing powers of the Secretary as a delegate under the Act.
REFERENCES

*Addresses, contact numbers and website links are correct as at 1 January 2014.*

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**Department of Social Services**


**Aged Care Provider Line**

For providers of aged care services.

ph 1800 057 616 (national)

**Aged Care Act 1997, Aged Care Principles**


**Dictionary - Aged Care Act 1997**

A list of definitions is in the Dictionary at the end of the Act, which can be accessed via ComLaw at [www.comlaw.gov.au](http://www.comlaw.gov.au)

**ComLaw**


**Forms - all**

All departmental forms are available on the following website


**Legislation**

ComLaw provides access to all Commonwealth legislation, including the Act, Principles and any other legislation mentioned in this Manual.


**My Aged Care**

*My Aged Care* is a consumer website and national phone line providing up-to-date information about aged care services.

My Aged Care provides consumers and their families, friends and carers with information on aged care, healthy and active living and support to find aged care services in their local area.

[www.myagedcare.gov.au](http://www.myagedcare.gov.au)

ph 1800 200 422
CHAPTER 2

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The new Quality Agency replaced the Aged Care Standards and Accreditation Agency Ltd (ACSAA Ltd). The Quality Agency commenced carrying out functions relating to residential aged care services on 1 January 2014 and will commence functions relating to home care services on 1 July 2014.

**BECOMING AN APPROVED PROVIDER**

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**OVERVIEW**

To receive Australian Government subsidies for providing aged care, an aged care service must be operated by an organisation that has been approved by the Department of Social Services (DSS) and has an allocation of places - i.e. an approved provider. If providing residential care, the facilities must also be accredited by the Quality Agency. For the approved provider to be eligible to receive subsidies, the care recipient must be assessed by
an Aged Care Assessment Team or Aged Care Assessment Service as eligible to receive that type of care.

To become an approved provider, an applicant only needs to submit one application, even if they plan to operate in more than one state or territory. Approval can be for one or more types of care - i.e. residential, home or flexible care. See legislative reference - section 8-1(2)(a), Aged Care Act 1997.

**Becoming an approved provider**

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

In order to become an approved provider:

- the applicant must make an application in a form approved by the Secretary. See legislative reference - 8-2(2), Aged Care Act 1997
- the applicant must be a corporation as defined in the Act. See legislative reference - section 8-1(1)(b), Aged Care Act 1997
- the applicant must be suitable to provide aged care. See legislative reference - section 8-1(1)(c) and 8-3, Aged Care Act 1997
- none of the applicant’s key personnel can be a disqualified individual as defined in section 10A-1 of the Act. See legislative reference - section 8-1(1)(d), Aged Care Act 1997.

State, territory and local government authorities are taken to be approved providers unless the approval has lapsed or been revoked. See legislative reference - section 8-6, Aged Care Act 1997.

**How to apply for approval as a provider of aged care**

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

- read the Guidelines for Applicants Seeking Approval to Provide Aged Care
- read the relevant sections of the Act and Aged Care Principles
- make an application on the approved form and include the required documents, and
- obtain a National Criminal Record History Check from the Australian Federal Police or another agency accredited by CrimTrac, for the applicant organisation and each of their associated key personnel. Original documents must be included with the application. See also section on Police checks in chapter 5 on Providers’ Responsibilities and Non-compliance in this Manual.

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

**Assessing an application to become an approved provider of aged care**

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

- the application
- information from:
  - the Quality Agency
  - the Australian Federal Police or another agency accredited by CrimTrac
  - the Aged Care Complaints Scheme
  - organisations which can independently investigate the financial probity and credit/debt of an applicant.

**When does an approval come into force?**

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

**When does an approval not come into force?**

For a provider approved on or after 1 January 2009, an approval will not come into force if the provider does not receive an allocation of places, a provisional allocation of places or a transfer of allocated places within two years from the day the approval is given. See legislative reference - subsections 8-1(3) and 8-1(4), Aged Care Act 1997.

**When does an approval lapse?**

An approval which is in force will lapse if the approved provider ceases to have allocated or provisionally allocated places or a transfer of allocated places has not occurred. See legislative reference - section 10-2, Aged Care Act 1997.

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

- no allocation of places was in effect
- no provisional allocation of a place was in force
- a transfer of places had not occurred.

An approval ceases if the approval does not come into force in respect of any aged care service within two years from the date on which the approval is given. See legislative reference - section 10-2, Aged Care Act 1997.

**Can an approval be revoked?**

Approval as a provider can be revoked if:

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

Approval as a provider can also be revoked as a sanction where an approved provider has not met its responsibilities. See legislative reference - section 66-1 - Aged Care Act 1997.

Suitability to provide aged care
The Secretary must consider a range of issues when assessing an applicant’s suitability to provide aged care, including:
- the suitability and experience of the applicant’s key personnel
- ability of the applicant to provide, and any experience, in providing aged care
- ability of the applicant to meet relevant standards for providing aged care
- commitment of the applicant to the rights of residents
- the applicant’s record of financial management and methods for ensuring sound financial management
- if the applicant has been a provider of aged care, its conduct as a provider and its compliance with its responsibilities and obligations arising from receiving any Government payments for providing aged care
- if key personnel are also relevant key personnel in common with a current or former approved provider, the record and suitability of that approved provider will be considered
- the conduct and experience of the applicant other than as a provider of aged care
- any other matters specified in the Approved Provider Principles.

Circumstances affecting suitability
When giving a provider written notice of their approval as a provider of aged care, the Secretary can specify any circumstance that would materially affect their suitability to provide aged care. The Secretary must agree to any changes to those specified circumstances before they are made. See legislative reference - sections 8-5(3) and (4) and section 63-1C, Aged Care Act 1997.

For example, if an approved provider has an ongoing arrangement to provide care through a management company and the Secretary specified that this is a circumstance that materially affects the provider’s suitability, then the provider must get the Secretary’s agreement before changing its management company or ceasing to engage a management company. An approved provider can be sanctioned (including revocation of its approval) if compliance with this responsibility is not met.

Definition of key personnel
In the Act, the definition of provider’s key personnel includes any person exercising one or more of the functions specified below:
- a member of a group of persons responsible for the executive decisions of the entity, including directors and board members
- a person who has authority or responsibility for, or significant influence over, planning, directing or controlling the activities of the entity
- any person who is, or is likely to be responsible for, the nursing services provided by the service
- any person who is, or is likely to be responsible for, the day-to-day operations of the service.
If a person performs one or more of these specified functions, they are one of the key personnel of the approved provider whatever their job title is and whether or not they are employed by the provider or applicant.

**Notifying the Department of Social Services about changes to key personnel**
Approved providers must inform the Secretary of any change to key personnel within 28 days after the change occurs, by completing the notification of key personnel changes form. See legislative reference - section 9-1(1)(b), Aged Care Act 1997.

An approved provider who does not inform the Secretary about changes to key personnel within 28 days can be sanctioned under Part 4.4 of the Aged Care Act 1997 and is guilty of a strict liability offence of 30 penalty units.

Refer to the References section at the end of this chapter for a link to the notification of key personnel changes form.

**Definition of disqualified individual**
A disqualified individual is anyone who:
- has been convicted of an indictable offence and the conviction is not a ‘spent conviction’
- is an insolvent under administration - i.e. an undischarged bankrupt; or
- is of unsound mind.

An approved provider must take all reasonable steps to ensure that none of its key personnel is a disqualified individual. Failure to do so may result in sanctions being imposed, and an offence of 300 penalty units (per day the offence continues) may apply. See legislative reference - section 10A-2, Aged Care Act 1997; Part 1A, Sanctions Principles 1997. Individual key personnel who are disqualified individuals and continue in their roles may also be liable to criminal prosecution. The maximum term of imprisonment for such an offence is two years.

**Ongoing suitability**
An approved provider must inform the Secretary of any change of circumstances that materially affects their suitability to be a provider of aged care. Apart from other matters, this includes issues relating to the provider’s financial management, such as:
- suspending trading in shares
- appointing an administrator
- appointing a receiver or manager
- entering into voluntary liquidation; or
- lodging an application for winding up.
See legislative reference - sections 8-3 and 9-1(1)(a), Aged Care Act 1997.

An approved provider who does not inform the Secretary about a change in circumstances that materially affects their suitability to be an aged care provider within 28 days can be sanctioned under Part 4.4 of the Aged Care Act 1997 and is guilty of a strict liability offence of 30 penalty units.
At any time, the Secretary can ask an approved provider for information relevant to the provider’s suitability to be an approved aged care provider. See legislative reference - section 9-2(1), Aged Care Act 1997. An approved provider who does not comply with such a request within the time specified in the notice can be sanctioned under Part 4.4 of the Aged Care Act 1997 and is guilty of a strict liability offence of 30 penalty units. See legislative reference - section 9-2(2) and 9-2(3), Aged Care Act 1997.

**Review Rights**

If an application for approved provider status is rejected, the applicant can write to the Secretary at the address listed under the ‘Approved Provider Status Application (postal address)’ heading in the References section following within 28 days of receiving notification, asking the Secretary to reconsider the decision. See legislative reference - section 85-5, Aged Care Act 1997. The applicant should provide reasons for the review and any relevant supporting material.

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

If an application is rejected, an applicant can reapply, at any time, on an approved form.
REFERENCES
Addresses, contact numbers and website links are correct as at 1 January 2014.

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Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Approved Provider Status Application
Send applications to:
Approved Provider Programs Section
Prudential and Approved Provider Regulation Branch
Office of Aged Care Quality and Compliance
Department of Social Services
MDP 454
GPO BOX 9848
CANBERRA ACT 2601

CrimTrac

Forms - all
All departmental forms are available on the following website

Form - notification of changes to key personnel

National Criminal History Record Check - consent, fees, form and guidelines

National Criminal History Record Checks - for more information on national police checks

Questions and queries
ApprovedProviderProgram@health.gov.au
Reviews - reconsideration of a decision
Send requests in writing to:
Approved Provider Programs Section
Prudential and Approved Provider Regulation Branch
Office of Aged Care Quality and Compliance
Department of Social Services
MDP 454
GPO BOX 9848
CANBERRA ACT 2601
ALLOCATED PLACES

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

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

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

Planning the Provision of Residential Aged Care Services
In planning the allocation of residential care services across Australia, the Government seeks to:

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

To meet these objectives, the Government aims to:

- have a national provision of 125 residential and community aged care operational places per 1,000 people aged over 70 years, to be achieved by 2021-22, often called the national planning benchmark
  - these 125 places comprise a ratio of 80 places in a residential setting and 45 places in a community setting
- ensure an equitable balance in the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care
- ensure that people with special needs have access to culturally appropriate, quality care
- provide an appropriate level of respite days
- increase the capacity for care recipients to age in place - i.e. to stay where they are most comfortable, as they age.

Aged care services with places approved before October 1997 can offer low level and high level care, in the absence of a condition specifying otherwise. Places allocated after October 1997 may have conditions attached to them, including whether the place can be used to provide high or low level care.
ALLOCATING PLACES

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

**Level 1 decision: number of places made available nationally**

The Minister for Social Services decides the number of new residential, home and flexible aged care places to be made available to each state and territory for the financial year. See legislative reference - section 12.3(1), Aged Care Act 1997.

These numbers are calculated having regard to the national planning benchmark. Factors relevant to the calculation of the number of new places include state and territory population projections and current service provision levels, being the total number of places which have already been allocated, including operational and provisional allocations (i.e. those which are yet to take effect).

**Level 2 decision: regional distribution of places**

The Secretary decides how the new places that have been made available should be distributed across the aged care planning regions in each state and territory in terms of the number available in each region as well as whether any places are targeted to special needs groups or other key issues such as particular geographic locations, provision for people with dementia or for respite care.

The distribution of new places across aged care planning regions aims to achieve a balance in providing services between:
- metropolitan, regional, rural and remote areas
- people needing differing levels of care, including people with special needs.

Details of the distribution of places to regions are provided in the Regional Distribution of Aged Care Places that is made available on the website at the beginning of each Aged Care Approvals Round (see further information on the Approvals Round below). The Aged Care Approvals Round Essential Guide is available on the following website http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acar

**Level 3 decision: allocation of places**

After deciding on the regional distribution of aged care places, the Secretary invites organisations, interested in providing aged care services, to apply for allocations of the places through the Aged Care Approvals Round (ACAR) process.

Advertisements, inviting providers to apply, are published in major national and regional newspapers in each state and territory. They may also be published on the following website at http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acar or through any other appropriate means. Advertisements will include details of the places made available and the application process.
All applications are competitively assessed by the Secretary against the criteria set out in the Act and Allocation Principles. See legislative reference - sections 14-1 and 14-2, Aged Care Act 1997; Part 5, Division 1, Allocation Principles 1997.

The allocation of places takes into account the number of places made available for the ACAR, the identified needs of an aged care planning region and the merits of each proposal against the criteria. Places can only be allocated to an applicant who has been approved under the Act or will be approved, to provide the type of aged care the places are for once the allocation takes effect (or a provisional allocation) is in force.

NOTIFICATION PROCESS
All applicants are notified of the outcome of their application in writing. The notification to successful applicants includes:

- the number and care type of the places allocated to them (e.g. 10 residential high-care places)
- the aged care planning region in which the service receiving allocations is located
- whether the places are allocated provisionally or take effect immediately
- any conditions related to the allocation.


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

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

A provider cannot receive a subsidy for a provisional allocation.

HOW ALLOCATED PLACES TAKE EFFECT
An allocation takes effect when the Secretary determines that the provider is ready to provide care. There are a number of matters that the Secretary will consider in deciding when a provider is ready to provide care, these considerations may include:

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

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

**CONDITIONS OF ALLOCATION**

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

- conditions that relating to allocations generally. **See legislative reference - section 14-6, Aged Care Act 1997**
- conditions relating to particular allocations. **See legislative reference - section 14-5, Aged Care Act 1997.**

**Conditions applying to particular allocations**

It is a condition of every allocation that the place is allocated for a specified location and a particular aged care service. **See legislative reference - section 14-5, Aged Care Act 1997.** Any care provided for that place must be at that location and service. Some conditions may relate to the allocation while it is provisional, for example, planning or timeline factors in the construction of an aged care service, while others may relate to the ongoing operation of the service.

**About special needs groups**

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

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

**See legislative reference - section 11-3, Aged Care Act 1997.**

People with special needs may also be specified in the *Allocation Principles 1997.*

Special needs groups are considered when the Secretary allocates places to approved providers. **See legislative reference - section 12-5, Aged Care Act 1997.**

Approved providers must be able to provide appropriate care to special needs groups. Providers may also have obligations in relation to people with special needs in their allocation conditions. **See legislative reference - section 14-5, Aged Care Act 1997.**

**Conditions applying to allocations generally**

A number of conditions apply to all allocations generally. **See legislative reference - section 14-6, Aged Care Act 1997; Part 5, Division 2, 4.43, Allocations Principles.**

For example, conditions that apply to all approved providers include:
that an approved provider cannot discharge and re-admit a resident to attract a concessional resident supplement or to charge the resident an accommodation bond

that an aged care service which relocates will only be recognised as a new service if the relocation is:
- to a new purpose-built facility for providing aged care
- or to a totally different catchment area.

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

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

**Applying to vary conditions for operational places**

An approved provider may apply to the Secretary to vary any of the specific conditions which apply to particular allocations of its operational places. *See legislative reference - Division 17, Aged Care Act 1997; Part 8, Allocation Principles 1997.* However, approved providers cannot apply to vary conditions that apply to all allocations generally under section 14-6 of the Act. *See legislative reference - sections 17-1 and 17-2, Aged Care Act 1997; Part 8, Allocation Principles 1997.*

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

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

*See legislative reference - section 17-4, Aged Care Act 1997.*

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

The Department requires that an application to vary conditions must be submitted via one of the following forms (available on the website listed in the References section at the end of this chapter):

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

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

It can be difficult for an approved provider to work out a variation date in advance and circumstances may change which affects the application.

Therefore the approved provider may need to make changes to the application to vary a condition that has already been submitted to the Secretary. For example, the proposed variation date stated in the application needs to be brought forward or extended.

If a change needs to be made to an approved provider’s application and the application has been submitted but not yet approved the approved provider must write to the Secretary about the proposed change. See legislative reference - section 17-2(8), Aged Care Act 1997.

If an application to vary conditions has been approved by the Secretary and an earlier variation day is required - i.e. a date earlier than the date nominated in the application to vary conditions - then a new application is required - the approved provider should write to the Secretary about the proposed new variation day, stating that this letter, together with the information in the original application, be treated as a new application. See legislative reference - section 17-2(5), Aged Care Act 1997.

If an application to vary conditions has been approved by the Secretary and a later variation day is required - i.e. a date later than the date nominated in the application to vary conditions - then the approved provider should apply to the Secretary for a new variation day. See legislative reference - section 17(7), Aged Care Act 1997.

The Secretary cannot approve a variation of conditions that would result in the care provided under an allocated place being provided in a different state or territory. See legislative reference - section 17-1(1)(d), Aged Care Act 1997.

The Secretary may request further information from the applicant if it is needed to decide whether a variation of conditions should be approved. The information must be provided within 28 days of the request. See legislative reference - section 17-3, Aged Care Act 1997.

Special conditions apply to a change of location of places which affect extra service status. See also the section on Allocations, Transfers and Variations in Chapter 2 on Extra Service Places in this Manual.

**Applying to vary conditions and extend allocation periods for provisionally allocated places**

An approved provider may also apply to vary its provisionally allocated places and the allocation period. See legislative reference - sections 15-5 and 15-7, Aged Care Act 1997.

The variation may be a reduction in the number of places to which the provisional allocation relates or a variation of the conditions to which the provisional allocation is subject. See legislative reference - subsection 15-5(2), Aged Care Act 1997.
Applications to vary the provisional allocations or extend the allocation period must be submitted in the required form. *See legislative reference - subsections 15-5(3) and 15-7(4), Aged Care Act 1997.*

Applications to vary a condition must be lodged before the end of the provisional allocation period - which is two years after the day on which the allocation was made, unless an extension to the provisional allocation period is approved or an application for an extension is pending. An application to extend the allocation period must be made at least 60 days, or less if approved by the Secretary, before the end of the original allocation period. *See legislative reference - subsections 15-7(2) and 15-7(3), Aged Care Act 1997.*

**TRANSFERRING OPERATIONAL PLACES TO ANOTHER PROVIDER**

Under the Act, a transfer occurs when operational places allocated to one approved provider *(the transferor)* are transferred to another approved provider *(the transferee)*. *See legislative reference - Division 16, Aged Care Act 1997; Part 7, Allocation Principles 1997.*

As a result of a transfer of places:
- any entitlement to unpaid aged care subsidy payable to the transferor passes to the transferee
- the transferee takes on any responsibilities for accommodation bond balances that the transferor had before the transfer day
- the transferee takes on any obligations that the transferor had before the transfer day under a resident agreement. *See legislative reference - section 16-11, Aged Care Act 1997.*

The transferor must give the following records or copies of records to the transferee for each resident whose place is being transferred:
- assessment and classification records
- individual care plans, medical care plans, progress notes and other clinical documentation
- details of fees and charges, including accommodation payments
- any agreements between those residents and the transferor
- the accounts of those residents
- where applicable, the prudential requirements for accommodation bonds relating to the transferor’s service
- name and contact details for each representative of those residents. *See legislative reference - section 16-10, Aged Care Act 1997; section 4.66B, Allocation Principles 1997.*

In addition, the Secretary may provide information to the transferee about the transferor, for example:
- the types of subsidies paid to the transferor relating to the places being transferred and any adjustments to those subsidies
- the classifications and financial status of relevant care recipients
- any compliance actions taken or proposed with respect to the transferor’s responsibilities under the Act. *See legislative reference - sections 16-9, Aged Care Act 1997; section 4.65, Allocation Principles 1997.*
Applying to transfer places
Before applying for a transfer of places, it is a good idea for the transferor and/or transferee to contact their state or territory office of DSS to discuss their proposal. DSS may ask both the transferor and the transferee to discuss specific aspects of their application. The Secretary must approve all transfers of places between approved providers.

When applying for transfer, an approved provider must use the standard form available on the website (see References section at the end of this chapter for links to the relevant form) and include the information required under the Act and the Allocation Principles, including:

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


Both the transferor and the transferee must complete this form.

The application must be made:

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


The proposed transfer day is the day specified in the application for the transfer of places, that is the ‘transfer day’. The transfer day is the date from which the Secretary will recognise the transferee as being responsible for the places. See legislative reference - section 16-7, Aged Care Act 1997.

In special circumstances, at the request of both the transferor and the transferee, the Secretary can reduce the notice periods. However approvals made by the Department to
transfer places cannot be backdated. Unless the transferor and the transferee agree to a later date, the Secretary will approve or reject the application at least 14 days before the proposed transfer day.

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

- if an application to transfer places has not yet been approved by the Secretary and either an earlier transfer day is required (that is, a date earlier than that nominated on the application form) or a later transfer day is required (that is, a date later than that nominated on the application form) then the transferor and transferee must jointly advise the Secretary in writing of the proposed change. See legislative reference - section 16-2(8), Aged Care Act 1997.

- if an application to transfer places has been approved by the Secretary and an earlier transfer day is required (that is, a date earlier than that nominated on the application form) then a new application is required. This can be done by advising the Secretary in writing of the proposed new transfer day and stating that this, together with the information in the original application, be treated as a new application. See legislative reference - section 16-2(2), Aged Care Act 1997.

- if an application to transfer places has been approved by the Secretary and a later transfer day is required (that is, a date later than that nominated on the application form), then the approved provider should apply in writing to the Secretary. See legislative reference - section 16-7(2), Aged Care Act 1997.

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

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


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

The Secretary may also use any other relevant information available to the Department, such as ACAR applications, planning information, complaints and compliance information and Annual Prudential Compliance Statements.

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

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

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

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

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

The transferor and transfeee must also include further information with the application which is listed in section 4.61 of the Allocation Principles. See legislative reference - section 4.61, Allocation Principles 1997.

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

If the transferor intends to close its service after a transfer, it is legally obliged to inform residents of their rights about leaving, including their right of access to internal and external complaints processes and advocacy services. The transfeee must not take action to make the resident leave, or imply that the resident must leave, before suitable alternative and affordable accommodation is available that meets the resident’s assessed long-term needs. See legislative reference – Part 2, Division 1, User Rights Principles 1997.

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

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

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

Special conditions apply to the transfer of extra service places. See also subsection on Allocations, Transfers and Variations in the Extra Service Places section further in this chapter.

**TRANSFERRING PROVISIONALLY ALLOCATED PLACES TO ANOTHER PROVIDER**

Provisionally allocated places can be transferred in very limited circumstances. See legislative reference - subdivision 16-B, Aged Care Act 1997; Allocation Principles 1997.

A transfer of provisionally allocated places may be approved in exceptional circumstances.

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

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

Where an approved provider seeks to transfer provisionally allocated places, they will need to apply to DSS and include all required information. See legislative reference - section 16-14 Aged Care Act 1997.

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

**RELINQUISHING OPERATIONAL PLACES**

An approved provider can voluntarily relinquish operational places by writing to the Secretary. To ensure that the needs of residents are met when operational places are relinquished, the approved provider must notify the Secretary, in writing, of their intention to relinquish the places at least 60 days before the proposed day of the relinquishment. Failure to give notice of a proposed relinquishment within this time frame is a criminal offence and sanctions under the Aged Care Act may also apply. See legislative reference - section 18-2, Aged Care Act 1997.

The written notice must include:
- details of the service and the number of places to be relinquished
- a proposal of how the care needs of residents who are affected will be appropriately met, including matters specified in the Allocation Principles
- a proposal of how the approved provider will continue to meet their responsibilities with respect to any accommodation bond or entry contributions balances they hold.


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

**REVOKING PLACES**

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

In deciding whether to revoke the allocation of a place, the Secretary will consider, amongst other matters:
- why the places have not been used
- whether they are likely to be used in the near future
- whether revoking the allocation would have detrimental effects on the local community.


The Secretary may also revoke provisionally allocated places if the conditions to which the allocation is subject have not been met. In this circumstance, the Secretary will invite the
provider to explain in writing within 28 days why the provisional allocation should not be revoked. See legislative reference - section 15-4, Aged Care Act 1997.

ABOUT SUPPORTED, CONCESSIONAL AND ASSISTED RESIDENTS
DSS determines a proportion of supported, concessional and assisted residents for each region. All aged care services in a region are expected to accept an appropriate proportion of supported (including concessional or assisted) residents to meet these levels. The proportions are determined by comparing information on the number of people in these groups aged 70 years and over with the general population aged 70 years and over in each region. DSS publishes regional ratio concessional and assisted resident targets. See legislative reference - section 12-5, Aged Care Act 1997.

These resident ratios are also listed in the References section at the end of Chapter 4 in this Manual.
REFERENCES

Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Aged Care Approvals Round - residential aged care places and capital grant allocations

Aged Care Approvals Round - Essential Guide

Application to Exchange Care Type - guidelines and form

Approved provider status guidelines and application form

Forms - all
All departmental forms are available on the following website

Form - transfer of places - application to transfer places other than provisionally allocated places to another approved provider

Form - variation of conditions - application for a variation of conditions of allocation - residential, home and flexible care places

Form - variation of conditions, respite - application for a variation of conditions of allocation - residential respite form for respite only - application form
Form - variation of provisional allocation of places - application for a variation of a provisional allocation of places


Supported Resident Ratios

EXTRA SERVICE PLACES

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

OVERVIEW

Extra service places provide a significantly higher standard of accommodation and services to residents, without impacting upon the level of care being provided.

Residents are usually charged a higher daily fee for the extra service - i.e. the extra service amount - and as a consequence, the provider receives a lower amount of residential care subsidy from the Government for an extra service place.

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

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

WHAT IS AN EXTRA SERVICE PLACE?

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

See legislative reference - section 31-1, Aged Care Act 1997.

Extra service status may be granted to an aged care service or a distinct part of a service – e.g. a separate wing. This allows more flexibility and choice, both for residents and providers. A distinct part is an area of the service that:
- is physically identifiable as separate from the rest of the premises
- includes sufficient living space for the residents
- includes dining and lounge areas (located together or separately) that are for the exclusive use of the residents
- has at least five extra service places.


In this chapter, references to an aged care service with extra service status includes services with extra service status in a distinct part of the service.
HOW IS EXTRA SERVICE STATUS GRANTED?

The Secretary invites applications for extra service status. This usually coincides with the annual Aged Care Approvals Round in which new and existing providers can apply for new residential aged care places. Applications are sought from both providers with existing places and providers seeking new places in the Aged Care Approvals Round. See legislative reference - section 32-2, Aged Care Act 1997.

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

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

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

In order to be able to properly assess the application against the selection criteria, the Secretary can ask an applicant for further information or to agree to an on-site visit. See legislative reference - section 32-3, Aged Care Act 1997; section 14.11, Extra Service Principles 1997.

Criteria for approval

In order to be approved for extra service status, the applicant must have been allocated places in the residential care service, or have applied for the places. A provider can apply for an allocation of places if they are approved to provide aged care or they will be approved to provide aged care by the time their allocated places take effect or their provisional allocations begin to be in force. See legislative reference - section 32-1, Aged Care Act 1997.

An application for extra service status, must also meet all the assessment criteria set out in the Act and the Extra Service Principles. If any one of the following criteria are not met, the Secretary will not approve the application:

• granting extra service status must not unreasonably reduce access to residential aged care for supported, concessional or assisted residents, or for people aged 70 years and over, in the same service, who may have difficulty affording an extra service amount. See section 44-5B of the Act for the meaning of supported resident, section 44-7 for the meaning of concessional resident and section 44-8 for the meaning of assisted resident
• the proposed standard of accommodation, food and services, must be significantly higher than the average standard provided in non-extra service facilities or places
• if the applicant has already been providing aged care, the applicant must have a very good record of conduct as an aged care provider and compliance with its responsibilities as a provider
if the applicant has relevant key personnel in common with a person who is or has been an approved provider, the person has a very good record of conduct as an aged care provider and compliance with its responsibilities as a provider
the service must be certified
the service must meet its accreditation requirements
there will be significant benefit to current and future residents in the region if the application is granted
there will be a significantly increased diversity of choice for current and future residents, their carers and families, if the application is granted
the extra services would provide current and future residents in the region with better access to continuity of care, if the application is granted


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

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

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

- the number of existing and allocated residential aged places in the state, territory or region concerned
- the proportion of residential aged care that must be provided to concessional and assisted residents
- the estimated number of places providing care mainly or exclusively to special needs groups in the region, including whether the applicant has a particular focus on, or is required to provide places for residents from a special needs group - for example, residents from a culturally and linguistically diverse background. See also subsection on Conditions Applying to Particular Allocations in the Allocated Places section further in this chapter
- if the application is approved, the level of remaining non-extra service places for that state, territory or region is not reduced significantly
- the socio-economic status of the region, including concessional resident data
- relevant factors relating to the population or services in an adjoining region.


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

The benchmarks for significantly higher standards of accommodation, food and services are met by providing a list of extra service choices that providers can offer. Providers do not have to offer each item listed but must score at least 60 out of a possible 100 points in order for the significantly higher criterion to be satisfied, and must achieve minimum scores in the three categories of accommodation, food and services. Each category allows points to be earned for innovation and special features. There is also a mandatory requirement in regard to building standards. Points cannot be claimed for services that must be provided to all residents as specified care and services, or for services that are claimable under the Aged Care Funding Instrument (ACFI).

The application form provides some examples of significantly higher standards of food, accommodation and services. These examples are not intended to be prescriptive, but rather provide guidance for applicants. Applicants are encouraged to be innovative in their proposals in regard to additional facilities and services for residents. See legislative reference - paragraph 32-4(1)(b), Aged Care Act 1997; section 14.18, Extra Service Principles 1997.

Record of the applicant

If an applicant for extra service status has been a provider of aged care then the applicant must have a very good record of conduct as a provider over the previous three years or over their period of operation, if less than three years. See legislative reference - paragraph 32 - 4(1)(c), Aged Care Act 1997; section 14.19, Extra Service Principles 1997.

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

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

Certification and accreditation

An aged care service must be certified and meet its accreditation requirement to be granted extra service status. See legislative reference - paragraph 32-4(1)(d), Aged Care Act 1997.
If a service ceases to be certified or no longer meets its accreditation requirement, its extra service status also ceases at the same time. See legislative reference - section 33-1, Aged Care Act 1997.

**Competitive assessment**

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

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

Consideration will be given to:

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


**Notification of extra service status**

If extra service status is granted, the Secretary will notify an applicant. The notice will include:

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


The notice can also specify that certain conditions must be met before extra service status commences. See legislative reference - section 32-8, Aged Care Act 1997; section 14.24, Extra Service Principles 1997.

**Conditions of extra service status**

A grant of extra service status is subject to the conditions set out in the Act and the Extra Service Principles, and the specific conditions set out in a notice relating to the grant of extra service status. See legislative reference - section 32-8, Aged Care Act 1997; section 14.24, Extra Service Principles 1997.

Conditions, other than those specified in the Act or the Extra Service Principles, may be varied by agreement between the provider and DSS. See legislative reference - subsection 32-8(6), Aged Care Act 1997; section 14.26, Extra Service Principles 1997.

DSS can take into consideration any relevant matter, and must consider the extent of any change in the level of the accommodation, food and services that may result from a proposed variation.
WHEN DOES EXTRA SERVICE STATUS CEASE?

Extra service status ceases when:

- the extra services lapse
- the extra service status is revoked or suspended
- the aged care service in which the place is located is no longer certified
- does not meet its accreditation requirements
- if the Extra Service Principles specify that extra service status ceases to have effect on the occurrence of an event and that event occurs.

*See legislative reference - Division 33, Aged Care Act 1997.*

Lapsing of extra service status

Extra service status can be revoked or suspended if:

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

*See legislative reference – section 33-3, Aged Care Act 1997.*

Revoking or suspending extra service status as a sanction

If a provider has not complied with its responsibilities under the Act, the Secretary can impose a sanction on the approved provider by suspending or revoking the extra service status. *See legislative reference - Part 4.4, Aged Care Act 1997.*

Revoking or suspending extra service status on request

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

DSS will notify the provider in writing of the day from which extra service status is revoked or suspended. *See legislative reference - section 33-4, Aged Care Act 1997.*

FEES AND PAYMENTS

Extra service fee

As part of the application for extra service status, the provider must apply to the Secretary to set an extra service fee. *See legislative reference - Division 35, Aged Care Act 1997; Part 6, Extra Service Principles 1997.*

The extra service fee can vary for different places in an aged care service - for example, a provider can set a higher fee for a bigger room with a private bathroom.
The application will be approved only if all aged care services operated by the applicant have a very good record of compliance with standards of care and meeting obligations arising from the receipt of payments from the Government for providing aged care, during the three years immediately before the lodgement of the application. See legislative reference - Part 6, Division 1, 14.29, Extra Service Principles 1997.

The Secretary cannot approve extra service fees where:
- the fee is a nil amount.
- the average daily extra service fee across all extra service places in the service is less than $10.


**EXAMPLE**

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

<table>
<thead>
<tr>
<th>ROOM TYPES</th>
<th>PLACES</th>
<th>EXTRA SERVICE FEE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single with ensuite</td>
<td>23</td>
<td>$12</td>
<td>$276</td>
</tr>
<tr>
<td>Single without ensuite</td>
<td>23</td>
<td>$10</td>
<td>$230</td>
</tr>
<tr>
<td>Double</td>
<td>4</td>
<td>$9</td>
<td>$36</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>50</strong></td>
<td></td>
<td><strong>$542</strong></td>
</tr>
</tbody>
</table>

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

**Extra service amount and extra service reduction**

If eligible, approved providers may receive a residential care subsidy from the Government for each resident. See legislative reference - section 42-1, Aged Care Act 1997. However, if the resident is occupying an extra service place then the residential care subsidy is reduced by 25 per cent of the approved extra service fee for that place. See legislative reference - section 44-18, Aged Care Act 1997.

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

The extra service amount equals the extra service fee plus the extra service reduction. See the example below and section on Extra Service Fees in Chapter 4 on Funding for Residential Aged Care in this Manual. See legislative reference - section 58-5, Aged Care Act 1997.
EXAMPLE
If the extra service fee for a place is $20 per day, then the Government subsidy for a resident receiving extra service care in the place will be reduced by 25 per cent or $5 per day. The $5 per day is the extra service reduction.

The extra service amount is $25 - i.e. the extra service fee ($20 per day) plus the extra service reduction ($5 per day).

An aged care service can charge GST for any item included in the extra service package that is not GST-exempt. This GST may be included in extra service payments agreed between the approved provider and the resident. Any accommodation, food or services listed in Schedule 1 - Specified Care and Services of the Quality of Care Principles 1997 are GST-exempt. See also Chapter 5 on Specified Care and Services in this Manual. See legislative reference - section 14.25, Extra Service Principles 1997; Schedule 1 - Specified Care and Services, Quality of Care Principles 1997.

An aged care service can decide to charge less than the full extra service amount. If they do so, the extra service agreement with the resident should specify the circumstances under which they can increase the fee. In this instance, the extra service reduction is still calculated using the approved extra service fee. A resident receiving care on an extra service basis must have an extra service agreement with the provider. See section on Extra Service Agreement in Chapter 2 on Extra Service Places in this Manual.

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

Respite supplement
Aged care services with extra service status are eligible for the respite supplement. See legislative reference - section 44-12, Aged Care Act 1997.

Residents receiving respite care on an extra service basis may also be charged the extra service amount. The extra service reduction also applies to the extra service amount charged. See also Chapter 4 on Residential Respite Care in this Manual.

Changes in the levels of the extra service fee
The Secretary cannot approve an application to change the extra service fee for a place or places unless 12 months since the last extra service fee was granted has lapsed. See legislative reference - paragraph 35-(3)(c), Aged Care Act 1997.

The Department strongly recommends that the application to vary the extra service fee be submitted to the Department’s state or territory office at least 60 days before the proposed starting date of the new fee. This will allow time for the application to be considered and if approved, for residents to be given reasonable notice about the variation.

The maximum amount by which an extra service fee may be increased is the total of:
- 20 per cent of the current fee
• plus the national consumer price index (CPI) percentage change, published for the most recent 12 month period, in which the additional extra service fee is currently being charged.


EXAMPLE
An aged care service has been charging an extra service fee of $20 per day per place for three years and their extra service amount is $25 per day. The service applies to DSS to increase the extra service fee by $2, up to $22. The application is received on 1 September 2012, with a request for the new fees to apply from 1 January 2013. The service sent the request more than 60 days before the proposed starting date of the new fee. The current fee: $20.

The permitted increase: 20 per cent plus 2.5 per cent (the national CPI rate change) which equals 22.5 per cent. 22.5 per cent of $20 equals $4.50.

Therefore, the maximum increase is $4.50, up to a maximum allowable of $24.50. The requested $2 increase falls within this maximum. An application to vary the fees has not been approved in the previous 12 months. Therefore, subject to the other conditions for approval, the application is approved and the new fees can apply from 1 January 2013.

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

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

Extra service agreement
A resident receiving care on an extra service basis must have an extra service agreement. See legislative reference - Division 36, Aged Care Act 1997; Part 7, Extra Service Principles 1997.

The agreement must contain:
• the level of extra service amount
• how the extra service amount may be varied
• the standard of the accommodation, food and services to be provided to the resident
• the provision set out in section 14.38 of the Extra Service Principles in relation to revocation, suspension or variation.


The extra service agreement may be included as part of a standard resident agreement. See legislative reference - section 36-1, Aged Care Act 1997.
The original of the agreement should be given to the resident and the aged care service should retain a copy.

For each extra service place, the approved provider must provide the resident with the accommodation, services and food to the standard specified in the extra service agreement. See legislative reference - Aged Care (Conditions of Allocation - Extra Service Places) Determination 2006 (No. 1).

In entering an agreement, the resident must not be subject to duress, misrepresentation or threat of disadvantage or detriment. See legislative reference - section 36-2, Aged Care Act 1997.

See also section on Accommodation Payments - Information Provided to Residents and Resident Agreements in Chapter 4 on Funding for Permanent Residential Aged Care and section on Resident Agreements in Chapter 5 on Residents’ Rights in this Manual.

**New residents**

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

**Existing residents**

Special arrangements apply for residents who are already living in an aged care service when extra service status becomes effective. These residents must be given a choice as to whether or not they wish to receive care on an extra service basis. They can continue to reside in the aged care service on a non-extra service basis, and therefore, cannot be charged an extra service amount.

Existing residents may choose to receive care on an extra service basis at any time, with a three month ‘cooling off’ period from the date of effect of the agreement, during which time they may change their mind. These residents need only notify the provider of their decision. The extra service agreement for such a resident must specify that the resident may terminate the agreement during this period without penalty of any kind. See legislative reference - section 36-4, Aged Care Act 1997.

**ELIGIBILITY FOR SUBSIDIES AND ADDITIONAL FUNDING**

An aged care service with extra service status is not eligible for the following subsidies or payments:
- viability and homeless supplements for any place in the service
- a hardship supplement, concessional resident supplement or supported resident supplement for a resident receiving care on an extra service basis

**EXTRA SERVICE STATUS AND CAPITAL REPAYMENT**

Aged care services may receive capital grant funding. A service which has received a capital grant may have to repay all or part of the grant if the service is approved for extra service
status.

An aged care service will have capital repayment amounts deducted from the service’s subsidy if:
- the service is granted extra service status
- DSS has previously made capital payments for the service, even if the payment was not made to that approved provider
- the payments have not been repaid to DSS.

See section 43-6 of the Act for a description of a capital payment. *See legislative reference - section 43-6, Aged Care Act 1997.* The requirement for repayment is also included in Deeds Of Agreement relating to capital payments for residential aged care services that have been made under arrangements other than those described in section 43.6 of the Act.

See also subsection on Capital Funding and Extra Service Status in the section on Capital Grants for Residential Aged Care in chapter 4 of this Manual.

Capital repayments can be deducted under an agreement signed between the provider and DSS and must be completed in three years. An aged care service will be required to repay only a proportion of the capital payment if:
- extra service status is granted for only a distinct part of a service. The proportion of capital to be repaid is equal to the proportion of places in the service which have extra service status
- or some or all of the capital payments were approved more than five years before the first of the deductions is to be made. The amount to be repaid is reduced by 10 per cent for each year beyond this five year period. See the example below.

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

The service would be liable for capital repayment deductions. The service and the Government would enter an agreement for those capital repayments to be repaid over three years. The proportion of capital repayment is calculated in the following way:
- a period of at least 6 months is counted as a complete year. In this example, the year 2000 is counted as a complete year.
- there are 9 complete years between date of approval and the due date for the first capital repayment deduction. For each complete year after 5 years, the proportion is reduced by 10 per cent. This means the amount to be repaid is reduced (by 4 x 10 per cent) to 60 per cent.
- $100,000 x 60 per cent = $60,000
- in addition, the service is being granted extra service status for a distinct part of 20 places from a total number of places of 80. The 20 places represent 25 per cent of the total places and therefore this means the amount to be repaid is further reduced to 25 per cent
- $60,000 x 25 per cent = $15,000
- the total amount to be repaid is $15,000.
EXTRA SERVICE STATUS AND SUPPORTED RESIDENT REQUIREMENTS

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

However, if a service has a separate wing with extra service status, it will have to meet supported resident requirements for the remainder of the places in the service which do not have extra service status. This will be a condition of allocation under section 14-5 of the Act in relation to each allocation.

ALLOCATIONS, TRANSFERS AND VARIATIONS

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

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

See also Chapter 2 on Allocated Places in this Manual.

TRANSITIONAL ARRANGEMENTS - EXISTING APPROVALS

Aged care services that were approved for exempt status under the National Health Act 1953 will continue to have this status under transitional arrangements made under the Aged Care (Consequential Provisions) Act 1997. These approvals are subject to conditions set out in the Act, the Extra Service Principles and any specific conditions that were attached to each approval. See References at the end of this chapter for a link to ComLaw for the National Health Act 1953. See legislative reference - Part 2.5, Aged Care (Consequential Provisions) Act 1997.

Fees and subsidies

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

The extra service amount is treated differently for different residents:
- for new residents who commence care on an extra service basis in the place on or after 1 October 1997 - the extra service reduction is 25 per cent of the approved extra service fee. These residents will be income tested and may pay the extra service reduction; or
- for people who were receiving care in an exempt bed prior to 1 October 1997 - the extra service reduction is 50 per cent of the approved extra service fee.

REFERENCES
Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Forms - all
All departmental forms are available on the following website

Form - application for extra service status

Legislation - other
Go to ComLaw to access other legislation mentioned in this chapter, including the National Health Act 1953 and the Aged Care (Consequential Provisions) Act 1997.
www.comlaw.gov.au
ACCREDITATION AND QUALITY OF CARE

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

OVERVIEW

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

Accreditation is the arrangement established under legislation to verify that aged care services provide quality care and services for residents. It involves an independent team of quality assessors, appointed by the Australian Aged Care Quality Agency Ltd (the Quality Agency), assessing a service’s performance against the legislated Accreditation Standards. See legislative reference - section 54-2, Aged Care Act 1997; Schedule 2, Quality of Care Principles 1997.

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

Accreditation is formal recognition that the service is:
- operating in accordance with the Act and the Principles made under it
- providing high quality care including:
  - working within a continuous improvement framework
  - making required improvements.

In addition to meeting the requirements of the Accreditation Standards, approved providers must also:
- comply with relevant local, state and Australian Government regulatory requirements
- comply with professional standards and guidelines
- adhere to requirements about charging fees, providing specified care and services and having appropriate staffing.

See also section on Specified Care and Services in chapter 5 of this Manual.

ABOUT THE AUSTRALIAN AGED CARE QUALITY AGENCY

The CEO of the Quality Agency has been given the following functions under the Australian Aged Care Quality Agency Act 2013:
- manage the residential aged care accreditation process using the Accreditation Standards
• promote high quality care, innovation in quality management and continuous improvement in order to help the industry improve
• providing information, education and training to the industry
• assess services working towards accreditation
• monitor compliance with the Accreditation Standards and liaise with DSS about services that do not meet the standards.

From 1 July 2014, the Quality Agency will also conduct the review of home care services using the Home Care Standards.

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

ACCREDITATION

Who audits aged care services?
A team of quality assessors appointed by the Quality Agency carries out accreditation audits of residential aged care services. All assessors have completed an approved training course and are registered as aged care quality assessors with the CEO of the Quality Agency. Quality assessors may either be employed by or contracted by the Quality Agency. All assessors must update their registration annually. See legislative reference - Part 3 of Chapter 2, Quality Agency Principles 2013.

Accreditation fees
The Government subsidises the accreditation process for small residential aged care services. Aged care services with less than 20 places do not have to pay accreditation fees. Fees for services with more than 20 but fewer than 26 places are subsidised. The fee for services with more than 25 places is set out in the legislation. See legislative reference - sections 2.5 and 2.73, Quality Agency Principles 2013.

See References at the end of this chapter for a link to Accreditation Fees on the Quality Agency’s website.

Accreditation - commencing services
An aged care service is considered a commencing service if:
• an approved provider has been allocated places for that service
• residential aged care has not previously been provided for those places
• the service is not currently accredited by the Quality Agency.

The Quality Agency will take into account information provided by the approved provider when deciding whether to accredit a commencing service. Residents will not yet be residing at a commencing service therefore a site audit will not be conducted as part of an application for accreditation. See legislative reference - Chapter 2, Part 1, Division 1 and 2, Quality Agency Principles 2013.
The Quality Agency must decide whether to accredit a commencing service within 16 days of receiving an application and application fee from the approved provider. The Quality Agency must notify the applicant of its decision within 14 days of the decision. Commencing services are accredited for 12 months. See legislative reference – Chapter 2, Part 1, Divisions 2 and 4, Quality Agency Principles 2013.

**Re-accreditation - existing services**

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

- an approved provider applies to the Quality Agency for re-accreditation for an aged care service, using the Quality Agency’s standard form. See References at the end of this chapter for a link to the form
- the application must include:
  - the appropriate fee
  - a commitment that the service will undertake continuous improvement
- the application may be accompanied by self-assessment information. See legislative reference – Chapter 2, Part 1, Quality Agency Principles 2013.

On receipt of a valid application, the Quality Agency must create a team of quality assessors to undertake a site audit of the accredited service and consult with the approved provider about when the assessment team will undertake the site audit. See legislative reference – Chapter 2, Part 1, Division 3, Quality Agency Principles 2013.

**The re-accreditation decision**

Within 28 days of receiving the site audit report from the assessment team, the Quality Agency must decide whether or not to re-accredit the service. The decision may be made at a later date if agreed to by the Quality Agency and the applicant. See legislative reference – Chapter 2, Part 1, Division 3, Quality Agency Principles 2013.

In deciding whether to re-accredit a service, the Quality Agency considers:

- the site audit report
- information received from the applicant in response to the report of the site audit
- information from DSS
- whether it is satisfied that the service will undertake continuous improvement measures against the Accreditation Standards. See legislative reference – section 2.18, Quality Agency Principles 2013.

If the Quality Agency decides not to re-accredit the service they must:

- decide whether there are any areas in which improvements would be necessary

If the Quality Agency decides to re-accredit the service they must decide:

- the further period for which the service is to be accredited
- whether there are any areas in which improvements must be made to meet the Accreditation Standards
- the arrangements for assessment contacts.

The Quality Agency must notify the applicant of the decision within 14 days of making the decision. See legislative reference - sections 2.23 and 2.24, Quality Agency Principles 2013.

**What happens once an aged care service is accredited?**

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

**Monitoring accredited services**  
*See legislative reference – Chapter 2, Part 2, Quality Agency Principles 2013.*

Throughout the accreditation period the Quality Agency will monitor the service to assess compliance with the Accreditation Standards and the approved providers’ responsibilities under the Act and the service’s plans for continuous improvement.

The Quality Agency will monitor services by undertaking assessment contacts and may use other means such as conducting review audits.

The Quality Agency may conduct a review audit if it believes on reasonable grounds that a service is not meeting the Accreditation Standards or the approved provider’s responsibilities under the Act. A review audit may also be conducted if there is any change in the service that the approved provider is required to tell DSS about under the Act - for example, a change in ownership or key personnel. See legislative reference - section 9-1, Aged Care Act 1997; section 2.35, Quality Agency Principles 2013.

**ACCREDITATION AND SUBSIDY**

A service must meet its accreditation requirements for the approved provider to be eligible to receive residential care subsidies. Generally, a service must be accredited to meet its accreditation requirements. See legislative reference - sections 42-1 and 42-4, Aged Care Act 1997.

However, in exceptional circumstances the Secretary can determine that a service is taken to be meeting its accreditation requirements, even if the service is not accredited. When deciding if an exceptional circumstance exists the Secretary may consider, the reasons the service is not meeting its accreditation requirements, what it needs to do to meet the requirements and the impact that not meeting the requirements has on the services it provides. See legislative reference - sections 42-4 and 42-5, Aged Care Act 1997; Part 1A, Residential Care Subsidy Principles 1997.
A determination of exceptional circumstances:

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


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

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

FAILURE TO MEET THE ACCREDITATION STANDARDS

If the Quality Agency conducts a review audit, a site audit or an assessment contact and finds that a service is not meeting the Accreditation Standards or has failed to implement required improvements the Quality Agency may (depending on the type of audit or assessment conducted) decide to:

- revoke, vary or not revoke accreditation of the service
- re-accredit the service or not re-accredit the service
- advise the service of any areas of improvement that are required for them to meet the Accreditation Standards, advise of a timetable for making those improvements and arrange assessment contacts.


DSS may take regulatory action if the Accreditation Standards are not met by issuing a notice of non-compliance or imposing sanctions. See section on Compliance Action in Chapter 5 of this Manual.

RECONSIDERATIONS AND REVIEWABLE DECISIONS

An approved provider may ask for reconsideration and/or review of a range of decisions resulting from the accreditation site audit. See legislative reference – Chapter 2, Part 6, Quality Agency Principles 2013.

The timeframes and processes for seeking reconsideration or review are outlined in the Quality Agency Principles and vary depending on the particular decision. When the Quality Agency receives a request for reconsideration, the decision is made by a new decision-maker – i.e. someone within the Quality Agency other than the original decision-maker. Following reconsideration of a decision by the Quality Agency, in some circumstances, the approved provider can also apply to the Administrative Appeals Tribunal (AAT) for a review of that decision. Most decisions must be reconsidered by the Quality Agency prior to review by the AAT.
See References at the end of this chapter for a link to the Administrative Appeals Tribunal.

**REVIEW AUDITS**

A review audit assesses a service’s quality of care against the Accreditation Standards. The Quality Agency may arrange for an assessment team to conduct a review audit of an accredited aged care service. *See legislative reference – Chapter 2, Part 2, Division 4, Quality Agency Principles 2013.*

On the last day of the review audit the assessment team will meet with the approved provider to discuss the assessment and provide a written report of the major findings of the review audit. Within seven days of that meeting, the approved provider or key personnel may give the Quality Agency a written response to the report.

The assessment team prepares a written report, which it gives to the Quality Agency within seven days of completing the review audit.

When the review audit report is received from the assessment team, the Quality Agency must decide whether or not to revoke the accreditation of the service or to vary the period of accreditation. The Quality Agency must tell the aged care service in writing of its decision within 14 days of receiving the review audit report. *See legislative reference – Chapter 2, Part 2, Divisions 5 and 6, Quality Agency Principles 2013.*

Within 14 days of being told about the decision, the approved provider may ask the Quality Agency to reconsider a decision to revoke the accreditation of the service. *See legislative reference - sections 2.66 and 2.67, Quality Agency Principles 2013.*

**REFERRAL TO THE DEPARTMENT OF SOCIAL SERVICES**

The Quality Agency must notify DSS of any serious risk or if any failure to meet the accreditation standards is identified during an audit or at the end of a timetable for improvement. *See legislative reference - Part 2, section 13, Quality Agency Reporting Principles 2013.* A delegate to the Secretary of DSS makes the decision about whether or not to apply sanctions in such cases. DSS will also be notified immediately if an aged care service’s accreditation is revoked. When accreditation is revoked, Government funding to the service will stop.
REFERENCES

Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Accreditation fees - administered by the Australian Aged Care Quality Agency

Administrative Appeals Tribunal
www.aat.gov.au

Australian Aged Care Quality Agency
www.aacqa.gov.au

Form – re-accreditation application – from the Australian Aged Care Quality Agency
Application for re-accreditation - administration information
This application does not apply to commencing homes (new residential aged care homes). Go to http://www.aacqa.gov.au for more information.

Forms - all
All departmental forms are available on following website at
CERTIFICATION

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

OVERVIEW

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

- charge residents accommodation payments - i.e. either an accommodation bond or an accommodation charge. See section on Accommodation Bonds in Chapter 4 of this Manual; or
- receive the accommodation supplement or the concessional resident supplement.

When assessing whether a service can be certified under section 38-1 of the Act, the Secretary must consider:

- the standard of the buildings and equipment that are being used to provide residential care
- the standard of residential care provided by the service
- the conduct of the approved provider and whether the provider has complied with its responsibilities and obligations under the Act
- key personnel that the applicant has in common with a person who is or has been an approved provider
- any of the matters set out in section 8.10 of the Certification Principles.


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

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

Certification is not time-limited - i.e. a service’s certification status generally does not expire. However, certification status can be reviewed. See legislative reference - section 39-4, Aged Care Act 1997.

A review may be undertaken if, for example, there are significant changes to the structure of the premises or an increase in the number of allocated places.
THE CERTIFICATION ASSESSMENT INSTRUMENT

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

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

The Certification Assessment Instrument includes the seven sections below:

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

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

Homes are not eligible to receive the increased fees and subsidies on 20 March 2008 until the targets for fire and safety, privacy and space are achieved. See legislative reference - Schedule 1, Residential Care Subsidy Principles 1997.

Fire and safety

Residential care services assessed for certification must score at least 19 out of 25 in section 1 of the Certification Assessment Instrument (Safety) to meet fire and safety standards.

Privacy and space

Residential care services assessed for certification must meet specific standards for privacy and space in residential aged care services based on the date of construction of the buildings.

Privacy and space requirements for buildings constructed post-July 1999

- Number of residents per room:
  - an average of no more than 1.5 residents per room
  - no one room can accommodate more than two residents
  - rooms to accommodate a higher number of residents may be approved in limited cases where the provider is able to demonstrate that a higher number of residents per room is culturally appropriate on an ongoing basis.

- Access to toilets and showers:
  - no more than three residents per toilet
- no more than four residents per shower or bath
- toilets, showers and baths distributed across the building to ensure that all residents have equitable and ready access. Showers and toilets used primarily by staff are not included when these averages are calculated.

*See legislative reference - Schedule 1, Residential Care Subsidy Principles 1997.*

**Privacy and space requirements for buildings constructed pre-July 1999**

- **Number of residents per room:**
  - an average of no more than four residents per room. It is expected however, that providers will strive to meet the optimal target of a maximum of two residents per room
  - rooms to accommodate a higher number of residents may be approved in limited cases where the provider is able to demonstrate that a higher number of residents per room is culturally appropriate on an ongoing basis.

- **Access to toilets and showers:**
  - no more than six residents per toilet
  - no more than seven residents per shower
  - toilets, showers and baths distributed across the building to ensure that all residents have equitable and ready access. Showers and toilets used primarily by staff are not included when these averages are calculated.

*See legislative reference - Schedule 1, Residential Care Subsidy Principles 1997.*

**CERTIFICATION ASSESSMENTS**

**The entire service is certified**

Certification is granted for an entire service, not for any one building or one part of a residential care service *See legislative reference - section 38-2(4)(a), Aged Care Act 1997.* If residential care is provided at more than one location through the same residential care service, only one application may be made for all those locations. *See legislative reference - section 38-2(3), Aged Care Act 1997.*

If a certified service moves to another site, certification lapses and the service must seek certification again for the new location. Every residential aged care service must be certified separately, including separate services run by the one provider and separate residential care services conducted in the same premises. *See legislative reference - section 38-2(4)(b), Aged Care Act 1997.*

**Applying for certification**

An application for certification of an aged care service must be made on the approved form, by a provider who has an allocation of places at that service. *See legislative reference - section 38-2, Aged Care Act 1997.* See References at the end of this chapter for a link to the form. The application must be signed by a person authorised in writing to act for the provider. *See legislative reference - section 8.6, Certification Principles 1997.*

The application must include:

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


A provider can apply for certification at any time. However, a service must be certified to be eligible to:
• charge an accommodation bond. See legislative reference - section 57-16(2), Aged Care Act 1997.
• charge an accommodation charge. See legislative reference - section 57A-8, Aged Care Act 1997.
• receive the accommodation supplement. See legislative reference - section 44-5A(2)(c), Aged Care Act 1997.
• receive the concessional resident supplement. See legislative reference - section 44-6(2)(c), Aged Care Act 1997.

DSS recommends that a provider applies for certification at least 30 days prior to occupancy.

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

The following non-refundable application fees are charged:
• $150 for a service with fewer than 10 places allocated to it
• $700 for a service with more than 46 places allocated to it
• for any other service, $15 for each place allocated to the service. Fees may increase with CPI.


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

Preparing for an inspection
Prior to applying for certification, an approved provider should be familiar with:
• Part 2.6, Divisions 37 to 39 of the Aged Care Act 1997
• the Certification Principles 1997
• the Aged Care Certification Assessment Instrument
• the Aged Care Certification Guidelines
• the Aged Care Certification Assessment Scoring Matrix
• the Building Quality for Residential Care Services - Certification guide.
See References at the end of this chapter for these links.

DSS has contracted a company with expertise in building survey and engineering to carry out assessments of residential care services. See legislative reference - section 8-12, Certification Principles 1997.

After DSS receives an application for certification, it may contact the authorised assessor to conduct an inspection at that facility. See legislative reference - section 38-4, Aged Care Act 1997.

The authorised assessor will contact the approved provider to arrange a suitable time and date for the inspection to take place.

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

**The inspection process**
On average, inspections take may take around five hours. At larger services, they may take up to eight hours. Inspections will focus on:
- whether the service provides a safe and secure environment
- exits from the service
- whether the service has adequate smoke-free compartments
- fire safety, including adequate fire protection and emergency evacuation systems
- hazards within or outside of buildings
- whether the service provides adequate personal privacy to residents
- facilities to allow access and mobility for residents to move freely within the building
- adequate heating and cooling
- adequate lighting and ventilation
- whether the service provides a home-like environment
- whether there is access to community services.
If the service is new, the assessor will also determine whether the service meets the privacy and space requirements for new buildings. See the section on the Certification Assessment Instrument earlier in this chapter of this Manual.

**Serious hazards**
During the inspection, the assessor will look for serious hazards - i.e. hazards which are potentially life threatening. Serious hazards include:
- blocked fire escape doors
- exposed electrical wiring
- evidence of asbestos
- contaminants such as flaking lead paint
- structural instability
- the absence of a fire emergency warning system or fire suppression system as required under the Building Code of Australia
- landscape features

If a facility has a serious hazard, certification assessment will not proceed until the hazard has been removed or rectified. See also section on Reviewing, Revoking or Suspending Certification further in this chapter of this Manual.

**After the inspection**

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

A full review of any additional approval documentation provided following the site assessment may highlight other matters that could impact on the final certification scores achieved.

Service providers will receive a copy of the assessment report and a copy of any other findings used by the Secretary of DSS in deciding whether to certify the service. See legislative reference - section 8.15(1), Certification Principles 1997.

**SUITABILITY OF RESIDENTIAL CARE SERVICE FOR CERTIFICATION**

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

- the standard of the buildings and equipment used by the service to provide residential care
- the standard of residential care provided by the service
- if the applicant has been a provider of aged care, its conduct as a provider, including compliance with responsibilities and obligations related to any Commonwealth payments made for providing aged care
- if key personnel are also relevant key personnel in common with a current or former approved provider, the conduct of that person as a provider of aged care will be considered
- the assessment of the residential care service carried out under section 38-4(1) of the Act
- whether DSS has imposed sanctions or taken any other action against the provider for non-compliance
- whether the service’s buildings and equipment and the residential care it provides meet the requirements of any relevant state law or state or local government authorities
• whether any of the service’s equipment or buildings are fire hazards or dangerous to the health or safety of residents or staff and therefore subject to an order by a state or local government authority for repair, renovation or restoration
• any findings by a Commonwealth, state or local government authority about the standard of the buildings or equipment or the standard of residential care being provided by the service.


Accommodation bonds
A resident cannot be required to pay an accommodation bond if a service is uncertified. See legislative reference - section 57-16(2)(b), Aged Care Act 1997. For more information, see subsection on Accommodation Bonds in the section on Funding for Permanent Residential Aged Care in chapter 4 of this Manual.

REVIEWING, REVOKING OR SUSPENDING CERTIFICATION

Reviewing certification
The Secretary may review the certification of a service at any time. An assessment can relate to any aspect of the residential care service that the Secretary considers relevant to the ongoing suitability of the service for certification. Providers will receive at least five business days’ notice before the start of a review. A review of certification relates to all buildings that make up the residential care service. See legislative reference - section 39-4, Aged Care Act 1997.

Lapse of certification
Generally, certification of a service will lapse if, after the service has been certified, there is a change in the location at which the residential care is provided through the service. However, if there is a temporary change in location due to exceptional circumstances, certification may not lapse. See legislative reference - section 39-2, Aged Care Act 1997.

Revoking certification
If a service is no longer suitable for certification the Secretary may revoke certification. However, before revoking certification the Secretary must:
• notify the provider in writing that revocation is being considered
• explain the reasons for considering the revocation
• and invite the provider to make a written submission to the Secretary within 28 days after receiving the notice.


If the Secretary is satisfied that the approved provider’s submission proposes appropriate action to rectify the unsuitability of the service or set out sufficient reason for the unsuitability, he or she can request that the approved provider give a written undertaking to rectify the unsuitability within a specified time period. If the undertaking is not complied with in the given time period the certification will be revoked. See legislative reference - sections 39-3A and 39-3B, Aged Care Act 1997.
If the Secretary is unsatisfied with the approved provider’s submission, he or she can request, from the approved provider, further information in relation to the submission. If after receiving the further information Secretary is still not satisfied, or the information is not received in time, the certification will be revoked. See legislative reference - section 39-3B, Aged Care Act 1997.

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

- if the provider’s application for certification contained information that was false or misleading in a material way. See legislative reference - section 39-3(1)(b), Aged Care Act 1997.
- by way of a sanction, if an approved provider has not complied with their responsibilities. See also chapter on Providers’ responsibilities and non-compliance in this Manual. See legislative reference - section 66-1(i), Aged Care Act 1997.

If an approved provider requests that certification be revoked, the Secretary must do so. A request by an approved provider to revoke accreditation must be made at least 60 days before the day on which the revocation is requested to take effect. The Secretary must notify the approved provider of the revocation by written notice at least 14 days before the day on which revocation is to take effect. See legislative reference - section 39-5, Aged Care Act 1997.

**Suspension**

The Secretary may, by way of sanction, suspend the certification of a residential care service if an approved provider has not complied with its responsibilities. See also the What Sanctions can be Imposed? subsection in the section on Providers’ Responsibilities and Non-compliance in chapter 5 of this Manual.

**Accommodation payments and the revocation or suspension of certification**

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

**RECONSIDERATION OF DECISIONS**

A service can seek reconsideration of a decision to:

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

For reconsideration of a decision, the approved provider must write to the Secretary within 28 days of receiving notice of the decision. See legislative reference - section 85-5, Aged Care Act 1997. The approved provider should give reasons for the request and include any relevant supporting material.
The Secretary must then reconsider the decision, and either confirm, vary or set aside and substitute a new decision. If the Secretary does not give notice of a decision within 90 days after receiving the request, the Secretary is taken to have confirmed the decision. If an approved provider wants to appeal against the decision after review by the Secretary, then it can apply to the Administrative Appeals Tribunal for external review.

COMPLIANCE WITH STATE OR TERRITORY FIRE SAFETY LAWS
An approved provider must give the Secretary a Fire Safety Exception Notice if the approved provider is notified by a State, Territory or local government authority that the approved provider is, in respect of a residential care service operated by the approved provider, non-compliant with any applicable State or Territory laws (including local by-laws) relating to fire safety. See legislative reference - section 18.6B, Quality of Care Principles 1997.

As the Australian Government does not have responsibility for fire safety laws, any non-compliant residential care services may be referred to the relevant local council (in the ACT, they are forwarded to the ACT Fire and Rescue). A copy of the Fire Safety Exception Notice may also be provided to the Quality Agency.

See References below for a link to a Fire Safety Exception Notice.
REFERENCES

Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Aged Care Certification Assessment Guidelines

Aged Care Certification Assessment Instrument

Aged Care Certification Assessment Scoring Matrix

Building Quality for Residential Care Services - Certification

Certification Hotline
(02) 6289 2066

Fire Safety Exception Notice
or call DSS on (02) 6289 2066

Forms - all
All departmental forms are available on the following website
Form - application for classification

Legislation
ComLaw provides access to all Commonwealth legislation, including the Act, Certification Principles and any other legislation mentioned in this Manual.
www.comlaw.gov.au
CHAPTER 3

From 18 September 2013, the *Aged Care Act 1997* is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services.

To reflect these changes, all references in this Manual to the former Department of Health and Ageing have been changed to the Department of Social Services.

However, it will take some time for the practical application of these changes to flow through. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at [www.health.gov.au](http://www.health.gov.au)

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

APPROVAL OF RESIDENTS

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

*known in Victoria as Aged Care Assessment Service.*

While it is the Secretary who approves a person as eligible to receive Government-subsidised care, the Secretary has delegated this power to ACAT and Department of Social Services (DSS) delegates.

ACATs help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance.

ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or home care. ACATs cover all of Australia and are based in the local community or hospitals.
People do not need to have a current ACAT approval to place their name on a waiting list for an aged care service.

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

**Approval for Government-subsidised Residential Aged Care**

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

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

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

The Aged Care Client Record (ACCR) is a record of the ACAT assessment. The ACCR contains:
- the Application for Approval form (completed by the client)
- the client’s assessment information (completed by the ACAT)
- an approval section (completed by the ACAT delegate).

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

If a person cannot complete the Application for Approval form themselves, it can be completed on their behalf. See section on Emergency Approvals further in this chapter of this Manual.

A person can be approved for one or more of the following types of care:
- residential care (including residential respite care)
- home care
- flexible care.

Flexible care in the form of Transition Care and Multi-Purpose Services may be provided in residential care facilities however in the case of Multi-Purpose Services are not required to be ACAT assessed.

The delegate can decide on any limitations to an approval - for example, a person may be approved for a low level of residential care - and will inform the person who applied for approval of these decisions in writing. These decisions are reviewable and can be appealed. ACAT delegates cannot revoke approvals. Only DSS delegates can revoke approvals. See sections on What Limits can be Placed on Approval to Receive Care and Reviewable
Decisions further in this chapter of this Manual.

**Who can be Approved for Residential Care?**
A person is eligible for residential care if:
- they have physical, medical, social or psychological needs which require residential care
- those needs cannot be met more appropriately through non-residential care services.

A person must meet the following criteria:
- having a condition of frailty or disability and requiring at least low level continuing personal care
- being incapable of living in the community without support
- meeting other eligibility criteria for a level of care for which they are assessed, as set out in the *Classification Principles 1997*.

*See legislative reference - section 5.5, Approval of Care Recipients Principles 1997.*

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

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

**What Limits can be Placed on Approval to Receive Care?**
An approval can be limited to:
- a particular kind of care
- care provided during a specific period starting on the day after the approval
- residential respite care for a specific period
- any other matters or circumstances specified in the Approval of Care Recipients Principles
- a low level of residential care.

*See legislative reference - section 22-2, Aged Care Act 1997.*

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

**Approval for High Level Residential Care**
An ACAT approval will determine whether a person is eligible to receive residential care at either a high or low level. *See legislative reference - section 22-4, Aged Care Act 1997.*

The ACAT will approve a person to receive a high level of residential care when their needs are significant enough to require it. *See legislative reference - section 22-4, Aged Care Act 1997.*

A person approved for a high level of residential care will often require some nursing services.
If a person is approved to receive high level residential care (permanent or respite), they are also eligible to receive residential care at a low level. See legislative reference - section 5.9, Approval of Care Recipient Principles.

Once a person enters permanent residential care, the aged care service must commence the ACFI appraisal within 28 days of their entry, to classify the resident for funding purposes. See also section on Classification of Residents in Chapter 3 of this Manual.

**Payment of Subsidy**
A Government subsidy can only be paid:
- for people who have a current approval to receive care
- for the type and level of care approved
- for care provided in line with any limits set by the approval.

In claiming a subsidy, an approved provider must ensure that the prospective care recipient has current ACAT approval for the type and level of care to be provided.

ACATs are unable to backdate an approval, except in emergency circumstances. See Emergency Approvals further in this chapter of this Manual.

For a person receiving residential respite care, subsidy will not be paid if the person has already used 63 days of respite care in each financial year covered by the approval and no additional 21 day extension periods have been approved prior to the end of the financial year. See legislative reference - section 21.18, Residential Care Subsidy Principles 1997.

**When does an Approval Cease to have Effect?**
An approval for residential care can cease to have effect in one of three ways - it can expire, lapse or be revoked:
- an approval **expires** if it is limited to a specified period of care and that period ends. See legislative reference - section 23-2, Aged Care Act 1997
- an approval for transition care **lapses** if the person does not enter care within four weeks from the day after the approval was given. Approval will also **lapse** if the person leaves transition care for at least one day after the lapsing period ends. See legislative reference - section 23-3(3), Aged Care Act 1997; section 5.14(1), Approval of Care Recipients Principles 1997
- an approval for low level residential care (not provided as residential respite care) **lapses** 12 months from the day after the approval was given. See legislative reference - section 23-3, Aged Care Act 1997
- an approval can be **revoked** if the Secretary is satisfied that the person has ceased to be eligible to receive the care for which they were approved. Only DSS delegates of the Secretary can revoke an approval. See legislative reference - section 23-4, Aged Care Act 1997.

A person can be reassessed at any time if their care needs change. See also chapter on Classification of Residents in this Manual.
When Should an Aged Care Service Request an ACAT Reassessment?

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

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

- there has been a significant change in the person’s care needs and they require approval for a different type or level of care
- a person approved for transition care is not provided with the care to which their approval relates for a period of at least one day after the lapsing period and the person needs additional transition care
- a person’s approval was time limited and has expired
- a person is transferring between facilities, they have aged in place and have a high ACFI classification and they want to pay an accommodation charge rather than rolling over the accommodation bond
- a person with a low level residential care approval leaves residential care for more than 28 days (excluding approved leave) after their approval has lapsed and they want to access Government-subsidised care in an aged care service
- a service provider wishes to remove the interim low subsidy limitation. An ACAT approval for high care is one way the full ACFI high care subsidy may be paid for a resident
- a person’s approval for residential respite care is limited to low and the person’s care needs have changed and they would be eligible for high level respite approval
- an approved provider asks a care recipient to leave a residential care service.

See also section on Four Steps - asking a Resident to Leave in chapter on Residents’ Rights in this Manual.

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

Emergency Approvals

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

Emergency admissions should occur rarely and will usually be precipitated by a crisis situation - for example, if there is no primary carer for the person and there are no other options available. See legislative reference - section 22-5, Aged Care Act 1997.

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

Within five business days the provider should:

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

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

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

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

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

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

Approval Form
The Aged Care Client Record (ACCR) form is held by the ACAT and contains:
• Application for Approval - completed by the person seeking approval
• record of assessment - completed by the ACAT
• approval - completed by the ACAT delegate.

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

When a client enters residential care, they are responsible for providing the aged care service with a copy of the ACCR as evidence of their approval status. Aged care services with access to Department of Human Services (Medicare) (DHS (Medicare)) Aged Care Online Claiming Gateway should always check if a potential client’s approval is valid. See References at the end of this chapter for a link. It is the provider’s responsibility to ensure that a client holds the requisite approval prior to entry if a subsidy is to be paid.
Reviewable Decisions
A decision not to approve a person to receive care, and to set limitations to an approval can be reviewed. A revocation of approval to receive care can also be reviewed. See legislative reference - Division 85, Aged Care Act 1997.

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

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

If someone wants to appeal a decision, they should:
- write to the Secretary within 28 days of receiving the decision (or within any extended period allowed by the Secretary) explaining their reasons for requesting a reconsideration of the decision; and
- send the letter to the state or territory office of DSS in the state or territory where the decision was made.

After receiving a request to review a decision, the Secretary will either:
- confirm the original decision
- vary the decision
- or make a new decision.

If the Secretary has not replied within 90 days of receiving the request, this means that the original decision stands. If the person is dissatisfied with the Secretary’s reconsideration of the decision, they can apply to the Administrative Appeals Tribunal in the state or territory where the decision was made, to review the decision.
The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

ACAT Finder

Administrative Appeals Tribunal
http://www.aat.gov.au

Aged Care Assessment Program Guidelines

Appealing a decision
If someone wants to appeal a decision, they should write to the Secretary of DSS at the following address, within 28 days of receiving the decision:
The Secretary
Department of Social Services
GPO Box 9848
In your capital city

Home Care Packages Program Guidelines

Forms - all
All Departmental forms are available on the following website

DHS (Medicare) Aged Care Online Claiming Gateway

Transition Care Program Guidelines
CLASSIFICATION OF RESIDENTS

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

Overview
Residents of residential aged care services are given a classification according to the level of care they need. The classification of a resident is undertaken primarily to determine the level of care funding payable for that resident. The care funding model is divided into the following three domains:
- activities of daily living (ADL)
- behaviour (BEH)
- complex health care (CHC).

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

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

The assessment of a resident’s care needs utilising the ACFI is called an appraisal. The aged care provider undertakes the appraisal of the resident’s care needs using an ACFI Answer Appraisal Pack. See legislative reference - section 9.17(2), Classification Principles 1997.

An ACFI User Guide is available to assist providers to undertake appraisals. See the References section at the end of this chapter for a link to the ACFI User Guide, ACFI Answer Appraisal Pack and email and telephone contacts for ACFI queries.

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

Applications for classification can be submitted electronically or in hard copy.

Electronic applications can be submitted via:
- Department of Human Services - ACFI web form
Department of Human Services Online Claiming Business to Business (known as B2B) and file upload channel. This requires software developed by a registered software vendor.

See References section at the end of this chapter for a link to the electronic application form.

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

It is an offence to provide false or misleading information on the Application for Classification form. See legislative reference – section 88-3, Aged Care Act 1997; Part 7.4, Criminal Code Act 1995.

The Act also provides a number of other possible consequences of giving false, misleading or inaccurate information in appraisals or reappraisals. For further information, see section on Inaccurate Assessments in Chapter 3 of this Manual.

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

- the requirements of the Act
- any other requirements determined by the Minister, the Secretary or the Chief Executive Officer of the Department of Human Services.

**Classification of Residents**

DSS determines the classification of a resident based on the application for classification completed by the aged care provider and sent to the Department of Human Services. This involves the following steps:

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


See Figure 1 below. See legislative reference - Parts 1 and 2, Schedule 1; and Parts 1 and 2, Schedule 2, Classification Principles 1997.
• **Step 2** - For the complex health care (CHC) domain, DSS will use the complex health care matrix.

See Figure 1 below. See legislative reference - Part 3, Schedule 1; and Part 3, Schedule 2, Classification Principles 1997.

• **Step 3** - The resident’s classification is summarised as a three part code. For example, the code for a resident assessed as being medium in the ADL domain, low in the BEH domain and having no or minimal needs in the CHC domain, would be M-L-N. A provider is not required to submit an application for a resident who has no or minimal assessed care needs in all three domains - i.e. an N-N-N classification.

Exceptions:

- If a valid behavioural diagnosis code is not supplied, the maximum level for the behaviour (BEH) domain is medium (M). See legislative reference - section 9.3B(2) Step 3(b), Classification Principles 1997.

- A resident whose approval by the ACAT delegate for permanent residential care is limited to low care but whose initial appraisal indicates the resident requires a high level of residential care will be classified at an interim low classification. The rate of subsidy for this classification will not exceed the amount determined by the Minister. The resident will remain on the interim low classification until:
  - the resident ages in place including when a DSS review officer confirms that the resident requires a high level of residential care during a review. See section on Existing Resident - Ageing in Place further in this chapter of this Manual
  - or a new approval by an ACAT delegate for permanent residential care is provided, which is not limited to low care.

**Figure 1 - Weightings and range of points for each category**

**ACFI Scores and Funding Categories**

These tables list the scores for the A, B, C and D ratings for each of the 12 ACFI questions, as well as the cut-off points for the Low, Medium and High funding categories in each of the three funding domains.

### Activities of Daily Living Domain (ADL)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scores</th>
<th>ADLs</th>
<th>Category Cut-Off Points:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>1 Nutrition</td>
<td>0</td>
<td>6.69</td>
<td>13.39</td>
</tr>
<tr>
<td>2 Mobility</td>
<td>0</td>
<td>6.88</td>
<td>13.76</td>
</tr>
<tr>
<td>3 Personal Hygiene</td>
<td>0</td>
<td>6.88</td>
<td>13.76</td>
</tr>
<tr>
<td>4 Toileting</td>
<td>0</td>
<td>6.11</td>
<td>12.21</td>
</tr>
<tr>
<td>5 Continence</td>
<td>0</td>
<td>5.79</td>
<td>11.53</td>
</tr>
</tbody>
</table>
### Behaviour Domain (BEH)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scores</th>
<th>Behaviour Domain*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>6 Cognitive Skills</td>
<td>0</td>
<td>6.98</td>
</tr>
<tr>
<td>7 Wandering</td>
<td>0</td>
<td>5.91</td>
</tr>
<tr>
<td>8 Verbal Behaviour</td>
<td>0</td>
<td>7.04</td>
</tr>
<tr>
<td>9 Physical Behaviour</td>
<td>0</td>
<td>7.70</td>
</tr>
<tr>
<td>10 Depression</td>
<td>0</td>
<td>5.71</td>
</tr>
</tbody>
</table>

**Category Cut-Off Points:**
- **High** \( \geq 50 \)
- **Med** \( \geq 30 \)
- **Low** \( \geq 13 \)

**Note:** A rating of C or D on Question 10 is conditional on there being a diagnosis or provisional diagnosis of depression. See ACFI User Guide available at [www.health.gov.au/acfi](http://www.health.gov.au/acfi)

*Behaviour Domain*

To qualify for the highest level of the Behaviour Domain, a dementia diagnosis, provisional dementia diagnosis, psychiatric diagnosis or behavioural diagnosis is required. In the case of diagnoses covering depression, psychotic and neurotic disorders (refer Mental and Behavioural Diagnoses codes 540, 550A, 550B, 560) the diagnosis, provisional diagnosis or re-confirmation of the diagnosis must have been completed within the past 12 months.

### Complex Health Care Domain (CHC)

<table>
<thead>
<tr>
<th>Question 11: Medication</th>
<th>Question 12: Complex Health Care</th>
<th>Complex Health Care Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>A</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>C</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>D</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**High and low care classifications**

In addition to determining the level of care funding, ACFI classifications are used to define a resident as requiring either a high level or a low level of care. The definition of high care under ACFI changed on 1 January 2010. Under the new definition, to be appraised as high care, a resident must have either:
- a score of high in the ADL domain
- or a score of high in the CHC domain
- or a score of medium or high in at least two of the three domains
- or a score of high in the behaviour domain together with a score above nil in at least one of the ADL or CHC domains.

Under the previous definition, to be classified under the ACFI as high care, a resident must have had a score of medium or high in the ADL domain, high in the behaviour domain or medium or high in CHC domain.

When the new definition was applied, some residents who were previously classified as high care or as interim low would have been classified as low care under the new definition. However, this change did not affect the quality of care provided to residents. Grandparenting arrangements were put in place to protect residents whose classification changed from 1 January 2010, from being eligible to pay additional costs.

The Quality of Care Principles 1997 were amended to ensure that existing residents whose classification shifted from high care to low care solely because of the change to the definition of high level of residential care are still entitled to receive the care and services specified in Part 3 of the Schedule of Specified Care and Services at no additional cost to them. See legislative reference - section 18.6(3) and (4), Quality of Care Principles 1997.

There was no change to the level of subsidies provided for different ACFI categories as a result of the new definition. The definition of high level of residential care will continue to include care given to a care recipient whose classification level is high level residential respite care.

**Classification expiry**

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

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


**ACFI Appraisals - When Must an Appraisal be Undertaken**

**New residents**

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

If a person is approved for residential aged care, after he or she enters care, the person will need to be appraised using the ACFI. A new ACFI appraisal is also required for a resident entering an aged care service for high dependency care leave.
Appraisals:
- cannot be conducted in the first seven days after a resident enters care. See legislative reference - section 25-3(2)(a), Aged Care Act 1997
- except if a resident leaves care before seven days have passed. In this instance, an appraisal can be conducted in less than seven days. See legislative reference - section 9.16, Classification Principles 1997
- cannot be submitted to DHS (Medicare), in an application for classification, until after the resident has been in care for 28 days, unless a resident has left care before seven days have passed
- should be conducted within two months of the resident entering care. See legislative reference - section 26-1, Aged Care Act 1997. Any application received by DHS (Medicare) more than two months after a resident has entered care is considered a late appraisal.

If an application is received late, the subsidy paid for that resident will be reduced:
- if the application is received within three months of the end of the appraisal period, the daily subsidy will be reduced by $25 for the period from entry to the day before the late form is received by DHS (Medicare)
- if the application is received more than three months after the end of the appraisal period, no subsidy will be paid from entry to the day before the late form is received by DHS (Medicare) - i.e. a subsidy can only be paid from the day the late form is received by DHS
- if an aged care service believes it sent the application to DHS (Medicare) in sufficient time to be received, the service can write requesting a review of the decision. The service should provide all information that is relevant to whether the application was sent in time.

See References section at the end of this chapter for address.

Reappraisals for Existing Residents
Reappraisals must be completed in the following circumstances:
- when the classification expires. See section on section on Classification of Residents earlier in this chapter of this Manual
- when DSS writes to the aged care service requesting a resident be reappraised. See legislative reference - section 27-3, Aged Care Act 1997.

A resident’s care needs can be reappraised in the following circumstances:
- at any time 12 months or more after the existing classification took effect
- when the resident has a significant change in care needs including when a resident becomes eligible for the Dementia and Severe Behaviours supplement
- at any time when a resident is classified at the lowest applicable classification level
- within two months of a resident transferring from another aged care service. See Existing Resident - Transfer from Another Aged Care Service further in this chapter of this Manual. See legislative reference - section 27-4, Aged Care Act 1997.
**Existing resident - significant change in care needs**

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

- an increase of two or more classification levels - this increase can be within a single care domain - e.g. an increase from low to high in the ADL domain or across two separate domains - e.g. increase from low to medium in both the BEH and CHC domains. See legislative reference - section 9.28(1)(a), Classification Principles 1997
- a single increase from medium to high in the CHC domain if the resident is already categorised as high in ADL. No change in the behaviour domain is required in these circumstances. See legislative reference - section 9.28(1)(b), Classification Principles 1997
- for a resident who is classified at an interim low classification, the resident’s care needs are taken to have changed significantly if this is the result of applying the above rules to the classification level that was determined for the resident by assessing their care needs using the ACFI. See Exceptions within the Classification of Residents section, above Figure 1, earlier in this chapter of this Manual. See legislative reference - section 9.28(2), Classification Principles 1997.

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

A significant change reappraisal can also be submitted if the care recipient becomes eligible for the Dementia and Severe Behaviours Supplement under section 21.26K of the Residential Care Subsidy Principles 1997. The classification resulting from this reappraisal does not expire six months after the date that the application was received by DHS (Medicare) but remains in place until the care recipient leaves care of unless another circumstance takes effect.

**Existing resident - reappraisal of lowest applicable classification**

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

**Existing resident - transfer from another aged care service**

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

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

However, an aged care service can reappraise a resident within two months of the resident entering care, if the existing classification does not reflect the resident’s current care needs. The provider of the original service can provide a copy of the resident’s ACFI Answer Appraisal Pack to the new aged care service. Because approval for permanent residential care will not lapse, a new ACAT approval is not required when a resident transfers from one...
aged care service to another. This includes situations where the initial ACAT approval was limited to low care and the resident has aged in place to high care in the original service.

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

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

Under ACFI, the high care subsidy may be paid for a resident with an ACAT approval limited to low care when the resident ages in place - that is, a high care ACFI reappraisal can be conducted if:
- an existing ACFI classification expires - e.g. following a period of extended hospital leave, or six months after entering care directly from hospital
- there is a significant change in care needs
- there is a voluntary reappraisal 12 months or more after a previous appraisal
- there is a voluntary reappraisal within 28 days of a transfer. See Existing Resident - Transfer from Another Aged Care Service further in this chapter of this Manual.
- a DSS review officer confirms the resident requires a high level of care during a classification review.

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

Exceptions:
- If a resident’s classification expires while they are on extended hospital leave, the reappraisal period is for two months starting on the day the person returns to the service from leave.
- The reappraisal period may also be extended in limited circumstances if an appraisal expires while the resident is on leave (other than extended hospital leave) or within one month after that leave ended.
- If the Secretary gives an approved provider a notice requiring a reappraisal, the reappraisal period is the period specified in the notice.

**Late applications for reappraisal**
If an application for classification is not received during the normal two month reappraisal period, the amount of subsidy paid for the resident will be reduced:
• If the application is received within three months of the end of the reappraisal period, the daily subsidy will be reduced by $25 from the day after the existing classification expires to the day before the late form is received by DHS (Medicare).
• If the application is received more than three months after the end of the reappraisal period, no subsidy is payable from the day after the existing classification expires to the day before the late form is received by DHS (Medicare).
• If an aged care service believes it sent the application to DHS (Medicare) in sufficient time to be received, the service can write to DSS requesting a review of the decision. The service should provide all information that is relevant to whether the application was sent in time. See References at the end of this chapter for address.

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

The Secretary has the power to change an incorrect classification. See legislative reference - Division 29, Aged Care Act 1997. Before changing a classification, the Secretary must review the classification by examining any relevant material on which it was based. The Secretary will examine relevant material or information, including material or information that has become available since the classification was made. See legislative reference - section 29 - 1(3)(c), Aged Care Act 1997.

Site visit classification reviews are undertaken by authorised officers from DSS. See legislative reference - section 91-1(2)(c), Aged Care Act 1997. If requested by the occupier of the aged care premises, the officer must produce their identity card, which includes their name and a photograph, on arrival at the aged care service. A classification review is not a reassessment. Review officers are seeking to confirm that the ACFI appraisal accurately reflected the level of care needed by the resident at the time it was completed by the aged care service and that appropriate evidence was available where required.

Normally, a review officer must not enter an aged care service without consent and must leave if consent is withdrawn. See legislative reference - section 91-1(3), Aged Care Act 1997. However, an approved provider has responsibility to cooperate with a review officer. See legislative reference - section 63-1(1)(b), Aged Care Act 1997. DSS can seek a warrant to conduct reviews without consent if it believes that an aged care service may be using fraudulent or deceptive practices. See legislative reference - Division 92, Aged Care Act 1997. If incorrectly appraised residents are found during a review visit, DSS may review the classification of any other residents in the same service, at its discretion.

Most review visits will be conducted along the following lines:
• A review officer will check the completeness and accuracy of ACFI Answer Appraisal Packs for a sample of residents in a service
• For each reviewed resident, the review officer will then see if the checklists and supporting documentation enclosed in the ACFI Answer Appraisal Pack (e.g. the ACCR, the medication chart, diagnoses) correspond; and may ask to meet the resident
• If there is incongruence between the checklists and the supporting documentation, the review officer may seek further information.

Review officers are authorised under section 90-3 of the Act. If a review officer is unable to support a claim using the available documentation, the review officer can request additional documentation from the approved provider as set out in section 90-4 of the Act. Providing this information at the time of the review allows claims to be validated immediately, thus reducing the need for follow-up actions by providers and review officers.

Review officers may also:
• interview staff
• interview the resident
• observe the resident
• assess the resident’s impairment using simple task assessments
• or undertake an ACFI assessment such as the Psychogeriatric Assessment Scales to confirm that the classification is correct.

Some review visits will focus on particular questions. Some ACFI questions/categories may be reviewed as a desk audit - for example, the service may be asked to provide DSS with copies of the depression diagnoses for residents where there is a C or D claim for ACFI 10 (Depression).

The ACFI record keeping requirements include the complete ACFI Answer Appraisal Pack including the specified enclosures (refer to the ACFI User Guide). In addition, post-appraisal records can be requested as part of the review process.

The service can be asked to produce records to demonstrate usual and ongoing care needs at the time of appraisal.

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

**Notice of a Review Visit**

DSS will usually telephone and give at least two business days’ notice to the aged care service before the proposed date of the review visit. The advance notice allows sufficient time for the approved provider (or occupier of the premises) to give consent to the authorised officers to enter the premises and to ensure that the care manager/director of nursing and the staff member who completed, or is familiar with, the ACFI appraisal process are available during the review. If required, these officers can clarify any aspects of the appraisal documentation.

An occupier of the premises may refuse to give consent for authorised officers to enter the premises and may withdraw consent at any time.
A review visit to an aged care service can be postponed if requested by the approved provider.

**Notice of an At-Desk Review**

DSS will contact the aged care service by telephone to inform them of the intention to conduct an ACFI at-desk review. This initial contact will ensure that the service agrees to this approach otherwise a site visit will occur. Information will then be emailed to the approved provider confirming the review process and giving details of the intention to undertake the at-desk review.

During the course of the review, the review officer will establish a service contact person and keep them advised by telephone as to how the review is proceeding. Following the completion of an at-desk review the review officer will:

- notify the service of the indicative outcomes of the review process, and advise the service that they have two business days to provide additional evidence; and
- offer the service an opportunity to discuss the process via teleconference.

**Roles and Responsibilities**

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

A review officer should:

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

The aged care service should:

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

There will be increasing use of electronic record keeping systems, including for the ACFI. In some cases, the completed ACFI Appraisal Answer Pack may be stored partly in hard copy - with third party documents such as medical practitioner notes and directives, comprehensive medical assessments and the ACCR in hard copy - and partly electronically.
If the electronic record being substituted for a paper record requires signature, date and identification details, the electronic record must contain the same details. If an electronic signature or graphic is used then an approved provider must be able to show that there are systems in place to ensure that the electronic signature or graphic uniquely identifies a person. See also chapter on Record Keeping in this Manual.

The aged care service should also provide the review officer with a work area which allows them to operate in a safe, clean and well-lit environment. If possible, this should include:
- a desk-height work area that has sufficient space to accommodate laptops/computer or IT equipment and documentation for the number of officers conducting the review
- adjustable office chairs
- heating/cooling
- access to power points.

**Exit Meetings**
After the review process, review officers may conduct an exit meeting with appropriate staff. Where classification changes are being considered, the exit meeting can provide the opportunity for the service to understand why a classification may be changed.

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

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

**Notifying the Approved Provider of the Review Outcome**
DSS will send a letter to an approved provider, informing them of the review outcome, usually within 14 business days of the review visit. This letter will include the following information:
- the date of the review decision
- the total number of reviews undertaken
- the name/s of the review officer/s
- a list of the names of residents whose classifications have changed, together with their original and revised categories
- for these residents, copies of the review sheets that constitute the reasons for the decision will also be included
- the right to request a reconsideration of these decisions and the timeframe for doing so.

In certain circumstances there may be a delay of more than 14 days before DSS sends the letter to the approved provider - for example, where the review officer allows the service additional time to locate documentation to support ACFI claims. In such cases, the review officer will notify the service of the delay.
The letter is sent to the approved provider, which is not always located at the same address as the service. It is the approved provider’s responsibility to forward this information to the relevant aged care service.

**Inaccurate Assessments**

The Secretary of DSS can require an approved provider to reappraise one or more residents in its care if it is found that the approved provider has continued to give false, misleading or inaccurate information in ACFI appraisals or reappraisals. DSS can also vary or revoke such a request. See legislative reference - section 27-3, Aged Care Act 1997.

DSS may suspend an approved provider from making ACFI appraisals or reappraisals if the approved provider or the authorised person gives false, misleading or inaccurate information in a number of appraisals that have been reviewed. See legislative reference - section 25-4, Aged Care Act 1997.

If an approved provider is suspended from appraising or reappraising, DSS can defer the suspension if the approved provider agrees to:

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


DSS can also impose sanctions on an approved provider if the approved provider has not complied, or is not complying, with one or more of its responsibilities in terms of accountability. See legislative reference - Part 4.4, Aged Care Act 1997.

**Complaints and Concerns**

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

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

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

**Risk Assessment Approach**

The classification review program uses a risk assessment approach to determine the priority of conducting review visits. DSS continues to refine this approach, based on analysis of the ACFI’s operation since its inception. Review activities may include reviews of complete appraisal documentation for a number of residents, and/or the review of specific questions.
This risk-based approach also aims to reduce the burden on approved providers who make accurate claims under the ACFI. DSS can choose to visit a facility to undertake a review visit at any time it deems necessary. Review officers undertaking visits do not select the services or residents for review and usually do not know why a service has been selected.

**Requests to the Department of Social Services for Reconsideration of Decisions**

An approved provider may request a reconsideration of these other types of decisions:
- to suspend an approved provider from making appraisals and reappraisals
- to refuse to lift such a suspension
- that an appraisal or reappraisal was not sent in sufficient time
- to refuse to renew a classification
- to change the classification of a care recipient.

*See legislative reference - section 85-1, Aged Care Act 1997.*

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

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

Before asking for a decision to be reconsidered, the approved provider should check that the appraisal or reappraisal was conducted in a proper manner. *See legislative reference - section 63-1(h), Aged Care Act 1997.*

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

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

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

A reconsideration decision will be made using the ACFI guidelines in force at the time of the original appraisal by the aged care service. The reconsideration process may require a visit to the aged care service. As reconsideration decisions must be made within a limited timeframe (90 days), a service may not be able to defer such a visit.
The reconsideration officer will:
- examine all relevant documents contained in the ACFI Answer Appraisal Pack used by the aged care service and other relevant documents that may be held by the approved provider, to assess the care needs of the resident against the ACFI, in determining whether the resident’s classification is accurate
- if necessary, interview the resident whose classification is the subject of the review
- clarify with the appropriate care staff, if required, any inconsistent or unclear documentation or details of the resident’s care needs.

Notification of the Reconsideration Decision
DSS must inform an approved provider of the outcome of the reconsideration within 90 days of receiving the request. DSS will:
- notify the approved provider in writing of the reconsideration decision
- inform the relevant DSS state or territory office of the reconsideration decision
- advise DHS (Medicare) to make any necessary adjustments to the subsidy paid to the aged care service.

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

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

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

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

The funding rates are determined by the Minister under section 44-3(2) of the Act. See legislative reference - section 44-3, Aged Care Act 1997. These amounts are subject to indexation - i.e. they are updated annually.

Grandparenting of Resident Classification Scale (RCS) Subsidies
Residents initially classified using the Resident Classification Scale (RCS) have been progressively appraised using the ACFI from 20 March 2008. Grandparenting arrangements ensure that an aged care service continues to receive at least the same subsidy for these residents as was paid under the RCS.
Once the ACFI appraisal has been submitted for existing residents previously classified using the RCS, the Department of Human Services will compare the calculated subsidy under the ACFI model with the existing RCS subsidy. If the subsidy under the ACFI model is $15 or more above the RCS amount, the ACFI subsidy amount will be payable. If not, the existing RCS amount will continue to be paid.
REFERENCES
Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Approved Provider Information Line
ph 1800 057 516

To contact an ACFI Program Manager:
Contact DSS’s switchboard on 1800 020 103 and ask for the relevant state or territory office.

ACFI queries
Email acfi@health.gov.au please include contact details.

ACFI User Guide

ACFI Answer Appraisal Pack

Administrative Appeals Tribunal
www.aat.gov.au

Requests for a change of a resident’s classification to be reconsidered
The Director
Accountability Section
Department of Social Services
MDP 454
GPO Box 9848
Canberra ACT 2601

Applications for classification - to the Department of Human Services
Hard-copy applications for classification should be sent to the Department of Human Services at the below address. In order to be processed, all questions on the application form must be answered clearly, the form must be signed and dated and a pen, not a pencil, must be used.

Telephone contact: 1800 195 206

For the following: NSW, ACT, WA and QLD:

GPO Box 9923
Sydney NSW 2001

For the following: VIC, TAS, SA and NT:

GPO Box 9923
Melbourne VIC 3001

**Forms - all**
All Departmental forms are available on the following website

**High care - ACFI definition from 1 January 2010**

**Late applications for reappraisal - request for review of decision**
The Assistant State Manager
Ageing and Aged Care
Department of Social Services
GPO Box 9848
capital city of the relevant state or territory
CHAPTER 4

FUNDING FOR PERMANENT RESIDENTIAL AGED CARE

From 18 September 2013, the *Aged Care Act 1997* is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services.

To reflect these changes, all references in this Manual to the former Department of Health and Ageing have been changed to the Department of Social Services.

However, it will take some time for the practical application of these changes to flow through. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at [www.health.gov.au](http://www.health.gov.au).

OVERVIEW

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

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

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

When a person enters residential aged care, an approved provider must offer the person a resident agreement, which both the provider and the resident sign. The agreement sets out the policies and practices the provider will follow in setting fees for the resident and the resident’s date of permanent entry to the aged care service. See legislative reference - sections 56-1 and 59-1, Aged Care Act 1997.

Providers may also be eligible to charge additional fees on top of the daily fees and any accommodation payment. A provider may charge an extra service fee, for providing a higher than standard level of accommodation services or food. Residents can also pay providers for additional services - such as hairdressing or hiring a television. These additional fees must be outlined and agreed to in the resident agreement. For more information on extra service, see section on Extra Service Places further in this chapter of this Manual and for more information on resident agreements, see section on Resident Agreements in chapter on Residents’ Rights in this Manual.

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

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

**ACCOMMODATION AND HOTEL SERVICES**

**OVERVIEW**

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

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

Rates and additional information
The maximum rates for fees and charges, including the standard resident contribution, change several times every year. For this reason, actual dollar amounts payable are not included in this Manual. Current rates are available on the website.

Please refer to the References section at the end of this chapter for a link to the relevant website.

How to calculate fees payable by a resident
To calculate the maximum daily fee that a resident may be asked to pay, approved providers should:
1. work out the applicable standard resident contribution
2. add any compensation payment reduction that applies for the resident
3. add any applicable daily income tested reduction for the resident
4. subtract any hardship supplement that applies for the resident
5. add any other amounts agreed between the provider and the resident, that is, agreed fees for additional services
6. if the resident is in an extra service place and receiving care on an extra service basis, add the extra service amount.


For residents residing in an aged care service that is located in a remote area, a remote area allowance amount is also added to the maximum daily fee. See legislative reference - sections 23.82 and 23.83, User Rights Principles 1997.

A resident with assets above the minimum permissible assets threshold may also be asked to pay either an accommodation bond or an accommodation charge.

STANDARD RESIDENT CONTRIBUTION (BASIC DAILY FEE)
The standard resident contribution - also known as the basic daily fee - is paid by all residents as a contribution towards their accommodation and the costs of daily living in the aged care service - such as meals, cleaning, laundry, heating and cooling in the service. From 1 July 2012, the general rule is that the standard resident contribution is 85 per cent of the basic age pension. See legislative reference - section 58-3, Aged Care Act 1997. This includes residents receiving respite care.

While this is the general rule, there are exceptions which fall into two groups:
• protected
• non-standard.
Residents in financial hardship can apply for help paying the standard resident contribution under financial hardship provisions. See Hardship, Standard Resident Contribution and Care Payments (Income Tested Fee) in this Manual.

**Protected resident contribution**
Aged care residents who were in care on 19 September 2009, and who on that day, were self-funded retirees or part pensioners whose private income was equal to or more than the threshold amount for protected residents, are protected from paying higher fees. The basic daily fee for these residents is set at the protected resident contribution rate. *See legislative reference - subsection 58-3B(3), Aged Care Act 1997.*

**Non-standard resident contribution**
Some residents who entered care prior to 20 March 2008 and who meet certain criteria pay the non-standard resident contribution rate until their circumstances change or they leave care. *See legislative reference - subsection 58-3C, Aged Care Act 1997.*

To pay the non-standard resident contribution rate, a resident must have first entered residential aged care before 20 March 2008, and on 19 September 2009 and on each day since that day, the resident must:
- not have a dependent child and meet one of the following criteria
  - not be receiving an income support payment
  - or have paid an accommodation bond that is a big bond*
- or have not provided income and asset information to the Department of Human Services (means not disclosed).

*a big bond is more than 10 times the basic age pension amount at the time of entry into care, if the person entered the service before 20 September 2009 OR nine times the basic age pension amount at the time of entry if the person entered the service on or after 20 September 2009.*

If a resident’s circumstances change on or after 20 September 2009 and the criteria are no longer met, the person would no longer fall into this group and the standard resident contribution rate would apply.

**Phased resident contribution**
The phased resident contribution was the applicable resident contribution rate for a resident who was considered to be a phased resident on a particular day in the period 20 September 2009 to 19 March 2013. From 20 March 2013, the phased resident status ceased to exist. *See legislative reference - section 58-4, Aged Care Act 1997.*

**ACCOMMODATION PAYMENTS**
Accommodation payments, which include accommodation bonds and daily accommodation charges, are worked out according to a resident’s assets - i.e. the proportion of an accommodation payment which the Government will pay and the proportion which the resident will be asked to pay depends on the resident’s assets.
Residents with assets above the minimum assets threshold can be asked to make a contribution toward the cost of their accommodation, through either an accommodation bond or a daily accommodation charge.

Accommodation supplements - including the accommodation supplement, the concessional supplement, the accommodation charge top-up supplement and transitional accommodation supplement - are paid to providers, for residents in their care who have very few assets.

The provider and the resident negotiate accommodation payments, they are not set by the Government. However, the Government does set various legal requirements for accommodation payments.

Only certified aged care services can receive accommodation payments. See also chapter on Certification in this Manual.

A provider cannot charge an accommodation bond unless the service is certified and complies with the various prudential requirements. See also Chapter 5 on Protection and Responsibilities Relating to Accommodation Bonds in this Manual.

A resident can apply to the Secretary to determine that paying an accommodation bond or charge would cause financial hardship to themselves, to their partner or to their dependent child. See section on Hardship and Accommodation Payments in this Manual.

**Accommodation payments and assets testing**

The amount of accommodation charge or bond a provider can ask a resident to pay - and any subsidies the Government may pay for that resident if they have supported, concessional or assisted resident status - depends on the resident’s assets.

For a resident to gain Commonwealth assistance with their accommodation payment, they need to have a current assets assessment completed by either the Department of Human Services (Centrelink) or the Department of Veterans’ Affairs (DVA).

Some residents may choose not to have an assets assessment, give information about their assets or do not provide enough information for the value of their assets to be properly determined. In these cases, the resident can be asked to pay the amount agreed between the resident and the provider, up to the maximum as listed in the current rate sheet. The resident is also ineligible for concessional, assisted or supported resident status and any corresponding supplements.

**The value of a resident’s assets**

The value of a resident’s assets is the net value of all the resident’s assets, including assets outside Australia. Assets can include, but are not limited to, the following:

- accounts including interest free accounts with banks, building societies and credit unions
- interest-bearing deposits
- fixed deposits
- bonds
- debentures
- shares
- investments in property trusts, friendly societies, equity trusts, mortgage trusts and bond trusts
- real estate (the family home may be exempt in some circumstances)
- businesses
- farms
- loans, including interest-free loans
- motor vehicles, boats and caravans
- surrender value of life insurance policies
- investment collections, including investment collections of coins or stamps
- superannuation assets, from which lump sums can be withdrawn
- household contents and personal effects. The value of household contents and personal effects is taken to be $5000 if there is no evidence of another value.


However, a home owned by the resident is not included as an asset if, at the time the assets are assessed:
- the resident’s partner or dependent child is living in it; or
- a carer of the resident has been living there for at least two years, and is eligible to receive an Australian Government income support payment; or
- a close relation has been living there for at least five years, and is eligible to receive an Australia Government income support payment.

See legislative reference - section 44-10(2), Aged Care Act 1997.

If the resident is a member of a couple, the value of the resident’s assets is half the value of the couple’s combined assets. A person will be a member of a couple:
- if they are legally married or in a relationship registered under a state or territory law, providing they are not living separately or apart from the other person on a permanent basis; or
- if they are living in a de facto relationship.

The other person in the relationship may be the same or a different sex. See legislative reference - section 44-10(3), Aged Care Act 1997.

Where an asset is held jointly, or in common, with a person other than the resident’s partner, the value of the asset is taken to be the value of the resident’s interest in the asset. See legislative reference - section 44-10(4), Aged Care Act 1997.

**ACCOMMODATION CHARGE**

Residents can be asked to pay an accommodation charge if they have assets above the minimum assets threshold at date of entry to care and require high level residential aged care that is not on an extra service basis and the resident cannot be charged an accommodation bond. See Legislative reference - section 57A-2(1)(a), Aged Care Act 1997.
An accommodation charge is payable in addition to the basic daily fee and any income tested fee that may apply for that resident.

From 1 October 2011 an approved provider may use accommodation charges at their discretion.

For residents to pay an accommodation charge, they must have assets above the minimum asset level and must have entered into an accommodation charge agreement with the approved provider, which specifies the amount of the accommodation charge. The provider must also advise the resident:

- of the interest rate to be charged on amounts owed under the accommodation charge or resident agreements; and
- when the accommodation charge is not required or, if paid, is refundable.

See Accommodation Payments - Information Provided to Residents and Resident Agreements in this Manual.

The accommodation charge is payable for the entire period of the resident’s admission (however, some exceptions apply) and is paid directly to the provider.

The accommodation charge cannot be charged more than one month in advance. The following residents cannot be asked to pay an accommodation charge:

- residents with assets below the minimum asset level at date of entry to care
- residents receiving low level residential aged care
- respite residents
- fully supported residents
- concessional residents
- a resident who has applied for a determination of financial hardship from the Secretary or for whom a current financial hardship determination applies. These residents can only be asked to pay an accommodation charge:
  - if their application is rejected - i.e. if the Secretary declines to make a determination of financial hardship for that resident. If the resident has agreed to pay an accommodation charge, the accommodation charge is payable from their day of entry to care as a permanent resident
  - if a determination of financial hardship ceases to be in force. If the resident has agreed to pay an accommodation charge, the charge is payable from the day after the determination ceases to be in force.
- residents entering an extra service place may be asked to pay an accommodation bond
- residents who first entered permanent care before 1 July 2004 and have already paid daily accommodation charges for a total of five years, irrespective of any break in care
- charge-exempt residents
- residents who were in care before 1 October 1997, as long as they remain in the same service.

A person other than the resident cannot be required to pay an accommodation charge as a condition of a resident’s entry to an aged care service.
How much is the accommodation charge?
The upper limit for any accommodation charge is set by legislation. The maximum amount of any accommodation charge, up to this limit, depends on the level of the resident’s assets when they enter the service as a permanent resident.

Though DSS advises on the maximum rate of accommodation charge for most residents, the actual amount payable can be negotiated between the resident and provider. See also section on Accommodation Payments and Assets Testing earlier in this chapter of this Manual.

Charge-exempt residents - residents who entered care prior to 1 October 1997
A person who was receiving high level care in an approved bed in an approved nursing home on 30 September 1997, and who then enters an aged care service as a permanent resident, where they are otherwise eligible to pay an accommodation charge (including residents who would be assessed as assisted or partially supported), will be a charge-exempt resident. See legislative reference - section 44-8B, Aged Care Act 1997.

The Department of Social Services will advise of a resident’s charge-exempt status in a fee advice letter. A charge-exempt resident cannot be asked to pay an accommodation charge. See legislative reference - section 57A-2(1)(b), Aged Care Act 1997.

Charge-exempt resident supplement will be paid by the Government where a charge-exempt resident is being provided with residential care in a certified residential care service (except if that care is provided on an extra service basis). See legislative reference - section 44-8A(2), Aged Care Act 1997.

The following residents, however, cannot be charge-exempt:

- residents of uncertified aged care services cannot start paying an accommodation charge and therefore, cannot become charge-exempt residents until the service becomes certified
- residents receiving low level care and those receiving care on an extra service basis cannot be asked to pay the accommodation charge and therefore, cannot be charge-exempt residents
- concessional and fully supported residents cannot be charge-exempt residents, as they cannot be asked to pay an accommodation charge
- residents who were receiving a low level of care on 30 September 1997.

Residents who entered care 1 October 1997 - 30 June 2004 (inclusive)
Depending on their assets, residents who entered care between 1 October 1997 and 19 March 2008 (inclusive):

- may be a concessional resident
- may be an assisted resident
- may have insufficient assets to pay an accommodation charge but are not a concessional resident
- may pay an accommodation charge.
Concessional residents

Concessional residents cannot be asked to pay an accommodation charge. The Government will pay the concessional resident supplement to the provider.

A person who entered care between 1 October 1997 and 30 June 2004 (inclusive), even if they have had a break in care of 28 days or more, will be a concessional resident if, at the time they entered care:

- they had assets less than the minimum permissible asset level
- they were receiving an income support payment
- they had not been a homeowner for two years or more or if they owned a home during that period, the home was occupied by:
  - their partner
  - their dependent child
  - a carer who had occupied the home for at least two years and was eligible to receive an income support payment
  - a close relation who had occupied the home for at least five years and was eligible to receive an income support payment. See legislative reference - section 44-7, Aged Care Act 1997.

A person who entered care between 1 October 1997 and 30 June 2004 (inclusive) will also be a concessional resident if there is a determination that paying an accommodation charge will cause the person financial hardship. See legislative reference - section 44-7(3), Aged Care Act 1997.

Assisted residents

A person who entered care between 1 October 1997 and 30 June 2005 (inclusive), even if they have had a break in care of 28 days or more, will be an assisted resident if, at the time they entered care:

- they had assets more than the minimum permissible asset level and for admissions:
  - prior to 20 September 2009, less than four times the basic single age pension amount
  - on, or after, 20 September 2009, 3.61 times the basic single age pension amount
- they were receiving an income support payment
- they had not been a homeowner for two years or more or if they owned a home during that period, the home was occupied by:
  - their partner
  - their dependent child
  - a carer who had occupied the home for at least two years and was eligible to receive an income support payment
  - a close relation who had occupied the home for at least five years and was eligible to receive an income support payment.


The maximum accommodation charge payable by assisted residents is the margin of assets above the minimum that the resident must be left with divided by 2,080 up to the maximum pre-1 July 2004 assisted accommodation charge rate.
For residents who meet the assisted resident criteria, the Government will also pay the concessional supplement at the assisted resident rate to the provider.

**Insufficient assets to pay an accommodation charge but not concessional**

Residents with assets below the minimum permissible asset value amount, although not concessional residents (for example, because they were not in receipt of an income support pension), cannot be asked to pay an accommodation charge. The concessional resident supplement is not payable for these residents. See legislative reference - sections 57A-2 and 57-12, Aged Care Act 1997.

**Charge-paying residents**

All other eligible residents who entered care between 1 October 1997 and 30 June 2004 (inclusive), even if they have had a break in care of 28 days or more, may be asked to pay an accommodation charge. The rate of accommodation charge is set at the date of entry.

For those residents who are eligible to pay an accommodation charge and entered care before 30 June 2004, the rate of accommodation charge is set at the date of entry and is payable for a maximum of five years.

The five year period is cumulative. Therefore, if a resident moves from one service to another after paying an accommodation charge to the first service, the accommodation charge is only payable to the second service for the remainder of the five years.

**Residents who entered care 1 July 2004 - 19 March 2008 (inclusive)**

The amount of the accommodation charge for residents who entered care between 1 July 2004 and 19 March 2008 (inclusive) can be asked to pay will be based on their asset assessment letter from the Department of Human Services (DHS) or the Department of Veterans’ Affairs (DVA). The approved provider determines the accommodation charge based on this letter.

Depending on their assets, residents who entered care between 1 October 1997 and 19 March 2008 (inclusive):
- may be a concessional resident
- may be an assisted resident
- may have insufficient assets to pay an accommodation charge but are not concessional
- may pay an accommodation charge.

If a resident first entered care between 1 July 2004 and 19 March 2008 (inclusive) but had a break in care of 28 days or more and re-entered care on or after 20 March 2008, they will be treated in the same way as a resident who first entered care on or after 20 March 2008.

**Concessional residents**

Residents with assets below the minimum asset amount who also meet the other concessional resident criteria cannot be asked to pay an accommodation charge. The Government will pay the concessional resident supplement to the provider.
Assisted residents

Residents with assets more than the minimum permissible asset level and for admissions prior to 20 September 2009, less than four times the basic single age pension amount and for admissions on or after 20 September 2009, 3.61 times the basic single age pension amount can be asked to pay a lesser small accommodation charge.

The maximum accommodation charge payable by assisted residents is the margin of assets above the minimum that the resident must be left with, divided by 1,825 up to the maximum pre-20 March 2008 assisted accommodation charge rate.

For residents who meet the assisted resident criteria, DSS may also pay the concessional supplement at the assisted resident rate to the provider.

Charge-paying residents

If the resident is non-concessional, the maximum accommodation charge payable is the margin of assets above the minimum that the resident must be left with, divided by 1,825 up to the maximum pre-20 March 2008 accommodation charge rate.

Insufficient assets to pay an accommodation charge but not concessional

Residents with assets below the minimum asset amount may not meet the criteria to be a concessional resident - for example, because they were not in receipt of an income support payment. While the concessional resident supplement is not payable for these residents, they cannot be asked to pay an accommodation charge.

Residents who entered from 20 March 2008 or entered 1 July 2004 - 20 March 2008 (inclusive) with a break in care and re-entered on/after 20 March 2008

Depending on their assets, post-2008 reform residents - i.e. residents who either entered care after 20 March 2008 or who entered care between 1 July 2004 and 19 March 2008 (inclusive) but who had a break in care of 28 days or more and re-entered care on or after 20 March 2008, may be:

- fully supported residents
- partially supported residents and may also be asked to pay an accommodation charge
- asked to pay an accommodation charge.

Residents with assets below the minimum permissible asset threshold are known as fully supported and cannot be asked to pay an accommodation charge. DSS will pay the maximum amount of accommodation supplement (appropriate to the service) to the provider.

If the resident is a pensioner resident, paying the maximum pensioner accommodation charge, then an accommodation charge top-up supplement will be payable to the provider for that resident. See also section on Accommodation Charge Top Up Supplement further in this chapter of this Manual.
If the resident’s assets are below the maximum asset amount, the maximum accommodation charge is the margin of assets above the minimum that the resident must be left with, divided by 2,080. These residents are known as partially supported and DSS will pay an accommodation supplement to the provider. The amount of accommodation supplement, when added to the amount of accommodation charge, will equal the maximum accommodation charge.

If the resident is not a fully or partially supported resident, the provider may charge the maximum applicable rate of accommodation charge.

**Residents who move to another aged care service**

Special arrangements apply to residents if they move aged care services within 28 days of leaving the previous service. *See legislative reference - section 57A-8A, Aged Care Act 1997.*

If the resident transfers within 28 days, the maximum rate of accommodation charge payable can be no more than the rate payable at the previous aged care service. There is also no requirement for another asset assessment to be done unless the resident believes that there has been a decrease in their assets since the time of the previous asset assessment.

Pre-20 March 2008 residents who were assessed as concessional or assisted in their previous admission can roll over their concessional or assisted status provided that this was determined through an asset assessment done by either Centrelink or DVA. Pre-1 July 2004 concessional or assisted residents will need to have an asset assessment done to determine their status if this had previously been determined by the aged care provider.

If the resident originally entered care after 1 July 2004 and there has been a break in care of 28 days or more, the maximum rate of accommodation charge payable will be reassessed at the date of re-entry into care as though the resident had not had any previous admissions into care.

**Interest on delayed payments**

If the accommodation charge is not paid when it is due, the provider can charge interest on the outstanding amount, provided this was specified in the resident agreement or accommodation charge agreement. Information on interest charges that can apply should be clearly outlined in the accommodation charge agreement.

Interest can be charged starting from one month after the due date. The maximum permissible rate of interest which may be charged is twice the below threshold rate as outlined in the *Social Security Act 1991.* See References at the end of this chapter for a link to ComLaw for this Act. *See legislative reference - section 57A-12, Aged Care Act 1997.*

**Accommodation charge and hardship arrangements**

See Hardship and accommodation payments for information about residents who cannot afford to pay an accommodation charge. *See legislative reference - section 57A-9, Aged Care Act 1997.*
**ACCOMMODATION CHARGE TOP-UP SUPPLEMENT**

The Accommodation Charge Top Up Supplement (ACTUS) is an additional primary supplement paid for pensioner residents who enter an aged care service for high-level care from 20 March 2008 to 19 March 2010 and for whom the combined accommodation supplement and the accommodation charge is less than the maximum accommodation supplement on the day they enter care. See legislative reference - Aged Care (Residential Care Subsidy - amount of accommodation charge top-up supplement) Determination 2008 (No.2) and section 21.25D, Residential Care Subsidy Principles 1997.

This supplement compensates aged care providers for the lower amount of accommodation charge these residents are eligible to pay.

The ACTUS is not payable during pre-entry leave because the resident does not pay the accommodation charge for pre-entry leave days. See Section E on Leave further in this chapter.

Providers may receive ACTUS payments for eligible pensioner residents if:
- the resident is in receipt of an income support payment; and
- is eligible to pay an accommodation charge on entry to the residential aged care service that is less than the accommodation charge the resident would have been eligible to pay if they had not been receiving an income support payment.

For a given eligible resident, the rate of the accommodation charge top up supplement will equal to:
- the maximum rate of the accommodation supplement payable for residents in that aged care service on the resident’s date of entry
- less the maximum rate of the accommodation charge payable by that resident.

**ACCOMMODATION SUPPLEMENT**

The accommodation supplement is payable for eligible permanent residents who entered an aged care service (or commenced pre-entry leave) from 20 March 2008, or have re-entered care (or commenced pre-entry leave) after a break of more than 28 days, from 20 March 2008.

The maximum rate of accommodation supplement increases on 20 March and 20 September each year, in line with movements in the Consumer Price Index (CPI). The accommodation supplement ensures that providers receive the equivalent of the maximum accommodation charge for all residents, either from the resident or the Australian Government or from a combination of both.

The amount of the accommodation supplement is determined by the Minister or worked out in accordance with a method determined by the Minister. For example, see the Aged Care (Residential Care Subsidy - Amount of Accommodation Supplement) Determination 2013 (No. 1). See legislative reference - section 44-5A(3), Aged Care Act 1997.

**Calculating a resident’s supplement**

The level of a new resident’s accommodation supplement depends on:
- the level of their assessable assets
• whether the aged care service meets the 1999 fire safety and 2008 privacy and space requirements
• whether the aged care service provides more than 40 per cent of its eligible care days to supported residents.

*See legislative reference - section 44-5A(4), Aged Care Act 1997; Part 4A, Residential Care Subsidy Principles 1997.*

For example, a 25 per cent discount applies to the supplement where a service does not provide more than 40 per cent of their eligible care days to supported residents. Services where more than 40 per cent of their new residents receive accommodation supplement or a hardship (accommodation bond or charge) supplement will be paid the undiscounted rate for those new residents. Supported, concessional and assisted residents count towards the supported resident ratio.

Supported residents are residents receiving one of the following:
• the concessional resident supplement
• the hardship (accommodation bond) supplement
• the hardship (accommodation charge) supplement
• or the new accommodation supplement.

*Accommodation supplement - assets test*
The Department of Human Services (DHS) or the Department of Veterans’ Affairs (DVA) assess a resident’s assets on behalf of DSS. A person will not be eligible for an accommodation supplement if they choose not to have the level of their assets assessed by DHS or DVA and can be asked to pay the maximum applicable accommodation charge or an accommodation bond. See section on Accommodation Payments and Assets Testing earlier in this chapter of this Manual.

*Accommodation supplement - financial hardship assistance*
Where a resident is provided with financial hardship assistance in respect of an accommodation charge, the accommodation supplement is paid. Where a resident is provided with financial hardship assistance in respect of an accommodation bond, an accommodation supplement is paid where the resident’s realisable assets are less than the maximum permissible asset level for the payment of an accommodation supplement.

*Encouraging quality*
A lower maximum supplement rate will apply to residents in aged care services that do not meet the 1999 fire safety and 2008 privacy and space requirements. This lower maximum supplement rate is equal to the sum of the indexed maximum rates of the current concessional resident supplement and the pensioner supplement.

**SUPPORTED RESIDENT RATIOS**
All aged care services, whether or not they are certified, are required to meet the supported resident ratio - formerly known as the concessional resident ratio - which applies to their region. Sanctions may be applied to those services that do not meet the required ratio.
Providers who are unsure about which region they are in should contact the relevant DSS state or territory office.

In addition to the requirement to meet regional targets, the accommodation supplement payable in respect of an eligible resident (concessional, assisted or supported resident) is reduced where the facility does not provide more than 40 per cent of their eligible care days to supported residents. The discount is set in Ministerial Determination and is 25 per cent. Supported, concessional and assisted residents count towards 40 per cent.

The regional ratio does not apply to services with extra service status or to those distinct parts of a service with extra service status. However, the regional ratio does apply to the non-extra service places in a service with an extra service distinct part. It is also only the residents in the non-extra service part of the facility who are considered when determining whether the facility has provided more than 40 per cent of its eligible care days to supported residents.

**ACCOMMODATION BONDS**

An accommodation bond may be payable by a resident who enters permanent care in a residential aged care service at a low level of care. Residents who enter permanent high level care in an extra service facility can also be asked to pay an accommodation bond. Residents who have previously paid an accommodation bond and who are moving to high care may elect to roll over their accommodation bond.

Some residents entering a Multi-Purpose Service for the equivalent of low level care in a residential setting may also be asked to pay an accommodation bond. See *legislative reference - section 57-2, Aged Care 1997, 23.28B, User Rights Principles 1997.*

With the exception of Multi-Purpose Services, an accommodation bond only becomes payable if the residential care service is certified. See *legislative reference - section 57-2(1)(a), Aged Care Act 1997.*

Residents can choose to pay an accommodation bond as a lump sum, a regular periodic payment or a combination of both. See section on Types of Accommodation Bond Payments further in this chapter of this Manual.

The provider can keep an amount out of the accommodation bond - a retention amount - with the balance of the bond to be refunded to the resident, or their estate, when they leave the service. Providers can also keep any interest from accommodation bonds.

The bond amount is negotiated between an approved provider and a resident. DSS does not receive any of the accommodation bond and does not determine the amount, although the maximum bond that can be paid must leave the resident with a certain level of assets. Providers are not required by law to ask residents for an accommodation bond. However, if they do there are various legal requirements regulating accommodation bonds. See sections on Amount of Accommodation Bond and Types of Accommodation Bond Payments further in this chapter of this Manual. See also section on Protection and Responsibilities Relating to Accommodation Bonds in Chapter 5 of this Manual.
The accommodation bond must be used for a permitted purpose outlined within section 57-17A(1) of the *Aged Care Act 1997* and the approved provider must comply with prudential requirements. See legislative reference - sections 57-2(1)(k) and 57-2(1)(ka) *Aged Care Act 1997*.

**Which residents can be charged an accommodation bond?**

In order for a provider to ask a resident to pay an accommodation bond, a resident must meet the following criteria. They must:

- not be eligible to pay an accommodation charge
- be a low care level resident or be in a service or a distinct part of a service with extra service status, or have agreed to roll over an accommodation bond
- have assets which exceed the minimum permissible asset level
- have entered into an accommodation bond agreement which specifies the amount of the accommodation bond
- have been provided with information about accommodation bonds by the approved provider before they enter care.


The following residents cannot be asked to pay an accommodation bond:

- residents receiving high level residential aged care (except if they are in a service, or a distinct part of a service, with extra service status, or have agreed to roll over their accommodation bond)
- residents with assets below the minimum asset level
- fully supported residents
- concessional residents
- respite residents
- charge-exempt residents
- residents for whom a hardship determination under section 57-14(1)(a) of the Act is in place
  - if such a determination is subsequently revoked or ceases to be in force, the resident can then be charged an accommodation bond, provided that they agreed to the accommodation bond at the time of entry
- residents who were in a nursing home or hostel before 1 October 1997, as long as they remain in the same service - these residents can only be charged an accommodation bond if they move to another service
  - bonds can be charged to existing residents only where the service moves to a totally new catchment area or to a new purpose-built service, either on the same site or in another location, and is classified by DSS as a new service.

A person other than the resident cannot be required to pay an accommodation bond as a condition of a resident’s entry to the aged care service.

**Varying amount of accommodation bond with existing resident**

The amount of an accommodation bond can be varied by mutual agreement between a provider and a resident, provided that any revised amount is not more than the maximum that applied at the time of the person’s entry to care.
Any agreed increase in a bond amount should be associated with an improvement in accommodation for the resident - for example, the resident moving from a shared to a single room.

This does not alter the requirement of the Act that a person transferring between providers cannot be charged as a bond an amount that is greater than the bond balance refundable by the provider they are transferring from, either at the time of transfer or thereafter.

**Amount of accommodation bond**
The maximum amount of any accommodation bond that a person can be asked to pay depends on the level of the resident’s assets when they enter the service as a permanent resident. See also section on Accommodation Payments and Assets Testing earlier in this chapter of this Manual. See legislative reference - section 57-12, Aged Care Act 1997.

Provided that the resident is left with the minimum permissible asset amount, there is no ceiling on the amount of an accommodation bond that can be charged. As of 20 September 2009, the minimum asset amount which a resident must be left with is 2.25 times the annual single rate age pension, rounded to the nearest $500, as at the day they enter care. This rate applies for people whose date of entry to care is after 20 September 2009.

Some residents may choose not to give an approved provider sufficient information to determine their assets. In these cases, the resident can be asked to pay the amount specified in the accommodation bond agreement, as long as the provider is assured that if the resident pays this amount, the resident will still have at least the minimum permissible asset level.

Residents who choose to pay an accommodation bond wholly or partly by periodic payments must still be left with at least the minimum permissible asset value when they enter the aged care service.

**Types of accommodation bond payments**
Residents can pay an accommodation bond as a lump sum, a regular periodic payment or a combination of both. See legislative reference - section 57-17, Aged Care Act 1997.

A resident must not be required to pay a lump sum accommodation bond, including retention and interest amounts, until six months after they have entered care. They can, however, choose to pay before this date. Retention amounts and interest may accrue from the resident’s date of entry to the service. If the service is not certified when the resident enters, the resident must not be required to pay an accommodation bond until the service has been certified for six months.

Periodic payments are payable from the date the resident enters the service, or the date the service is certified if this is later. The resident and the service provider must agree on the frequency of periodic payments, which cannot be more often than weekly.

If the resident has applied for a determination of financial hardship, the resident must not be required to pay an accommodation bond unless the Secretary declines to make such a
determination, or the determination of financial hardship ceases to be in force. See section on Hardship and Accommodation Payments further in this chapter of this Manual.

If the resident has agreed to pay an accommodation bond, and the Secretary does not make a determination of financial hardship, or a determination ceases to be in force, the resident must not be required to pay an accommodation bond until six months after receiving notice from the Secretary.

If the resident has agreed to pay an accommodation bond by periodic payment, these are usually payable from the resident’s date of entry.

**Retention amounts**

A retention amount may be deducted from an accommodation bond balance for each month, or part of a month, for a maximum of five years. The maximum monthly retention amount that a provider may keep from a resident’s accommodation bond is the lower amount of:

- the capped maximum amount applicable at the time the resident enters the aged care service. The capped maximum amount is indexed annually in July in line with the Consumer Price Index
- the amount the provider and resident agree on in the accommodation bond agreement entered into when the resident entered the service.


The retention amount is not set down in the legislation, but the legislation does specify the maximum amounts that may be deducted. The amount needs to be agreed on by the provider and the resident and included in the accommodation bond agreement. Bond agreements may not specify an amount that exceeds the capped maximum.

Where a bond is paid partly by lump sum and partly by periodic payments, the maximum retention amount applies to the total (lump sum equivalent) accommodation bond.

The monthly retention amount that providers can keep cannot change while the resident lives at that aged care service.

Once the five year limit is reached no further retention amounts can be deducted from the bond. The five year period is cumulative and is reduced by each month for which retention amounts were deducted from an accommodation bond (or entry contribution) the resident paid to another aged care service.

If a resident is provided with care for two months or less, retention amounts can be retained for a total of three months - i.e. the whole of the month in which the resident entered the aged care service plus the following two months.

Months commence on the date the resident entered the service and end on the day before the corresponding date in the next month. If there is no such corresponding day, the month ends on the last day of that next month.
The five year period generally commences on the day the recipient enters as a permanent resident. However:

- if the aged care service is not certified on that day, it commences on the day the service becomes certified
- or if a determination of financial hardship is in force for that resident, the day after the day it ceased to be in force
- or if the resident is transferred from respite care to permanent accommodation, the day of the transfer.

If a resident transfers to another aged care service, the maximum retention amount that applies in the new service may be different to the maximum retention amount that applied in the old service:

- in some cases it will increase - for example, where it is linked to CPI and a CPI increase has taken effect. See legislative reference - Part 4, Division 11, User Rights Principles 1997.
- in other cases it will decrease - for example, where it is linked to the amount of the bond and the new bond is less than the old bond due to the deduction of retention amounts. See legislative reference - section 23.71(1)(b), User Rights Principles 1997.
- in some cases, it will stay the same - for example, where it is linked to the amount of the bond, but no retention amounts have been deducted or where it is linked to CPI, and the CPI increase matches the effect of the deduction of retention amounts.

**Example:** Peggy is a bond-paying resident, who entered an aged care service on 30 January 2008 and left on 26 February 2009. The provider could keep 13 months of retentions from Peggy’s bond - i.e. 12 full months from 30 January 2008 to 29 January 2009, plus the part month from 30 January to 26 February 2009.

**Example:** Frank is a bond-paying resident who entered an aged care service on 31 January 2008 and left on 1 March 2009. The provider could keep 14 months of retentions from Frank’s bond - i.e. 13 full months from 31 January 2008 to 28 February 2009 plus the part month of one day in March.

**Interest charges**

Provided that the accommodation bond agreement allows interest to be charged, providers can charge interest on overdue accommodation bonds. While the legislation sets a maximum rate of interest that can be charged, agreements may specify a rate that is less than the maximum permissible interest rate.


The legislation determines the maximum permissible interest rate which residents may be asked to pay:

- on lump sum accommodation bonds which are paid after the date due, including bonds which are unpaid at the time of departure from the aged care service
- on periodic payments of accommodation bonds
- on amounts owed which may be deducted from the bond balance
• in certain situations where the resident leaves the aged care service within two months of entering care.

The rate that applies when the resident arrives is the maximum that can be charged for the period that the resident stays in the service - i.e. the rate does not change. The maximum permissible interest rate for each quarter is available on the website. See References at the end of this chapter for website link and contact information.

Interest can be charged:
• when the resident pays a lump sum bond after the due date - for the days starting on the due date and ending on the day the lump sum was paid. The due date will usually be the date of the resident’s entry to the aged care service or may be the date of certification, if the service is uncertified when the resident enters
• when the resident receives care for two months or less and their bond is refunded within three months of their entry to the aged care service - for the number of days between the day of the refund and the three months after they entered
• when the resident pays a lump sum bond after the due date and it is refunded within three months of entry, the total of the two points above
• when the resident was provided with care for two months or less, and agreed to pay an accommodation bond but did not pay it before they left the aged care service - for the days starting on the due date and ending three months after they entered
• when the resident was provided with care for more than two months, and agreed to pay an accommodation bond, wholly or partly as a lump sum, but did not pay before they left the aged care service - for the days starting on the first day of the month in which the resident entered and ending on the last day of the month in which they left the service.

Interest cannot be charged when a service is uncertified. The number of days detailed above must be reduced to exclude any period during which the service was not certified.

**Periodic payments**

Periodic payments are:
• regular payments from a resident to a provider
• of an amount equivalent to the amount of interest the provider could have derived from the accommodation bond if it had been paid as a lump sum
• plus a retention amount. See legislative reference - section 57-17, Aged Care Act 1997; Part 4, Division 8, User Rights Principles 1997.

Periodic payments are not refundable, unless they are paid for a period for which the resident was not liable for a periodic payment.

The provider may charge the full amount of the periodic payment for the month that the resident leaves the service.

If a resident is in care for less than three calendar months, the service can still charge an amount equal to the periodic payments payable for three months.
A periodic payment includes a component for the retention amount the provider could have received on the lump sum equivalent, and a component for the income that the provider could have derived from the lump sum equivalent. See previous section on Interest Charges earlier in this chapter of this Manual.

**Retention component of a periodic payment**

Periodic payments can only include a retention component for a maximum of five years. For the remainder of the person’s period in care, the periodic payment would be based only on the income the provider could have derived from the lump sum equivalent.

If an accommodation bond is paid partly as a lump sum, and partly through periodic payments, the retention amounts can be included wholly in the periodic payment formula or deducted wholly from the lump sum, or partly through each in an agreed proportion.

**Calculating periodic payments**

The formula for calculating the periodic payment for the first five years in care is (rounded to the nearest cent):

\[
\frac{(\text{lump sum equivalent} \times \text{interest rate per cent}^*) + (12 \times \text{monthly retention amount})}{\text{number of periodic payments in the year}}
\]

* A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the website. See References at the end of this chapter for a link.

**Examples**

The total accommodation bond is $90,000 and is not paid at date of entry. The interest rate is 10 per cent (example rate only*), and payments are made monthly. The monthly periodic payment, including retention and interest, is:

\[
\frac{($90,000 \times 10 \text{ per cent}) + (12 \times $299.00)}{12} = $1049.00
\]

* A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the website. See References at the end of this chapter for a link.

After the first five years in care, the payment would be calculated only on the interest* payable on the lump sum. In the above example, the monthly periodic payment would be reduced to:

\[
\frac{$90,000 \times 10 \text{ per cent}}{12} = $750
\]

* A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the website. See References at the end of this chapter for a link.
The total accommodation bond is $90,000. The resident pays $60,000 of it as a lump sum with a remaining lump sum equivalent of $30,000. If the monthly retentions of $299.00 were taken equally from the periodic payment and the lump sum, then the monthly periodic payment for the first five years in care would be:

\[
\frac{($30,000 \times 10\text{ per cent}^*) + (12 \times $299.00 \div 2)}{12} = $399.50
\]

* A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the website. See References at the end of this chapter for a link.

The total accommodation bond is $90,000, with $60,000 of it agreed to be paid as a lump sum and the remaining lump sum equivalent of $30,000. If the monthly retentions were taken wholly from the lump sum, with none of them included in the periodic payments, then the periodic payment for the whole of the period in care would be:

\[
\frac{($30,000 \times 10\text{ per cent}^*) + $0}{12} = $250
\]

* A provider can charge interest up to the maximum permissible interest rate. The current maximum permissible interest rate is available on the website. See References at the end of this chapter for a link.

**Refunding the accommodation bond balance**


**Residents who move to another aged care service**

Special arrangements apply to residents if they move aged care services within 28 days of leaving the previous service. *See legislative reference - section 57-13, Aged Care Act 1997.*

If the resident transfers to another service, to receive low level care, the maximum amount of accommodation bond that can be charged by the second service is the balance of the previous accommodation bond.

If the resident transfers to another service to receive high level care, they can choose (with the agreement of the service provider) to either have the balance of their accommodation bond rolled over to the second service or to begin to pay an accommodation charge.

Pre-20 March 2008 residents who were assessed as concessional or assisted in their previous admission can roll over their concessional or assisted status provided that this was determined through an asset assessment done by either the Department of Human Services or the Department of Veterans’ Affairs.
Pre-1 July 2004 concessional or assisted residents will need to have an asset assessment done to determine their status if this had previously been determined by the aged care provider.

**What if the resident’s care needs increase after entry?**

If a bond-paying resident’s care needs increase from low to high care after entering a service, the original bond agreement cannot be changed into an accommodation charge agreement.

However, if a resident moves from one service to another because the first service is unable to provide the higher level care the resident needs, then a new accommodation payment agreement may be entered into for the second entry.

**Transitional accommodation supplement**

Approved providers will be eligible for a transitional accommodation supplement for some new residents who enter low level care.

The transitional accommodation supplement will be paid for new permanent residents who entered low-level care after 20 March 2008 and before 19 September 2011, for whom the level of the accommodation supplement would be less than the level of the pensioner supplement it replaces. Initially, this transitional accommodation supplement will fully offset the loss of pensioner supplement and largely offset the loss of the additional basic day fee for these residents. The rate of the supplement will depend on the resident’s entry date.

**Accommodation bonds and hardship**

Financial hardship assistance is available to aged care residents who do not have sufficient assets to pay their accommodation payment. See section on Hardship and Accommodation Payments further in this chapter in this Manual. See legislative reference - section 57-14, Aged Care Act 1997.

**CHANGES TO ACCOMMODATION PAYMENT ARRANGEMENTS**

New accommodation payment arrangements commence on 1 July 2014 and replace the current system of accommodation bonds and accommodation charges for new residents entering care from this date. Information on accommodation payments can be found on the Living Longer Living Better website including in the fact sheet ‘Changes to Accommodation Payments from 1 July 2014’. This manual will be updated to include information on the new accommodation payments regime when it commences.

**Approval of Accommodation Payments Above $550,000**

From 31 January 2014, approved providers are required to seek approval of accommodation payments above a threshold of $550,000 (set by the Minister) that they intend to charge residents from 1 July 2014. The Aged Care Pricing Commissioner may approve the higher maximum accommodation payment after having considered certain factors specified in the Fees and Payments Principles 2014.

More information can be found at the Pricing Commissioner’s website at [www.acpc.gov.au](http://www.acpc.gov.au).
Approval of Accommodation Payments Above $550,000

From 31 January 2014, approved providers are required to seek approval of accommodation payments above a threshold of $550,000 (set by the Minister) that they intend to charge residents from 1 July 2014. The Aged Care Pricing Commissioner may approve the higher maximum accommodation payment after having considered certain factors specified in the Fees and Payments Principles 2014.

More information can be found at the Pricing Commissioner’s website at www.acpc.gov.au.

Transitional Business Advisory Services

The Government announced that it will provide Government subsidised business advisory services for residential aged care providers to assist them to prepare for and transition to the new accommodation payments system that take effect from 1 July 2014. The Transitional Business Advisory Services will be made available to providers from late March 2014.

More information can be found at www.kpmg.com/au/tbas.

ACCOMMODATION PAYMENTS - INFORMATION PROVIDED TO RESIDENTS AND RESIDENT AGREEMENTS


The approved provider should enter into an accommodation payment agreement with the care recipient within 21 days of entering a facility in order to charge an accommodation payment. Extensions may be sought in limited circumstances. See legislative reference - sections 57A-2 and 57A-3, Aged Care Act 1997.

An accommodation payment agreement is required even if the accommodation payment will not be payable until the facility becomes certified or where financial hardship provisions apply.

An accommodation payment agreement may be incorporated into a resident agreement. See legislative reference - section 57A-4, Aged Care Act 1997.

Essential information in accommodation charge agreements

Providers must include the following in an accommodation charge agreement:

- the amount of the daily accommodation charge
- the resident’s date of permanent entry to the aged care service
- how the daily accommodation charge is to be paid and when it is payable
- if interest is payable on outstanding charges, the interest rate to be charged
- if the accommodation charge entitles the resident to specific accommodation or additional services (additional services are those which the provider is not required to provide under the Act)
- if the resident has obtained or has applied to the Department of Social Services (DSS) for a determination that paying an accommodation charge would cause financial hardship,
the amount of daily accommodation charge which will be payable if the determination stops being in force, or if DSS declines to make such a determination

- information about the accommodation charge which the resident agrees that the provider can give to the approved provider of a different residential aged care service, if a resident wants to move to that service. This includes whether the care recipient has agreed to pay an accommodation charge and the period remaining for which accommodation charges may be levied.


If an agreement does not include the above detail, it is not an accommodation charge agreement under the Act. No provision in an accommodation charge agreement can override the provisions of the Act or the Aged Care Principles. See legislative reference - Division 57A, section 57A-5, Aged Care Act 1997.

**Essential information to be provided to care recipients**

If a provider asks a resident to pay an accommodation bond, the provider must give the resident the following information before they enter the service:

- the amounts of bonds charged
- payment options available to the resident - e.g. lump sum, periodic or a combination of both
- the retention amount and the periods for which retention amounts can be retained by the provider
- the interest rate on the bond if there is a delay in payment, or if the bond is paid wholly or partly by periodic payments, and the periods when interest is payable by the resident
- that amounts owed by the resident under the accommodation bond agreement, any resident agreement and any extra service agreement, plus any accrued interest on these amounts owed, can be deducted from the accommodation bond balance before it is refunded to the resident
- when a bond is not required, or is refundable
- refund arrangements
- information about the service’s prudential arrangements - this includes providing a copy of the service’s most recent Annual Prudential Compliance Statement
- if the resident has given the provider sufficient information to establish the value of their assets, the requirement that the resident must be left with assets of at least the minimum permissible asset value after paying the bond. See legislative reference - section 57-2(1)(d), Aged Care Act 1997; section 23.28, User Rights Principles 1997.

**Accommodation bond agreements**

An accommodation bond agreement must specify:

- the bond amount
- the resident’s date of permanent entry to the aged care service
- how and when the bond is to be paid
- if the bond is to be paid wholly or partly by periodic payments
  - the amount of the lump sum equivalent
  - the amount and frequency of periodic payments
  - the components representing retention and income

Residential Care Manual 2014
- whether interest charges are payable if periodic payments are overdue
- the right of the resident to convert to a lump sum at any time
- the interest rate payable if there is a delay in payment of the bond or if the bond is paid wholly or partly by periodic payments
- that before the accommodation bond balance is refunded to the resident, amounts owed by the resident under the accommodation bond agreement, resident agreement or extra service agreement, plus any accrued interest on these amounts can be deducted from the balance
- conditions which will apply if a person agrees to pay a bond but does not enter the aged care service
- if agreement to pay a bond, or a bond of a certain size, entitles the resident to specific accommodation or additional services (additional services are those which the provider is not required by legislation to provide)
- if the accommodation bond is more than nine times (10 times if prior to 20 September 2009) the annual basic single age pension, any additional resident fees payable by the resident as a result of the aged care service not being entitled to pensioner supplement for that resident
- if the resident has obtained, or has applied to the Department of Social Services (DSS) for a determination that payment of an accommodation bond would cause financial hardship, the amount of accommodation bond that would be payable if the determination stopped being in force, or if DSS declined to make such a determination
- the amount the provider can charge if the resident stays two months or less
- the dollar amount of each retention amount and when it will be deducted
  - such an amount must not exceed the maximum retention amount which applies at the time of entry to the aged care service
  - if transferring to another aged care service, the retention amount should be the amount calculated on the bond payable at the second service
- the circumstances in which the bond must be refunded and the way the refund will be worked out
- prudential arrangements for the bond
- information about the accommodation bond which the resident agrees that the service provider may provide to the new aged care service when the resident wishes to move to that new service, including:
  - the amount of any accommodation bond agreed, including the lump sum equivalent if the amount is to be paid wholly or partly by periodic payments
  - the retention amounts and the period remaining in which retention amounts can be deducted
  - any amounts owed under an accommodation bond agreement, resident agreement or extra service agreement which can be deducted from the accommodation bond balance, if the bond was paid wholly or partly as a lump sum. See legislative reference - section 57-9, Aged Care Act 1997; Part 4, Division 5, User Rights Principles 1997.

If an agreement does not set out the above matters, it is not an accommodation bond agreement under the Act. No provision in an accommodation bond agreement can override the provisions of the Aged Care Act 1997 or the Aged Care Principles. See legislative reference - Division 57, section 57-11, Aged Care Act 1997.
An accommodation bond agreement can be incorporated into another agreement, for instance a resident agreement or extra service agreement.

**EXTRA SERVICE FEE**
The extra service amount is the maximum additional amount a provider can charge a resident for receiving extra service in a residential care service with extra service status. Extra service status is granted for services, or distinct parts of services, where residents are provided with significantly higher standards of accommodation and food. See legislative reference - *Part 2.5, Division 35, Aged Care Act 1997; Part 6, Extra Service Principles 1997.*

A resident pays an extra service amount in addition to other fees, which includes the resident contribution (also known as the basic daily fee) and may include an income tested fee.

The amount of the extra service fee must be approved by the Secretary. A provider cannot charge any fees above the approved extra service fee amount, for any of the accommodation, services or food specified in the conditions of grant of extra service status.

If a resident is occupying an extra service status place, the residential care subsidy for that resident is reduced by 25 per cent of the approved extra service fee for that place.

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

The extra service amount is $25 - i.e. the extra service fee ($20 per day) plus the extra service reduction ($5 per day).

See section on Fees and Payments in Chapter 2 on Extra Service Places in this Manual.

**The Aged Care Pricing Commissioner**
The Aged Care Pricing Commissioner (Pricing Commissioner) is an independent, statutory office holder appointed under the *Aged Care Act 1997* and reports to the Assistant Minister for Social Services.

The functions of the Pricing Commissioner include:
- the approval of extra service fees;
- the approval of proposed accommodation payments that are higher than the maximum amount determined by the Minister; and
- any other functions conferred on the Pricing Commissioner by the Minister or under Commonwealth law.

Applications for approval to charge above the maximum accommodation payment determined by the Minister may be submitted to the Pricing Commissioner from 31 January 2014. Residential care providers must publish their accommodation prices from 19 March 2014 and may charge the approved prices from 1 July 2014.
New arrangements for the approval of extra service fees will commence on 1 July 2014. From that date, residential aged care providers will need to apply to the Pricing Commissioner for approval of new or increased extra service fees that a residential aged care provider may charge a person.

More information can be found at the Pricing Commissioner’s website, [www.acpc.gov.au](http://www.acpc.gov.au).

**FEES FOR ADDITIONAL SERVICES**
An approved provider may charge a resident additional fees for additional services - for example hairdressing - which the resident has asked the provider to provide and which have been set out in the resident agreement. The amount of any charge for additional services must be agreed beforehand with the resident and an itemised account given to the resident once the service has been provided. *See legislative reference - section 56-1(d), Aged Care Act 1997.*

Residents cannot be asked to pay extra for the care and services that the provider is required to provide. See also chapter on Specified Care and Services in this Manual.

**GRANDPARENTING ARRANGEMENTS**

*Concessional resident supplement*
A concessional resident is a person who cannot afford to pay an accommodation bond or accommodation charge and who initially entered permanent care prior to 20 March 2008. The Government pays the concessional resident supplement for them and providers are required to set aside a certain number of places for concessional and supported residents. *See legislative reference - sections 44-6 and 44-7, Aged Care Act 1997.*

A person can also be a concessional resident if the Secretary has made a determination that paying an accommodation bond or charge would cause the person financial hardship. *See legislative reference - section 57-14 and 57A-9, Aged Care Act 1997.*

The concessional resident supplement stops if this determination ceases to be in force because, for example, previously unrealisable assets have actually been realised.

Concessional resident supplement can only be paid:
- for concessional and assisted residents who initially entered an aged care service between 1 October 1997 and 19 March 2008 and who are in a certified service.

Concessional resident supplement cannot be paid for:
- residents receiving care on an extra service basis
- respite residents
- the lowest classification level. The supplement can be paid if the resident’s classification level rises. The supplement may still be paid when a resident, classified at a higher level, is attracting basic subsidy at the lowest level only because the resident is on extended hospital leave.
Providers must meet regionally-based ratios for concessional, assisted and supported residents. Assisted residents are also counted towards concessional resident ratios.

**Concessional resident - eligibility**

Concessional resident status is determined based on a resident’s circumstances on the day he or she entered the aged care service. To be a concessional resident, a resident:

- must be a pre-March 2008 reform resident - i.e. have initially entered an aged care service before 20 March 2008
- must not have had an absence from care for a continuous period of more than 28 days after 20 March 2008
- must be receiving an income support payment
- must not have owned a home for the past two years or more; and
- have assets of less than the applicable minimum asset level.

For concessional resident purposes, a person is taken not to have owned a home if at the time they entered the aged care service their home is occupied by:

- their partner or dependent child
  - a dependent child includes a child under 16 years or a full-time student under 25 years. A child is dependent even if the resident does not have custody of that child, if the resident is paying child support for that child under the Child Support Scheme or another legally binding arrangement
- a carer who has lived in the home continuously for the past two years and that carer is eligible for an income support payment at the time the person enters the aged care home
- or a close relation who has lived in the home continuously for the past five years and that close relation is eligible for an income support payment at the time the person enters the aged care home.

The resident is not classed as a home-owner in determining concessional resident status if the value of their interest in the home does not exceed an amount that is 2.25 times the basic age pension amount at the time they enter the aged care service. The value of their home is still included in calculating their assets.

A person is not considered to be a home-owner in determining assisted resident status if the value of their interest in the home does not exceed an amount that is 3.61 times the annual single basic rate age pension. The value of their home is still included in calculating their assets.

**Structure of the concessional resident supplement**

The concessional resident supplement is paid at a high and a low rate depending on the proportion of place days occupied by the combined number of concessional and assisted residents, as follows:

- The lower rate is paid for all concessional residents in services where up to 40 per cent of post-30 September 1997 residents are supported, concessional or assisted residents
- The higher rate is paid for all concessional residents in services where more than 40 per cent of their post-30 September 1997 residents are supported, concessional or assisted residents
• Aged care services will be paid the full rate of the accommodation supplement for new residents, if more than 40 per cent of their permanent residents are supported residents. See section on Accommodation Supplement in this Manual.

**Assisted residents**
Aged care services receive an assisted resident supplement. The criteria for determining assisted resident status are the same as for concessional resident status except that:
• an assisted resident has assets of between 2.25 and 3.61 times the annual single basic age pension amount, rounded to the nearest $500.

An assisted resident, unlike a concessional resident, may be asked to pay an accommodation bond or charge as long as the resident is left with assets of at least 2.25 times the annual single basic pension amount.

**Charge-exempt resident supplement**
The rate of charge-exempt resident supplement is equal to the concessional supplement and is also indexed in March and September each year. The charge-exempt resident supplement rate is reduced by the amount of the assisted or supported resident supplement for charge-exempt residents who are also assisted or supported residents. See References at the end of this chapter for a link to current supplement rates. See legislative reference - sections 44-8A and 44-8B, Aged Care Act 1997.

**Charge-exempt residents and supported resident ratios**
Service providers should encourage any potential charge-exempt residents to complete a request for an assets assessment form if they have not already done so, even though the resident will not be asked to pay an accommodation charge. Residents assessed as concessional, assisted or supported will be counted towards an aged care service’s supported ratios, whereas charge-exempt residents are not.

**Pensioner supplement**
Pensioner supplement is payable for pre-March 2008 reform residents who either have a dependent child or receive an income support payment and have not agreed to pay a big bond. A big bond is more than 10 times the basic age pension amount at the time of entry into care, if the person entered the service before 20 September 2009 or nine times the basic age pension amount at the time of entry if the person entered the service on or after 20 September 2009. See legislative reference - section 44-28, Aged Care Act 1997.

**Transitional supplement**
Residents who were already in aged care services prior to 1 October 1997 cannot be asked to pay an accommodation charge or an accommodation bond or be considered for a supported or concessional resident status while they remain a resident in the same service. See legislative reference - Part 10, Division 3, Residential Care Subsidy Principles 1997.

Providers also have a responsibility to provide security of tenure for all residents, and it is a condition of approval that residents are not discharged and re-admitted in order to receive extra funding.
Providers therefore receive a transitional supplement for these residents.

**Grandparenting of hostel variable fees**

Residents who entered a hostel before 1 October 1997 and who had sufficient income may have agreed to pay a higher variable fee at that time. The grandparenting arrangements allow providers to continue to charge the 30 September 1997 variable fee for these residents, less any residential care allowance (rent assistance) the residents may have received at that time.

The grandparenting arrangements only apply to residents who:

- occupied a hostel place on 30 September 1997
- on that day, paid a fee which, after deducting any residential care allowance they may have received, was greater than the fee would otherwise have been under the Act.

Grandparented fees cease permanently if:

- the resident leaves the hostel
- the resident’s fee under the grandparenting arrangements falls below the applicable resident contribution.

Providers must review the resident’s grandparented fee annually or more often if the resident requests it. The grandparented fee must be reduced if the review indicates that the resident’s income has fallen from the 30 September 1997 level, or from the most recently reviewed level of income. The amount of the reduction to the grandparented fee is the amount of reduction in the resident’s net income.

The grandparented fee cannot be increased as a result of a review.

Income for the purpose of reviews of grandparented fees is to be calculated in accordance with the General Conditions formulated under section 10F of the *Aged or Disabled Persons Care Act 1954*. Actual income, rather than the deemed amount is to be used and the income amount should be net of any income tax and Medicare levy.

Where residents get non-weekly income, such as periodic interest payments through the year, the payments are averaged to a weekly rate and added to any other weekly income to produce an average weekly income. See ComLaw at [www.comlaw.gov.au](http://www.comlaw.gov.au) for a link to this Act.

**Transitional arrangements for entry contributions**

Special transitional arrangements apply for residents who agreed, prior to the 1 October 1997 introduction of the current arrangements, to pay an entry contribution under the *Aged or Disabled Persons Care Act 1954*.

The requirements of the general conditions under section 10F of the *Aged or Disabled Persons Care Act 1954* continue to apply for those entry contributions, including:

- refunds of the appropriate entry contribution amount must be made within six calendar months of the resident’s departure from the service, unless the resident moves to
another aged care service within 28 days of departing, in which case the rules of the Aged Care Act apply

- in calculating the amount of the entry contribution refund, retention amounts may be deducted for each six-month period the resident has lived in the hostel. If the resident’s period of residence is not exactly divisible by six-month periods, the final period is deemed to be a six-month period
- if a resident delays payment of the entry contribution, in addition to the usual retention amounts, the service can retain an amount equivalent to the retention amount for each six month period, or part thereof, that the payment is delayed, up to a maximum of five years.
- if a resident moves to another aged care service within 28 days of leaving the first aged care service where an entry contribution was paid, or agreed to be paid, the maximum accommodation bond which may be charged by the second service is the amount of the entry contribution refund from the first service
- the entry contribution refund from the first service must be made within seven days.

The five-year period for which retention amounts can be deducted from accommodation bonds are affected by any periods for which the resident’s entry contribution has had retention amounts deducted. Each six-month period for which retention amounts have been deducted from the entry contribution count as six months toward the five-year period.

**FUNDING AND INCOME FOR CARE SERVICES**

**OVERVIEW**
Care payments contribute to the cost of providing care for residents of aged care services.

The care payment includes a basic subsidy or residential care subsidy amount, which is based on a resident’s classification under the Aged Care Funding Instrument (ACFI) and additional supplements.

The amount of basic subsidy which the Government pays to a provider for providing residential care to a resident may be reduced if the resident is able to contribute to the cost of their own care and pay an income tested fee. If they can contribute, then an amount known as the income tested subsidy reduction will apply to the basic subsidy.

The Government sets the maximum income tested fee that the provider may charge, depending on the resident’s income.

For residents who enter care from 1 January 2010, the income tested fee will apply from the day of entry.

For residents who entered care before 1 January 2010, an income tested fee did not apply until the 29th day after a resident’s date of admission.

Residents may be asked to pay an interim fee until they are advised of their income tested fee amount. The purpose of the interim fee is to prevent the resident being faced with a large back payment once they are advised of their income tested fee. The amount of the
interim fee is to be agreed between the resident and the aged care provider and should be included in the resident agreement.

**Rates and additional information**
The rates for fees, subsidies and supplements, including the basic subsidy and the income tested fee, change several times every year. For this reason, actual dollar amounts payable are not included in this Manual. Current rates are available on the website.

Refer to the References section at the end of this chapter for a link to the relevant website.

**How to calculate fees payable by a resident**
To calculate the maximum daily fee that a resident may be asked to pay, approved providers should:

1. work out the applicable standard resident contribution
2. add any compensation payment reduction that applies for the resident
3. add any applicable daily income tested reduction for the resident
4. subtract any hardship supplement that applies for the resident
5. add any other amounts agreed between the provider and the resident, that is, agreed fees for additional services
6. if the resident is in an extra service place and receiving care on an extra service basis, add the extra service amount.

For residents residing in an aged care service that is located in a remote area, a remote area allowance amount is also added to the maximum daily fee. See legislative reference - sections 23.82 and 23.83, User Rights Principles.

A resident with assets above the minimum permissible assets threshold may also be asked to pay an accommodation bond or an accommodation charge.

**RESIDENTIAL CARE SUBSIDY**
The Government pays approved providers an amount of residential care subsidy, where they are eligible to receive subsidy, for the residential care they provide to residents approved for that form of care. See legislative reference - Part 3.1, Aged Care Act 1997.

Residential care subsidy is paid monthly and is calculated by adding the amounts due for each resident for each day of the month. Providers submit a claim for each month, including the details of each resident for whom they are claiming subsidy in that month. They receive an advance payment in the first few days of each month. This advance payment is then reconciled with the claim for that month and the following month’s payment is adjusted accordingly, either by making an additional payment or by reducing the total amount paid in lieu of the previous month.

A provider can be paid residential care subsidies in the following circumstances:
- only accredited services are eligible for subsidies
on any day, subsidy can only be paid for the number of places allocated to the provider
- if subsidy is claimed for more residents than the allocated number of places, residents are excluded from subsidy in reverse order - i.e. the last resident who entered is the first one excluded from the claim
- if another person is operating the aged care service, for example under a contract or a lease arrangement, the approved provider remains the person eligible for the subsidy. This means that it is the approved provider who is responsible for meeting all the responsibilities of providing approved residential care
- providers are paid for a resident’s first day of care
  - a resident’s day of entry and day of departure are counted as one day.

**How residential care subsidy is paid**

Residential care subsidy is payable to approved providers for each eligible approved resident cared for during the claim period. If a provider has approved places in more than one service, separate claims must be made for each service.

The claim period for residential care subsidy is one calendar month:
- if a service opens during a month, the first claim period is from the opening day to the end of the month, and thereafter monthly
- if a service closes during a month, the claim period is from the first day of the month to the day of closure.

The Department of Human Services (Medicare) (DHS(Medicare)) makes an advance payment at the start of each month, generally by the third working day of each month. The calculation of the monthly advance payment is based on a service’s actual entitlements for the monthly claim period two months ago.

For example, the calculation of the advance payment for September is based on the actual entitlements for July.

Therefore, a service’s claim form must have been received and processed by DHS(Medicare) before the advance can be made. In the case of new services, the first two advances will be manually estimated by DHS(Medicare).

At the end of each month, a service must submit a formal claim for payment to DHS(Medicare). To assist services, DHS(Medicare) provides each service with a pre-populated claim form listing their residents’ details. Each service is then required to confirm or amend the details on the claim before the form is submitted to DHS(Medicare) for processing.

Upon receipt of the claim form, DHS(Medicare) calculates the actual entitlement of the service. If the entitlement exceeds the advance, an additional payment will be made to DHS(Medicare) whereas if the advance exceeds the entitlement, a negative amount will be carried forward to a future claim. At this stage DHS(Medicare) will also send the service a payment statement and include a pre-populated claim form for the next month.
Example
This is how the funding cycle would operate for September and October:
• the September advance is based on the final entitlement for July
• this July entitlement is pro-rated for the number of days in September - i.e. if the final calculated entitlement for July was $100,000, the September advance would be $100,000 divided by 31 days (the number of days in July) times 30 days (number of days in September)
• the July entitlement is calculated in late August and paid in early September
  - the provider acquits the September advance in October, advising changes to resident details that occurred during September
  - the September claim is processed within seven working days of it being received and any adjustments are made to the advance
• if the advance was too small, a further payment is made
• if the advance was too large, a negative amount is carried forward to a future claim
• late in September, the October advance is calculated, based on the final entitlement for August, and paid by the third working day in October.

Claims for residential care subsidy
Every month DSS sends providers an explanatory advice about their payments and provides forms to be completed for claiming subsidy for residents within the aged care service.

For each month, the claim for payment:
• must be forwarded on the approved form along with any supporting documentation, such as a medical practitioner’s certification for a claim for enteral feeding
• providers should ensure that any changes to bank account details are notified promptly on the banking details for the direct deposit of payments form.

Working out the amount of residential care subsidy
A provider’s residential subsidy amount for the claim period is:
• the sum of the subsidy for each resident of the aged care service
• for each day during which residential care was provided to the resident; and
• for each day on which the resident was eligible for subsidy.

The amount of residential care subsidy for a month can be calculated from:
1. the basic subsidy amount, given the service’s number and mix of residents and their classification under the Aged Care Funding Instrument (ACFI)
2. plus any primary supplements
3. less any reductions in subsidy
4. less any reduction resulting from income testing of residents
5. plus any other supplements.

In certain circumstances, some other amounts may also be deducted from the payments to a provider in relation to repayment of capital grants, payment of additional recurrent funding and recovery of overpayments.
Basic subsidy amount

The basic subsidy for a resident, for the payment period, is obtained by adding the amounts applicable for each day in the period for which the resident received residential care through the aged care service. Different rates apply depending on a range of factors. These include:

- each resident’s ACFI classification
- whether the care provided is respite. Respite care recipients can be admitted at either high care or low care level
- each resident’s Aged Care Assessment Team (ACAT) assessment
- periods of leave.

See legislative reference - section 44-3, Aged Care Act 1997; section 21.11, Residential Care Subsidy Principles 1997

Subsidies will not be paid:

- for the day a resident leaves an aged care service
- to one provider if another provider is being paid for providing care to the resident for that same day - this ensures that if a resident is on leave, the original service is still eligible for subsidy for that resident, even if the resident enters another service during the leave period. See section on High-dependency Care Leave further in this chapter of this Manual for the only exception to this rule.

Transitional measures

Because nursing service proprietors were paid for the last day of care rather than the first prior to 1 October 1997, nursing service proprietors are paid for the day on which existing residents at 1 October 1997 leave the aged care service.

Conditional adjustment payment

The Conditional Adjustment Payment (CAP) provides financial assistance to residential care providers to assist them to become more efficient and to improve their corporate governance and financial management practices.

Receipt of CAP funding by individual approved providers is voluntary, and is conditional on compliance with requirements set out in the Residential Care Subsidy Principles.

The CAP payment is calculated as a percentage of the basic subsidy payable in respect of each resident. CAP is also applied to the basic subsidy amounts in calculating the rates of payment for the Multi-purpose Services program and the flexible services funded under the Aboriginal and Torres Strait Islander Aged Care Strategy.

For providers to remain eligible to receive CAP, they must satisfy the following three eligibility conditions see legislative Reference –Part 10, Division 4, Residential Care Subsidy Principles 1997:

- encourage staff training
- prepare a general purpose financial report for each financial year have that report audited and be able to provide a copy of that report to residents or a person or agency authorised by the Secretary to DSS
• participate in any aged care workforce census conducted by DSS.

**Eligible oxygen treatment and enteral feeding supplement**

Oxygen and enteral feeding supplements are primary supplements paid to aged care services for residents with a specified medical need for the continual administration of oxygen and/or enteral feeding. This includes residents receiving respite care and is irrespective of the classification level of the resident. *See legislative reference - sections 44-13 & 44-14, Aged Care Act 1997; Parts 8 & 9, Residential Care Subsidy Principles 1997.*

A medical practitioner must certify in writing that the care recipient has a continual need for the administration of oxygen or a medical need for enteral feeding and DHS(Medicare) must sight this documentation.

Standard supplements are available for residents who require oxygen and/or enteral feeding. A higher supplement may be approved where higher costs are incurred. To apply for the oxygen and/or enteral feeding supplement, the aged care service must complete an application for the oxygen and/or enteral feeding supplement. This form is available on the DHS(Medicare) website. See References at the end of this chapter for a link.

**Oxygen supplement**

*See legislative reference - section 21.21, Residential Care Subsidy Principles 1997.*

To be eligible for the oxygen supplement, a resident must have an ongoing medical need for the administration of oxygen - i.e. the resident must need oxygen on a continual basis rather than for episodic or short-term illnesses, such as bronchitis. This need will normally be met by a concentrator.

The standard supplement allows for some cylinder oxygen, such as for social outings and required use within the aged care service.

A higher supplement may be approved for a resident whose medical requirements cannot be met by concentrator oxygen. A higher level supplement may only be approved if the costs incurred are 25 per cent or more above the standard supplement. Oxygen must be administered in the most economical way available, taking into account the medical needs of the resident.

To verify the care recipient’s medical needs, a medical practitioner must certify in writing:
- the care recipient’s particular oxygen requirements; and
- that the care recipient has a continual need for the administration of oxygen.

**Enteral feeding supplement**

*See legislative reference - section 21.23, Residential Care Subsidy Principles 1997.*

To be eligible for an enteral feeding supplement a resident must be receiving a nutritionally complete formula by means of a nasogastric, gastrostomy or jejunostomy feeding method.
The enteral feeding supplement is not payable for intermittent or supplementary enteral feeding that is given in addition to oral feeding.

There are two levels of the supplement, one for bolus and another for non-bolus feeding.

A higher level supplement may only be approved if the costs incurred are 25 per cent or more above the standard supplement.

The enteral feeding must be administered in the most economical way available, taking into account the medical needs of the care recipient.

To verify the care recipient’s medical needs, the following is required:

- written certification by a medical practitioner that the care recipient has a medical need for enteral feeding. See legislative reference - section 21.23(1), Residential Care Subsidy Principles 1997.
- written certification by a medical practitioner or dietician that the dietary formula prescribed is nutritionally complete. See legislative reference - section 21.23(3), Residential Care Subsidy Principles 1997
- the care recipient’s particular enteral feeding requirements. These can be detailed in the medical certificate, the resident’s care plan, hospital discharge papers or in the dietician’s enteral feeding instructions.

**Payroll tax supplement**

Payroll tax is a state/territory based tax levied upon employers whose total payroll costs exceed the relevant threshold amount in their particular state or territory. The payroll tax supplement is paid to aged care services in recognition of the unique costs associated with the provision of aged care.

The supplement is paid with respect to care related staff only, rather than for all staff employed by business enterprises, such as administrative assistants. The supplement is payable to approved residential aged care facilities only. It is not payable to independent living units, or in respect of Home Care Packages, Home and Community Care (HACC) and any other non-residential aged care programs.

Approved providers are eligible for the payroll tax supplement in relation to all permanent and respite residents, except for those classified as N-N-N under the Aged Care Funding Instrument (ACFI), and for any remaining residents classified at Resident Classification Scale (RCS) 1 to 7, if:

- they are an approved provider under the Act
- they provide that resident with residential care under the Act; and
- they have either a direct payroll tax liability or an indirect payroll tax liability.

Facilities can claim either a direct or indirect liability.

Direct payroll tax liability is the payroll tax owed by an employer to the relevant state or territory revenue office for wages paid by that employer to its employees. The employer is
registered with the relevant state or territory revenue office as being either individually, or as part of a group, responsible for the payment of payroll tax.

A payroll tax group occurs where two or more businesses are registered with their respective relevant state or territory revenue office where, in total, they are responsible for the payment of the group’s direct payroll tax liability. Groups may consist of businesses across more than one state or territory, and/or more than one approved provider. To find out more about grouping contact the Department of Human Services - Medicare Australia.

Employers who are charitable and not-for-profit organisations typically incur an indirect payroll tax liability. Indirect payroll tax liability occurs where a provider is not registered with a state or territory revenue office for the purposes of paying payroll tax, but pays invoices to another business, including a cost breakdown showing the payroll tax component of any services rendered.

Who can claim the payroll tax supplement?

To be eligible to claim the payroll tax supplement, an aged care service must meet the following criteria:

- the service must be operated by an approved provider. See legislative reference - Part 2.1, Aged Care Act 1997.
- the approved provider must either be a registered or non-registered entity
  - a registered entity is an approved provider that is registered with their relevant state or territory revenue office for payroll tax. See legislative reference - section 21.25(4), Residential Care Subsidy Principles 1997.
  - a non-registered entity is an approved provider that is not registered with their relevant state or territory revenue office for payroll tax. These providers have incurred a liability to pay payroll tax to a registered entity in relation to residential care services. See legislative reference - section 21.25(5), Residential Care Subsidy Principles 1997.
- the approved provider must be able to substantiate to DHS(Medicare) any claims for payment of the supplement - i.e. invoices or evidence of registration for payroll tax liability.

How the payroll tax supplement is calculated

The way in which the amount of supplement is calculated will vary according to whether the approved provider has a direct or indirect payroll tax liability in relation to residential care provided to care recipients.

The payroll tax supplement calculation includes the total of basic subsidy payments, primary supplement payments, relevant subsidy reductions, as well as bed day totals paid in the previous financial year to determine the payroll tax supplement in the current financial year. More detail on the calculation is set out in the Aged Care (Payroll Tax Supplement) Determination 2001, which is available at www.comlaw.gov.au. New facilities that have no prior funding history to draw from are paid a default rate which is equal to the state or territory average payroll tax supplement rate for the state in which the service is located.
Approved providers should consult their financial or tax adviser for information on the relevant state or territory payroll tax supplement rates which may apply to their services and how to calculate payroll tax supplements.

**INCOME TESTED FEE**
The aged care income test determines whether a person is eligible to pay an income tested fee and, if so, the amount of fee that is payable.

Residents who have the means to pay an income tested fee can be asked to pay this fee from the first day that they receive care. A person on pre-entry leave is taken to have commenced receiving care. See section on [Income Tested Fees Payable from First Day of Care in this Manual](#).

**Which residents cannot pay an income tested fee?**
The following residents cannot be asked to pay income tested fees:
- full pensioners (means tested pension)
- respite care resident
- former Australian prisoners of war
- residents who have one or more dependent children
- residents who the Secretary determines should have their income tested fees reduced to zero - when considering a care recipient’s application for a determination the Secretary must have regard to the factors set out in section 21.29A of the Residential Care Subsidy Principles
- residents who die before their maximum income tested fee has been notified to the provider by the Department of Social Services (DSS). There will be a lapse between the death of a resident and DSS updating its records to reflect the death, so DSS may advise of the maximum income tested fee for that resident after they have died. Providers must not recover income tested fees from the resident’s estate in these cases
- residents who depart from the aged care service before their income tested fee amount has been notified to the provider and who do not move to another service
- residents who could otherwise have been asked to pay a maximum income tested fee of less than $1.00 per day
- residents who do not receive sufficient income to be asked to pay an income tested fee
- people who were permanent residents in an aged care service between 1 October 1997 and 28 February 1998 inclusive, even if they move to another service or take a break before entering another service.


**Maximum income tested fee**
The maximum income tested fee that a resident can be asked to pay, is the lesser of:
- the assessed income tested fee based on their income
- or the maximum income care tested fee
- or the cost of care.

The maximum income tested fee is capped and from 20 September 2009 is equivalent to 135 per cent of the basic age pension worked out on a daily basis.
**Working out the amount of income tested fee**

Residents may be asked to pay an income tested fee if their total assessable income is above the applicable threshold rate. The income tested fee is then calculated as 5/12th of income above the applicable threshold rate.

The only exception to the above calculation is for pre-March 2008 reform residents who will have their income tested fee set at the lesser of the amounts calculated as follows:
- 5/12th of all income above the threshold rate
- or 25 per cent of private income above the age pension income test amount.

**INCOME TESTING PROCESS**

The major steps and processes in the income testing process are as follows:

**Resident entry record (RER)**

The provider completes and sends in a RER for each new resident to their Aged Care, DHS(Medicare) state office. Providers are required to complete an RER for each new resident within 28 days of them entering permanent care. However, providers are advised to return the RER as soon as possible after the resident enters care, so that the matching process can commence. See legislative reference – section 63-1B, Aged Care Act 1997, section 21.30; Residential Care Subsidy Principles 1997.

**Data matching and income assessment**

Information from the RER is passed electronically to the Department of Human Services (DHS) and the Department of Veterans’ Affairs (DVA) for data matching. For people receiving an income support payment such as age or service pensions, the resident’s income amount is identified by either DHS or DVA from information already on record for that person. For other residents, and for people receiving non-means tested pensions such as aged blind pension, DVA war widow pension, or DVA disability pension, their income amount can be worked out on the form ‘Residential aged fee income assessment’. This form is available from DHS Centrelink. See References section at the end of this chapter for information on how to obtain this form.

To protect residents’ privacy, only agreed information is transferred between Departments in the income testing process. Serious penalties apply if any of the protection of resident privacy is breached.

Data matching occurs automatically in most cases and a person’s income amount is passed electronically to DSS.

**Applicable fees and fee advice letters**

DSS uses the income amount to calculate the maximum basic daily fee and income tested fee. DSS writes to both the resident and provider to inform them of their assessed maximum basic daily fee and/or income tested fee.
Residents cannot appeal to DSS against the advised maximum income tested fee, since this is based on a formula applied to the assessed income. However, they can appeal through either DHS Centrelink or DVA if they disagree with the assessed income amount on which the maximum income tested fee is based.

A resident can apply to DSS under the aged care hardship provisions, if the resident can show that paying their advised daily fee would cause genuine financial hardship. If a determination of financial hardship is granted, the resident’s fee will be reduced by the amount of the hardship supplement notified in the determination. See Section D on Hardship further in this chapter of this Manual.

For most residents, the income testing process is completed within a week of DSS being advised of their entry to permanent care.

However, if no letter has been received within a month of the RER being sent:
- the provider should check that the information on the RER is exactly the same as it appears on the resident’s pension concession card
- check whether non-pensioner residents have completed and returned the form ‘Residential aged fee income assessment’ to DHS Centrelink
- pensioners may also need to contact DHS Centrelink or DVA if they have not been matched
- the provider can contact DSS for further investigation.

Revised fees

DHS Centrelink and DVA electronically pass revised income amounts to DSS as they occur. Changes may occur automatically - for example, financial assets reviews - or as a result of information provided by the resident or their representative. DSS uses the revised income amount to calculate the revised maximum basic daily fee and/or income tested fee, if applicable. DSS advises the service and the resident about changes to the fees at quarterly review times or when a significant change occurs - DHS Centrelink form ‘Residential aged fee income assessment’.

For residents who cannot be automatically matched for income assessment, DHS Centrelink uses information obtained from this form to assess income. Residents such as self-funded retirees and those who do not receive a means-tested payment, should complete and return this form as soon as possible, so that this information can be used for their income assessment.

Residents who choose not to provide income information should be informed that they may be asked to pay the maximum fee, or their cost of care, whichever is less. Residents should be encouraged to seek financial advice before choosing this option. This form is available from DHS Centrelink. See References at the end of this chapter for information on how to obtain this form.

Residents who do not provide income information (means not disclosed residents)

Residents who cannot be identified as DVA or DHS Centrelink means-tested pensioners and who do not complete the form ‘Residential aged fee income assessment’ will be identified
to DSS by DHS Centrelink as means not disclosed (MND). For these residents, DSS will apply the maximum income tested fee.

MND residents can choose, at any time, to provide their income and asset information to DHS Centrelink. Once DHS Centrelink has conducted the income assessment, the income tested fee will be reassessed and adjusted accordingly.

**Reviews of income tested fees**
The Department of Social Services (DSS) will conduct reviews of residents income tested fees. These reviews can occur automatically when a resident’s circumstances change, at set times or manually. Some reviews will also calculate any refund of overcharged income tested fees that the resident may be entitled to. Residents will only receive review advice letters if there has been a change in their income tested fee or they are entitled to a refund.

The different types of reviews are:
- significant change - this review will occur when there is a significant change in the resident’s income status - for example, when a resident’s status changes from MND to having provided information to DHS Centrelink.
- ACFI - an ACFI review occurs if the initial ACFI assessment is placed on the aged care payment system after the resident has had an initial income tested fee set. This ensures that residents are not asked to pay an income tested fee that is more than their cost of care.
- ad-hoc - DSS can perform ad-hoc reviews if requested to by a resident. If the resident believes that there has been a reduction to their income, and they have had a reassessment done by either DHS Centrelink or DVA, they can contact My Aged Care on 1800 200 422 to request a review of their income tested fee.
- quarterly (which can calculate a refund amount) - DSS reviews all residents income tested fees four times a year. The effective date of the changes to the income tested fees will be 20 March, 1 July, 20 September and 1 January. The set income tested fee will only change if it has been reduced or there has been an increase of more than 10 cents per day. These reviews will also calculate any refund amount that the resident may be entitled to for periods prior to the quarterly review effective date. See section on Refunds of Overcharged Income Tested Fees further in this chapter of this Manual.
- discharge (which can calculate a refund amount) - when DSS receives advice that a resident has been discharged from an aged care service, a discharge review will be conducted to calculate any refund amount that the resident may be entitled to for overcharged income tested fees for periods up to the date of discharge.

**Refunds of overcharged income tested fees**
When the Department of Social Services (DSS) conducts quarterly and discharge reviews, a calculation of the previously charged amounts will occur to determine whether the resident has been overcharged for any past periods.

Generally the refund calculation will only look at periods that have not previously been included at quarterly review times, up to the date of the last certified claim period. For example, if a resident was admitted on 1 January and the first quarterly review was conducted on 20 March, the refund calculation would look at the period from 1 January to
28 February (provided that this was the last certified claim month for the aged care service). The following quarterly review, if conducted on 10 June, would look at the period from 1 March to 31 May (provided that this was the last certified claim month).

However, refund calculations will also look at any periods in which the resident has had a change to their assessed income amounts. For example, if in the above situation DSS had received advice, on 20 May, that the resident had a change to their income backdated to date of admission, the quarterly review conducted on 10 June would then look at the period from date of admission up to 31 May.

Providers are required, under the Act, to charge residents no more than the amount permitted under the Act. They therefore must pay any advised refund amounts to the resident or their estate. Full details of the refund, including the period and the corrected amount of income tested fee, are provided on the next payment statement generated after the review is conducted.

REMOTE AREA ALLOWANCE
DHS Centrelink pays a remote area allowance to pensioners who live in certain remote areas. Providers whose aged care service is located in one of these areas may charge residents of that service an additional daily amount. See legislative reference - subsections 23.82 and 23.83, User Rights Principles 1997.

Providers who wish to check whether their aged care service is located in a qualifying remote area should contact DHS Centrelink. The maximum amount from the remote area allowance an approved provider can currently charge a resident can be found on the website. See the References section at the end of this chapter for the website link.

GOVERNMENT-FUNDED SUPPLEMENTS AND SUBSIDY REDUCTIONS
OVERVIEW
Additional supplements referred to in the following pages are funded wholly by the Government. They are paid to approved providers in recognition of the high costs associated with providing certain types of residential aged care, such as respite care or with providing residential aged care in certain locations, such as remote and rural areas.

Information on reductions in subsidy which apply to residents who have a compensation entitlement and to residents receiving care in extra service places is also outlined in the section on Reductions in Subsidy further in this chapter of this Manual.

Rates and additional information
The rates for supplements change over the course of a year. For this reason, actual dollar amounts payable are not included in this Manual. Current rates are available on the website. See the References section at the end of this chapter for website link.

HOW TO CALCULATE FEES PAYABLE BY A RESIDENT
To calculate the maximum daily fee that a resident may be asked to pay, approved providers should see legislative reference - sections 58-1& 58-2, Aged Care Act 1997:
1. work out the applicable standard resident contribution
2. add any compensation payment reduction that applies for the resident
3. add any applicable daily income tested reduction for the resident
4. subtract any hardship supplement that applies for the resident
5. add any other amounts agreed between the provider and the resident, that is, agreed fees for additional services
6. if the resident is in an extra service place and receiving care on an extra service basis, add the extra service amount.

For residents residing in an aged care service that is located in a remote area, a remote area allowance amount is also added to the maximum daily fee. See legislative reference - sections 23.82 and 23.83, User Rights Principles.

A resident may also be asked to pay an accommodation bond or an accommodation charge.

**HOMELESS SUPPLEMENT**

The Homeless Supplement aims to better support aged care homes that specialise in caring for people with a history of, or at risk of, homelessness. The Homeless Supplement commenced from October 2013.

Aged care homes registered for the homeless component of the Viability Supplement with greater than 50% of all residents meeting the homeless criterion automatically receive the Homeless Supplement.

There is no additional application process for the Homeless Supplement for aged care homes registered for the homeless component of the Viability Supplement. New aged care homes can apply for the homeless component of the Viability Supplement through existing Viability Supplement processes.


**VIABILITY SUPPLEMENT**

Some residential aged care services in rural and remote areas receive the Viability Supplement in recognition of the higher costs of providing care in those regions. See legislative reference - Part 14, sections 21.33 to 21.35C, Residential Care Subsidy Principles 1997.

The Viability Supplement aims to improve the capacity of small, rural aged care services to offer quality care to residents. Providers do not need to apply for the Viability Supplement. The supplement is paid automatically, every month, to eligible providers. However, to be eligible for the expansion points, a home must be registered with DSS and have appraised more than 50 per cent of care recipients as meeting the criteria for homelessness and/or Indigenous Australians. See Viability Supplement - Additional Support for Residential Aged Care Homes Specialising in Care for Indigenous Australians and the Homeless.
Services with extra service status are not eligible for the Viability Supplement.

In addition to the current Viability Supplement scheme, which is known as the 2005 scheme, there are two previous schemes - the 2001 scheme and the 1997 scheme.

The amount paid under the current Viability Supplement increased from 1 January 2010 and also expanded as part of the 2011-12 budget.

Services will continue to be paid under previous schemes, unless they would receive an increase in the supplement under the 2005 scheme.

**Viability Supplement-current 2005 scheme**

The amount of Viability Supplement paid to eligible services through the 2005 Viability Supplement scheme increased from 1 January 2010, under one of several 2009 Budget measures related to aged care funding arrangements. See legislative reference – section 21.35C, Residential Care Subsidy Principles 1997.

Payment of the additional Viability Supplement will automatically be made through the existing aged care payment system. Providers do not need to apply for the increased supplement.

The increase only relates to the 2005 scheme - the current scheme. This measure does not result in a reduction in payment for the 1997 or 2001 schemes. If an aged care provider participating in the 1997 or 2001 schemes would receive a higher supplement under the 2005 scheme, it will be transferred to the 2005 scheme.

Funding for the current 2005 scheme is based on points scored in relation to the following three criteria:

- the location
- the amount of residents requiring low level care and that the service is in a very remote location, a remote location or a moderately accessible location; and
- care is targeted towards homeless people and Aboriginal and Torres Strait Islander people (or both).


To be eligible for the 2005 scheme, a service must score at least 50 points out of a possible 100. See Points System at the end of this Chapter.

**Viability Supplement points calculator:**

<table>
<thead>
<tr>
<th>Step 1.</th>
<th>Work out the number of points (if any) applicable to the service in respect of its location under subsection (3).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2.</td>
<td>Add an additional 15 points if more than 50 per cent of care recipients of the service (other than care recipients receiving respite care) require a low level of residential care and the service is in a very remote location, a remote location or a moderately accessible location.</td>
</tr>
</tbody>
</table>
Viability Supplement points calculator:

<table>
<thead>
<tr>
<th>Step 3.</th>
<th>Add the number of points (if any) applicable to the service in respect of targeting care for homeless people, people from an Aboriginal and Torres Strait Islander community, or both, under subsection (4).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 4.</td>
<td>If the total of Steps 1, 2 and 3 is more than 65, then reduce the total to 65 points.</td>
</tr>
<tr>
<td>Step 5.</td>
<td>Add the number of points (if any) applicable to the service in respect of its number of places under subsection (5).</td>
</tr>
<tr>
<td>Step 6.</td>
<td>Add an additional 5 points if more than 50 per cent of care recipients are *people with special needs (other than people who are people with special needs only because they live in rural or remote areas or are financially or socially disadvantaged).</td>
</tr>
</tbody>
</table>

See the References section at the end of this chapter for a link to Accessibility/Remoteness Index of Australia (ARIA) scores for all locations and for current rates for the Viability Supplement.

**Viability Supplement-previous schemes**

All services that received viability funding under the 1997 or 2001 viability funding arrangements will continue to receive at least their level of viability funding received under the previous arrangements until they close, relocate or cease to be eligible under the previous arrangements.

Where a service’s score under the 2005 scheme’s criteria is such that the rate of funding under the 2005 arrangements is greater than the rate of funding under the previous arrangements, the service will receive its entitlement under the 2005 arrangements.

If adjacent services combine and at least one of these facilities was receiving Viability Supplement under a previous scheme, the combined service will be reassessed for the Viability Supplement under the 2005 viability arrangements.

**Viability Supplement - Additional Support for Residential Aged Care Homes Specialising in Care for Indigenous Australians and the Homeless**

As part of the 2011-12 Budget, measures were introduced to expand existing funding under the Viability Supplement to provide additional support to:

- aged care homes in very remote to moderately accessible locations that target low care
- eligible aged care homes that provide specialist aged care services to Indigenous Australians
- eligible aged care homes that provide specialist aged care services to people with a history of (or who may be at severe risk of) homelessness.

The extension of the Viability Supplement to services that target low level residential care in very remote to moderately accessible locations will automatically be paid by the DHS(Medicare). Approved providers will not need to notify DHS of eligibility in this instance.
Who is eligible to register?
Eligible providers are those funded by the Australian Government with aged care homes specialising in caring for homeless and/or Indigenous Australians. Funding is only available to residential aged care providers that receive subsidies for care recipients based on Aged Care Funding Instrument (ACFI) appraisals. Funding is not available to home care and other services supported through the flexible care provisions of the Aged Care Act 1997.

How do providers register their eligibility?
To establish that the approved provider targets care for homeless and ATSI people, the service must send an email to Viability.Supplement.expansion@health.gov.au with the following information:

- a history and track record in providing access for people who are homeless or at risk of homelessness and/or Indigenous Australians
- a continuing commitment to target and predominantly focus on the needs of one or both of these groups
- the capacity to provide high quality care that meets the specific needs of these groups
- the capacity to promote access to the broad range of services relevant to the needs of these groups; and
- the capacity to link with relevant local services and communities, including agencies which may provide sources of client referrals.

Upon request, supporting evidence must be made available to DSS.

APPRAISAL OF CARE RECEIPIENTS
It is important to note that while registration is necessary to receive payment, it does not automatically result in additional payments.

Approved providers have two months after the day a resident enters the service to complete the appraisal procedures and notify the DHS of the outcome of the appraisal, but should not submit the notification until at least 28 days after the resident entered the service. This is in line with requirements under the ACFI. Where late submission of appraisal outcomes are received, any additional amount of viability supplement will be payable only from the day the notification is received by DHS.

Appraisal Tools A or B must be used when appraising residents under step 3 of the Viability Supplement points calculator.

More information will be provided to eligible providers, upon successful registration, on the process to provide notification to DHS on eligible care recipients for inclusion towards the 50 per cent requirement quota.

Points system

<table>
<thead>
<tr>
<th>Item</th>
<th>Criterion</th>
<th>Points</th>
<th>Viability supplement points calculator</th>
</tr>
</thead>
</table>

Residential Care Manual 2014
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Location/provider type:</strong> The sum of points for each of the following three elements, up to a maximum total of 65: <strong>Location:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- very remote location</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>- remote location</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>- moderately accessible location</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>- accessible location</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>- highly accessible location</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>- Targets low care needs in above locations (very remote), (remote) or (moderately accessible location)</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>- Targets Homelessness and/or Indigenous people with complex behavioural and social needs</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td><strong>Places:</strong> <strong>Step 5</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- less than 20</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>- more than 19 but less than 25</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>- more than 24 but less than 30</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>- more than 29 but less than 35</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>- more than 34 but less than 40</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>- more than 39 but less than 45</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td><strong>Special needs:</strong> the proportion of residents in the service who have special needs (excluding people who are financially or socially disadvantaged and people living in rural and remote areas). If more than 50 per cent of the residents are Aboriginal or Torres Strait Islander people, people from a non-English speaking background, veterans or war widows, the service receives 5 eligibility points</td>
<td>5</td>
</tr>
</tbody>
</table>

1. To qualify for this item the aged care provider must:
   - be registered with the Department of Social Services (DSS) as a specialist service targeting Homelessness and/or Indigenous people with complex behavioural and social needs; and
   - have more than 50 per cent of care recipients who have been appraised as having care needs associated with homelessness against the approved DSS Appraisal Tool A ‘Homelessness: additional special needs’ or Appraisal Tool B ‘Indigenous Australians: additional special needs’. Refer to the website for more information about these Appraisal Tools A and B at [http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rural-viability-](http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rural-viability-)
2. More than 50 per cent of residents have a Low Care classification level i.e. one that consists of domain categories other than those mentioned in the definition of high level of residential care.

3. Homes eligible under item 1 - Targets Homelessness and/or Indigenous people with complex behavioural and social needs above will automatically be eligible for 5 points under this category - effectively, eligibility under item 1 - Targets Homelessness and/or Indigenous people with complex behavioural and social needs will confer a total of 65 points.

**RESPITE SUPPLEMENT**

An approved provider is eligible for residential care subsidy, including the respite supplement, for each day they provide residential respite care to an approved respite care recipient who has not used up his or her annual allocation of respite days. For more information on the respite supplement, see section on Residential Care Subsidies in the chapter on Residential Respite Care in this Manual.

**REDUCTIONS IN SUBSIDY**

*Compensable residents*

If a resident with a compensation entitlement (such as an entitlement to compensation arising from a workplace or motor vehicle accident or from a common law claim) is admitted to an aged care service, the service must inform the Department of Social Services (DSS).

DSS may then apply a compensation payment reduction amount from the day that the resident is admitted and will advise the aged care service and the compensable resident of the amount of the compensation payment reduction. The service will be able to invoice the compensable resident for the total amount of the compensation payment reduction in addition to the other relevant resident fees and charges.

A provider should inform DSS about a compensable resident by completing the relevant section on the Resident Entry Record form.

If a service does not tell DSS that a resident is entitled to compensation and DSS only becomes aware of this later, DSS will recover the residential care subsidy paid on behalf of the compensable resident for the period where a compensation payment reduction should have applied.

Approved providers can email Compensation.Enquiries.ACC@health.gov.au

*Claim not settled yet*

If a compensable resident’s claim has not been settled, the Department of Social Services will continue to pay subsidy for that resident until settlement. After settlement, conditions
for compensable residents will apply, as outlined above in the section on Compensable Residents.

**Extra service reduction**
If a resident receives care on an extra service basis, the residential care subsidy will be reduced for the care of this resident. The amount of this reduction is called the extra service reduction. See also Extra Service Amount and Extra Service Reduction in the chapter on Extra Service Places in this Manual.

**Adjusted subsidy reduction**
The adjusted subsidy reduction is applicable for residents in an aged care service, or part of a service, that is determined to be an adjusted subsidy aged care service. Since 1 July 2007, only services that are operated by state or territory governments are subject to this subsidy reduction.
The adjusted subsidy reduction is indexed annually and is approximately nine per cent of the daily high care subsidy. Any places affected by the adjusted subsidy reduction that are transferred to the non-Government sector have the reduction removed effective from the date of transfer.

**DEMENTIA AND SEVERE BEHAVIOURS SUPPLEMENT**
A new Dementia and Severe Behaviours Supplement was implemented in Residential Aged Care (Residential Care) from 1 August 2013. See legislative reference - Part 10, Division 6, Residential Care Subsidy Principles 1997. The purpose of this supplement is to provide additional financial assistance to approved providers in recognition of the additional costs associated with caring for people with severe behavioural and psychological symptoms of dementia and other conditions. Approved providers will be able to claim the supplement on top of the basic subsidies for care recipients who meet the relevant eligibility criteria.

The eligibility requirements for the Dementia and Severe Behaviours Supplement in residential aged care are outlined in separate guidelines and focus on identifying those residents with severe behavioural and psychological symptoms associated with dementia or other conditions.

Approved providers are required to apply for the Dementia and Severe Behaviours Supplement in residential care in respect of an eligible resident using an application form which was developed and released by the Department of Human Services.

Further information on the supplement can be found in the guidelines for the Dementia and Severe Behaviours Supplement which can be accessed at [www.health.gov.au/dementia](http://www.health.gov.au/dementia)

**VETERANS’ SUPPLEMENT**
The Veterans’ Supplement in Residential Care has been introduced to facilitate access to residential aged care for veterans with service related mental health conditions. See legislative reference - Part 13A, Division 2, Residential Care Subsidy Principles 1997. The supplement aims to minimise difficulties that these veterans may experience in accessing
residential aged care services and ensures that a veteran’s service related mental health condition does not act as a barrier to accessing appropriate care.

Any veteran who resides in an Australian Government-subsidised residential aged care facility and has a mental health condition(s) accepted by the Department of Veterans’ Affairs (DVA) as related to their service is eligible to attract the Veterans’ Supplement.

Eligibility is determined automatically on the basis of a veterans’ accepted mental health condition. Prior to the supplement being paid to the relevant provider, the veteran or their legal representative must first have consented for DVA to disclose their eligibility information to the provider. This process will not reveal information about the veteran’s specific mental health condition(s) to a residential aged care provider.

Where a veteran in residential aged care meets the criteria for both the Veterans’ Supplement and the Dementia and Severe Behaviours Supplement, they may attract both supplements. Further information on the supplement can be found in the guidelines for the Veterans’ Supplement which can be accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-dem-vet-supps

HARDSHIP PROVISIONS

OVERVIEW
Residents who have difficulty paying the standard resident contribution, an accommodation payment or a fee (income tested fee) can apply for assistance under the hardship provisions.

If a resident meets the hardship criteria, the Department of Social Services will pay the provider the appropriate hardship supplement/subsidy for this resident.

In general, residents need to apply for a hardship supplement. However, there are five classes of people for whom an amount of hardship supplement is automatically paid. See Class Hardship Determinations below.

A hardship supplement will not be payable for a resident:
• who is an ex-hostel resident paying a variable fee agreed to under the Aged or Disabled Persons Care Act 1954
• who is receiving care on an extra service basis.

Rates and additional information
The rates for fees, subsidies and supplements change over the course of a year. For this reason, actual dollar amounts payable are not included in this Manual.

Current rates are available on the website.
CLASS HARDSHIP DETERMINATIONS

There are five classes of people for whom an amount of hardship supplement is automatically paid. These are see legislative reference - section 21.37, Residential Care Subsidy Principles 1997:

- **Class A** - paid to residents under 21 years of age who receive an income support payment and whose total income is below the amount of the single age pension. The resident’s basic daily fee is reduced by the amount of supplement. The Department of Social Services (DSS) will contact these residents about the reduction in fees and to ascertain whether additional financial hardship assistance is required. If these residents do not have an income support payment, they may apply for financial hardship assistance.

- **Class B** - paid to residents under 16 years of age who are dependent children and whose total income is below the single rate of the social security pension amount. As with Class A, the resident’s basic daily fee is reduced and DSS will contact the resident’s representative regarding the reduction in basic daily fees and any additional financial hardship assistance that may be available.

- **Class C** - paid to pre-March 2008 self-funded retirees who receive an income that is just above the pension income test cut-off and therefore may be asked to pay up to the non-standard rate of basic daily fees. It is recognised that these residents may be disadvantaged by paying the difference between the standard and non-standard rate of the basic daily fee. The Class C Hardship supplement ceases if a resident’s income is not within a specific range.

- **Class D** - paid to residents who were in receipt of an income support payment that was lost as a result of the aged care arrangements that commenced on 1 October 1997.

- **Class E** - paid to residents who were living in a hostel on 30 September 1997, who have not since moved to a nursing home which was approved prior to 1 October 1997.

INDIVIDUAL HARDSHIP DETERMINATIONS

A resident can apply to the Secretary for a determination that paying the standard resident contribution, an accommodation payment or a fee (income tested fee) would cause financial hardship. Each case of hardship assistance is assessed on an individual basis. See legislative reference - section 44-22, section 44-31, section 57A-9, section 57-14, Aged Care Act 1997.

The Department of Social Services (DSS) may ask the applicant for further information in order to make the determination. In these cases, the extra information will generally need to be provided to DSS within 28 days, or the hardship application will be taken as withdrawn. An applicant can reapply. Where a legal guardian signs on behalf of the resident, a copy of their authority to act on the resident’s behalf must be attached to the application.

The resident and the provider will be notified in writing of the decision on whether to make a determination under the hardship provisions. This will usually happen within 28 days of DSS receiving the application, or within 28 days of receiving any other information that has been requested.

A hardship determination may include a specified period during which it will remain in force or a particular event which will cause the determination to cease to be in force. The
inclusion of any such period or event is a reviewable decision.

A hardship determination can take effect retrospectively - for example, the determination may apply from the resident’s date of entry to the aged care service, or from the date a resident’s assets are not realisable.

An applicant may also seek a review of a decision not to make a hardship determination. DSS will provide details of how to apply for a review with the notification of determination.

Applications must be made on the approved application for financial hardship assistance form.

**How are hardship assessments conducted?**

An assessment of a resident’s income and assets is undertaken by the Department of Human Services (DHS) or the Department of Veterans’ Affairs (DVA). A resident, or the resident’s representative lodges an application, on the approved form, for financial hardship assistance with the Department of Social Services. The assessment and the decision whether or not to provide financial hardship assistance with a resident’s basic daily fee, income tested fee, accommodation bond or accommodation charge, takes into consideration information provided by DHS, DVA and information provided by the applicant. The outcome of the assessment is provided in writing to the resident, or the resident’s representative and the provider.

**How do hardship determinations end?**

If a hardship determination will end following a specified period or event, the Department of Social Services will advise both the resident and the provider of this as part of the notice of hardship determination. For example, the notice of hardship determination may state that the determination will end on a particular date, or earlier if the resident’s circumstances change. If the determination ends earlier than expected due to a change in circumstances, the aged care provider and resident will be advised. The Department does not send a reminder to mark the cessation of assistance and late applications will not be backdated.

**Revoking financial hardship**

A determination of financial hardship may be revoked. The Department of Social Services (DSS) will write to the resident and the provider if revocation is being considered, giving 28 days in which to respond to DSS with a written submission. If no submissions are made within that time, revocation of the hardship determination will take effect on the day after this 28 day period has lapsed. Once the date for submissions has passed, DSS has a further 28 days in which to make a decision about whether to proceed with revocation and to advise the resident and the provider. See legislative reference - section 57-15, 57A-10 Aged Care Act 1997.

A revocation takes effect the day after both the resident and the provider have received notice of the decision. If they received notice on separate days, this means the day after the later day.
**Reviewable decisions**

The following decisions relating to a determination for financial hardship assistance are reviewable see legislative reference - section 85-1, Aged Care Act 1997:

- refusing to make a determination that a resident is eligible for a hardship supplement in respect of the standard resident contribution
- specifying that at the end of a certain period or due to the occurrence of a certain event, a determination under section 44-31 of the Act will cease to be in force
- refusing to make a determination that the daily income tested reduction is zero
- specifying a period that at the end of which a daily income tested reduction is zero ceases to be in force
- to refuse to make a determination that payment of an accommodation payment would cause financial hardship
- to refuse to make a determination that paying an accommodation payment of more than a specified maximum amount would cause financial hardship or to specify a particular maximum amount under such a determination
- revocation of a determination that paying an accommodation payment would cause financial hardship.

The commencement date of a determination for financial hardship assistance is not a reviewable decision.

**HARDSHIP, STANDARD RESIDENT CONTRIBUTION AND CARE PAYMENTS (INCOME TESTED FEE)**

Financial hardship assistance is available to aged care residents who do not have sufficient assets to pay their standard resident contribution and/or income tested fee. Each case is assessed on an individual basis, taking into consideration a range of issues which may be unique to the resident.

The maximum reduction of the standard resident contribution (basic daily fee) that is available under the financial hardship provisions is a reduction to zero. In most instances, a favourable assessment results in a partial reduction of the basic daily fee. Applications can be considered for both permanent and respite care.

An income tested fee may only be set to zero. Income-tested fees cannot be partially reduced and for this reason it is more common to see a reduction in the basic daily fee which takes into consideration the impact of the payment of the income tested fee.

Currently, hardship assistance with the basic daily fee and income tested fee may be approved in situations where a resident retains less than the equivalent of 15 per cent of the maximum rate of the basic single age pension, following the payment of their essential expenses. This amount is subject to change.

The resident’s realisable assets are also taken into account by the decision maker where a reduction in the basic daily fee and/or income tested fee has been requested and for an application to be approved the resident must have less than $15,000 in realizable assets. This amount is also subject to change.
Examples of expenses taken into consideration in assessing an application for financial assistance with the basic daily fee or income tested fee include:

- pharmaceutical expenses
- podiatry and continence aid expenses (not for high level care as these services are supplied by the approved provider)
- optical, dental or podiatry expenses
- other non-discretionary expenses.

For the basic daily fee for respite care only, a wider range of expenses are taken into account due to the need for a resident to maintain their living arrangements in the community. Additional expenses able to be considered are:

- utilities and rates expenses
- home and contents insurance
- rental or mortgage payments.

**How is a hardship supplement paid where financial assistance is given for the basic daily fee?**

Where a determination has been made regarding a basic daily fee, an individual hardship supplement is paid to the approved provider, and the resident’s basic daily fee is reduced accordingly. The total amount of the hardship supplement the approved provider receives for a resident must be subtracted from the total basic daily fee that the resident would otherwise have been charged. Approval is time-limited. At the end of the specified period, a resident must reapply if they require ongoing assistance. It is important for a resident to lodge an application for continued financial hardship assistance prior to the cessation of any current financial assistance to ensure that, if approved, the financial assistance is continuous. The Department of Social Services does not send out reminders about the cessation of financial hardship assistance and late applications are not backdated.

**How is subsidy paid where financial assistance is given for income tested fees?**

Where an income tested fee is set to zero, the provider receives increased subsidy to compensate for not receiving the income tested fee.

**HARDSHIP AND ACCOMMODATION PAYMENTS**

Financial hardship assistance is available to aged care residents who do not have sufficient assets to pay their accommodation payment. Each case is assessed on an individual basis, taking into consideration a range of issues which may be unique to the resident.

From 1 January 2009, the financial hardship provisions have been amended to allow for circumstances where a person has the ability to pay an amount towards their full accommodation bond or accommodation charge. Where it has been determined that a person’s assets are below the maximum threshold for the payment of either a concessional resident supplement, assisted resident supplement or accommodation supplement, the appropriate amount of supplement will be paid to the provider where a hardship determination is in place.
In cases where a resident’s realisable assets are determined to be above the maximum threshold, the Act allows for a resident to pay a lesser amount of accommodation bond for a period of time, while a hardship determination is in place. As the resident’s assets remain above the maximum threshold, the care provider would not be entitled to receive a supplement.

While a determination of financial hardship is in force, the resident must not be asked to pay an accommodation bond or the daily accommodation charge greater than the maximum amount determined under the financial hardship provisions.

If a resident has logged a financial hardship application, and if that resident would otherwise be eligible to pay an accommodation payment, then an accommodation payment agreement must still be entered into within 21 days of the resident’s entry to the service. The accommodation payment agreement must specify the accommodation payment which will be payable if the hardship application is declined or if a hardship determination ceases to be in force.

**How is a hardship supplement paid where financial assistance is given for the accommodation payment?**

Where financial hardship assistance is provided in respect of an accommodation charge, an accommodation supplement is paid. Where financial hardship assistance is provided in respect of an accommodation bond an accommodation supplement is paid if the resident’s realisable assets are less than the maximum permissible asset level for the payment of an accommodation supplement.

**Financial hardship - circumstances**

The circumstances in which a determination can be made include, but are not limited to, cases in which payment of an accommodation payment would cause hardship to the resident, or to their partner or dependent child.

A number of factors are taken into consideration, including unrealisable assets. See legislative reference - section 11(12)-(13), Social Security Act 1991.

Unrealisable assets are assets which the resident either cannot or cannot reasonably be expected to sell or realise or use as security for borrowing. Examples include a farm that was supporting other family members, a property that has been on the market for six months at a price commensurate with the amount given on a resident’s Asset Summary Statement for entry to residential aged care, or frozen financial resources.

Applications for financial hardship must be made on the approved form.

For information on assessment of hardship applications, see chapter on Individual Hardship Determinations in this Manual.
LEAVE

FEES DURING PERIODS OF LEAVE
The Act provides the number of days a resident may be on leave from the residential aged care service. For each day that a resident is on leave, the aged care service receives resident fees and a Government subsidy as though the resident was actually receiving care. This means that a provider’s responsibilities, including security of tenure for the resident’s place, still apply when a resident is on leave.

When a provider is counting days of leave, they should:
- include the day when the resident left the aged care service
- and not include the day of return. See legislative reference - section 42-3(1), Aged Care Act 1997.

A resident and an approved provider can agree that the resident can be absent for periods in excess of leave entitlements. In this case, the maximum fee that the resident can be charged is the applicable resident fee plus an amount equal to the subsidies which would normally be paid to the provider for that day. See legislative reference - section 58-6, Aged Care Act 1997.

HOSPITAL LEAVE
A resident can take unlimited days of leave to receive hospital treatment. A subsidy continues to be paid for residents during periods of hospital leave. A resident is on hospital leave on the day on which they attend a hospital to receive hospital treatment, however, a resident is not on leave on the day on which the approved provider recommenced providing residential care to the person. See legislative reference - section 42-2, Aged Care Act 1997.

Extended hospital leave
Extended hospital leave is where a resident has hospital leave for a continuous period of 30 days or more, in order to receive treatment in hospital.

For residents who are on extended hospital leave, the basic subsidy amount paid to the aged care service is reduced after 28 consecutive days by:
- 50 per cent, for residents classified under the ACFI
- or two category levels, if the resident is still on a Residential Classification Scale (RCS).

Resident fees cannot be increased during extended hospital leave to cover the drop in subsidy payments.

SOCIAL LEAVE
Residents are entitled to up to 52 overnight absences - i.e. 52 days of social leave - per financial year. This enables residents to spend weekends with their families, without losing their place at the aged care service.

Subsidies to the service will continue during social leave. However, once a resident has used up their 52 days of social leave, government subsidies for that resident will stop. The
approved provider can then charge residents the subsidy amount in addition to their daily fee. See legislative reference - section 58-6, Aged Care Act 1997.

**PRE-ENTRY LEAVE**

Up to seven days of social leave can be used as pre-entry leave, immediately before a resident enters an aged care service. Pre-entry leave gives a prospective resident time to make arrangements to enter an aged care service or to transfer from one service to another. It enables the service to receive a subsidy and keep the place vacant for the resident for up to seven days after he or she agrees to enter care. See legislative reference - section 42-3(3), Aged Care Act 1997. It is the only type of leave which can be taken before a resident enters a service.

Pre-entry leave is only available if the room is ready for the resident to occupy.

If pre-entry leave is used for a resident to transfer directly from one service to another, subsidies are not payable to the second service for the pre-entry leave period. The resident may be charged the basic daily fee but cannot be charged for the loss of subsidy in this case.

Pre-entry leave:
- can only be taken from the date the resident agrees to enter the service
- can be claimed for days on which the intending resident is in hospital
- can only be taken for up to seven days before the resident enters care
- can only be claimed where the resident actually enters the service
- ceases to be paid once the resident enters the service permanently
- cannot be claimed where the person is on leave from another aged care service
- the resident can be charged applicable aged fees for the period of pre-entry leave but cannot be charged for the loss of subsidy.

For residents who are on pre-entry leave, the basic subsidy amount paid to the aged care service is 30% of the full subsidy amount.

The following supplements are not payable until the resident enters the service:
- Accommodation Supplement
- Concessional Supplement
- Charge Exempt Resident Supplement
- Transitional Supplement
- Accommodation Charge Top Up Supplement
- Transitional Accommodation Supplement
- Hardship Supplement.

**HIGH-DEPENDENCY CARE LEAVE**

High-dependency care leave is when a low care resident temporarily needs a high level of care and is transferred to an aged care service providing high-level care.

Subsidy is payable for both service providers and the resident may be required to pay fees to both providers.

The requirements for high dependency care leave are:
the permanent service is unable to provide a high level of care
the resident temporarily requires a high level of care
the resident’s Aged Care Assessment Team (ACAT) approval cannot be limited to low level care
the resident must have available social leave days.

Providers should advise the Department of Human Services about high-dependency care leave as follows:
- on the monthly claim form, the permanent service advises of the resident’s use of social leave days while the resident is at the temporary service
- completes a Resident Entry Record for this new resident, identifying them as a high dependency care leave resident
- undertakes the usual resident ACFI appraisal process to determine the level of funding for the resident’s period of stay.

The permanent and temporary aged care services will receive subsidy according to the relevant ACFI categories - i.e. the permanent service will continue to receive low care subsidy, so long as there is a current appraisal in force, and the temporary service will receive high care subsidy in accordance with the ACFI.
REFERENCES
Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Accessibility/Remoteness Index of Australia (ARIA)
ARIA scores for all locations

Current rates for the viability supplement are listed with other subsidy and supplement rates at

Aged Care Pricing Commissioner
www.acpc.gov.au

Compensable residents - queries
Providers with queries about compensable residents email Compensation.Enquiries.ACC@health.gov.au

Department of Human Services - Aged Care forms

Financial information service - free - for residents
DHS Centrelink provides a free financial information service for residents of aged care services and other citizens - ph 132 300 or www.humanservices.gov.au

Forms - all
All departmental forms are available on the following website at

Form - banking details for the direct deposit of payments
Form - financial hardship assistance - application form
Form - Residential aged fee income assessment
This form is sent to self-funded retirees by the Department of Human Services - ph 132 300 - www.humanservices.gov.au

Forms - oxygen treatment/enteral feeding supplement

Form - nominee - appointment of
or www.humanservices.gov.au/provider/aged-care/forms.jsp

Form - resident entry record (RER)

Interest rates - base interest rate and maximum permissible interest rate - current
The Department of Social Services updates the base interest rate and the maximum permissible interest rate each quarter. For current rates check www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-refundrates.htm

Legislation - other
Go to ComLaw to access other legislation mentioned in this chapter, including the Social Security Act 1991 and Aged or Disabled Persons Care Act 1954. www.comlaw.gov.au

Remote area allowance
The maximum amount of the remote area allowance that an approved provider can charge a resident is listed with other current rates information www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-resfees.htm

Request for an asset assessment form
These forms are included with the 5 Steps to Entry into Residential Aged Care information pack, which is available online http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-aaform.htm

Resident entry record (RER)

Residential fees, subsidies and supplements - current

Subsidy rates - current
For current Australian government subsidies and supplements, including ACFI go to

**Supported resident ratios - by region**
Supported, concessional and assisted residents count towards the supported resident ratios for each region.

*Note: These ratios and regions may be subject to review at a later date.*

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**South Australia**

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<td>Metropolitan North</td>
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<td>Mid North</td>
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<td>Riverland</td>
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**Tasmania**

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**Victoria**

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<td>Gippsland</td>
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</table>
Grampians 18.20%
Hume 18.50%
Loddon-Mallee 18.20%
Northern Metro 23.40%
Southern Metro 18.20%
Western Metro 24.70%

**Western Australia**

Goldfields 24.40%
Great Southern 21.80%
Kimberley 40.00%
Metropolitan East 23.10%
Metropolitan North 21.50%
Metropolitan South East 22.60%
Metropolitan South West 22.60%
Mid West 20.10%
Pilbara 40.00%
South West 19.00%
Wheatbelt 17.20%

Viability supplement
RESIDENTIAL RESPITE CARE

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

OVERVIEW

Residential respite care provides a break for people living in the community and their carers.

Respite care is defined in the Act as:
residential or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement. A person can have up to 63 days of respite care in a financial year with the possibility of 21 day extensions if approved by an Aged Care Assessment Team (ACAT) or the Aged Care Assessment Service (ACAS) in Victoria. Residential respite care is provided as either low or high level care. However, it does not include residential care provided through a residential care service while the care recipient in question is on leave under section 42-2 from another residential care service. See legislative reference - Schedule 1-Dictionary, Aged Care Act 1997.

This chapter of the Manual is intended as a guide to the administrative procedures relating to the provision of residential respite care.

In summary:
- as part of the planning process for residential care, the Government aims to ensure there is adequate provision of respite care, providing for an equitable distribution across regions
- in order to provide residential respite care, service providers need to be approved to provide residential aged care. See also chapters on Becoming an Approved Provider and Allocated Places in this Manual
- in making an allocation of places to an approved provider subject to conditions, the Secretary can set a minimum proportion of care that must be provided as respite. See legislative reference - section 14-5, 14-6, Aged Care Act 1997
- respite care recipients are not assessed against the ACFI. Classifications for respite care are based on an ACAT approval for either high or low level care.
- permanent residents of a residential aged care service cannot be approved for residential respite care in another aged care service.

How are places which can be used for respite allocated to new and existing services?
The Minister determines how many residential aged care places are available for allocation in each state and territory for each financial year, based on population projections and the level and type of current service provision against a national planning benchmark. The Secretary DSS then distributes these places among the regions, deciding among other things
what proportion of care is to be provided as respite care. In order to determine this proportion, the Secretary must take into account the demand for respite care and permanent care in the region, the needs of carers and care recipients and equity of respite provision between regions. See legislative reference - Division 12, Aged Care Act 1997.

When it applies for an allocation of residential care places, an approved provider may specify the proportion of care, if any, to be given as respite care. In considering the application, the Secretary will take into account the applicant’s ability to provide respite care and the need for respite in the particular area.

CONDITIONS OF ALLOCATION
The Secretary may allocate places with a condition specifying the proportion of respite care to be provided by that service as a condition of approval of the places. The approved provider will be notified of this condition if their application is successful. The condition is often expressed as a minimum proportion of care.

Compliance with conditions of allocation is an approved provider responsibility under the Act. An approved provider may apply for a variation to the conditions of allocation of places under Division 17 of the Act.

If a service is applying to vary its conditions of allocation - including conditions for the allocation of respite care - it should fill out the Application for a Variation of Conditions of Allocation - Residential Respite form. If the variation is granted, this varied condition will continue into future financial years unless the service requests another variation. See the References section at the end of this chapter for a link to the form.

Conditions of Allocation of Respite Places - Transferring Places
When allocations of residential care places are transferred, any condition of allocation will generally transfer with the places, unless the transferor and transferee apply to have the conditions varied. See legislative reference - section 16-2(2)(d). Aged Care Act 1997.

As the obligation to provide respite is a condition of allocation of these places, the proportion of care that must be provided as respite will continue to apply, and this obligation to provide respite transfers to the provider who is transferred these places. See legislative reference - section 16-6(e)(iii), Aged Care Act 1997.

APPROVAL OF RESPITE CARE RECIPIENTS
A potential respite care client must initially be assessed by an ACAT. Based on the assessment, residential respite care recipients will be approved for either high or low level care. This care may be limited to a specific period. See legislative reference - section 22-2(1)(c), Aged Care Act 1997.

The approval must expressly cover the provision of respite care. If it does not, the approval is limited to the provision of care other than respite care. See legislative reference - section 22-2(1), Aged Care Act 1997.
Both residential care subsidy and respite supplement can only be paid where a person is approved as a respite care recipient. See legislative reference - section 44-12, Aged Care Act 1997. High level subsidy and supplement will be paid for care recipients approved by an ACAT as needing high level residential respite care. The lower subsidy and supplement level is paid for all care recipients approved by the ACAT as needing low level residential respite care. A person approved to receive high level respite care can, however, receive low level respite care. See legislative reference - section 5.9(2), Approval of Care Recipients Principles. This would normally occur if both the aged care service and the resident agree that this is more appropriate and in such a case, the low level respite subsidy and supplement would be payable. See also chapter on Approval of Residents in this Manual.

**How does a person become approved as a respite care recipient?**

Approval for residential respite care is obtained in the same manner as approval for permanent residential care and other forms of Government-subsidised care. The approval must be on the Aged Care Client Record, and indicate that the person is eligible and approved for residential respite care at either a high or low level.

**Who is eligible for approval as a respite care recipient?**

People who meet the eligibility criteria for approval for residential care, and who need respite care, are eligible for approval for residential respite care. It is possible for a person to be approved for both residential respite and permanent care at the same time.

However, a permanent resident of a residential aged care service cannot receive residential respite care in another aged care service.

**What are the limits on approval to receive respite care?**

The ACAT can limit a person’s approval for residential respite to a specific level of care or to a specified period of time. See legislative reference - section 22-2, Aged Care Act 1997.

ACAT approvals specify the level of residential respite care a person needs as either high or low. This is used to determine the level of respite subsidy and supplement payable for the person.

Respite care subsidies and supplements are only paid where the care recipient is approved by an ACAT to receive residential respite care.

**When does an approval cease to have effect?**

An approval for residential respite care will not lapse but can expire if it is either time limited or revoked.

An approval allows for up to 63 days of subsidised residential respite care in a financial year. If respite care is needed for longer than this, a person can apply for a 21 day extension. See section on Approving an Extra 21 days of Respite in this Manual.

Where a care recipient’s approval is limited to a low level of residential respite care and their care needs have changed, they must be reassessed by an ACAT before they can be
approved for high level residential respite care.

Example
Tessa was approved for residential respite care, limited to a low level, almost two years ago. Since being approved by the ACAT, Tessa has twice been admitted to hospital and her care needs have increased significantly and she requires some nursing care. Tessa’s daughter, who is her primary carer, has booked to go on a six week holiday and contacts the local nursing home to book Tessa in for respite care. In discussing Tessa’s care needs and recent hospitalisations, it is clear to the care team manager that Tessa will require high level care. The care team manager advises Tessa’s daughter that even though Tessa’s approval for low level respite care is current, as it does not lapse, her care needs have changed, so a new ACAT assessment and approval for high level care is required prior to Tessa commencing respite care, so that Tessa can occupy a high level bed and the aged care provider can be paid the correct rate of subsidy. Tessa’s daughter contacts the ACAT and arranges a reassessment prior to Tessa’s admission.

Example
Bill is approved for high level residential respite care. He applies to enter an aged care service for respite, not having used residential respite care since the ACAT signed the approval over twelve months ago. Bill does not need to be reassessed by the ACAT unless his care needs have changed.

CLASSIFICATION APPRAISAL
There are only two levels of classification and therefore subsidy available to respite care residents:

- high level care; or
- low level care.

The classification level applies from the day that the person enters care, as determined based on their ACAT approval level only.

Respite care recipients are not appraised and the ACFI does not need to be completed for respite care recipients.

When do classifications cease to take effect?
A respite care recipient’s classification ceases if the care recipient has used more than 63 days of respite care in the financial year plus any extra periods of 21 days approved by an ACAT. In this case the classification ceases on the day after the number of days is used. See legislative reference - Item 7, section 27-2(1), Aged Care Act 1997.

Respite care residents, if not already approved for permanent care, need to be reassessed and approved for permanent care by an ACAT before transferring to permanent care.

As a permanent care recipient, they will also be assessed against the ACFI. See chapter on Transfers from Respite to Permanent Care see also chapter on Approval of Residents in this Manual.
APPROVED PERIOD OF RESPITE CARE

Respite days used by the respite care recipient are cumulative across services. The approved number of respite days is the maximum number a resident may use during the approval period, regardless of the number of services that provide the care to them. See legislative reference - section 44.12(2)(c), Aged Care Act 1997, section 21.18(1), Residential Care Subsidy Principles 1997.

The approved provider must satisfy themselves that the care recipient has sufficient respite days remaining to cover the proposed period of respite and a valid ACAT approval. If in doubt the provider should contact the Department of Human Services to check on ph 132 300.

A care recipient can receive up to 63 days of subsidised respite in any financial year. This total covers respite admissions to all Government-subsidised residential aged care services. However, if a person needs more than 63 days of respite care in the financial year, the ACAT can approve extension periods of 21 days at a time. See section on Approving an Extra 21 Days of Respite below. See legislative reference - section 21.18(1), section 21.18(2), Residential Care Subsidy Principles 1997.

The service is also unable to claim subsidies for the person as a permanent care recipient unless an ACAT:
- has either approved the care recipient for both respite and permanent care (and the approval is still valid) or has reassessed and approved the person as eligible for permanent residential care.

APPROVING AN EXTRA 21 DAYS OF RESPITE

If a care recipient has entered residential respite care, and their 63 day allocation is due to expire, an application for a 21 day extension should be made to the Secretary through the ACAT. More than one 21 day extension may be approved in a financial year.

In deciding whether or not to extend residential respite care, the delegate will consider circumstances such as carer stress, a temporary or unexpected increase in the severity of a care recipient’s condition, absence of the carer and any other relevant matter.

The care recipient’s needs, abilities and wishes, access to and use of appropriate community and social supports will also be considered. In extending residential respite care, delegates must consider the appropriateness of continued respite care arrangements or whether permanent residential care may be a more suitable option.

Any extension must be at the same level of care as approved on the Aged Care Client Record. If an approval is limited to a low level of residential respite care and the person now requires high level residential respite care, reassessment and approval by the ACAT is required.

If an extension is granted the ACAT will complete a Residential Respite Extension Form and submit the form to the Department of Human Services. The care recipient automatically becomes eligible for another 63 days of residential respite at the commencement of the
new financial year. The extension form must be completed each time an extension is required.

An ACAT reassessment and approval is required if:
- the original ACAT approval was time limited and has expired
- the care needed is permanent and the original approval did not include approval for permanent residential care
- the original ACAT approval was limited to a low level of residential care and the care needed is high level care.

If a person uses his or her approved number of days and an ACAT does not approve an extension, the service will not receive further subsidy for that person.

**RESPITE CARE FOR VETERANS AND WAR WIDOWS AND WIDowers**
Veterans and war widows and widowers share the same entitlement of up to 63 days of respite in a financial year. Extensions are also available.

Subject to prior approval, Department of Veterans’ Affairs (DVA) beneficiaries who have full entitlement to treatment services can have the resident’s daily fee for up to 28 days respite care per financial year paid at DVA’s expense. This can be taken as residential respite, in-home respite, or a combination of both, and is not cumulative from one financial year to the next. This means that any in-home respite access will reduce the number of days for which DVA meets the cost of residential respite.

For former prisoners of war (POWs) who receive the higher level of respite care, DVA will meet the daily fee for the full length of stay in a residential aged care service.

**EXTRA SERVICE PLACES**
Services with extra service status are eligible for the respite supplement. Respite care recipients receiving care on an extra service basis may also be charged the extra service amount. The extra service reduction also applies to these residents. See chapter on Extra Service Places in this Manual.

**RESIDENTIAL CARE SUBSIDIES**
An approved provider is eligible for residential care subsidy, including the respite supplement, for each day they provide residential respite care to an approved respite care recipient who has not used up his or her annual allocation of respite days.

A provider is not eligible for subsidy if:
- the service does not meet its accreditation requirements after the accreditation day
- the provider is not providing respite care in accordance with its conditions of allocation
- the provider does not provide respite care in an allocated place.

Respite care recipients attract either high or low level residential care subsidy, as determined by the ACAT assessment, including the respite supplement. Other supplements can be paid where applicable.
RULES ABOUT THE PAYMENT OF SUBSIDIES AND SUPPLEMENTS

The respite supplement can only be paid for days on which:

- the care provided was respite care
- the care recipient had been approved for respite care by an ACAT
- the care recipient had not used more than 63 days of respite care in that financial year, or an extended period of respite care approved by an ACAT
- the service has provided the care in an allocated place and has met any conditions of allocation.

The accommodation and concessional supplements are not paid for respite recipients, as an equivalent amount is already built into the respite supplement. The days used by respite care recipients cannot be counted towards concessional resident levels.

Services which are certified are eligible for a higher respite supplement.

Other supplements - for example, oxygen and enteral feeding - can be paid as applicable.

A service will not be paid for any form of leave for a respite care recipient. The resident is discharged from the service upon exit for any reason.

ADDITIONAL AMOUNT FOR HIGH CARE RESPITE

An additional amount for high care respite is available for eligible providers. Providers are eligible for the additional rate if they use an average of 70 per cent or more of their available respite places up to the end of the current claim period, based on an averaging period of 12 months. If the 70 per cent target is met, a payment is made at the end of the month for each of the high care respite days provided during that month. See legislative reference - section 21.19, Residential Care Subsidy Principles 1997.

While low care respite residents count towards the 70 per cent target, they do not attract the higher amount - i.e. low and high respite care days are counted to reach the 70 per cent but only high care respite days attract the higher payment.

The averaging period will generally be the current claim month and the preceding 11 claim months. A provider is eligible for the additional rate of the high care respite amount if, on any given day, the average number of respite bed days provided over the previous 11 months and current claim month is equal to or greater than 70 per cent of the average number of respite bed days required to be provided over that period of time under the provider’s conditions of allocation.

The averaging period takes into consideration the date respite care places are first allocated. Any increase or decrease in the level of allocation will be reflected in the averaging methodology from the date the increase or decrease takes effect. While the total number of places may fluctuate across the averaging period, the impact of any increase or decrease is gradual as it is spread out across the relevant period.
Respite bed days are not counted in the averaging period if they are provided:
- in excess of the level specified in the conditions of allocation relating to respite
- to non-eligible care recipients
- in excess of the maximum number of days per care recipient.

If a provider is eligible for any additional respite amount it will automatically be included in the normal advance monthly payments for residential subsidy, based on the provider’s claim form for residential respite. See the References section at the end of this chapter for a link to current subsidy rates.

The sale of an aged care home will not affect the averaging period. That is, the averaging period will continue to be calculated regardless of changes in association, with the new provider taking on the old provider’s usage averages.

A provider receiving the additional payment can apply for a variation to their allocation of respite. See section on Applying to Vary Conditions for Operational Places in the chapter on Allocated Places in this Manual.

**TRANSFERS FROM RESPITE TO PERMANENT CARE**

Care recipients can only transfer from respite to permanent care if:
- they have an ACAT approval for both respite and permanent care; or
- they are reassessed by the ACAT and approved for permanent care.

**DATE OF ENTRY INTO PERMANENT CARE**

Subsidies and supplements are payable for the day of admission, but not for the day of discharge. If a person transfers from respite care to permanent care, respite subsidy will be paid from the first day of admission to the day before the day of transfer.

Permanent care subsidy will then be paid from (and including) the day of transfer.

**NOTIFICATION OF ENTRY INTO RESPITE CARE**

Respite care recipients in receipt of pensions and allowances through DHS Centrelink should be advised to notify DHS Centrelink that they are entering an aged care service to receive respite care. This is to ensure that DHS Centrelink can continue sending them correspondence relating to their pensions and allowances. A person’s entry into respite care can also affect the payment of carer’s payment or carer’s allowance.

**MONTHLY CLAIM FORMS**

The provider claims the appropriate subsidy via the normal monthly claims process with DHS Centrelink, that is, by recording the care recipient’s details on the monthly ‘Claim for Commonwealth Subsidy for Care Recipients in Approved Residential Aged Care Services’ and lodging the form with DHS Centrelink. Further details on the respite supplement and associated claims process can be found under the chapter titled Residential Care Subsidies in this Manual.
FEES
The fee for respite recipients is the same as the standard pensioner contribution regardless of their income or eligibility for income support payments. See legislative reference - section 58-3(2)(b), Aged Care Act 1997.

What fees can be charged for respite care?
There are no income-tested fees or accommodation payments for respite care recipients and they pay the standard resident contribution. Respite care recipients can be charged an extra service fee if the place they occupy is an extra service place.

Respite booking fees
Booking fees are paid to a service in advance to secure a period of respite care. Booking fees must not exceed the equivalent of the fee for one week’s respite care, or 25 per cent of the fee for the proposed period of respite care, whichever is less. See legislative reference - section 23.26(1), User Rights Principles 1997.

It is one of an approved provider’s responsibilities to charge no more than the amount permitted under the User Rights Principles by way of a booking fee for respite care. See legislative reference - section 56-1(c), Aged Care Act 1997.

Any resident agreement must specify the period that the care and services will be provided and any respite care booking fee. See legislative reference - section 59-1(1)(d), Aged Care Act 1997.

Once the resident enters the service, the booking fee must be deducted from the care recipient’s daily fees.

Example
If George books two weeks of respite care he can be charged a booking fee equivalent to 25 per cent of the period or 3.5 days’ worth of the booking fee - i.e. 25 per cent of 14 days is 3.5 days. He will then only need to pay fees for the additional week and a half once he has entered the aged care service.

Example
If Georgia books six weeks of respite care, she can only be charged one week’s fee - i.e. 25 per cent of 42 days is 10.5 days, and therefore greater than one week. Georgia will then be charged for the remaining five weeks after she enters for her period of respite care.

REASONS FOR NOT TAKING UP A RESpite ADMISSION
If the care recipient cancels their booking more than seven days before the proposed day for entry into respite care, the booking fee must be refunded within 14 days after the approved provider was notified that the care recipient cancelled the booking. See legislative reference - section 23.16(3A), User Rights Principles 1997.

However, if the care recipient cancels their booking less than seven days before the proposed day for entry, in any circumstances other than where the care recipient has died.
or is entering hospital, the approved provider can retain all or part of the booking fee. See legislative reference - section 23.16(3B), User Rights Principles 1997.

If a person enters hospital or dies within seven days before the proposed day for entry into respite care, the booking fee must be returned to the person or their estate. See legislative reference - section 23.16(3), User Rights Principles 1997. The booking fee must also be refunded if the approved provider requires the respite recipient to leave before the end of the booked period. See legislative reference - section 23.16(4), User Rights Principles 1997.

In any other circumstance, all or part of the booking may be retained. See legislative reference - section 23.16(3B), 23.16(5), User Rights Principles 1997.

Example
If Terence booked for four weeks of respite care and paid one week’s booking fee, then died two days prior to the proposed day of entry into respite care, the service must refund the booking fee to Terence’s estate.

LEAVING A SERVICE BEFORE THE END OF A BOOKED PERIOD
If the respite care recipient decides to leave the service before the end of the booked respite period, all or part of the fee for the unused part of the booked period may be retained from the booking fee. See legislative reference - section 23.16(5), User Rights Principles 1997.

Example
Denise booked for four weeks of respite care, paid one week’s booking fee and then decided to leave after two days of care. The service may decide to keep the remainder of Denise’s booking fee, which is equivalent to a fee for five days respite.

RESIDENT’S AGREEMENT
All care recipients must be offered a resident agreement. Such an agreement must set out the dates on which respite care is to be provided, as well as details of any booking fees. Conditions relating to the booking fee must be included in the respite resident agreement. See legislative reference - section 59-1(1)(d), Aged Care Act 1997.

This agreement must also state the dates on which respite care is to be provided. While a booking fee may be charged to respite care recipients, it must be deducted from the fee charged for the respite care.

ACCOMMODATION PAYMENTS
Care recipients receiving respite care cannot be charged an accommodation bond (for low level care) or accommodation charge (for high level care).

Care recipients receiving respite care who later become permanent residents can be charged an accommodation bond, if they require a low level of residential care, or an accommodation charge, if they require a high level of residential care. Once they become permanent residents, the entry date is taken to be the day of transfer to permanent care.
Retention amounts, amounts representing income derived, and periodic payments cannot be charged for the period of respite care. See also chapter on Funding for Residential Aged Care in this Manual.

RESIDENTS’ RIGHTS
All new respite residents must be offered a resident agreement with the approved provider before they enter the service. See legislative reference - section 56-1(g), Aged Care Act 1997. A resident agreement may also be entered into at any time during the recipient’s stay. Respite recipients have the right to choose whether or not they wish to enter into a written agreement with the approved provider. See also section on Resident Agreements in chapter on Residents’ Rights in this Manual.

FREQUENTLY ASKED QUESTIONS
1. What happens if there is a need for emergency residential respite care and there is no ACAT approval?

In an emergency situation, a person can receive residential respite care before approval by an ACAT if they urgently need care and it is not practicable to apply for approval beforehand. Emergency admissions should occur rarely and will usually be precipitated by a crisis situation.

ACAT telephone numbers may be listed in the ‘Age Page’ of your local telephone book or may be provided by your local doctor or hospital. Commonwealth Respite and Carelink Centres can also refer people to their local ACAT. You can contact your nearest Centre on 1800 052 222 during business hours or, for emergency respite support outside standard business hours on 1800 059 059. Information on respite care is also available on the My Aged Care website http://www.myagedcare.gov.au/.

To make sure subsidy is payable for the care recipient, the ACAT must be satisfied that an emergency existed and the service provider must arrange for an ACAT approval within 5 business days. See Residential Care Manual www.resicaremanual.health.gov.au/ ‘Emergency Approvals’ for further information.

2. Can a resident be granted an extension without ACAT approval?

No. If a care recipient has entered residential respite care, and their 63 day allocation is due to expire, an application for a 21-day extension should be made through the ACAT. More than one 21 day extension may be approved in a financial year.

3. With an ACAT approval for both respite and permanent residential care, can a permanent resident of an aged care home receive respite care in another aged care service?

No. While a person is a permanent resident of a residential aged care service, they cannot receive government subsidised residential respite care in another aged care service. The person would first have to be discharged from their permanent residential aged care service to be able to receive residential respite care in another aged care service.
4. Can a respite resident take hospital leave?
   Respite residents are not entitled to any kind of leave and an approved provider will not be paid for any form of leave for a residential respite care recipient.

5. How does a person, their representative or service provider check the person’s residential respite balance?
   To find out the remaining residential respite days a person is entitled to, contact the Department of Human Services - Medicare Australia Aged Care Enquiries Line on 1800 195 206 (free call) and then select Option 1. Please note that details about care recipients can only be provided to people authorised to act on the care recipient’s behalf.

6. What is the maximum daily fee a person can be charged in residential respite care?
   The maximum daily fee for respite recipients is the same as the standard resident contribution regardless of their income or eligibility for income support payments.

   The level of the maximum daily fee for respite residents is available on the following website http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-resfees.htm under the heading ‘Schedule of resident fees and charges’.

7. Do residential respite residents need to pay an accommodation bond?
   No. Residential respite care recipients are not required to pay an accommodation bond, an accommodation charge or an income tested fee.

8. What if a respite resident has financial difficulty in paying the daily fee?
   There are hardship provisions for respite residents. Residents seeking financial assistance for respite fees can submit an application to the Department of Social Services. An application for financial hardship assistance can take up to 28 days to process after all the necessary information has been received. Therefore, residents who would like to receive approval before entering respite care should, as far as possible, lodge an application well in advance of the planned respite care dates.

   For an application form for a care recipient to apply for a reduction in care fees, see the information at the following link http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-fha-form.htm
REFERENCES
Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

ACAR Essential Guide

Aged Care Complaints Scheme
www.health.gov.au/agedcarecomplaints or ph 1800 550 552

Department of Human Services
www.humanservices.gov.au or ph 132300.

Forms - all
All departmental forms are available on the following website at

Form - approval for respite care

Form - varying respite allocation conditions

Residential fees, subsidies and supplements - current
For current rates for residential fees and charges go to

For current Australian Government subsidies and supplements go to
Scheme - Aged Care Complaints Scheme
www.health.gov.au/agedcarecomplaints or ph 1800 550 552

Veterans, war widows and widowers - respite care for - Department of Veterans’ Affairs
For more information on respite care paid by the Department of Veterans’ Affairs:
- callers from metropolitan areas ph 133 254.
- callers from regional areas ph 1800 555 254.
CAPITAL GRANTS FOR RESIDENTIAL AGED CARE

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

OVERVIEW

Limited capital funding is made available for Residential Care Grants program through the Rural, Regional and Other Special Needs Building Fund to assist service providers who are unable to meet the cost of necessary capital works.

Residential Care Grants are allocated on a competitive basis through the annual Aged Care Approvals Round. Applicants for capital funding are responsible for providing information based on thorough research and analysis of all aspects of the proposal, including any associated building costs and the current and future financial capacity of the applicant organisation. Grants may also be made outside this process to address urgent and immediate needs. See also chapter on Allocated Places in this Manual.

ELIGIBLE CAPITAL WORKS

Financial assistance is available for:

- buying buildings or land on which to construct buildings, for providing residential aged care
- acquiring, erecting, altering or extending buildings to provide residential aged care
- acquiring furniture, fittings or equipment for buildings to provide residential aged care
- altering or installing furniture, fittings or equipment in buildings to provide residential aged care.


Capital funding is not available for:

- routine administration of the service, whether or not the costs are related to the proposed works
- acquiring and operating vehicles
- costs associated with obtaining finance for the project
- interest costs related to any finance for the project
- rent, insurance or state and local Government statutory charges - e.g. rates
- any taxation payable by the service, including any tax which is payable as a result of receiving a grant.

See legislative reference - section 20.6(3), Residential Care Grant Principles 1997.

Grants will not be made for capital works which have been contracted, commenced or completed prior to the execution of a grant agreement - i.e. the signing of the agreement by both a grantee and an Australian government representative.
ELIGIBILITY
The eligibility criteria for a Residential Care Grant are:

- a majority of care recipients who receive, or who will receive, the care to which the grant relates are:
  - supported, concessional or assisted residents
  - people with special needs, as defined under the Aged Care Act 1997
  - people who live in a location where there is a demonstrated need for additional residential care services*
  - people who do not live in a major capital city**
- the applicant demonstrates its ongoing financial and organisational viability
- the applicant demonstrates its lack of capacity to fund the proposed works, taking into consideration all possible sources of finance
- the applicant has approved provider status and has an allocation of residential aged care places (this includes applicants that have applied for approved provider status and an allocation of places before the capital grant is allocated)
- the applicant has a good record, or a demonstrated commitment to improvement, in meeting its responsibilities and obligations under the Act and other legislation relating to the provision of Australian Government-subsidised aged care.

See legislative reference - section 20.6, Residential Care Grant Principles 1997.

* ‘A demonstrated need for additional residential care services’ is defined as regions where the ratio of residential aged care places per 1000 people aged 70 or over is significantly below the national average.


SERVICES NOT ELIGIBLE FOR A GRANT
Capital grants are not available to:

- residential care services that have been granted extra service status for a residential care service or a distinct part of a residential care service. See legislative reference - section 72-1(4), Aged Care Act 1997.
- services run by an approved provider which is a state/territory government or a state/territory government body.

See legislative reference - section 20.6, Residential Care Grant Principles 1997.
ASSESSMENT OF CAPITAL FUNDING PROPOSALS

All applications are assessed on a competitive basis. In ranking applications, the following will be considered:

- the proportion of care recipients who are supported, concessional or assisted residents, and people with special needs the location of the aged care service, and particularly whether it is in a rural or remote area
- the availability of other aged care services in the area where the service is or will be located
- the need for the grant to assist in establishing or upgrading the relevant service
- whether there is an urgent need for the grant due to unforeseen circumstances
- the extent to which the project would meet the needs of care recipients living with dementia
- whether the project would provide high quality accommodation for care recipients
- whether the project would provide significantly improved operational efficiency
- the adequacy of any arrangements proposed for the care of care recipients and other residents while the project is being completed

Priority will be given to applications where the project meets an urgent need and offers the Commonwealth the best value for money. See legislative reference - section 20.7, Residential Care Grant Principles 1997.


Applications from services conducted in leasehold premises are unlikely to be given high priority in the competitive allocation of capital funds. Funding will be provided to applicants in leased premises only if:

- the lessor agrees to the proposal; and
- agrees to operate the premises as a residential aged care facility for a period of interest, dependent on the size of the grant, after the capital works are finished.

These conditions would form part of the Grant Agreement.

THE GRANT AMOUNT

In deciding the amount of the grant, the Secretary will consider:

- the cost of the project
- the extent to which the applicant has a demonstrated lack of capacity to fund the proposed works, taking into consideration all possible sources of finance.

The Secretary may allocate less than the amount applied for.

There is no provision for increasing an approved grant. The maximum amount payable is the amount approved at the time of allocation. Any increases in costs are to be met by the grantee. Where a grantee requires additional funding, and the capital works have not been contracted, commenced or completed, it may apply for an additional capital grant. The
application for an additional grant will be considered on its merits in the competitive Aged Care Approvals Round.

The grantee is expected to meet its contribution to the capital works project. If total expenditure on the project is less than the amount specified in the Agreement, the grant amount would be reduced to the point that the grantee maintains its minimum contribution.

**AGREEMENT AND CONDITIONS OF GRANT**

As a general rule, one of the conditions of Grant is that the approved provider enters into a formal agreement with the Commonwealth which incorporates the Conditions of Grant. *See legislative reference - section 73-1(2)(a), Aged Care Act 1997.*


**PAYMENT ARRANGEMENTS AND REPORTING REQUIREMENTS**

Payments will be made:
- in line with the payment schedule set out in the Conditions of Grant
- once the provider has given the Department of Social Services (DSS) the documentary evidence which meets the requirements described in the Conditions of Grant.

Under the Conditions of Grant, the grantee also has to make periodic reports to DSS on the progress of the capital works project for which the grant was allocated.

**CEASING TO PROVIDE RESIDENTIAL AGED CARE**

A condition of any grant is that the grantee continues to provide residential aged care, funded under the Act, in the building constructed with the assistance of a grant.

If the grantee stops providing residential aged care in the building, or sells, transfers or demolishes the building, the Government can ask for all or part of the grant to be repaid. In considering whether to ask for all or part of the grant to be repaid, DSS will consider:
- the amount of the grant
- the time which has elapsed since the capital works were completed/occupied
- the circumstances in which the grantee stopped providing residential aged care
- the proposed future use of the buildings constructed with the grant
- the impact that any requirement to repay all or part of the grant might have on achieving the Government’s aged care policy objectives
- whether the building is likely to be sold, or ownership of the building otherwise transferred to a third party and the financial arrangements associated with any transfer
- the overall financial situation of the grantee and the impact repaying all or part of the grant may have on the organisation’s future financial viability
- any other matters the grantee or DSS considers relevant.

Grantees should advise DSS as early as possible if they intend to stop providing care in a building, to transfer ownership or effective control, or to sell, demolish or otherwise dispose...
of the building.

Grantees will be given an opportunity to make a submission, before a decision on the amount of any repayment is made. The grantee’s submission should include detailed, relevant information and any associated documentary evidence.

Further information on decisions to seek repayment of all or part of a grant is set out in the Recovery of Aged Care Capital Funding guidelines at http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-finance-capfund.htm

REVOKEING OR DECREASING AN ALLOCATION
The Secretary can revoke or decrease a residential care grant if a condition of the grant has not been met. See legislative reference - section 73-4, Aged Care Act 1997.

Before deciding to revoke or decrease the allocation, the Secretary will advise the approved provider in writing, and invite a written submission within a specified timeframe (usually 28 days).

In deciding to revoke or decrease an allocation, the Secretary will consider any submissions made within the specified time.

If no submission is received, the grant will be revoked or decreased on the day after the last day for making submissions. The approved provider will be notified of the decision in writing.

VARYING CONDITIONS OF AN ALLOCATION
Grantees are required to meet the conditions of allocation set out in the Conditions of Grant. If a grantee is unable or unwilling to meet these conditions, it must apply to vary the conditions prior to doing anything which would cause it to breach the conditions of the grant. It is the grantee’s responsibility to apply for a variation prior to breaching any grant condition. See legislative reference - section 73-5, Aged Care Act 1997.

A grantee can apply to the Secretary at any time to vary a condition of allocation of a residential care grant. A variation can be either to reduce the amount of the grant or to vary any of the conditions of the grant.

CAPITAL FUNDING AND EXTRA SERVICE STATUS
If extra service status is granted after a capital grant has been allocated, the applicant will be required to repay the grant. See legislative reference - section 43-6, Aged Care Act 1997.
REFERENCES
Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Aged Care Approvals Round Essential Guide

Forms - all
All departmental forms are available on the following website at

Recovery of Aged Care Capital Funding guidelines
CHAPTER 5

From 18 September 2013, the *Aged Care Act 1997* is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services.

To reflect these changes, all references in this Manual to the former Department of Health and Ageing have been changed to the Department of Social Services.

However, it will take some time for the practical application of these changes to flow through. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at [www.health.gov.au](http://www.health.gov.au)

The *Australian Aged Care Quality Agency Act 2013* provides for the establishment of a new Australian Aged Care Quality Agency (the Quality Agency) on 1 January 2014. This new body is the sole agency providers of Australian Government funded aged care will deal with in relation to quality assurance of the aged care services they deliver.

The new Quality Agency replaced the Aged Care Standards and Accreditation Agency Ltd (ACSAA Ltd). The Quality Agency commenced carrying out functions relating to residential aged care services on 1 January 2014 and will commence functions relating to home care services on 1 July 2014.

RESIDENTS’ RIGHTS

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

OVERVIEW

Approved providers must ensure that the civil, human and legal rights of older people living in subsidised aged care services are protected. In order to do so, they must have in place systems, services and staff that respect the rights of residents.
CHARTER OF RESIDENTS’ RIGHTS AND RESPONSIBILITIES
The Charter of Residents’ Rights and Responsibilities is designed to ensure that a person’s rights are not diminished when they move into an aged care service. The Charter, reproduced below, also sets out that residents in aged care services should exercise their individual rights in ways that do not adversely affect other residents’ rights. See legislative reference - section 56-1, Aged Care Act 1997, section 23.12, section 23.14, Schedule 1, User Rights Principles 1997.

Charter of Residents’ Rights and Responsibilities

A. Each resident of a residential care service has the right:
• to full and effective use of his or her personal, civil, legal and consumer rights
• to quality care which is appropriate to his or her needs
• to full information about his or her own state of health and about available treatments
• to be treated with dignity and respect, and to live without exploitation, abuse or neglect
• to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation
• to personal privacy
• to live in a safe, secure and service-like environment, and to move freely both within and outside the residential care service without undue restriction
• to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect
• to continue his or her cultural and religious practices and to retain the language of his or her choice, without discrimination
• to select and maintain social and personal relationships with any other person without fear, criticism or restriction
• to freedom of speech
• to maintain his or her personal independence, which includes a recognition of personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should then not be used to prevent or restrict those actions
• to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions
• to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service
• to have access to services and activities which are available generally in the community
• to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service
• to have access to information about his or her rights, care, accommodation, and any other information which relates to him or her personally
• to complain and to take action to resolve disputes
• to have access to advocates and other avenues of redress; and
• to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights.
B. Each resident of an aged care service has the responsibility:
- to respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole
- to respect the rights of staff and the proprietor to work in an environment which is free from harassment
- to care for his or her own health and well-being, as far as he or she is capable; and
- to inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and his or her current state of health.

INFORMATION FOR RESIDENTS
Residents of aged care services must be given enough information to help them make informed choices. When a new resident enters a service, the provider must give the resident information about residents’ rights and obligations as specified in the Charter, and the requirements of the User Rights Principles as set out in this chapter. See legislative reference - section 23.14, User Rights Principles 1997.

This information can be included in the formal agreement between the resident and the service. Residents can also choose not to enter into a written agreement with the approved provider. If a resident does not want to sign a formal agreement, the approved provider must still give them comprehensive information, including details about the levels of care and service the service can provide for the resident. See section on Signing Agreements further in this chapter of this Manual.

RESIDENT AGREEMENTS
An approved provider must offer each resident a formal resident agreement. See legislative reference - 56-1 (g), Aged Care Act 1997.

A formal agreement is usually an agreement in writing, signed by both the approved provider and the resident when the resident enters the service.

However, the agreement may be signed by the resident at any future time during their stay. The agreement must specify the care and services the service will provide and the resident’s rights and responsibilities while staying in the service. It must also provide information on fees and charges and any other matters negotiated between the approved provider and the resident. A formal agreement may be entered into at any time during the resident’s stay.

The agreement between the resident and the approved provider must:
- treat the resident and provider as equal parties to the agreement and clearly set out the rights and obligations of each party
- be written in plain language
- be easy to understand.

It should specify the following:
- the name of the aged care service
- the levels of care and service that the provider has the capacity to provide to the resident and any limitations to these levels of care and service
- the policies and practices that the provider will follow in setting fees for the resident
the period of the agreement if the resident is not entering the service on a permanent basis
- circumstances in which the resident can be asked to leave the aged care service
- assistance the provider will give the resident to obtain suitable alternate and affordable accommodation if the resident is asked to leave
- the internal complaints resolution mechanism that the aged care service provides to deal with complaints made by or on behalf of a resident
- the resident’s responsibilities as a resident in the aged care service
- any other matters relevant to the agreement, and/or matters negotiated between the approved provider and the resident.

An agreement should also:
- allow for the terms of the agreement to be varied, by mutual consent following adequate consultation
- allow for the agreement to be terminated upon seven days written notice from the resident or their representative
- allow for the agreement to be voided if the resident or their representative tells the provider in writing that they wish to withdraw from the agreement, within 14 days after signing the agreement. In these circumstances, the resident is still liable for any fees and charges accrued under the agreement during their time in the aged care service
- providers must refund any other amount paid by the resident under the agreement.
- explain and help the resident or their representatives understand all the terms of the agreement.


The rights the agreement gives the resident are in addition to any other rights the resident has in law. The agreement must not contain any provision that would allow the resident to be treated less favourably than they would otherwise be treated under any law of the Commonwealth. See legislative reference - section 59-1(3), Aged Care Act 1997.

If a resident does not want to have a formal agreement with the aged care service, the service must still comply with aged care legislative requirements, including those set out in the User Rights Principles in order to continue to receive Government funding.

**SIGNING AGREEMENTS**

If the resident chooses to enter into a resident agreement, the agreement must be signed by both the provider and the resident. If a resident is physically unable to sign the agreement, the resident can ask another person to sign on his or her behalf and the agreement should be annotated to this effect. If a resident is cognitively impaired and cannot understand and sign the agreement, a legally authorised representative should sign for them.

If a resident is unable to sign an agreement and does not have a legally authorised alternative decision maker, an approved provider can contact the relevant state or territory guardianship authority, or public advocate, or public trustee. See the following list of these:
### New South Wales

Office of the Public Guardian  
Parramatta Office  
160 Marsden St  
Parramatta NSW 2150  
Ph (02) 8688 2650  
Ph 1800 451 510 (outside Sydney)  
Fax (02) 8688 9797  

Gosford Office  
Level 3, 4 Watt St  
Gosford NSW 2350  
Ph (02) 4320 4888  
Fax (02) 4320 4818

Sydney Office  
Level 2, Suites 204–206  
83 York St  
Sydney NSW 2000  
Ph (02) 8083 9100  
Fax (02) 8083 9111

Guardianship Tribunal  
2a Rowntree Street  
Balmain NSW 2041  
Ph (02) 9556 7600  
Ph 1800 463 928  
Fax (02) 9555 9049  

NSW Trustee and Guardian  
160 Marsden St  
Parramatta NSW 2124  
Ph (02) 8688 2600  
TTY 1800 882 889  
Fax (02) 8688 9783

Victoria  
State Trustees Ltd  
168 Exhibition Street  
Melbourne VIC 3000  
Ph (03) 9667 6444  
Fax (03) 9663 4260

Office of the Public Advocate  
5th Floor  
436 Lonsdale Street  
Melbourne VIC 3000  
Ph 1300 309 337  
Fax (03) 9603 9501

Guardianship List  
55 Kings Street  
Melbourne VIC 3000  
Ph (03) 9628 9911  
Ph 1800 133 055  
Fax (03) 9628 9932

Western Australia  
Office of the Public Advocate  
Level 1, Hyatt Centre  
30 Terrace Road  
East Perth WA 6004  
Ph 1300 858 455  
Ph 1800 807 437 (WA only)  
Fax (08) 9278 7333

Public Trustee  
PT Building  
565 Hay Street  
Perth WA 6000  
Ph 1300 746 212  
Ph 1800 642 777  
Fax (08) 9222 6607
State Administrative Tribune Western Australia
Level 4
12 St George Terrace Road
Perth WA 60040
Ph (08) 9219 3111
Ph 1300 306 017
Fax (08) 9325 5099

Queensland
Office of the Adult Guardian
PO Box 13554
George Street
Brisbane 4003
Ph (07) 3234 0870
Ph 1300 653 187
Fax (07) 3239 6367

Guardianship and Administration Tribunal
Level 9
259 Queen St
Brisbane QLD 4000
GPO Box 1639

South Australia
Public Trustee Office of South Australia
25 Franklin Street
Adelaide SA 5000
GPO Box 1338
Adelaide 5001
Ph (08) 8226 9200
Ph 1800 673 119
Fax (08) 8231 9518

Guardianship Board of SA
ABC Building
Level 8
85 Northeast Road
Collinswood SA 5081
Ph (08) 8368 5600
Ph 1800 800 501 (SA only)
Fax (08) 8368 5699
Tasmania
Public Trustee
116 Murray Street
Hobart TAS 7001
Ph (03) 6233 7598
Ph 1800 068 784
Fax (03) 6231 0621

Guardianship and Administration Board
54 Victoria Street
Hobart TAS 7000
PO Box 1307
Hobart 7001
Ph (03) 6233 3085
Fax (03) 6233 4509

Office of the Public Guardian
Level 3
15 Murray Street
Hobart TAS 7000
PO Box 825
Hobart 7001
Ph (03) 6233 7608
Fax (03) 6233 4882

Australian Capital Territory
Public Advocate of the ACT
Level 3
12 Moore Street
Canberra City
ACT 2601
PO Box 1001
CIVC SQUARE 2600
Ph (02) 6207 0707
Fax (02) 6207 0688

Public Trustee
PO Box 221
Civic Square ACT 2608
Ph (02) 6207 9800
Fax (02) 6207 9811

ACT Civil and Administrative Tribunal
ACT Magistrates Court
Knowles Place
Canberra ACT 2600
Ph (02) 6207 1740
Fax (02) 6205 1740

Northern Territory
Office of the Public Guardian
Darwin Office
Shops 1 & 2
Ground Floor
Casuarina Plaza
Trower Road
Casuarina NT 0811
Ph (08) 8922 7116
Fax (08) 8922 7051

Public Trustee
Nichols Place
Corner Cavenagh & Bennett Streets
Darwin NT 0800
Ph (08) 8999 7271
Fax (08) 8999 7882

Alice Springs
AAHS Building
Flynn Drive
Alice Springs NT 0870
Ph (08) 8951 6741
Fax (08) 8951 6789
**Resident agreement for respite residents**

A formal agreement between the resident and the approved provider must be offered to all new residents, including respite residents, before they enter the service. See section on Resident Agreements earlier in this chapter of this Manual. Conditions about any booking fee must be included in respite agreements. These agreements must also state the dates between which respite care is to be provided. Respite residents do not pay an accommodation bond or charge. They can occupy an extra service place and if they do, an approved provider may ask the resident to pay additional fees for that extra service place. See also chapters on Extra Service Places and Residential Respite Care in this Manual.

**TRANSITIONAL ARRANGEMENTS FOR AGREEMENTS**

To ensure that existing resident agreements will continue to be honoured, agreements between nursing service or hostel proprietors and residents which were in place before the Act came into effect are considered resident agreements under the Act.

**INFORMATION FOR RESIDENTS WHO DO NOT SIGN AGREEMENTS**

If the resident does not enter into a resident agreement, the provider must still give them all the information in writing that would otherwise be provided in a resident agreement, including:

- the levels of care and service that the provider can provide to the resident
- the policies and practices that the provider will follow in setting fees for providing care and services to the resident
- if the resident is not entering the service on a permanent basis, the period of respite care to be provided to the resident and, if applicable, any respite care booking fees
- conditions under which the resident can be asked to leave
- assistance the provider will give the resident to obtain suitable, alternative and affordable accommodation if the resident is asked to leave
- the internal complaints resolution mechanism that the aged care service provides to deal with complaints made by or on behalf of a resident
- the resident’s responsibilities as a resident in the aged care service.

**DISCLOSURE OF FINANCIAL INFORMATION TO RESIDENTS**

Approved providers are required to provide the following information to residents:

- a copy of any accommodation bond agreement and guarantee
- routine provision of information at the end of the financial year
- provision of information on request, at any other time.

See also section on Disclosure to Residents in Chapter 5 on Protection and Responsibilities Relating to Accommodation Bonds in this Manual.

**PROTECTING RESIDENTS’ INFORMATION**

Providers must protect the personal information of a resident. Personal information can only be used:

- for a purpose related to providing aged care services to the resident, by the provider
- for a purpose for which the resident or his or her representative provided the information. See legislative reference - Division 62, Aged Care Act 1997.
Without the written consent of the resident, personal information must not be disclosed to any other person other than for:
- a purpose related to the provision of aged care services to the resident by the provider
- a purpose related to the provision of aged care to the resident, by another approved provider but only relating to the person’s accommodation bond balance
- a purpose agreed to by the resident or his or her representative.

Personal information must be protected by safeguards which protect against the loss or misuse of information. See legislative reference - section 62-1(c), Aged Care Act 1997. However, approved providers are not precluded from providing a resident’s personal information to a court, tribunal or authority. See legislative reference - section 62-2, Aged Care Act 1997.

SECURITY OF TENURE
Under the legislative provisions for security of tenure, a provider may ask a resident to leave if:
- the aged care service is closing
- the aged care service can no longer provide accommodation and care suitable for the resident, having regard to the resident’s long-term assessed needs, and the provider has not agreed to provide the care that the resident presently needs in cases where the resident’s care needs have changed
- the resident no longer needs the care provided through the aged care service, as assessed by an Aged Care Assessment Team (ACAT)
- the resident has not paid any agreed fee to the provider within 42 days after the due date, for a reason within the resident’s control
- the resident has intentionally caused serious damage to the aged care service, or serious injury to the provider, an employee of the aged care service, or to another resident
- the resident is away from the aged care service for a continuous period of at least seven days for a reason other than permitted by the Act or an emergency.


The provider must give written notice if the resident is required to leave the service and must give the notice to the resident or his or her representative at least 14 days before the resident is to leave. See legislative reference - section 23.6, User Rights Principles 1997.

Four steps - asking a resident to leave
There are four steps that the provider must follow in asking a resident to leave.

Step 1 - assessing the resident’s long term needs
Where the resident is asked to leave because the aged care service can no longer provide accommodation and care suitable for the resident’s long-term assessed needs, and the provider has not agreed to provide the care that the resident presently needs, the long-term needs of the resident must be assessed by:
- an ACAT; or
- at least two medical or other health practitioners who meet the following criteria:
- one must be independent of the provider and the aged care service and chosen by the resident; and
- both must be competent to assess the aged care needs of the resident.

After such an assessment, if those conducting the assessment consider that the present accommodation and care cannot continue to meet the care needs of the resident, then the process associated with requiring the resident to leave must be undertaken.

**Step 2 - providing written notice**

The written notice from the approved provider must include:

- the decision
- reasons for the decision
- when the resident is to leave (which must be at least 14 days after the notice is given)
- the resident’s rights about leaving, including his/her access to complaints resolution mechanisms independent complaints processes and one or more representatives of an advocacy service.

**Step 3 - considering suitable alternate accommodation**

The approved provider should discuss with the resident whether they wish to find their own alternate accommodation. However, ultimately it is the approved provider’s responsibility to ensure that accommodation is available for the resident, before the resident can be required to leave.

The suitability of the alternate accommodation is linked to the assessment of the resident’s long-term care needs - for example, a service that provided only low level care would not be suitable alternate accommodation for a resident who was assessed as having more complex needs.

The alternate accommodation does not necessarily have to be the preferred accommodation of the resident who is being asked to leave. However, the alternate accommodation does have to be available and able to provide care which is suitable to meet the needs of the resident. Some alternate accommodation may not be considered suitable, such as a service where there are sanctions in place or a service that is a great distance from the existing service.

The resident must be able to afford the suitable alternate accommodation - for example, an extra service facility may not be appropriate for a concessional resident. Hospital is not considered to be suitable alternate accommodation.

**Step 4 - when the resident is no longer required to leave**

If the decision requiring the resident to leave was based on their behaviour, and since giving the original notice to leave, the approved provider has agreed with the resident that the
Residential Care Manual 2014

resident should stay because their behaviour has changed, then the approved provider should give the resident a notice stating that they are no longer required to leave.

SECURITY OF PLACE WITHIN THE RESIDENTIAL SERVICE - MOVING RESIDENTS
It is important that residents feel secure in their room or bed within an aged care service. Accordingly, a resident can only be moved to another bed or room in the following circumstances:

• if the resident asks to be moved
• if the resident agrees to move, after being fully consulted and without any pressure
• if the move is necessary on genuine medical grounds as assessed by an ACAT or at least two medical or other health practitioners
  – one of whom is independent of the provider and the aged care service and chosen by the resident
  – both of whom are competent to assess the aged care needs of the resident
• if the place occupied by the resident becomes an extra service place and the resident elects not to pay the extra service fee
• if the move is necessary because repairs or improvements to the aged care service need to be carried out and the resident has the right to return to the bed or room, if it continues to exist as a bedroom for residents, once the repairs or improvements are completed.


RESPITE BOOKING FEES
Respite booking fees are prepaid daily fees, paid to ensure a period of respite care. Conditions relating to the booking fee must be included in a resident’s agreement. The agreement must also state the date on which respite care is to be provided. See also section on Respite Booking Fees in chapter on Residential Respite Care in this Manual. See legislative reference - section 23.16, User Rights Principles 1997.

RESIDENTS’ RIGHTS - COMPLAINTS MECHANISMS
Care recipients have a number of rights in relation to complaint mechanisms. These include the right to:

• be treated with respect and accepted as an individual, and to have their individual preferences taken into account and treated with respect
• freedom of speech
• complain and take action to resolve disputes
• have access to advocates and other avenues of redress
• be free from punishment, or well-founded fear of punishment, in any form for taking action to enforce their rights.

Service providers are obliged to not act in a way that is inconsistent with these rights. See legislative reference - section 56-4, Aged Care Act 1997.
RESOLVING COMPLAINTS

Complaints help to improve the quality of aged care services in Australia. There are two options available to people wanting to make a complaint about the quality of care or services provided by an Australian Government-subsidised aged care service:

- internal (using the complaint handling system within the service)
- external (through the Aged Care Complaints Scheme (the Scheme)).

**Internal complaint resolution**

Approved providers are required to establish and operate an effective system for handling complaints. The system should be accessible, confidential, prompt, fair and well publicised within the service.

The internal process established and operated by approved providers must meet the requirements set out under:

- the *Aged Care Act 1997*
- the Aged Care Principles (particularly the Quality of Care Principles - see the Accreditation Standards and User Rights Principles - see the Charter of Residents’ Rights and Responsibilities)
- the *Complaints Principles 2011*
- funding agreements between the Australian Government and approved providers.

Resolving complaints within the service in the first instance can achieve timely and sustainable solutions that lead to improved aged care services for older Australians. This can prevent issues from being raised with the Scheme unnecessarily.

To support better practice in complaint handling within aged care services, the Department of Social Services (DSS) has developed a Better Practice Complaint Management Toolkit (the Toolkit). The Toolkit contains a range of digital, print and web-based tools, exercises and reference materials as well as a booklet on *Better Practice Guide to Complaint Handling in Aged Care*. The suite of resources and tools is available on the Scheme’s website ([www.health.gov.au/agedcarecomplaints](http://www.health.gov.au/agedcarecomplaints)).

However, despite the best efforts of approved providers, some complaints cannot be resolved internally. Services are required to ensure that people are aware that they can complain to the Scheme in instances where the service is unable to resolve their complaint.

**Access to external complaint mechanisms**

Australian Government standards for aged care require that approved providers ensure care recipients and other interested parties have access to external complaint mechanisms and advocacy support at any time.

Care recipients and their representatives need to know who they can complain to when the service is unable to resolve their complaint, and who can support them at any time of making a complaint. Support includes access to advocacy services and the Scheme.
Care recipients can choose to make a complaint to the Scheme if they do not feel comfortable making a complaint within the service. Care recipients can also choose to get help from an advocacy service.

Responsibilities of service providers in relation to complaint resolution mechanisms in their service are outlined in Section 56-4 of the Act.

**AGED CARE COMPLAINTS SCHEME**

Raising a concern with the approved provider can achieve a fast and sustainable outcome, but if that approach is not possible, the Scheme can examine the concern. The Scheme is managed by DSS’s Office of Aged Care Quality and Compliance.

The Scheme provides a free service for anyone to raise their concerns about the quality of care or services being delivered to people receiving aged care services subsidised by the Australian Government, including:

- residential care
- Home Care Packages
- Commonwealth HACC services.

Complaints can be made openly, anonymously or confidentially. The Scheme encourages people to lodge complaints openly - by providing a name and contact number - as this means the Scheme can assist more effectively in resolving concerns. The Scheme is unable to provide feedback to someone who has chosen to remain anonymous.

The aim of the Scheme is to resolve concerns and achieve the best possible outcome for care recipients. Concerns can be resolved in a number of different ways that are timely and proportionate. These range from simple, relatively quick and informal approaches, to more formal and lengthy processes.

The Scheme can examine complaints relating to an approved provider’s responsibilities under the *Aged Care Act 1997*. Examples of concerns that can be examined include:

- health and personal care, e.g. infection control, personal hygiene
- communication, e.g. information and internal complaints processes
- personnel, e.g. conduct and training
- physical environment, e.g. safety, security, cleaning and call bells
- financial matters
- facility equipment
- activities, choice and comfort
- discrimination.

There are some things the Scheme is unable to do. For example, the Scheme is unable to:

- say who should make financial, legal or health decisions on behalf of a care recipient
- comment on industrial matters such as wages or employment conditions
- provide legal advice
- ask approved providers to terminate someone’s employment
- investigate the cause of death (this is the role of the coroner)
• determine whether or not a specific event occurred (especially if there are conflicting accounts of the event)
• provide clinical advice about what treatment a person should be receiving.

Complaints that fall outside of the scope of the Scheme can be referred to other organisations, professional registration boards or other complaints bodies.

The Scheme can be contacted in writing, by telephone, email or by submitting an online complaint form. See the references at the end of this chapter for contact information.

All parties to a complaint have the right to be kept informed about what is happening with their complaint, except where someone has lodged a complaint anonymously.

In examining complaints, the Scheme aims to work with all parties to achieve a positive outcome for the care recipient. If people have concerns about the Scheme’s work, they can seek a review of the issue. If a person is not satisfied at any stage of the complaint process, they are encouraged to raise the concern directly with the DSS manager responsible for the Scheme in the relevant state or territory.

Approved providers and complainants can also ask for a review of a Scheme decision, as well as provide feedback on or seek examination of the Scheme’s complaint process. For more information on review rights, there is a fact sheet available from the Scheme website under the Resources tab at www.health.gov.au/agedcarecomplaints.

The Office of the Aged Care Commissioner
The Aged Care Commissioner (the Commissioner) can review certain decisions made by the Scheme and examine complaints about the Scheme’s processes for handling matters under the Complaints Principles 2011. The Commissioner can also examine complaints about the Quality Agency’s processes for accrediting aged care services and conducting the quality review of home care services under the Quality Agency Principles 2013.

From 1 August 2013 the Scheme is required to take into account the Commissioner’s view in the review of a complaints resolution process.

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

A care recipient 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:
• assisting care recipients to resolve problems or complaints in relation to aged care services
• supporting care recipients to be involved in decisions that affect their life
• providing care recipients with information and advice about their rights and responsibilities
• promoting the rights of care recipients to approved providers.
Aged care advocacy services achieve this through the delivery of advocacy, information and education. The provision of information and education, to both care recipients and approved providers of aged care, can contribute to the protection of consumers’ rights and foster improvements to the quality of life for care recipients.

Approved providers must accept the care recipient’s choice of advocate. Care recipients may choose to use an independent advocacy service or ask a family member or friend to fulfil this role.

Approved providers should give care recipients information about the role of advocates, and support care recipients to contact an advocacy service if required.


Aged care services must allow advocacy services access to the premises during normal business hours, or at any other time if a resident or their representative has asked the advocacy service to call. See legislative reference - section 56-1(k), Aged Care Act 1997.

COMMUNITY VISITORS’ SCHEME

The Community Visitors’ Scheme (CVS) helps to establish links between people living in an aged care service and their local community. The CVS aims to improve the quality of life of residents of aged care services who have limited family and social contact, and may be at risk of isolation from the general community for social or cultural reasons, or through disability.

The CVS provides volunteers for one-to-one visits and group visits (from 1 July 2013) to socially isolated residents of Australian Government-subsidised aged care homes. The Scheme is funded by DSS and operated by funded community-based organisations which recruit, train and monitor the volunteer visitors.

The role of the approved provider in the Community Visitors’ Scheme is to:

1. identify care recipients who would benefit from being matched with a community visitor
2. liaise with the local CVS provider(s), through their CVS co-ordinator, to facilitate that provider successfully matching a volunteer to those care recipients
3. enable the CVS volunteer, once successfully matched, to visit the care recipient on a regular (at least fortnightly) basis. CVS volunteers should be viewed, once successfully matched, as a friend visiting a care recipient:
   • it is especially important during times of change within the aged care facility (such as a change of management or key personnel) that an existing relationship between a CVS volunteer and a care recipient is maintained. At no time should an approved provider prevent an existing CVS volunteer/care recipient friendship from continuing, as this could be distressing for both the care recipient and the volunteer visitor
• if an approved provider has concerns about a CVS volunteer/care recipient match, they should discuss their concerns with the CVS co-ordinator as soon as possible
• where possible, the approved provider should advise the CVS auspice coordinator if a resident cannot receive visits, for example, if the resident has become very ill or has passed away.

**Police Checks for CVS volunteers**

It is worth noting that although a CVS volunteer visitor does require a police check (formally known as a national criminal history record check), it is up to the CVS provider to arrange this police check, as part of their role in recruiting new CVS volunteer visitors. approved providers are not required to ensure police checks have been undertaken for CVS volunteer visitors.

Access to the CVS by residents in aged care services is supported by the *Aged Care Act 1997*.

*Section 56-1(1), Aged Care Act 1997* requires approved providers of aged care services not to act in a way that is inconsistent with any rights and responsibilities of care recipients that are specified in the *User Rights Principles 1997*.

The Charter of Residents' Rights and Responsibilities in Schedule 1 to the User Rights Principles states that each resident of a residential aged care service has the right to:
• select and maintain social and personal relationships with anyone else without fear, criticism or restriction; and
• to be involved in activities, associations and friendships of his or her choice, both within and outside the residential aged care service.
REFERENCES
Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

National Aged Care Advocacy Program
http://www.agedrights.asn.au/rights/agencies.html

The Office of the Aged Care Commissioner
www.agedcarecommissioner.net.au or ph 1800 500 294

Aged Care Complaints Scheme
ph 1800 550 552

The Scheme operates:
Weekdays - 9am to 5pm (AEST)
Weekends - 10am to 5pm (AEST)
Outside of these hours (including on public holidays), a message can be left on the Scheme’s answering machine requesting an officer to return the call during business hours.

People can also write a letter to the Scheme and address the letter to:

Aged Care Complaints Scheme
Department of Social Services
GPO Box 9848
(In your capital city)

An online complaints form can be found on the Scheme’s website via the ‘Raise a Concern’ tab at:
PROTECTION AND RESPONSIBILITIES RELATING TO ACCOMMODATION BONDS

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

OVERVIEW
This chapter is designed to help approved providers, holding accommodation bonds and entry contributions, comply with:
- the timeframes for repayment of accommodation bonds
- requirements to pay interest to residents for the period between the resident leaving a service and the refund of the accommodation bond balance or entry contribution balance
- permitted use requirements

This chapter also provides information about the Accommodation Bond Guarantee Scheme (Guarantee Scheme).

PERMITTED USE OF ACCOMMODATION BOND FUNDS
The legislation and User Rights Principles provide for clear arrangements to protect residents’ savings held in the form of accommodation bonds. These include limiting the use of accommodation bonds to specified permitted uses that reflect the intended purposes for accommodation bonds - to provide a source of capital funding for investment in aged care infrastructure.

Approved providers must not use accommodation bonds charged on or after 1 October 2011 for a purpose that is not a permitted use as specified in the Act or the User Rights Principles. The permitted uses reinforce the role of accommodation bonds in financing capital investment in residential and flexible aged care.

The permitted uses allow flexibility to invest in and transfer accommodation bonds between corporate entities provided appropriate safeguards are in place.


What are the permitted uses for accommodation bonds?
Permitted uses are limited to:
- capital expenditure for residential or flexible care that is reasonable in the circumstances
• investment in particular financial products
• loans for:
  – capital expenditure
  – investments in particular financial products
  – refunding accommodation bond balances or entry contributions
  – repaying debt accrued for the purposes of capital expenditure or for refunding accommodation bond balances
• refunds of accommodation bond or entry contribution balances
• repayment of debt accrued for the purposes of capital expenditure or for refunding accommodation bond balances
• repayment of debt that accrued before 1 October 2011 if accrued for the purposes of providing aged care to residents
• reasonable business losses during the first 12 months that the approved provider operates a residential or flexible aged care service
• investments of accommodation bonds into Religious Charitable Development Funds (RCDFs).


CAPITAL EXPENDITURE

What is capital expenditure?
The primary policy intent of accommodation bonds is to provide approved providers with a source of capital funding for investment in residential and flexible aged care infrastructure. Capital expenditure improves services for residents and provides asset backing to support the refund of accommodation bond balances. Capital expenditure is broadly defined and includes ancillary expenses directly linked to capital expenditure.

Approved providers may use accommodation bonds, if it is reasonable under the circumstances, for expenditure to:
• acquire land on which an existing residential or flexible aged care service is built
• acquire land for building residential care services or flexible care services
• acquire, build or significantly alter premises for providing residential care or flexible care
• acquire or install furniture, fittings or equipment used in providing residential care or flexible care. This is a permitted use where the premises are initially erected or following an extension, a significant alteration or significant refurbishment
• pay for costs that are directly attributable to the above expenditure.

See legislative reference - subsections 57-17A(1) (a) and 57-17A(2), Aged Care Act 1997.

In administering and enforcing the permitted use requirements, the Department of Social Services (DSS) will principally focus on the primary use or purpose of the capital expenditure. In order to meet the requirements, the primary use or purpose of the capital expenditure must be for the delivery of residential or flexible care services. The use of infrastructure funded by accommodation bonds for non-residential or flexible care services would be acceptable provided it is an incidental or ancillary use.

The use of accommodation bonds for capital expenditure is only permitted if it is reasonable under the circumstances. The inclusion of this ‘reasonableness test’ (which is commonly used in legislation and readily interpreted by courts) is to avoid approved providers using
accommodation bonds for other than their intended purposes. It also affords protection against paying above market rates for capital items and other associated costs.

For example, approved providers are able to use accommodation bonds to acquire land on which premises for providing residential or flexible care services are to be built, and expenditure directly attributable to such an acquisition, if the expenditure is reasonable. In order for this reasonableness to be demonstrated, DSS may request from the approved provider documented evidence to demonstrate the intention to use the land for building premises for providing residential or flexible care such as development approvals, evidence of land zoning, architects plans, feasibility studies and contracts of sale. DSS might also request evidence of the market value of the land at the time of purchase.

Accommodation bonds must not be used for paying unreasonable fees to building contractors or others. For example, it is expected that any architects fees would be directly attributable to the erection or significant alteration of an aged care service. However, in order for accommodation bonds to be used to meet such an expense, the fees must be reasonable in the circumstances i.e. they must be charged at commercial, arms’ length rates. It would be unreasonable for an approved provider to pay inflated fees to related parties who may provide services to the approved provider (for example, partners or family members who are also builders or architects).

Example
An approved provider with three residential aged care services intends to build another residential aged care service nearby. The following are examples of what would constitute permitted capital expenditure of accommodation bonds:
- the initial purchase of the land
- architect and other professional fees
- council fees
- site remediation
- foundation works
- construction of the service
- installation and purchase of furniture, fittings and equipment.

During the design of the building, the approved provider asks their architect and construction team to add an additional room, for use as a General Practitioner/Nurse Practitioner/allied health professional consultation room for residents. Since the primary purpose of the building is for the provision of residential aged care, the approved provider may use accommodation bonds to pay for the capital works associated with the General Practitioner/Nurse Practitioner/allied health professional consultation room.

Example
An approved provider would like to significantly refurbish its service. The approved provider has arranged for all residents to move temporarily to other services during the refurbishment. A supermarket and restaurant have approached the approved provider and offered to rent the ground floor space, which would also be refurbished. The approved provider is permitted to use accommodation bonds to pay for the significant refurbishment of premises used to provide residential aged care. However, it would not be permitted to
use accommodation bonds to pay for the refurbishment of the space used by the supermarket and restaurant.

**Example**
An approved provider enters into a lease arrangement for an old building where the approved provider plans to operate a residential aged care service. The approved provider has approval to significantly alter the premises by adding a new wing to the service as well as refurbishing the entire building. These would all be permitted uses of accommodation bonds.

**Example**
An approved provider wants to use accommodation bonds to purchase the land and buildings of an existing aged care service from another approved provider. This would be a permitted use of accommodation bonds.

**What is not capital expenditure?**
Except for reasonable business losses in the first 12 months of operating a service (see legislative reference - section 23.64B, User Rights Principles 1997), accommodation bonds must not be used for routine repairs or maintenance such as painting, plumbing, electrical work, gardening or vehicle leasing. Accommodation bonds must not be used to cover the normal day to day costs of operating a service such as staff wages or the purchase of consumables.

Accommodation bonds must not be used for routine replacement of furniture items such as wardrobes or lounges. It is expected that approved providers would use operational budgets to replace worn furniture. By contrast, if a significant refurbishment is planned whereby, for example, all furniture is removed and replaced, this would constitute a significant refurbishment and accommodation bonds could be used for this purpose (as it is improving the capital value of the service). Similarly, if an approved provider were to repair an existing call bell system this would not be capital expenditure for which accommodation bonds can be used. However, if the approved provider were to replace the call bell system with an entirely new and improved system and this represented a significant capital outlay then accommodation bonds could be used for this purpose.

In determining whether or not expenditure is significant, DSS will take into account the circumstances of the investment and whether or not the expenditure was reasonable in the circumstances. See legislative reference - section 57-17A2, Aged Care Act 1997.

**Example**
An approved provider wants to replace one lifting device in one of its residential aged care services. It would be expected that the approved provider would use its operational budget to replace this piece of equipment. By contrast, if the approved provider was to replace all lifting devices as part of a significant refurbishment or alteration, accommodation bonds could be used for this purpose.
Example
An approved provider wishes to replace the bus used for the transport of residents to social events and appointments. As this bus is not furniture, fittings or equipment for premises used or proposed to be used for providing residential care or flexible care, and could not be considered to be purchased following a significant alteration or a significant refurbishment of a premises used for providing care, its purchase or leasing is not a permitted use. Sources of funding other than lump sum accommodation bonds are available for the purchase or leasing of a facility bus. Such funding includes accommodation charges, retention amounts and interest earned on the investment of accommodation bonds.

Example
An approved provider wishes to construct independent living units adjacent to one of its residential aged care services. As independent living units are not used in providing residential or flexible care, using accommodation bonds for this purpose is not permitted. Independent living units do not fall within the definition of capital expenditure at section 57-17A(2) of the Act as they are not premises for providing residential care or flexible care.

INVESTMENT IN FINANCIAL PRODUCTS
Where accommodation bonds are not immediately required for other permitted uses, approved providers may choose to invest them in order to generate additional income. Approved providers are able to invest accommodation bonds in a broad range of permitted financial products.

What financial products can approved providers invest in?
Where accommodation bonds are not immediately required for other permitted uses, investing the accommodation bonds to generate additional income is a legitimate use. Accommodation bonds may be invested in a broad range of financial products, subject to the provider being able to demonstrate it has an appropriate level of risk management in place. The use of the profit from these investments is not regulated by the Act.

Given that bond balances must be refunded within statutory timeframes, an approved provider must consider the impact of investment risks on its ability to refund accommodation bond balances as they become due.

When deciding whether or not to invest in financial products, and the classes of financial products to invest in, approved providers should consider their business model, their liquidity needs, and the risks of such investments to their liquidity and capacity to meet accommodation bond balance refunds as, and when, they become due.

Permitted financial products are (within the meaning of section 764A of the Corporations Act 2001):
- deposits with an authorised deposit-taking institution (ADI) made available in the course of its banking business (e.g. deposits in bank accounts and term deposits)
- debentures, stocks or bonds issued by the Commonwealth, states or territories
- securities (other than a security of kind specified in the User Rights Principles. As at 1 August 2013 there are no securities specified in the Principles).
- registered managed investment schemes
unregistered managed investment schemes established for the purpose of investment in residential or flexible aged care.

Where an approved provider invests accommodation bonds in investments other than deposits with an authorised deposit-taking institution made available in the course of its banking business, then investment risk must be assessed and managed through the Governance Standard, including an Investment Management Strategy (IMS). See legislative reference - subsections 57-17A(1) (b) and 57-17A(3), Aged Care Act 1997, section 23.38B, User Rights Principles 1997. (IMS). See legislative reference - subsections 57-17A(1) (b) and 57-17A(3), Aged Care Act 1997, section 23.38B, User Rights Principles 1997.

Financial products are listed in section 764A of the Corporations Act 2001. Not all financial products listed in section 764A of the Corporations Act are permitted uses of accommodation bonds. For example, investment in derivatives is not a permitted use of accommodation bonds. Approved providers may wish to seek professional advice if unsure whether a financial product is a permitted use for accommodation bonds.

Approved providers investing accommodation bonds in financial products, other than a deposit with an ADI, are required to have in place an IMS prior to making such investments. An IMS is also required where a provider invests in Religious Charitable Development Funds. See section on Investments of accommodation bonds into Religious Charitable Development Funds (RCDFs) further in this chapter.

Refer to the section on the Governance Standard later in this chapter for further information regarding the IMS.

Example
Approved provider ACMI Pty Ltd is in negotiations with approved provider ACE Pty Ltd to fully acquire ACE Pty Ltd. ACE Pty Ltd is registered under the Corporations Act 2001 and has 100 issued shares. ACMI Pty Ltd may use accommodation bonds to purchase the issued shares in ACE Pty Ltd at an agreed price.

Example
An approved provider has taken $5 million in accommodation bonds since 1 October 2011. Their normal business practice is to place a portion of their accommodation bonds into a bank account to ensure they have sufficient liquidity to refund accommodation bonds as they fall due. They would also like to invest $500,000 in shares in a blue chip company and a further $500,000 in an unregistered managed investment scheme that complies with the requirements for such schemes in the Corporations Act and was established for the purpose of investment in residential aged care services. In doing so this approved provider will have invested their accommodation bonds in permitted financial products.

Since the approved provider has invested in financial products other than deposits with an ADI, it will need to implement an IMS prior to making such investments.

For further information regarding the IMS, see section on Investment Management Strategy later in this chapter.
Example
The executive decision makers of an approved provider wish to invest in an unregistered managed investment scheme established for the purpose of providing capital for the development of retirement villages. Investing accommodation bonds in such an unregistered managed investment scheme would not be a permitted use, as a retirement village is not a residential or flexible aged care service.

AMOUNTS RETURNED FROM THE SALE, DISPOSAL OR REDEMPTION OF PERMITTED FINANCIAL PRODUCTS
When accommodation bonds have been invested in permitted financial products and the products are sold, disposed of or redeemed, the approved provider must use the original amount invested from accommodation bonds for permitted uses. There are no restrictions on the profit made from investment in permitted financial products. The requirements regarding the permitted uses of accommodation bonds continue to apply regardless of how many investments are made using the same accommodation bond amount.

Example
In accordance with their IMS, an approved provider has invested $20 million of accommodation bonds in shares in blue chip companies. The executive decision makers of the approved provider decide to sell the shares for $22 million. The $2 million profit can be used at the approved provider’s discretion. However, the principal amount of $20 million (the accommodation bond amount invested) must only be used for permitted uses.

USING ACCOMMODATION BONDS TO MAKE LOANS
The permitted use arrangements recognise the diversity of approved providers and the wide range of corporate structures that are utilised within the aged care sector. The arrangements ensure that there is flexibility to shift accommodation bonds between different entities, provided appropriate safeguards are in place.

Approved providers may use accommodation bonds to make a loan that meets the following conditions:
- the loan is not made to an individual
- the loan is made on a commercial basis
- there is a written agreement in relation to the loan
- it is a condition of the written agreement that the money loaned will only be used for:
  - capital expenditure as defined by section 57-17A(2) of the Act
  - investment in financial products defined by the section 57-17A(3) of the Act
  - refunding accommodation bond balances or entry contribution balances
  - repaying debt that is accrued for the purposes of capital expenditure (as defined by section 57-17A(2) of the Aged Care Act 1997) or refunding accommodation bond balances
- the agreement includes any other conditions specified in the User Rights Principles (as at 1 August 2013 there are no other conditions specified in the User Rights Principles). See legislative reference - section 57-17A (1) (c), Aged Care Act 1997, section 23.64B, User Rights Principles 1997.
WHAT IS THE MEANING OF ‘ON A COMMERCIAL BASIS’ FOR THE PURPOSES OF SECTION 57-17A(1)(C)(II) OF THE ACT?

A loan is made on a commercial basis if the borrower and the lender, even if they are related parties, deal with one another at arm’s length i.e. in a way that independent parties would normally deal with one another. The written loan agreement will include a legal requirement to repay the loan within a specified period, a method for working out the interest payable on the loan and an appropriate guarantor or other security. An interest free loan, or a loan with no security or backed only by a letter of comfort, or a loan for an indefinite period would not be a loan made on a normal commercial basis.

Example
An approved provider is part of a larger group of companies. The business of the group includes residential care services and independent living units. The approved provider has $15 million in accommodation bonds in a bank account with an authorised deposit-taking institution. The executive decision makers of the group are considering how they will fund the construction of a new independent living unit complex by one of the group’s companies. In this case, the approved provider cannot lend the $15 million for the purposes of constructing the independent living units. Loans may only be made conditional on the money being used for permitted uses specified in section 57-17A(1)(a) and 57-17A(1)(b) of the Act. Independent living units are not capital expenditure within the meaning of section 57-17A(2) of the Act as they are not premises for providing residential care or flexible care.

Example
An approved provider is part of a larger group of companies. The business of the group includes residential care services and independent living units. The approved provider has $15 million in accommodation bonds in a bank account with an authorised deposit-taking institution. The executive decision makers of the group are considering how they will fund the construction of a new residential aged care facility by one of the group’s companies. In this case, the approved provider can lend the $15 million for the purposes of permitted capital expenditure. The loan agreement must specify that the loan monies must only be used for investment in permitted capital expenditure.

REFUNDING ACCOMMODATION BONDS

It is a permitted use for accommodation bonds to be used to refund accommodation bond balances or entry contribution balances.

Repayment of debt accrued for the purposes of capital expenditure or refunding of accommodation bonds

If an approved provider accrues debt from capital expenditure (see above section for what constitutes capital expenditure) or from refunding accommodation bond balances, it is a permitted use for accommodation bonds to be used to repay this debt.
Repayment of debt accrued before 1 October 2011 for the purposes of providing aged care to residents

If an approved provider has accrued debt before 1 October 2011 incurred for the purpose of providing aged care, it is a permitted use for accommodation bonds to be used to repay this debt.

INVESTMENTS OF ACCOMMODATION BONDS INTO RELIGIOUS CHARITABLE DEVELOPMENT FUNDS (RCDFs)

RCDFs are established by religious and charitable organisations for the purpose of seeking investments from the public to help further the funds' religious and charitable goals and objectives. This fundraising activity meets the definition of banking business under the Banking Act 1959. The Australian Prudential Regulation Authority has exempted RCDFs from the requirement to be authorised under the Banking Act where specified conditions are met. RCDFs that bonds may be invested into are listed in Schedule 1 of the Banking Exemption No 1 of 2011. The deposit of accommodation bonds into RCDFs is a permitted use only when covered by an Investment Management Strategy (IMS). For further information about an Investment Management Strategy, see section on Investment Management Strategy further in this chapter.

Where the approved provider and the RCDF are the same legal entity, the RCDF must use bonds invested with it for permitted uses only.

REASONABLE BUSINESS LOSSES DURING THE FIRST 12 MONTHS OF AN APPROVED PROVIDER OPERATING A SERVICE

The permitted use requirements reflect the intended purposes for accommodation bonds, ie. to provide a source of capital funding for investment in aged care infrastructure (not operational costs). However, recognising that the construction of a new aged care service or the acquisition of an existing aged care service may involve losses in the initial stages of operation, and that these losses are closely related to the capital investment, a time limited capacity to use bonds to support operational costs is available.

Business losses may be incurred during the start-up of a residential or flexible care service, including where a new service opens or where an approved provider makes changes to the business operations of a newly purchased existing service. It is permitted for an approved provider to use accommodation bonds to meet reasonable business losses of that service for the first 12 months of that service beginning to be operated by the new approved provider. If using accommodation bonds to meet reasonable business losses, the approved provider must ensure that they have sufficient liquidity to repay accommodation bond balances as, and when, they fall due.

Example

On 9 March 2012 an approved provider opens a new residential care service. The executive decision makers of the approved provider wish to use accommodation bonds to pay for the recruitment, training and retention of staff in anticipation of projected occupancy. The approved provider may use accommodation bonds to meet such operational losses up to and including 8 March 2013.
Example
On 25 January 2012 approved provider Acme Pty Ltd purchases the existing residential care service from approved provider Ace Pty Ltd that is experiencing financial difficulty. Acme Pty Ltd can use accommodation bonds to purchase the land and buildings and fund costs directly attributable to purchasing the residential care service. The executive decision makers of Acme Pty Ltd also want to use accommodation bonds to improve the business operations of the purchased service. Acme Pty Ltd may use accommodation bonds to establish new record keeping systems and to cover other operational losses up to and including 24 January 2013.

TRANSITIONAL ARRANGEMENTS
See legislative reference - Schedule 1, Part 2, Aged Care Amendment Act 2011.
The permitted use arrangements took effect on 1 October 2011. The two year transition period to allow approved providers to become familiar with the permitted use requirements and make any necessary adjustments to fully comply with them expires on 30 September 2013.

During the transition period, an approved provider may use accommodation bonds charged for entry on or after 1 October 2011 for a purpose relating to providing residential or flexible aged care. That is, during the transition period, approved providers will be able to continue to use accommodation bonds for both capital and non-capital purposes in delivering these aged care services.

From 1 October 2013 approved providers must only use bonds charged on or after 1 October 2013 (and bonds that have been charged after 1 October 2011 and were not used before 1 October 2013) for permitted uses. This includes where bonds are returned to the approved provider from the sale, redemption or disposal of financial products and where bonds are returned to the provider following investment in an RCDF.

Approved providers may continue to use accommodation bonds acquired before 1 October 2011 in line with the requirements that were in place before 1 October 2011.

DEDUCTIONS FROM ACCOMMODATION BOND BALANCES
Approved providers may make the following deductions from an accommodation bond only if a valid accommodation bond agreement has been entered into:
• retention amounts. See also section on Accommodation Payments in Chapter 4 on Funding for Residential Aged Care in this Manual.
• amounts owed to the approved provider by the resident under an accommodation bond agreement, a resident agreement or an extra service agreement
• interest on the amounts owed to the approved provider by the resident under an accommodation bond agreement, a resident agreement or an extra service agreement.

Approved providers must not deduct any other amounts from the accommodation bond balance.
USE OF RETENTION AMOUNTS AND INCOME DERIVED FROM ACCOMMODATION BOND BALANCES

Approved providers are entitled to retain income derived from investing accommodation bond balances. The *Aged Care Amendment Act 2011* removed the restriction on the use of retention amounts and income derived from accommodation bond balances. This means that an approved provider may use these amounts at their discretion. This provides more flexibility to manage cash flow and helps offset the limits on permitted uses for the lump sum element of the accommodation bonds.

CRIMINAL OFFENCES RELATING TO NON-PERMITTED USE OF ACCOMMODATION BONDS

*See legislative reference - section 57-17B, Aged Care Act 1997.*

The introduction of criminal offences for serious non-compliance encourages compliance with the permitted uses and builds consumer confidence in paying accommodation bonds. It clearly reinforces the importance of appropriately managing accommodation bond funds.

From 1 October 2011, approved providers will be committing a criminal offence if they misuse accommodation bonds and fail financially, owing accommodation bond balance refunds within two years of the misuse occurring. Offences apply to both approved providers and to key personnel who knew about the misuse, or were reckless or negligent as to whether the accommodation bonds were being misused, if they could have taken steps to prevent the misuse but failed to do so.

The offences are intended to reinforce the significance of approved providers’ obligations to their residents in dealing appropriately with residents’ funds and ensuring that refund obligations are met. They are not intended to be used in circumstances where a breach has been minor and unintentional. Rather, they are structured to ensure that they only become available in the most extreme of circumstances - where an approved provider has failed to comply with their statutory obligations on the use of accommodation bonds and they have been unable to meet their refund obligations to residents.

It is not necessary that the non-permitted use of the accommodation bond can be shown to have actually caused the insolvency, but simply that there was a non-permitted use and there was also an insolvency event (and failure to repay one or more accommodation bonds) within two years.

The penalties can only apply to key personnel where they have known that accommodation bonds are being used for non-permitted purposes, they have not taken reasonable steps to prevent the misuse of accommodation bonds and, within two years of the misuse, the approved provider has been placed into liquidation while owing refunds of accommodation bonds.

An individual commits an offence (punishable by up to two years imprisonment) if:
- the individual is one of the key personnel of an approved provider or former approved provider (noting that *key personnel* is defined by a person’s role and not through notifying DSS of their key personnel status)
the approved provider or former approved provider uses an accommodation bond for a non-permitted use
the individual knew that, or was reckless or negligent as to whether, the accommodation bond would be used for a purpose that was not permitted. Strict liability applies to this element of the offence
the individual was in a position to influence the conduct of the entity in relation to the use of the accommodation bond
the individual failed to take all reasonable steps to prevent the misuse of the accommodation bond
within two years of the non-permitted use of the accommodation bond, the Accommodation Bond Guarantee Scheme was triggered. In other words, an insolvency event (within the meaning of the Aged Care (Bond Security) Act 2006) has occurred in relation to the approved provider or former approved provider and there is at least one outstanding accommodation bond balance. Strict liability applies to this element of the offence
at the time that the accommodation bond was used for the non-permitted use, the approved provider (or former approved provider) was a corporation. Strict liability also applies to this element of the offence.

An individual convicted of such an offence would automatically become a disqualified individual for the purposes of the Act and would be unable to be one of the key personnel of any other approved provider.

Approved providers can avoid potential liability for an offence by using accommodation bonds for permitted uses only.

Regardless of whether or not an approved provider has failed financially, sanctions can be imposed if approved providers do not comply with one or more of their prudential obligations (see section on Providers Responsibilities and Non-Compliance in Chapter 5 of this Manual).

**INFORMATION ON REFUNDING ACCOMMODATION BOND BALANCES**

Information on refunding accommodation bond balances is arranged under the following four headings:

- To whom accommodation bonds are refunded - i.e. they must be refunded in the name of the resident
- When a refund is due
- The amount of the refund
- Interest payable on late refunds.

Approved providers are required to refund accommodation bond balances when they fall due. Failure to refund an accommodation bond balance when it falls due constitutes non-compliance with the Act, and sanctions may be imposed where an approved provider fails to meet this requirement. Non-compliance with this requirement must be disclosed to DSS through the Annual Prudential Compliance Statement (see section on the Annual Prudential Compliance Statement further in this chapter of this Manual) and to residents, prospective residents and their representatives on request. Non-compliance with this requirement may
also be considered where DSS assesses the on-going suitability of a person or approved provider to provide aged care.

**Recipient of the refund**
The accommodation bond must be refunded to the resident. *See legislative reference - section 57-21(2), Aged Care Act 1997.*

This means that if a cheque is drawn for the accommodation bond balance, the cheque should be made out to the resident (or the resident’s estate if the resident is deceased). Similarly, if the refund is made by direct deposit, the deposit should be made into a bank account in the name of the resident.

This protects the resident who paid the accommodation bond by ensuring that the refund is dealt with according to their wishes, including, where the refund occurs following the resident’s death, as set out in their will. It also protects the approved provider by ensuring they are able to clearly identify the person who may deal with the refund. These protections for the resident and the approved provider are increasingly important as the value of accommodation bonds is likely to continue to rise over time.

If a resident moves from one service to which they had paid an accommodation bond to another service, they may negotiate with the new service to pay an accommodation bond including paying an accommodation bond instead of an accommodation charge if they are entering the new service as a high care resident. *See legislative reference - sections 57-13 and 57-23, Aged Care Act 1997.*

If a resident leaves a residential care service and enters another service within 28 days the accommodation bond paid to the new service cannot be greater than the bond balance refunded or payable to the resident by the first service. *See legislative reference –section 57-13, Aged Care Act 1997.*

When a resident leaves a service to move to another service, the first service must refund the resident’s accommodation bond balance. The Act requires that the refund be made to the resident. However, DSS accepts that as a matter of practical administration, the refund of the original accommodation bond balance and payment of the new accommodation bond can be done in one of two ways with the explicit agreement of the resident:

- If the resident transfers to a new service operated by the same approved provider, the bond balance continues to be held so that it is not refunded to the resident and then paid again by the resident to the same approved provider
- If the resident transfers to a service operated by a different approved provider, the original approved provider, to whom the resident paid an accommodation bond, pays the accommodation bond balance to the second approved provider.

These practices are only acceptable when performed with the prior agreement of the resident or their legally appointed representative. In the second circumstance, a new accommodation bond agreement must be entered into.
Refunding accommodation bond balances - resident transfers from one service to another


An approved provider is required to refund the accommodation bond balance if the resident is to enter another service to receive residential care. The timing of the refund will vary, depending on whether the care recipient has notified the approved provider that they will be leaving, as set out below:

- If the resident has notified the approved provider more than 14 days before they leave, then the accommodation bond balance must be refunded on the day the resident leaves.
- If the resident notified the approved provider only 14 or fewer days before they leave, then the accommodation bond balance must be refunded within 14 days of the day that the notification was given.
- If the resident did not notify the approved provider they were leaving, then the accommodation bond balance must be refunded within 14 days of the day the resident leaves.

The provisions do not require a resident to notify the approved provider of the date when the resident was to enter another service to receive residential care. As a matter of practice, approved providers may wish to request that residents provide notice in writing and if they do not, approved providers might wish to record the communication. This will assist in avoiding any dispute regarding the date of notification. See legislative reference - subsection 57-21, Aged Care Act 1997

Refunding accommodation bond balances - resident leaves a service to move back to their home or carer’s home


If a resident leaves a service to return to their own home or the home of a carer, the approved provider must refund the accommodation bond balance within 14 days of the resident leaving the service.

Refunding accommodation bond balances - resident dies


If a resident dies, an approved provider must refund their accommodation bond balance within 14 days after the day on which the approved provider is shown the probate of the will or letters of administration. In practice, this means the approved provider may:

- make a refund at any time (which must be in the name of the former resident) without evidence of probate or letters of administration if they are sufficiently confident that the person receiving the payment may deal with it; or
- wait for the probate or letters of administration before refunding the accommodation bond balance.

When an approved provider is shown grant of probate or letters of administration, they should take a copy and date stamp it. This will assist in record keeping and reduce the risk of any dispute regarding when the approved provider was shown the probate or letters of administration.
Refunding entry contribution balances

Entry contributions must be refunded in accordance with the formal agreement.

Delaying refunds to secure re-entry


A resident who leaves a service, other than on leave, may agree with the approved provider to delay refunding the accommodation bond balance, on the following conditions:

- If the resident wants to re-enter the service, the approved provider must allow the resident to enter the service if there are any places vacant, and the resident is an approved resident.
- The resident must not be charged an increased amount of accommodation bond or a second accommodation bond for re-entry.

If the accommodation bond balance is carried over in this way, retention amounts must not be deducted for the period from the day after the recipient leaves to the day they re-enter the service (inclusive). This period does not count towards the five years for which retention amounts can be deducted. See legislative reference –subsection 57-22, Aged Care Act 1997.

Record keeping requirements in relation to accommodation bond balance refunds


Approved providers holding accommodation bonds or entry contributions are required to maintain a bond register which includes details of all accommodation bonds and entry contributions.

When an accommodation bond balance or an entry contribution is refunded by an approved provider, certain information about the refund must be entered on the bond register, including:

- Relevant dates - i.e. when the resident left the service or died, the date the resident notified the approved provider they were leaving, when the accommodation bond balance or entry contribution was due to be refunded and when the accommodation bond balance or entry contribution was actually refunded, and any periods where the service failed to be certified.
- Information about the amount of the accommodation bond balance or entry contribution that was refunded and the amount of any interest paid. See section on The Records Standard - Bond Register further in this chapter of this Manual.

Former approved providers must refund accommodation bonds

From 1 January 2009, where an approved provider ceases to be an approved provider in respect of a service and continues to run that service, they must refund any accommodation bonds paid for entry to that service. It is an offence for a former approved provider which is a corporation not to repay the accommodation bond balance within the set period. A court may impose a penalty of up to 30 penalty units. See legislative reference - section 57-21AA(3), Aged Care Act 1997.
The timing for the former approved provider to refund the accommodation bond balance will be different depending on the circumstances of the resident.

If the resident dies within 90 days of the former approved provider ceasing to be an approved provider, then the accommodation bond balance must be refunded within 14 days after the former approved provider is shown the probate of the will or letters of administration. In practice, this means the approved provider may:

- make a refund at any time (which must be in the name of the former resident) without evidence of probate or letters of administration if they are sufficiently confident that the person receiving the payment may deal with it; or
- wait for probate or letters of administration before refunding the accommodation bond balance.

If the care recipient is entering another service to receive residential care, the timing of the refund will vary, depending on whether the care recipient has notified the former approved provider within 90 days of it ceasing to be an approved provider that they will be leaving:

- if the resident has notified the former approved provider more than 14 days before they leave then the accommodation bond balance must be refunded on the day the resident leaves
- if the resident notified the former approved provider 14 or fewer days before they leave, then the accommodation bond balance must be refunded within 14 days of the day that the notification was given
- if the resident did not notify the former approved provider they were leaving, then the accommodation bond balance must be refunded within 14 days of the day the resident leaves.

In any other case, including if the resident decides to stay in the same service, the refund must be made within 90 days of the day on which the former approved provider ceased to be an approved provider.

**PAYING INTEREST**

Approved providers pay interest to residents at two different rates. Interest must be paid to the resident on the same day that the accommodation bond balance or entry contribution is refunded. *See legislative reference - section 57-21A, Aged Care Act 1997, Division 14, 15, Part 4, User Rights Principles 1997.*

Providers pay interest with respect to accommodation bonds:

- at the base interest rate (BIR) for the period between the day after the resident dies or leaves the approved provider’s service and the date the accommodation bond balance is refunded OR the end of the legislated timeframe for refund of the accommodation bond balance, whichever comes first
- at the maximum permissible interest rate (MPIR) between the end of the legislated timeframe for refund of the accommodation bond balance and the date the accommodation bond balance is actually repaid.

*See legislative reference - section 23.3(2), 23.79B and 23.79D, User Rights Principles 1997.*

Providers pay interest with respect to entry contributions:
• at the MPIR for entry contributions refunded from the day after the refund date (in accordance with the formal agreement) or 1 July 2006, whichever occurs later, and ending on the day the entry contribution is refunded.

*See legislative reference - section 23.3(2) and 23.80D, User Rights Principles 1997.*

Approved providers are required to refund accommodation bond balances when they fall due. Failure to refund an accommodation bond balance when it falls due constitutes non-compliance with the Act, and sanctions may be imposed. Non-compliance with this requirement must be disclosed to DSS through the Annual Prudential Compliance Statement and to residents, prospective residents and their representatives on request. Non-compliance with this requirement may also be considered where DSS assesses the on-going suitability of a person or approved provider to provide aged care.

**Base interest**

The Base Interest Rate (BIR) is not payable for the day a resident leaves a service, but for each day after the resident has departed the service until the accommodation bond balance is actually refunded or the legislated timeframe expires, whichever is earlier. The BIR used in calculating interest is the BIR applicable on the day after the resident’s departure.

The interest payable at the BIR rate is calculated by:
• multiplying the BIR by the bond balance and the number of days for which interest is payable, then;
• dividing the above amount by 365.


**Maximum permissible interest rate**

The rate of Maximum Permissible Interest Rate (MPIR) used in calculating interest is the MPIR applicable on the day after the end of the legislated timeframe for the refund of the accommodation bond. *See legislative reference - section 23.3(2), User Rights Principles 1997.*

The interest rate remains fixed at this rate until the accommodation bond is refunded.

If the provider refunds the accommodation bond after the legislated timeframe for refund has expired, the interest payable is calculated by:
• multiplying the MPIR by the bond balance and the number of days for which interest is payable; then
• dividing the above amount by 365.

*See legislative reference - section 23.79D, User Rights Principles 1997.*

**Period during which interest accrues and how to calculate interest**

The accommodation bond balance has been refunded:
• when the approved provider deposits the money in the resident’s account
• on the day the approved provider sends a cheque payable to the resident (or their representative), regardless of when the resident actually cashes the cheque
• when the approved provider otherwise makes the funds available to the resident (or their representative).

In the examples provided below
• If the resident dies after leaving the service and before expiry of the legislated timeframe for the refund of the accommodation bond, then the approved provider will accrue interest at the BIR if it chooses to await presentation of evidence of probate or letters of administration before refunding the bond (though it may choose to refund the bond without such evidence).
• If the resident dies after expiry of the legislated timeframe for the refund of the accommodation bond, and the approved provider has not refunded the accommodation bond within that timeframe, then the approved provider is required to pay interest at the rate of MPIR for the period from the day after expiry of the legislated timeframe and until the refund is made.

**Accrual of interest - resident gives approved provider more than 14 days’ notice of moving to another service (applicable since 1 July 2006)**

If the resident gives more than 14 days’ notice of moving to another service, then the accommodation bond balance is due to be refunded on the day that the resident leaves the service. If the approved provider refunds the accommodation bond balance on the day the resident leaves the service, then they will not have to pay any interest. If the approved provider does not refund the accommodation bond balance by the time the resident leaves the service, then the approved provider must pay the interest calculated at the MPIR for the period starting the day after the resident leaves the service and ending on the day the accommodation bond balance is actually refunded.

**Example**

On 1 July 2006, John told Scott’s Aged Care Service that he would move to Andy’s Aged Care Service on 16 July 2006. He moves on 16 July 2006. If Scott’s Aged Care Service gave the accommodation bond balance to John on:

• 16 July 2006, then no interest would be payable.
• 25 July 2006, then MPIR is payable for the period 17–25 July 2006 - i.e. from the day after John left the service and the accommodation bond balance should have been refunded until the accommodation bond balance is refunded.

**Accrual of interest - resident gives less than 14 days’ notice of moving to another service (applicable since 1 July 2006)**

If the resident provides notice within 14 days before leaving the service, then the accommodation bond balance must be refunded within 14 days after the day on which notice was given. If the accommodation bond balance is refunded within 14 days, then BIR is payable from the day after the resident leaves the service until the end of 14 days after the resident provided notice or until the accommodation bond balance is paid.

If the approved provider does not refund the accommodation bond balance within 14 days of when the notice was given, then the approved provider must pay the MPIR for the period commencing on the day after 14 days’ notice was given and ending on the day the accommodation bond balance is actually refunded.
Example
On 10 July 2006, Fred told Georgie’s Aged Care Service that he was moving to Sunset Aged Care Service on 15 July 2006. He moves on 15 July 2006. If Georgie’s Aged Care Service gave the accommodation bond balance to Fred on:

- 15 July 2006, then no interest is payable.
- 18 July 2006, then BIR is payable for 3 days.
- 28 July 2006, then BIR is payable for the period 16–24 July 2006 and MPIR is payable for the period 25–28 July 2006.

**Accrual of interest - resident leaves service to move to another service without giving any notice (applicable since 1 July 2006)**

The accommodation bond balance must be refunded within 14 days of the day after the resident leaves the service. If the accommodation bond balance is refunded within the 14 days, then the approved provider pays BIR for the period commencing the day after the resident left the service and finishing on the day the approved provider actually refunded the accommodation bond balance. If the approved provider does not refund the accommodation bond balance within the 14 day period, then the approved provider pays BIR for the period from the day after the resident left the service to the expiration of 14 days and MPIR for the period commencing on the day after the accommodation bond balance should have been refunded and finishing on the day the accommodation bond balance is actually refunded.

Example
Bob left Rosie’s Aged Care Service on 10 July 2006 to move to another service and did not provide any notice. If the accommodation bond balance was refunded on:

- 15 July 2006, then BIR is payable from 11 July 2006 until the accommodation bond balance was actually refunded on 15 July 2006.
- 28 July 2006, then BIR is payable for the period 11–24 July 2006 and MPIR is payable for the period 25–28 July 2006.

**Accrual of interest - resident dies (applicable since 1 July 2006)**

BIR begins to accrue from the day after the day on which the resident dies. If the approved provider refunds the accommodation bond balance before the end of 14 days after the approved provider has been shown probate or letters of administration, then the approved provider pays BIR for the period commencing on the day after the resident died and finishing on the day the accommodation bond balance is actually refunded. No MPIR is payable because the approved provider has refunded the accommodation bond balance within the legislated timeframe. See legislative reference - section 57-12(3)(a), Aged Care Act 1997, 23.79D, User Rights Principles 1997.

If the approved provider does not refund the accommodation bond balance within 14 days after being shown probate or letters of administration, then the approved provider must pay:

- BIR for the period from the day after the resident died to the end of 14 days after being shown probate or letters of administration
• MPIR for the period commencing on the day after the accommodation bond balance should have been refunded and finishing on the day the accommodation bond balance is actually refunded.

An approved provider can also decide to refund an accommodation bond balance before being shown probate or letters of administration.

**Example**

Paula died on 5 July 2006 and probate was shown to the approved provider on 20 August 2006. The accommodation bond balance was due to be refunded by 3 September 2006, 14 days after probate was shown.

• If the approved provider refunds the accommodation bond balance on 2 September 2006, then BIR is payable for the period 6 July–2 September 2006.

• If the approved provider refunds the accommodation bond balance on 10 September 2006, BIR is payable for the period 6 July–3 September 2006 and MPIR is payable 4–10 September 2006.

**Resident paid entry contribution for entry into hostel before 1 October 1997 under formal agreement**

Under this arrangement, entry contributions must be refunded by the timeframe detailed in the formal agreement between the care recipient and the approved provider. If the entry contribution is not refunded by this time, then the approved provider pays MPIR from the day after the entry contribution was required to be refunded under the formal agreement, until the day the entry contribution is actually refunded. See legislative reference - 23.80C, 23.80D, User Rights Principles 1997.

If the formal agreement required the entry contribution to be refunded prior to 1 July 2006 and it was not, the approved provider must pay MPIR for the time between 1 July 2006 and the date the entry contribution is actually refunded. See legislative reference - 23.80C, 23.80D, User Rights Principles 1997.

An exception is where the approved provider is awaiting probate or letters of administration prior to refunding the entry contribution, interest is not payable for the period during which the approved provider is awaiting probate or letters of administration.

**Record keeping requirements in relation to interest**

Certain information about interest payments must be entered on the bond register. This includes information about BIR and MPIR paid to the resident. See section on The Records Standard - Bond Register further in this chapter of this Manual.

**Pre-allocation lump sums of new approved providers**

From 1 January 2009, where a person who does not already have allocated residential care places for a particular aged care service receives an allocation of residential care places, either by transfer or allocation of new places for that facility, they may be required under the conditions of allocation of those places to refund any pre-allocation lump sums taken from existing residents.
A pre-allocation lump sum:
- does not accrue daily
- is for the care recipient’s entry to a residential care service or flexible care service run by
  the pre-allocation lump sum holder
- is not an accommodation bond, as was not paid to an approved provider
- is not an entry contribution, as it is was not paid prior to 1 October 1997 for entry to an
  aged care facility
- is not an unregulated lump sum as it was not paid to an approved provider before 1
  January 2009 or fails to meet the other criteria in section 6(3) of the Aged Care (Bond
  Aged Care Act 1997.

Once the pre-allocation lump sum has been refunded, the approved provider may then ask
the care recipient to pay an accommodation bond or accommodation charge as if the
resident had entered care on the day that the approved provider’s allocation took effect
and on terms that cannot be less advantageous to the resident than the previous

This will ensure that the existing care recipients receive the same protections for their
payments as new care recipients under the Act and the Guarantee Scheme. See section on
the Accommodation Bond Guarantee Scheme further in this chapter of this Manual.

Pre-allocation lump sum paid to an organisation not yet approved as a
provider
Where an allocation or transfer of places results in an aged care service becoming eligible to
receive Government funding then the Secretary may determine conditions of allocation for
these places, which can include:
- the treatment of pre-allocation lump sums by an approved provider, including its refund
  or forgiveness within certain timeframes, with the consent of the care recipient
- the conditions and entry into force of any accommodation bond agreement entered into
  once the pre-allocation lump sum has been refunded.

Protection of unregulated lump sums held by existing approved providers
Some approved providers hold lump sums which are not accommodation bonds because
the payment was made before the approved provider became an approved provider. See

If the person to whom the payments were made was an approved provider immediately
before 1 January 2009, these unregulated lump sums are protected by the Guarantee
Scheme. The aim of this was to ensure that residents in similar circumstances receive similar
protections.

From 1 January 2009, requirements for the refund of pre-allocation lump sums prevent the
flow of new unregulated lump sums into the Government-subsidised aged care sector.
THE FOUR PRUDENTIAL STANDARDS

All approved providers holding accommodation bonds or pre-1997 entry contributions are required to comply with four prudential standards:

- the Liquidity Standard
- the Records Standard
- the Governance Standard; and
- the Disclosure Standard.


Approved providers holding accommodation bonds or entry contributions must report to the Secretary annually on their compliance with the prudential standards within four months of the end of their financial year - i.e. approved providers operating on a standard financial year of 1 July to 30 June must report on compliance by the end of October each year.

Under these arrangements, approved providers are responsible for the corporate governance and financial management of their business and meeting their regulatory responsibilities. The aim of the prudential arrangements is to reduce the risk of default on the refund of accommodation bond balances or that accommodation bonds are used for other than permitted uses.

The Liquidity Standard

See legislative reference – Part 4, Division 3, 3.2, User Rights Principles 1997. The aim of the Liquidity Standard is to ensure that approved providers have access to sufficient, readily available funds so that they can refund accommodation bond balances as they fall due over the coming 12 months.

The Liquidity Standard requires approved providers to develop, implement and adhere to a Liquidity Management Strategy (LMS). The purpose of the LMS is to apply a systematic approach and a level of rigour to determining the level of funding that will be required to meet expected accommodation bond balance refunds as they fall due. A LMS should include a nominated minimum level of liquidity.

In assessing their funding needs to ensure that they can refund accommodation bond balances as they fall due, approved providers must:

- have sources of funding that can be accessed quickly - i.e. access to liquid funding.
- be mindful of expected accommodation bond payments received from new residents.

The minimum level of funding which approved providers may need ready access to, may be the difference between expected accommodation bond refunds and expected accommodation bond payments.

Approved providers are required as part of their Annual Prudential Compliance Statement to confirm that the approved provider has, during the financial year, complied with the Liquidity Standard. The minimum level of liquidity determined by the approved provider must be disclosed in the Annual Prudential Compliance Statement (see the section on the Disclosure Standard further in this chapter of this Manual). The approved provider’s
independent auditor is required to provide an opinion on whether the approved provider has complied with all prudential requirements including the Liquidity Standard in the relevant financial year.

**Requirements of the Liquidity Standard**

Any approved provider holding at least one accommodation bond balance (including entry contributions) during the financial year must comply with the Liquidity Standard, which requires approved providers to:

- maintain sufficient liquidity to ensure that they can refund accommodation bond balances (including entry contributions) as they fall due in the following 12 months. See legislative reference - section 23.36, User Rights Principles 1997.
- implement and maintain a written Liquidity Management Strategy (LMS), which identifies:
  - the minimum level of liquidity - the amount required to ensure that the approved provider has enough liquidity to refund accommodation bond balances (including entry contributions) as they fall due
  - the factors an approved provider considered in determining the minimum level of liquidity
  - form(s) in which the approved provider will maintain the minimum level of liquidity. See legislative reference - section 23.37, User Rights Principles 1997.

The approved provider must then:

- maintain the minimum level of liquidity in the form specified in the LMS to ensure that the LMS is up-to-date; and
- ensure that it complies with the requirements of the Liquidity Standard.

An approved provider must modify or replace its LMS if it no longer meets the requirements of the Liquidity Standard.

At any point in time, an approved provider must meet the requirements of the Liquidity Standard. See legislative reference - section 23.37(2), User Rights Principles 1997.

The provider must maintain the minimum level of liquidity identified in the LMS necessary to meet refunds over the following 12 months. See legislative reference - section 23.36, User Rights Principles 1997.

**Determining the minimum level of liquidity**

Each approved provider should identify and assess the factors used in determining its minimum level of liquidity, based on their individual circumstances and experiences.

While some factors might be common to many approved providers, their relative importance can differ for individual approved providers. Factors that approved providers could consider in determining their minimum level of liquidity include:

- cash requirements for operating and capital expenditure
- their historical pattern of accommodation bond balance refunds
• characteristics of the residents in their care, such as Aged Care Funding Instrument (ACFI) categories, ages, genders and length of time spent in care, which can affect the timing of accommodation bond balance refunds
• the average value of accommodation bond balances held
• the average time taken to replace departing residents
• the expected number and amount of accommodation bonds that will be paid by new residents
• the time taken for new residents to make accommodation bond payments.

An approved provider should consider a range of different approaches in assessing their liquidity requirements, to determine the most appropriate approach for their circumstances. Possible approaches that approved providers could consider include the following:
• in some cases, the minimum level of funding which is readily accessible may be the difference between the expected accommodation bond balance refunds and the expected accommodation bond payments over the next 12 months
• the need to refund several of its largest accommodation bond in the next 12 months
• for its minimum level of liquidity, an approved provider could use the likely value of accommodation bond balance refunds that will be required over the coming 12 months, by identifying residents who are likely to leave the service in the coming 12 months and the size of their accommodation bonds. For example, an approved provider could decide to maintain as its minimum level of liquidity the total value of accommodation bonds held on behalf of residents with a greater than 50 per cent likelihood of leaving, less expected accommodation bond payments from new residents. This may be appropriate for approved providers that have a significant proportion of residents with characteristics, such as age or Aged Care Funding Instrument (ACFI) category, which may mean they are more likely to leave the service over the coming 12 months.

An approved provider can also maintain a prudent margin to provide a buffer against unexpected developments. A prudent margin could be incorporated into the minimum level of liquidity in various ways. For example, approved providers may choose to adopt conservative estimates for key parameters or include an explicit additional buffer to their level of liquidity. Factors that could be considered include conservative assumptions for:
• the average size of accommodation bonds expected to be received from new residents in the region given market conditions
• the rate of replacement of exiting residents.

**Identifying forms in which the minimum level of liquidity is maintained**

To ensure that an approved provider can refund accommodation bond balances as they fall due, it is important that the minimum level of liquidity for an approved provider is maintained in readily accessible forms.

It is the responsibility of the approved provider to determine the appropriate form(s) in which their minimum level of liquidity will be maintained. Many financial instruments have a high level of liquidity, including:
• cash
• bank bills
• stand-by lines of credit
• guarantees.

In considering the form(s) in which they hold their minimum level of liquidity, approved providers may also wish to consider cost issues. The cost to approved providers could be considered in terms of both the actual cost of accessing the funds (that is the actual cost of the transaction) and the economic cost (the difference between the purchase price and the price realised on disposal). For example, liquid instruments such as cash and financial products like term deposits have relatively low costs as the fee for accessing them is not significant and they can be redeemed at their face value.

**Review of Liquidity Management Strategy (LMS)**

The Liquidity Standard requires approved providers to:

1. ensure that the Liquidity Management Strategy (LMS) remains up-to-date and complies with the requirements of the Liquidity Standard
2. modify or replace the LMS if it no longer complies with the requirements of the Liquidity Standard.

Approved providers should review the LMS at least annually. This review should include an assessment of whether the factors used to determine the minimum level of liquidity are still appropriate. Approved providers should consider:

- whether changes in services they operate or the profile of their residents require variations to the factors included in the LMS
- whether parameters or assumptions such as the size of accommodation bonds received from new residents should be adjusted
- whether to include events in the LMS that would trigger a review outside of an annual review cycle. These events may increase the risk that they would not have the liquidity to meet accommodation bond balance refunds over the coming 12 months. They include:
  - the acquisition or divestment of residential services
  - a significant change in the allocated places within a residential service
  - a significant change in the profile of residents
  - a significant change in the size of accommodation bonds received
  - changes in legislative requirements
  - changes in the corporate structure of the approved provider.

**Other issues**

The approach to documenting the LMS is a matter for individual approved providers. In determining their approach, approved providers should consider:

- that they must be able to demonstrate their compliance with the Liquidity Standard to their auditor; and
- that DSS might ask to see the LMS for monitoring and compliance purposes.

See the section on Monitoring Compliance of the Prudential Requirements further in this chapter of this Manual.
**The Records Standard - bond register**


The Records Standard is designed to ensure that accurate, comprehensive and up-to-date information on accommodation bond holdings (including entry contributions) is collected and maintained.

An accurate record of accommodation bonds will help approved providers to refund accommodation bond balances within required timeframes once a resident leaves a service. It will also enable DSS to accurately assess the amount owed to residents, if an approved provider becomes bankrupt or insolvent and fails to refund outstanding bonds to the residents. (This would trigger the Guarantee Scheme, under which the Australian Government refunds accommodation bond balances to residents.)

Under the Records Standard, all approved providers holding accommodation bonds must establish and maintain a bond register:

- The bond register may be maintained at a service level or at approved provider level. However, for the Annual Prudential Compliance Statement, approved providers must report at approved provider level, referring to the name and number of services covered by the statement.
- If a resident has paid partly by lump sum and partly by periodic payments, an entry on the bond register, including all of the information detailed below, must be made for the lump sum component of the accommodation bond. An approved provider might also voluntarily include additional information in the bond register about the periodic payments.
- The bond register may be kept in hard copy or electronic form. The bond register will contain personal information that should be protected by the approved provider. *See legislative reference - Division 86, Aged Care Act 1997.*
- Historical bond register entries should be kept for a minimum of three years, after the 30 June of the year in which the record was made, as should other records detailed in section 88-1, Division 88 of the Act and in the *Records Principles 1997.*

**Information included in the bond register**

Resident details including resident ID number and resident name must be recorded and kept for each resident. An approved provider can include additional information in this part of the bond register. For example, they might want to include a resident's RCS/ACFI category. They must also include the information below:

- accommodation bond details
- the date the resident entered the service
- if a resident is transferring from another service, the date the resident entered the original aged care service. This information is useful so that the current approved provider knows the period over which retention amounts may continue to be drawn. If a resident has moved a number of times, approved providers may wish to record any other relevant details that will enable them to determine when retention amounts should cease being drawn
- the date the accommodation bond was paid by the resident. If a resident pays an accommodation bond in more than one instalment, each date must be entered
• the amount of accommodation bond paid by the resident. If an accommodation bond has been paid in more than one instalment this figure must reflect the amount of each instalment and the total paid.

**Deductions**
The bond register should include the following information about deductions:
• the amount of accommodation bond balance as at 1 July 2006 (for accommodation bond balances held prior to 1 July 2006)
• the date, amount and reason for each deduction taken from an accommodation bond balance (from 1 July 2006). The type of deduction may be interest on an unpaid accommodation bond, extra services drawn from accommodation bond, fees that the resident has agreed should be paid from the accommodation bond, retention amounts, or any other deduction authorised under the Act.
• the accommodation bond balance at the end of each calendar month. An approved provider should update the bond register on a monthly basis. During any month there may be one or more deductions and these deductions may have been made on one or more dates. One of the purposes of the bond register is to ensure that all approved providers retain a record of the details of all deductions made (date, amount and type of deduction) from 1 July 2006.

**Refund of accommodation bond**
The bond register should include the following information about the refund of an accommodation bond:
• date of refund event and other relevant dates including, where appropriate:
  – the date the resident died and the date probate or letters of administration were shown to the approved provider
  – the date the resident left the service, and if notice was provided, the date the notice was provided; or
  – the date the service ceased to be certified.
• date the accommodation bond is due to be refunded in accordance with the requirements under Subdivision 57-G of the Act
• date the accommodation bond was actually refunded
• amount of accommodation bond refunded
• have interest paid and the date paid
• maximum permissible interest paid and the date paid.

The refund event is the initial trigger for determining when the accommodation bond refund is due. The refund event may be the death of the resident or the departure of the resident from the service. The date that the resident left the service should be the date on which the resident was formally discharged from the service. Residents may enter hospital on hospital leave and then transfer to another service without returning to the original service, but the date to be recorded will be the date that the resident was discharged, not the date they went on leave.

**Entry contributions**
The bond register must include the following information about entry contributions:
• resident details including the resident’s name and resident ID number
- the date the entry contribution was paid
- the amount of the original entry contribution
- the date the resident left the facility
- the date the entry contribution is due to be repaid in accordance with the formal agreement
- the date the entry contribution was refunded
- the amount of entry contribution balance refunded
- maximum permissible interest paid and the date paid.

Additional information
An approved provider can also keep other information in the bond register to assist with record-keeping. For example, approved providers can include information on periodic payments of accommodation bonds and accommodation charges or information that is needed for completing DSS’s annual survey of aged care services.

The Governance Standard
The Governance Standard is designed to help approved providers develop sound governance systems to ensure accommodation bonds are only used for permitted uses and are refunded in accordance with the timeframes required by the Act. The Governance Standard promotes sound business practices by requiring governance arrangements in line with the size and complexity of an approved provider’s business.

The Governance Standard requires approved providers that hold accommodation bonds to have a governance system in place to manage accommodation bonds. The governance system must ensure that accommodation bonds are only used for permitted uses and that accommodation bond balances are refunded to residents in accordance with the timeframes required by the Act. Approved providers are also required to implement and maintain a written investment management strategy (IMS) if they propose to invest accommodation bonds in financial products specified in section 57-17A(3)(b) to (e) of the Act or if they invest accommodation bonds in a Religious Charitable Development Fund.

The Governance Standard is designed to ensure that approved providers that hold accommodation bonds have governance systems in place to:
- manage the risks of non-compliance in relation to the permitted uses of accommodation bonds
- ensure the board or governing body of the approved provider have sufficient information to exercise their responsibilities in relation to their accommodation bond obligations
- reduce the exposure of the approved provider to fraudulent or otherwise imprudent activities in relation to accommodation bond balances held.

The Governance Standard does not prescribe the particular type of system. Instead, it describes the key features that need to be incorporated. This allows approved providers the flexibility to implement a governance system that suits their particular size and corporate structure and that is appropriate for prudent and accountable management of the accommodation bonds they hold, regardless of when the accommodation bonds were charged.
**Requirements of the Governance Standard**

The purpose of the Governance Standard is to ensure that, where an approved provider holds accommodation bonds, there is an appropriate system in place to ensure that the approved provider complies with their prudential responsibilities in relation to accommodation bonds.

The Governance Standard only applies to the management of accommodation bonds. Broader corporate governance is a matter for commercial judgement, taking into account wider statutory requirements such as the legislation under which the approved provider is incorporated and best practice resources such as voluntary national standards.

To comply with the Governance Standard, approved providers that hold accommodation bonds need to implement and maintain a documented governance system that:

- allocates responsibilities to key personnel for managing accommodation bonds held by the approved provider
- monitors and controls any delegation or outsourcing of these responsibilities
- ensures relevant key personnel, and anyone to whom responsibilities are delegated or outsourced, are aware of the legal requirements for accommodation bonds
- has reporting mechanisms to ensure responsible key personnel can monitor and control the use of accommodation bonds
- detects, records and addresses any instances of non-compliance.

Approved providers need to document their governance system and ensure this documentation is kept up-to-date.

If an approved provider becomes aware that their governance system no longer complies with these requirements, they need to modify or replace it with a system that does comply. See legislative reference - section 23.38A, User Rights Principles 1997.

**Allocating responsibilities to key personnel**

Approved providers are required to disclose their key personnel to DSS and update any changes to key personnel. An approved provider’s key personnel is defined by a person’s role or the functions they perform, and is not based on what notification DSS has received of their key personnel status. Refer to the sections on Approved Provider, Allocations, Accreditation and Certification in Chapter 2 of this Manual.

In the context of the Governance Standard, key personnel are people who have authority or responsibility for (or significant influence over) planning, directing or controlling the management of accommodation bonds.

It is important for approved providers to clearly define the person or position that has responsibilities for managing accommodation bonds, and what those responsibilities are. This ensures that people with responsibilities for accommodation bonds are aware of their role and that the giving of responsibility for the management of accommodation bonds is conscious and documented. This will also assist DSS in managing any compliance issues.
The key personnel responsible for accommodation bonds will vary depending on the corporate complexity of the approved provider. For a small approved provider with a single service, the key personnel may, for example, be the Director of the approved provider entity. For more complex approved providers, the key personnel may, for example, be the Chief Financial Officer and the members of the governing board.

**Monitoring and controlling delegations**

Key personnel responsible for managing accommodation bonds, and staff with delegated responsibilities for managing accommodation bonds, should have their responsibilities documented as part of their position descriptions. Responsibilities that might be delegated by key personnel to staff include calculating and processing accommodation bond balance refunds, monitoring the allocation and use of accommodation bonds, updating the bond register and responding to requests for information.

DSS’s compliance monitoring program has identified that late accommodation bond refunds are often due to inadequate administrative controls over the refund processes or a lack of knowledge by staff of refund obligations.

The governance system must ensure that key personnel responsible for managing accommodation bonds, and staff or other people who have a role in managing accommodation bonds, are aware of the legal requirements for accommodation bonds. This should include ensuring that an approved provider plans for when these staff are on leave or unexpectedly absent. Such leave or absence does not in any way affect an approved provider’s obligations to refund accommodation bond balances when they fall due.

**Reporting mechanisms**

The reporting mechanisms an approved provider may have in place to ensure that responsible key personnel can monitor and control the use of accommodation bonds will depend on the size and complexity of the approved provider and the sophistication of the management of accommodation bonds. For example, a small approved provider with a single service may deposit all of its accommodation bonds into a banking account with an authorised deposit-taking institution (ADI) and use that account to refund accommodation bond balances. In this case, the reporting mechanism may be as simple as ensuring periodic review of the bond register and statements for the banking account. Larger and more complex businesses will require more sophisticated monitoring and control of the use of accommodation bonds.

**Detecting, recording and addressing non-compliance**

Approved providers holding accommodation bonds must ensure that their governance system has mechanisms for detecting, recording and addressing non-compliance with the requirements for accommodation bonds.

Approved providers should establish, for example, mechanisms to identify and address the late repayment of accommodation bonds, insufficient liquidity to pay accommodation bond balances, non-compliance with requests for information from residents, and non-compliance with permitted use requirements.
**Review of the governance system**

Approved providers may experience changes to their business which may require updating their documented governance system, including:

- changes to key personnel
- changes to corporate structure
- changes to outsourcing of responsibilities for managing accommodation bonds
- acquisition or divestment of aged care services.

Where an approved provider detects non-compliance with the requirements for accommodation bonds, the governance system should be reviewed.

**Can the requirements of the Governance Standard be incorporated into existing corporate governance documents?**

The requirements of the Governance Standard can be included in broader corporate documents of the approved provider. However, approved providers must clearly identify where the governance arrangements relate to the management of accommodation bonds in order to demonstrate their compliance with the prudential requirements to their auditor.

**INVESTMENT MANAGEMENT STRATEGY**

Where accommodation bonds are not immediately required for other permitted uses, approved providers may choose to invest them in order to generate additional income. The Act allows for accommodation bonds to be invested in a broad range of financial products and in Religious Charitable Development Funds (RCDFs). This enables approved providers to manage their financial investments in line with their broader business model and corporate capabilities and provides an additional source of income.

While investment in particular financial products and RCDFs is a permitted use for accommodation bonds, these investments bring with them a range of risks that need to be recognised and appropriately managed. If investing in financial products other than a deposit facility (made available by an authorised deposit-taking institution (ADI) in the course of its banking business) or investing bonds in a RCDF, approved providers must implement and maintain an Investment Management Strategy (IMS). See legislative reference - section 23.38B, User Rights Principles 1997.

If an approved provider invests solely in a deposit taking facility provided by an ADI, then the approved provider is not required to implement an IMS. A list of ADIs is located at [www.apra.gov.au/adi/pages/adilist.aspx](http://www.apra.gov.au/adi/pages/adilist.aspx)

The aim of an IMS is to ensure that approved providers have arrangements in place to make informed and prudent decisions on the investment of accommodation bonds, to assess the risks of financial investments, including to their liquidity and obligation to refund accommodation bond balances, and respond to changing risk. This approach ensures that regulation targets the main risks arising from approved providers investing accommodation bonds, while minimising the regulation of low risk investments.
The requirement for an IMS ensures that the executive decision makers of approved providers have considered and addressed the prudential and other risks that these investments may pose.

**Requirements of an Investment Management Strategy**

At a minimum, an Investment Management Strategy (IMS) must:

- set out the approved provider’s investment objectives
- set out the approved provider’s assessment of the level of risk to the approved provider’s ability to refund accommodation bond balances in accordance with the Act
- detail a strategy to achieve the approved provider’s investment objectives whilst ensuring that the approved provider is able to refund accommodation bond balances in accordance with the Act
- specify the asset classes the approved provider may invest in and the investment limits for each asset class
- detail key personnel with appropriate skills and experience who are responsible for implementing the IMS.

The IMS must be approved by the key personnel who are responsible for the approved provider’s executive decisions.

Approved providers must ensure that any investment of accommodation bonds is in accordance with the IMS.

Approved providers are responsible for keeping their IMS up-to-date and modifying or replacing strategies that do not comply with the requirements.  

**Considerations for an investment management strategy**

Where accommodation bonds are not immediately required for other permitted uses, it is a legitimate use to invest the accommodation bonds to generate additional income. Investment in financial products and RCDFs must not be undertaken in such a way that the approved provider might not be able to refund accommodation bond balances when they fall due. Approved providers should not invest accommodation bonds in financial products which may adversely affect the requirement to maintain sufficient liquidity to repay accommodation bond balances.

The investment management strategy (IMS) requires approved providers to carefully consider their approach to investing accommodation bonds in financial products and RCDFs. This should be undertaken considering a wide range of factors including the nature and complexity of their business, the availability of surplus funds, any existing investments and access to skills and advice to determine and manage their investments.

Approved providers must analyse the risk of any investment under consideration for its effect on the ability to refund accommodation bonds when they fall due. Approved providers may wish to seek professional advice when considering these risks.
Approved providers that invest in financial products (other than deposits with authorised deposit-taking institutions (ADIs) made available in the course of their banking business) or RCDFs must document a strategy for achieving the investment objectives and ensuring that they are able to repay accommodation bonds when they fall due. This strategy should include triggers for disposing of the investment and making up any losses incurred.

The IMS must document the asset classes (i.e. the permitted financial products, and any sub-groups of those products) and the limits of investments in those classes that the approved provider considers to be prudent.

Approved providers must ensure that only key personnel with appropriate skills and experience are responsible for implementing the IMS. These key personnel must ensure that the investment of accommodation bonds in financial products or RCDFs is undertaken in accordance with the IMS. Accommodation bonds should not be invested in financial products requiring an IMS if the key personnel of the approved provider are not suitably skilled and experienced in making financial investments.

The IMS must be documented and approved by those key personnel who have responsibilities for executive decisions of the approved provider. Depending on the size and complexity of the approved provider, these may or may not be the same key personnel with allocated responsibilities for managing accommodation bonds as identified through documenting the governance system.

As a minimum, the IMS should be reviewed when:
- there is a change in executive decision makers
- there is a change in key personnel with responsibilities for managing accommodation bonds
- there is a change in the objectives of the investments
- there is a significant devaluation of any of the financial products invested in.

Example
An approved provider has accommodation bonds invested in ADIs as well as shares that they assessed as being low risk. Even though the approved provider assessed investment in shares as low risk, they would still be required to implement and maintain a written IMS for the accommodation bonds invested in shares. The approved provider is not required to include deposits made with ADIs in their IMS, but may choose to do so.

Example
An approved provider has $5 million in accommodation bonds charged prior to 1 October 2011. They are not receiving new accommodation bonds. The $5 million in accommodation bonds has been invested in a registered managed investment scheme. The approved provider did not develop a written IMS at the commencement of the investment however, from 1 February 2012 the approved provider is required to implement and maintain a written IMS for the investment of the accommodation bonds in the registered managed investment scheme.
Example
An approved provider, as part of current business practice, invests in shares of a management company related by common directors. In this case the approved provider is required to implement and maintain a written IMS for the investment in shares in the management company.

Example
An approved provider only uses its accommodation bonds for deposits in a banking account and refunding bond balances. This approved provider is not required to implement and maintain an IMS.

The Disclosure Standard
The Disclosure Standard requires approved providers holding accommodation bonds (including entry contributions) to give the Secretary, residents, prospective residents and their representatives information on their compliance with the Liquidity and Records Standards; and information on their financial standing.

DISCLOSURE TO RESIDENTS
There are three requirements for information that must be provided to residents (or their representatives) by approved providers.

Copy of accommodation bond agreement and guarantee
Within seven days of an accommodation bond agreement being entered into, approved providers must provide the resident (or their representative) with a copy of the accommodation bond agreement and a copy of the written guarantee of the refund of the accommodation bond balance.

Routine provision of information at the end of each financial year
Within four months after the end of each financial year, approved providers are required to provide residents who have paid an accommodation bond or an entry contribution with the following information:
- a copy of the resident’s entry in the bond register, as at the end of the financial year (assuming that the resident had paid an accommodation bond prior to the end of the financial year)
- a written statement that the approved provider will provide, within seven days of request, the information specified in section 23.42(1)(c) User Rights Principles 1997. the resident is entitled to.

Provision of information on request at any other time
If a resident who has paid an accommodation bond or entry contribution requests the following information, an approved provider must provide it within seven days:
- summary of the permitted uses that accommodation bonds have been used for in the previous financial year
• if accommodation bonds have been invested in financial products other than through an ADI, a statement explaining the approved provider’s investment objectives and the asset classes they may invest in
• information about whether the approved provider has complied with the prudential requirements and permitted uses for accommodation bonds
• a copy of the independent audit opinion of the Annual Prudential Compliance Statement (APCS) from the previous financial year
• information about the number of accommodation bond balances that were not refunded in accordance with the Act or, for entry contributions, a formal agreement
• the approved provider’s most recent audited accounts or, if the service is part of a broader organisation, the statement relating to the aged care component
• a copy of the resident’s entry in the bond register, current at the time of the request.


**Keeping records of disclosures to residents**
Approved providers must demonstrate their compliance with the Disclosure Standard on an annual basis, as part of their Annual Prudential Compliance Statement (APCS). To do this, and to provide evidence of compliance to auditors or the Secretary, approved providers need to keep records of the following types of information:
• number of requests made
• whether the information was provided within seven days.

An approved provider may want to specify that information requests be made in writing. If a request is made in writing, an approved provider should keep a copy of it. If the request is not in writing, an approved provider may wish to make a note of the date the request was made, the type of information requested and the date the information was provided.

**Disclosure to prospective residents**
A prospective resident is a person approved as a recipient of residential care and who is considering receiving residential care through that service. In the case of residential aged care services, a prospective resident is someone who is approved by an Aged Care Assessment Team (ACAT or Aged Care Assessment Service (ACAS) in Victoria). An approved provider might want to confirm that somebody is a prospective resident if that person requests information.

Prospective residents (or their representatives) can request the following:
• summary of the permitted uses that accommodation bonds have been used for in the previous financial year
• if accommodation bonds have been invested in financial products other than through an ADI, a statement explaining the approved provider’s investment objectives and the asset classes they may invest in
• information about whether the approved provider has complied with the prudential requirements and permitted uses for accommodation bonds
• a copy of the independent audit opinion of the Annual Prudential Compliance Statement (APCS) from the previous financial year
• information about the number of accommodation bond balances that were not refunded in accordance with the Act or, for entry contributions, a formal agreement
• the approved provider’s most recent audited accounts or, if the service is part of a broader organisation, the statement relating to the aged care component. See legislative reference - section 23.43, User Rights Principles 1997.

If a prospective resident (or their representative) requests any of the above information then the approved provider must give the information to the prospective resident within seven days of the request. This does not limit the information that an approved provider may voluntarily choose to give a prospective resident.

As detailed in the previous section, approved providers will be required to attest to their compliance with the Disclosure Standard on an annual basis, as part of their Annual Prudential Compliance Statement (APCS). Approved providers will therefore need to keep records in order to be able to demonstrate their compliance with the requirement to provide information to prospective residents (or their representatives).

This statement is taken by DSS to be a statement that complies with paragraphs 23.42(1)(c) and 23.42(2)(b) of the User Rights Principles 1997. This statement is provided as a guide only. Approved providers may draft their own statements. See an example of a Disclosure Statement below.
Example of a Disclosure Statement

DISCLOSURE STATEMENT
Information you are entitled to.
[insert approved provider’s name] is the approved provider for [insert the name of the service]. Under the Aged Care Act 1997 (the Act), residents and prospective residents or their representatives are entitled to receive particular information from their approved provider on request.

This includes, in relation to the previous financial year:
- a summary of the permitted uses for which we have used accommodation bonds
- information about whether we complied with the requirements for permitted uses of accommodation bonds and with the prudential requirements for accommodation bonds
- information about the number of accommodation bond balances (if any) that were not refunded in accordance with the timeframes set by the Act. For entry contributions (payable before 1997), information about the number (if any) that were not refunded in accordance with the entry contribution agreement
- a copy of the independent audit opinion on our compliance with the prudential requirements for accommodation bonds
- our most recent statement of audited accounts
- if we invest accommodation bonds in particular kinds of permitted financial products, our investment objectives and the asset classes we may invest in.

We must also provide:
- if you have already paid an accommodation bond, a copy of your entry in the bond register.

Residents, prospective residents or their representatives may request any or all of the available information. We must provide the information within seven days of the request, and the information must be correct at the time of the request.

More details are in section 23.42 and section 23.43 of the User Rights Principles 1997 available from www.comlaw.gov.au

Disclosure to the Secretary of the Department of Social Services
The approved provider will be required to give a written statement (the Annual Prudential Compliance Statement (APCS)) to the Secretary within four months of the end of each financial year about their dealings with accommodation bonds. The approved provider must make certain disclosures in their APCS regarding their prudential compliance.

Annual disclosure requirements
DSS will issue an APCS template to approved providers at the end of the approved provider’s financial year which the approved provider must complete. The approved provider must include the following information in the APCS see legislative reference - paragraph 23.40, User Rights Principles 1997:
Information about accommodation bonds held
- total number of accommodation bond balances (including entry contributions) held by the approved provider as at the end of the approved provider’s financial year
- total value of accommodation bond balances (including entry contributions) held by the approved provider as at the end of the approved provider’s financial year
- whether there was any period during the year when the approved provider was not entitled to charge accommodation bonds
- the total amount deducted by the approved provider during the financial year from accommodation bond balances in accordance with section 57-19 of the Act.

Information about the use of accommodation bonds and expenditure on permitted uses
- details about the use of accommodation bonds
- whether any use of accommodation bonds by the approved provider was not a permitted use but that use was in accordance with the transitional arrangements in accordance with the Aged Care Amendment Act 2011
- amounts expended on by the approved provider (whether or not from bonds) on permitted uses
- the amount returned to the approved provider:
  - from the sale, disposal or redemption of permitted financial products excluding any deposit-taking facility made available by an authorised deposit-taking institution (ADI) in the course of its banking business; and
  - from investments of bonds into Religious Charitable Development Funds (RCDFs).

Information about compliance with accommodation bond agreement and written guarantee requirements
- whether an accommodation bond agreement was entered into with all residents who paid an accommodation bond during the year and whether the agreements were in accordance with the legislation
- whether each resident who paid an accommodation bond during the year was provided with a written guarantee of the refund of the accommodation bond balance and a copy of the accommodation bond agreement.

Information about the repayment of accommodation bond balances
- whether any accommodation bond balances or entry contributions were required to be refunded
- whether all accommodation bond balances (including entry contributions) that were required to be repaid were repaid within the legislated timeframes (or in the case of entry contributions, refunded within the time required by the formal agreement). If not, approved providers will be required to provide details of accommodation bonds not paid within required timeframe and the reason for delay.

Information about compliance with the prudential standards
- whether the approved provider has complied with each of the prudential standards during the financial year and, if not, how many times and the reasons for this
the amount identified in the approved provider’s liquidity management strategy, as the minimum level of liquidity under paragraph 23.37 (1) (a) of the User Rights Principles 1997.

**Approved provider declaration**
- including all the statements and information required by the form, approved provider details and the signature of one of the approved provider’s key personnel who is authorised by the approved provider to sign the statement.

**AUDIT OPINION**
The Annual Prudential Compliance Statement (APCS) must be supported by an independent audit opinion from an independent auditor. The audit must be undertaken by a registered company auditor within the meaning of the Corporations Act 2001 or a person approved by the Secretary. See legislative reference - section 23.40(1)(f), User Rights Principles 1997. Go to [www.comlaw.gov.au](http://www.comlaw.gov.au) for the Corporations Act.

The Secretary will only approve an alternative auditor if he/she is satisfied that the person has appropriate qualifications and experience.

The independent audit must include an audit opinion on whether the approved provider has complied with the prudential standards and other prudential requirements in the financial year.

**MONITORING COMPLIANCE OF THE PRUDENTIAL REQUIREMENTS**
DSS is responsible for monitoring compliance with the prudential requirements and DSS’s principal focus in this area is on working with approved providers to assist them to comply with the prudential requirements. However, in some instances, DSS may need to take compliance action - including imposing sanctions.

**Responsibilities of approved providers**
All approved providers that hold accommodation bonds must ensure they comply with the prudential requirements. Approved providers must implement and maintain appropriate systems and processes to meet the legislative requirements and also to demonstrate compliance.

If an approved provider is having difficulties complying, or has any queries regarding the requirements, they can seek further advice from their professional advisors, from their peak body or from their auditor. DSS can help approved providers understand their regulatory obligations, but it is the approved provider’s responsibility to determine the most appropriate way to meet the requirements. To contact DSS, please send an email to prudential@health.gov.au

**Mechanisms used to monitor compliance**
Possible compliance issues may be identified via information:
- obtained through the Annual Prudential Compliance Statement (APCS)
obtained from an approved provider - this may be through a formal request for information. See legislative reference - section 9-2, 9-3, 9-3A, 9-3B, Aged Care Act 1997.

- from the Quality Agency
- from the Aged Care Complaints Scheme
- obtained from other reporting by approved providers or the public.

**Annual Prudential Compliance Statement (APCS)**

A key element of monitoring the compliance of approved providers is through the requirement for approved providers to lodge an audited APCS. This requirement ensures that an approved provider’s compliance is scrutinised by an independent party (an auditor). Failing to lodge the APCS, or to obtain the opinion of a registered company auditor (or a person approved by the Secretary), will provide DSS with an initial indication of potential compliance concerns.

**Information obtained from an approved provider**

The Secretary can ask the approved provider for information on issues relating to its financial management. For example, the Secretary can ask for further information on an approved provider’s bond use, governance arrangements, bond register or liquidity management strategy. Such a request can be part of routine monitoring by DSS or may be in response to more specific events such as complaints from residents or information from the Quality Agency.

**AUSTRALIAN AGED CARE QUALITY AGENCY**

The Quality Agency has general responsibility for checking that approved providers meet the requirements for the provision of care to residents. The Quality Agency may become aware of possible prudential compliance issues through its auditing arrangements, and this information may be used by DSS to assess an approved provider’s compliance with the Act.

**Aged Care Complaints Scheme**

The Aged Care Complaints Scheme (the Scheme) seeks to resolve complaints and concerns about Australian Government-subsidised aged care including residential and home care. Concerns about compliance with the requirements for accommodation bonds may be reported to the Scheme and will then be investigated by DSS in accordance with the rules governing the Scheme.

**Other reporting by approved providers or the public**

DSS may receive information about potential compliance issues from approved sources such as other approved providers and concerned members of the public.

This information would be compared to information received through other mechanisms and may also be followed up or verified with the approved provider concerned.

**Actions DSS can take in the event of non-compliance**

In the area of prudential regulation, the primary objective of DSS is to work with the aged care industry to promote compliance with the prudential requirements. In line with this objective, the Secretary will consider taking compliance action if the Secretary, or delegate,
is concerned about the security of accommodation bonds or the actions of an approved provider.

Any compliance action considered by the Secretary may be influenced by:
- the level of risk posed by the non-compliance in terms of the security of residents’ accommodation bonds and entry contributions
- whether the non-compliance involved failure to refund an accommodation bond balance within the required timeframe
- the extent and frequency of non-compliant behaviour by the approved provider in relation to prudential requirements
- whether the approved provider failed to remedy the non-compliance after it was brought to the approved provider’s attention.

DSS may respond in one of the following ways:
- No action
- If alleged non-compliance is unsubstantiated, no further action will be taken although DSS or the Quality Agency may continue to monitor the provider.

**Education**
If an approved provider’s non-compliance was unintentional and based on a misunderstanding of the requirements, DSS may work with the approved provider to help put in place systems to enable it to comply.

**Issue a non-compliance notice**
Following assessment and possible investigation by DSS, a notice of non-compliance may be issued. See legislative reference - section 67-2, Aged Care Act 1997. The notice of non-compliance will ask the approved provider to submit details about what it has done or intends to do to remedy the non-compliance.

**Impose sanctions**
If the approved provider’s response to a notice of non-compliance is not satisfactory, this may result in further compliance action including the imposition of sanctions. The Secretary could impose any of the following sanctions:
- prohibiting the charging of accommodation bonds
- restricting funding to existing residents
- revoking or suspending the existing allocation of places
- revoking or suspending the approved provider’s approval as a provider of aged care services
- varying the conditions of approval for allocated places
- prohibiting any further allocation of places.
ACCOMMODATION BOND GUARANTEE SCHEME

Aged Care (Bond Security) Act 2006 (the Bond Security Act)
In addition to prudential requirements placed on approved providers and the regulation of these requirements by the Secretary, further protection of accommodation bonds is provided by the Bond Security Act.

The Bond Security Act establishes a scheme to guarantee the repayment of aged care residents’ accommodation bond balances if an approved provider is bankrupt or insolvent and has failed to refund one or more outstanding accommodation bond balance.

The Bond Security Act enables the Australian Government to pay to a person an amount equal to the accommodation bond balance owed to them by an approved provider, including outstanding interest. In exchange for the payment, the Bond Security Act provides that any rights that a person had to recover the amount from an approved provider are transferred to the Commonwealth.

The Bond Security Act does not create any day-to-day obligations with which approved providers must comply. Approved providers should be aware that if they become bankrupt or insolvent they must immediately notify DSS. Penalties may be imposed for non-compliance.

Aged Care (Bond Security) Levy Act 2006 (the Bond Levy Act)
This Bond Levy Act operates in conjunction with the Bond Security Act and enables levies to be imposed on approved providers to recover any costs to the Australian Government from repaying accommodation bond balances to residents.

Approved providers would only be liable to pay a levy if there is a default on refunding accommodation bonds by an approved provider and the Minister for Mental Social Services imposes a levy to recover costs - for example, if costs cannot be recovered from the defaulting provider. If this happens, DSS will notify all approved providers.

Similar to the Bond Security Act, the Bond Levy Act imposes no daily obligations on approved providers.
REFERENCES

Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Aged Care Complaints Scheme
ph 1800 550 552 (a free call from fixed lines calls from mobiles may be charged)

The Scheme operates:
Weekdays - 9am to 5pm (AEST)
Weekends - 10am to 5pm (AEST)
Outside of these hours (including on public holidays), a message can be left on the Scheme’s answering machine requesting an officer to return the call during business hours.

People can also write to the Scheme at:
Department of Social Services
GPO Box 9848
(In your capital city)
An online complaints form is available at:

Australian Aged Care Quality Agency
www.aacqa.gov.au

Forms - all
All Departmental forms are available on the following website

Interest rates - current
Base Interest Rate (BIR) and Maximum Permissible Interest Rate (MPIR) - current and previous rates are updated quarterly

Legislation - other
Go to ComLaw to access other legislation mentioned in this chapter, including the Corporations Act 2001, the Privacy Act 1988, the Aged Care (Bond Security) Act 2006 and the
Aged Care (Bond Security) Levy Act 2006.

www.comlaw.gov.au

Prudential regulation - enquiries
Email: prudential@health.gov.au
SPECIFIED CARE AND SERVICES

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

OVERVIEW

Approved providers of residential aged care are required to provide a range of care and services to residents, as specified in Schedule 1 of the Quality of Care Principles 1997, at no additional cost to residents. The care and services must be provided in a way which meets the needs of the individual resident and also meets the outcomes under the Accreditation Standards.

The resident agreement should clearly state all the care and services that an approved provider is obliged to provide under the Act, as well as any additional care or services provided either at no additional cost to the resident or which the resident may have to pay for. Any other matters negotiated with the resident should also be included in the resident agreement.

See also section on Resident Agreements earlier in this chapter on Residents’ Rights of this Manual.

Approved providers are not only subsidised by the Government, but residents may also make a significant contribution to the cost of their care and are therefore entitled to receive the care and services they require.

While some of the items listed in Schedule 1 to the Quality of Care Principles are non-specific, the intent of the legislation must be remembered - that is, to ensure that residents receive the care and services they require, taking into account their individual needs.

For example, a mattress must be provided for all residents irrespective of whether the resident is high care or low care. In providing a mattress the approved provider must ensure that the mattress meets the assessed care needs of the resident, whether that is compromised skin integrity, falls prevention or another matter.

If an approved provider makes this commitment to residents in the quality of care and services provided, then the requirements under the Accreditation Standards, set out in Schedule 2 to the Quality of Care Principles, may also be addressed.

See also chapter on Accreditation and Quality of Care in this Manual.

If an approved provider does not meet the responsibilities specified in Schedule 1, then compliance action may be taken. Approved providers have a responsibility under the Act and the Principles to:
• provide the care and services specified in the Quality of Care Principles for the type of aged care required. See legislative reference - section 54-1(1)(a), Aged Care Act 1997.
• only charge the amount permitted under Division 58 for provision of the care and services the approved provider is responsible for providing. See legislative reference - section 56-1(b), Aged Care Act 1997.
• to charge no more for any other care or service than an amount agreed beforehand with the resident and to give the resident an itemised account of the other care or services. See legislative reference - section 56-1(d), Aged Care Act 1997.
• to comply with the Accreditation Standards set out in Schedule 2 to the Quality of Care Principles. See legislative reference - section 54-1(d), Aged Care Act 1997.

SCHEDULE 1: SPECIFIED CARE AND SERVICES FOR RESIDENTIAL CARE SERVICES

The three Parts to the Schedule are reproduced in the following tables. The information set out in the third column is intended to assist providers to interpret each item, and has been developed in response to a wide range of enquiries from providers, residents and their representatives about specified care and services.

However, the list of examples is not exhaustive, as it would be difficult to cover all the care and services that could be provided under each item. In providing specified care and services, approved providers should bear in mind that they must meet the individual needs of each resident, and provide a level of care and services which is in step with current care regimes and practice.

The resident agreement must clearly state all the care and services that will be provided at no additional cost as well as those care and services which the resident has agreed to pay for.

Part 1, Hotel Services - to be provided for all residents who need them
(See legislative reference - Schedule 1, Part 1, Quality of Care Principles 1997)

Part 1 refers to the hotel services to be provided for all residents who need them. Aged care services are required to supply these items, unless a resident specifically wishes to bring their own items with them, and this has been agreed on by the provider.

<table>
<thead>
<tr>
<th>ITEM AND SERVICE</th>
<th>CONTENT</th>
<th>EXAMPLES</th>
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| Item 1.1 Administration | General operation of the residential care service, including resident documentation. | An approved provider cannot charge a resident for:  
  • registering a resident for a place on a waiting list  
  • preparing a resident agreement  
  • preparing invoices and statements for a resident’s care  
  • residents’ handbook  
  • informing residents of meetings  
  • administration/booking fees for all residents, |
except for recipients of residential respite care. See also section on Respite Booking Fees in chapter on Residential Respite Care in this Manual.

If specified in the resident agreement and agreed by the resident (or their representative), a resident may be charged for:
- storage fees
- television rental
- management of resident trust accounts provided:
  - the arrangement is voluntary - i.e. resident can handle their finances without placing their money in a trust account with the provider
  - the provider charges no more than an amount agreed beforehand with the resident
  - the provider gives the resident an account showing the amount charged.

| Item 1.2 | Maintenance of buildings and grounds | Adequately maintained buildings and grounds. | An approved provider cannot charge a resident for:
|          |                                    |                                             | • gardening
|          |                                    |                                             | • maintenance inside and outside the service
|          |                                    |                                             | • any repairs/replacements necessary because of normal wear and tear.
|          |                                    |                                             | •
|          |                                    |                                             | If specified in the resident agreement and agreed by the resident (or their representative), a resident may be charged for:
|          |                                    |                                             | • repairs and replacements necessary because of deliberate damage.

| Item 1.3 | Accommodation | Utilities such as electricity and water. | An approved provider cannot charge a resident for:
|          |               |                                            | • inspection of the approved provider’s electrical equipment for occupational health and safety purposes
|          |               |                                            | • telephone sockets
|          |               |                                            | • access to pay telephone
|          |               |                                            | • the cost of heating/cooling the service to provide a comfortable environment for residents
|          |               |                                            | • moving from one room to another within the service.
|          |               |                                            | If specified in the resident agreement and agreed by the resident (or their representative), a resident may be charged for:
• inspection of a resident’s electrical equipment for occupational health and safety purposes where a resident chooses who performs the inspection - this could be a qualified electrician on behalf of the service, or a qualified electrician of the resident’s choice
• if a resident has a heating/cooling unit for their own use (in addition to an effective cooling/heating system provided by the service) then the resident may be asked to pay the cost of running the unit. The approved provider must inform the resident beforehand about the policies regarding personal heating/cooling systems. This should be included in the resident agreement or in a variation to the resident agreement
• telephone line rental and handset for the resident’s personal use and cost of calls made by the resident.

<table>
<thead>
<tr>
<th>Item 1.4 Furnishings</th>
<th>Bedside lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw-screens (for shared rooms), resident wardrobe space and towel rails.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Excludes furnishings a resident chooses to provide.</td>
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<td></td>
<td>An approved provider cannot charge a resident for:</td>
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<tr>
<td></td>
<td>• a comfortable lounge chair for each resident to meet their care, comfort and safety needs</td>
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<td></td>
<td>• if a high care resident has been assessed by an appropriate allied health professional or doctor as needing a chair with particular features in order to provide for the safety, care and comfort of the resident, then the approved provider cannot charge the resident for a chair with these features.</td>
</tr>
</tbody>
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<tr>
<th>Item 1.5 Bedding</th>
<th>Beds and mattresses, bed linen, blankets, and absorbent or waterproof sheeting.</th>
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<tbody>
<tr>
<td></td>
<td>An approved provider cannot charge a resident for:</td>
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<td></td>
<td>• beds, pillows and mattresses that meet the assessed care, comfort and safety needs of residents</td>
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<td></td>
<td>• non-standard beds if required to meet the needs of exceptionally tall or heavy residents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 1.6 Cleaning services, goods and facilities</th>
<th>Cleanliness and tidiness of the entire residential care service.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An approved provider cannot charge a resident for:</td>
</tr>
<tr>
<td></td>
<td>• cleaning each resident’s room and ensuite</td>
</tr>
<tr>
<td></td>
<td>• cleaning of floor covering including carpet</td>
</tr>
</tbody>
</table>
|                                                 | • cleaning materials including materials for the...
| Item 1.7  | Waste Disposal | Excludes a resident’s personal area if the resident chooses and is able to maintain it himself or herself. | An approved provider cannot charge a resident for:  
- the safe disposal of sharps and contaminated waste. |
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</thead>
<tbody>
<tr>
<td>Item 1.8</td>
<td>General laundry</td>
<td>Safe disposal of organic and inorganic waste material.</td>
<td>Heavy laundry facilities and services, including laundering of clothing that can be machine washed. Excludes cleaning of clothing requiring dry cleaning or another special cleaning process, and personal laundry if a resident chooses and is able to do this himself or herself.</td>
</tr>
</tbody>
</table>
|          |                | An approved provider cannot charge a resident for:  
- general laundry, including both washing and ironing of clothing that can be machine washed. Aged care services are not obliged to hand-wash residents’ clothing.  
- the service must have in place a system for identification of residents’ clothing and laundry items. However, a resident may choose and pay for their own identification system as long as it is at least of an equivalent standard to the service’s system - e.g. woven name tapes rather than laundry marking pen. |
| Item 1.9  | Toiletry goods | Bath towels, face washers, soap and toilet paper. | An approved provider cannot charge a resident for:  
- suitable soap, or soap substitute for residents who cannot use soap because of clinical need. If specified in the resident agreement and agreed by the resident/legal representation a resident may be charged for:  
- a resident’s personal choice to use alternative items to those provided by the service such as specific brands of soap. |
| Item 1.10 | Meals and refreshments | Meals of adequate variety, quality and quantity for each resident, served each day at times generally | An approved provider cannot charge a resident for:  
- quality food in accordance with residents’ individual nutritional needs. Residents should be consulted about menu planning to ensure that menu choices take into account their preferences. |
acceptable to both residents and management, and generally consisting of 3 meals per day plus morning tea, afternoon tea and supper

(b) Special dietary requirements, having regard to either medical need or religious or cultural observance

(c) Food, including fruit of adequate variety, quality and quantity, and non-alcoholic beverages, including fruit juice.

- food appropriate to meet medical, cultural and religious needs as well as special dietary requirements, e.g. vegetarian, kosher, halal, gluten free, low fat and thickened drinks if required by an individual resident.
- nutritional supplements - for residents who are assessed by an appropriate health professional as needing a special dietary supplement to ensure they receive adequate nourishment and hydration.

<table>
<thead>
<tr>
<th>Item 1.11</th>
<th>Resident social activities</th>
<th>Programs to encourage residents to take part in social activities that promote and protect their dignity, and to take part in community life outside the residential care service.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Aged care services are expected to consult with residents and/or their representatives in the care, planning and development of activity programs and base the activities offered on the needs, wishes and abilities of residents.</td>
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<tr>
<td></td>
<td></td>
<td>While residents may choose not to be involved in social activities, services should discuss the reasons for non-participation with a resident and/or their representative.</td>
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<tr>
<td></td>
<td></td>
<td>If specified in the resident agreement and agreed by the resident/legal representation a resident may be charged for:</td>
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<tr>
<td></td>
<td></td>
<td>● special packaging of medication for residents going on social leave</td>
</tr>
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<td></td>
<td></td>
<td>● outing costs - for example, transport costs, entry fees and food. However, many services may choose to pay for these costs. Residents must be advised in advance of any costs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 1.12</th>
<th>Emergency assistance</th>
<th>At least one responsible person is continuously on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The number of residents and their dependency levels should be considered in deciding the number and qualifications of emergency assistance.</td>
</tr>
</tbody>
</table>
call and in reasonable proximity to render emergency assistance.

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**Part 2, Care and services - to be provided for all residents who need them**

*See legislative reference - Schedule 1, Part 2, care and services - to be provided for all residents who need them, Quality of Care Principles 1997.*

<table>
<thead>
<tr>
<th>ITEM AND SERVICE</th>
<th>CONTENT</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Item 2.1 Daily living activities assistance</strong></td>
<td>Personal assistance, including individual attention, individual supervision, and physical assistance, with:</td>
<td>An approved provider cannot charge a resident to ensure that all care needs are assessed and appropriately met.</td>
</tr>
<tr>
<td></td>
<td>(a) bathing, showering, personal hygiene and grooming</td>
<td>Assistive devices should be available for use by residents who need this equipment so that activities of daily living can be appropriately maintained.</td>
</tr>
<tr>
<td></td>
<td>(b) maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management</td>
<td>Low care residents may be able to access continence aids through the Continence Aids Payment Scheme.</td>
</tr>
<tr>
<td></td>
<td>(c) eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(d) dressing, undressing, and using dressing aids</td>
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</tbody>
</table>
(e) moving, walking, wheelchair use, and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids.

(f) communication, including to address difficulties arising from impaired hearing, sight or speech, or lack of common language (including the fitting of sensory communication aids), and checking hearing aid batteries and cleaning spectacles. Excludes hairdressing.

| Item 2.2 Meals and refreshments | Special diet not normally provided. Approved providers must provide individual residents with medically prescribed special diets or components of special diets. See also Item 1.10. Additional funding is only available for an enteral feeding formula provided enterally.
| Item 2.3 Emotional support | Emotional support to, and supervision of, residents. An approved provider cannot charge a resident for:
- individual support in adjusting to life in the new...
environment and on an ongoing basis, where needed
• support in exercising rights under the Charter of Residents’ Rights and Responsibilities
• ensuring that residents have access to support through counsellors, appropriate health professionals, chaplains, community visitors and advocacy.

If a resident needs professional counselling services, they may be asked to pay the counsellor’s fee provided that the amount is agreed beforehand with the resident.

<table>
<thead>
<tr>
<th>Item 2.4 Treatments and procedures</th>
<th>Treatments and procedures that are carried out according to the instructions of a health professional or a person responsible for assessing a resident’s personal care needs, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of state or territory law.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>An appropriately qualified health professional must identify what treatments and procedures a resident requires. The treatments and procedures must be carried out by an appropriately qualified health professional, or undertaken under the supervision of an appropriately qualified health professional as required under state or territory law.</td>
</tr>
<tr>
<td></td>
<td>An approved provider cannot charge a resident for:</td>
</tr>
<tr>
<td></td>
<td>• nurses to come in to the service to provide treatment. If the service chooses to employ Home and Community Care (HACC), community or agency nurses then the approved provider pays for this. This includes nurses employed to administer regular injections - for example, insulin injections - or to provide complex wound care.</td>
</tr>
<tr>
<td></td>
<td>• services must have a system in place for ordering, reordering, safely storing and administering medications. If a packaging system is the chosen medication administration system, then the service must pay for this system and must not charge the resident or arrange for the pharmacist to charge the resident.</td>
</tr>
<tr>
<td></td>
<td>A resident may be charged for:</td>
</tr>
<tr>
<td></td>
<td>• the cost of medications and other pharmaceutical items unless these are for a high care resident and are covered by Item 3.7</td>
</tr>
<tr>
<td></td>
<td>• a different medication administration system to the one used in the service, if a resident chooses</td>
</tr>
</tbody>
</table>
to have a different system
• for a low care resident, the cost of any dressings or equipment, required for the treatment or procedure. For high level care residents, see Item 3.7 in this table.

DSS provides assistance to aged care services for those residents who have an ongoing need for oxygen treatment irrespective of whether the resident is classified as receiving high or low level care. For more information about assistance for residents with an ongoing need for oxygen treatment, see also section on Oxygen Supplement in chapter on Funding for Permanent Residential Aged Care in this Manual.

| Item 2.5 Recreational therapy | Recreational activities suited to residents, participation in the activities, and communal recreational equipment. | This item is considered essential for the general health and well-being of residents. Services are expected to consult with residents and/or their representatives as part of the care planning activities so they can provide activities that residents enjoy and include activities that cater to minority interests. While residents may choose not to be involved in social activities, services should discuss the reasons for non-participation with the resident and/or their representative. See also Item 1.11 in this table.

If specified in the resident agreement and agreed by the resident (or their representative), a resident may be charged for:
• outing costs - for example, transport costs, entry fees and food. However, many services choose to pay the costs. Residents must be advised in advance of any costs.

| Item 2.6 Rehabilitation support | Individual therapy programs designed by health professionals that are aimed at maintaining or restoring a resident’s ability to perform daily tasks for himself or herself, or assisting residents to obtain access to such | An approved provider cannot charge a resident for:
• an assessment by an appropriate health professional - for example, a physiotherapist, occupational therapist or nurse practitioner - of the resident’s rehabilitation support needs. This may involve a health professional visiting the service to design an appropriate program, or the service making arrangements for the resident to visit the health professional. This should include discussion with residents and/or their representative regarding achievable goals.
### Item 2.7 Assistance in obtaining health practitioner services

Arrangements for aural, community health, dental, medical, psychiatric and other health practitioners to visit residents, whether the arrangements are made by residents, relatives or other persons representing the interests of residents, or are made direct with a health practitioner.

Approved providers are required to make arrangements for the listed health practitioners to visit the resident at the service, as appropriate to a resident’s needs. Alternatively, they should make arrangements for the resident to visit a health practitioner if the practitioner is not able to visit the service.

The provider should assist with arranging transport to and from appointments when necessary.

### Item 2.8 Assistance in obtaining access to specialised therapy services

Making arrangements for speech therapy, podiatry, occupational or physiotherapy practitioners to visit residents, whether the arrangements are made by residents, relatives or other persons representing the interests of residents.

Approved providers are required to:

- make arrangements for the listed health practitioners to visit the resident at the service, as appropriate to the needs of the resident
- assist with the arrangements of transport
- arrange for a relative, representative or volunteer to accompany the resident to appointments.

### Item 2.9 Support for residents with cognitive impairment

Individual attention and support to residents with cognitive impairment (e.g. dementia, and other behavioural disorders), including individual therapy activities and specific programs designed and carried out to
prevent or manage a particular condition or behaviour and to enhance the quality of life and care for such residents and ongoing support (including specific encouragement) to motivate or enable such residents to take part in general activities of the residential care service.

**Part 3, Care and services - to be provided for all residents receiving a high level of residential care**

See legislative reference - Schedule 1, Part 3, Care and Services - to be provided for residents receiving a high level of residential care, Quality of Care Principles 1997.

<table>
<thead>
<tr>
<th>ITEM AND SERVICE</th>
<th>CONTENT</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Item 3.1</strong> Furnishings</td>
<td>Over-bed tables.</td>
<td></td>
</tr>
<tr>
<td><strong>Item 3.2</strong> Bedding materials</td>
<td>Bed rails, incontinence sheets, restrainers, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each resident’s condition.</td>
<td>Bedding materials must meet the resident’s individual needs as assessed by an appropriate health professional. The service must provide pressure-relieving items of suitable type and quality. An approved provider cannot charge a resident for: • water, air and gel cushions and comfort chairs used for pressure relieving purposes • if a high level care resident is unable to walk or move about independently, and cannot use a conventional arm chair, then the provider should provide the resident with a chair, such as an air, water or gel chair, which meets the residents comfort, safety and care needs.</td>
</tr>
<tr>
<td><strong>Item 3.3</strong> Toiletry goods</td>
<td>Sanitary pads, tissues, toothpaste, denture cleaning preparations,</td>
<td></td>
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</table>
shampoo and conditioner, and talcum powder.

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<thead>
<tr>
<th><strong>Item 3.4</strong></th>
<th><strong>Goods to assist residents to move themselves</strong></th>
<th><strong>An approved provider must provide:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crutches, quadruped walkers, walking frames, walking sticks, and wheelchairs.</strong></td>
<td>• sufficient numbers of the listed equipment, including non-motorised wheelchairs, so that they are available for a resident as required within the aged care service</td>
<td></td>
</tr>
<tr>
<td><strong>Excludes motorised wheelchairs and custom made aids.</strong></td>
<td>• sufficient wheelchairs appropriate to the needs of high care residents, which take into account pressure care and allow for optimum levels of mobility and participation. The fact that one resident needs full time use of a wheelchair should not deny other residents access or mean that the resident using the chair fulltime has to purchase a wheelchair in order to have use of one.</td>
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</table>

If specified in the resident agreement and **agreed** by the resident/legal representation a resident may be charged for:
- custom made aids specifically made for a resident and only for the use of that resident - for example, tailor made arm, hand and/or leg splints.

<table>
<thead>
<tr>
<th><strong>Item 3.5</strong></th>
<th><strong>Goods to assist staff to move residents</strong></th>
<th><strong>Approved providers must have sufficient lifting devices on hand to provide access for all residents who need this type of support and to ensure occupational health and safety obligations are met. Equipment must be fit for the purpose intended and staff trained in its use.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mechanical devices for lifting residents, stretchers, and trolleys.</strong></td>
<td><strong>An approved provider cannot charge a resident for:</strong></td>
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<td></td>
<td>• slings for lifting machines.</td>
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<tr>
<th><strong>Item 3.6</strong></th>
<th><strong>Goods to assist with toileting and incontinence management</strong></th>
<th><strong>An approved provider cannot charge a resident for:</strong></th>
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<tbody>
<tr>
<td><strong>Absorbent aids, commode chairs, disposable bed pans and urinal covers, disposable pads, over-toilet chairs, shower chairs and urodomes, catheter and urinary drainage appliances, and</strong></td>
<td>• assessment by an appropriately qualified health professional to ensure that the individual continence needs of a resident are determined and met. If a resident is assessed as requiring continence pads or other equipment to manage their continence and the resident is receiving high level care, then the provider must provide the pads/equipment at no additional cost to the resident.</td>
<td></td>
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<tr>
<td></td>
<td>• absorbent sheets</td>
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</tbody>
</table>
disposable enemas. • items to meet the needs of all high level care residents in regard to toileting and incontinence.

See the References section at the end of this chapter for a link to the Continence Aids Payment Scheme.

Stoma related products are available free of charge through the Stoma Scheme to eligible residents who are ostomates. See the References section at the end of this chapter for more information on the Stoma Scheme.

<table>
<thead>
<tr>
<th>Item 3.7</th>
<th>Basic medical and pharmaceutical supplies and equipment</th>
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<tbody>
<tr>
<td>Analgesia, anti-nausea agents, bandages, creams, dressings, laxatives and aperients, mouthwashes, ointments, saline, skin emollients, swabs, and urinary alkalising agents.</td>
<td>It is expected that basic medical and pharmaceutical supplies and equipment provided are in accord with current care regimes and practices, and comply with relevant state and territory legislation.</td>
</tr>
<tr>
<td>Excludes any goods prescribed by a health practitioner for a particular resident and used only by the resident.</td>
<td>Obtaining a doctor’s prescription for an over-the-counter item that would normally be provided by the aged care service at no additional cost does not necessarily mean a resident can be charged for this item. If large quantities of a generally available item are prescribed by a doctor for ongoing treatment to meet an identified care need as documented in the resident’s care plan, and the item is to be used only by that resident, then the resident can be asked to pay for this item.</td>
</tr>
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<tr>
<th>Item 3.8</th>
<th>Nursing services</th>
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<tr>
<td>Initial and ongoing assessment, planning and management of care for residents, carried out by a registered nurse. Nursing services carried out by a registered nurse, or other professional appropriate to the service (e.g. medical practitioner, stoma therapist, speech pathologist,</td>
<td>A service must not charge a high care resident for nursing services or nursing consultancy services, if an aged care service employs a nurse consultant for advice concerning specialist nursing care. The list of services in this item is not exhaustive, they are only examples of what may be included.</td>
</tr>
<tr>
<td>Stoma related products and supplies are available through the Stoma Scheme free of charge to eligible residents who are ostomates. See the References section at the end of this chapter for more information on the Stoma Scheme.</td>
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</tbody>
</table>
physiotherapist or qualified practitioner from a palliative care team).

Services may include, but are not limited to, the following:
(a) establishment and supervision of a complex pain management or palliative care program, including monitoring and managing any side effects
(b) insertion, care and maintenance of tubes including intravenous and naso-gastric tubes
(c) establishing and reviewing a catheter care program, including the insertion, removal and replacement of catheters
(d) establishing and reviewing a stoma care program
(e) complex wound management
(f) insertion of suppositories
(g) risk management procedures relating to acute or chronic infectious conditions
(h) special feeding for care recipients
(i) suctioning of airways
(j) tracheostomy care
(k) enema administration
(l) oxygen therapy requiring ongoing supervision because of a care recipient’s variable need
(m) dialysis treatment.

| **Item 3.10 Medications** | Medications subject to requirements of State or Territory law. | An approved provider cannot charge a resident for:

- the provision of systems for dispensing medication - for example, blister packs. The provider pays the costs of these types of systems. See also Item 2.4 |

| **Item 3.11 Therapy services, such as recreational, speech therapy, podiatry, occupational and physiotherapy services** | (a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain residents’ levels of independence in activities of daily living. | This includes assessment by a relevant health professional.

- Following the assessment the health professional can deliver the care or direct the care, which may be provided by care staff in accordance with the relevant state and territory legislation.

(b) More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow residents to
reach a level of independence at which maintenance therapy will meet their needs.

Excludes intensive, long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma.

<table>
<thead>
<tr>
<th>Item 3.12 Oxygen and oxygen equipment</th>
<th>Oxygen and oxygen equipment needed on a short-term, episodic or emergency basis.</th>
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<tbody>
<tr>
<td></td>
<td>This item indicates that oxygen must be available for emergency use. It includes the provision of tubing and masks for the administration of oxygen.</td>
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<tr>
<td></td>
<td>DSS provides assistance to aged care services for those residents who have an ongoing need for oxygen treatment irrespective of whether the resident is classified as receiving high or low level care. See also section on Oxygen Supplement in chapter on Funding for Permanent Residential Aged Care in this Manual.</td>
</tr>
</tbody>
</table>
REFERENCES

Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Continence Aids Payment Scheme and Continence Aids Assistance Scheme
On 1 July 2010, the Continence Aids Payment Scheme replaced the Continence Aids Assistance Scheme. For information on both go to:
www.bladderbowel.gov.au

Forms - all
All Departmental forms are available on the following website

Stoma scheme
PROVIDERS’ RESPONSIBILITIES AND NON-COMPLIANCE

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

OVERVIEW
This chapter explains the actions that can be taken when providers do not comply with their responsibilities under the Act for:
- user rights - i.e. the rights of residents. See legislative reference - Part 4.2, Aged Care Act 1997.
- accountability for the care that is provided. See legislative reference - Part 4.3, Aged Care Act 1997.

QUALITY OF CARE
Approved residential care providers must:
- provide such care and services specified in the Quality of Care Principles in respect of the type of aged care that is provided by the service
- maintain an adequate number of appropriately skilled staff to ensure that the care needs of residents are met
- provide care and services of a quality that is consistent with any rights and responsibilities of residents specified in the User Rights Principles
- comply with the Accreditation Standards. See legislative reference - section 54-1(1)(d), Aged Care Act 1997, Schedule 2, Quality of Care Principles 1997.

USER RIGHTS
Approved providers must:
- provide quality care and services consistent with the Charter of Residents’ Rights and Responsibilities and requirements in the User Rights Principles relating to:
  - residents’ security of tenure for their places in an aged care service
  - access to the aged care service by residents’ representatives, advocates and community visitors
  - providing information to residents about their rights and responsibilities and, on request, about the financial viability of the aged care service
  - restrictions on moving a resident within an aged care service
  - booking fees for respite stays
- comply with prudential and other requirements in relation to any accommodation payments charged for a resident’s entry to an aged care service
- not charge more than the amount permitted under the Act and the User Rights Principles for the care and services which the approved provider is responsible for providing
- not charge more for other care or services than an amount agreed beforehand with the resident, and to provide an itemised account of the care and services provided
• offer to enter into a resident agreement with the resident and enter into such an agreement if the resident wishes
• ensure that a resident’s personal information is only used for a purpose connected with providing aged care to the resident, or for a purpose for which the information was given to the provider. See legislative reference - section 62-1, Aged Care Act 1997.
• comply with the requirements of the Act in relation to complaints resolution mechanisms for the service. See legislative reference - section 56-4, Aged Care Act 1997.
• if the aged care service has extra service status, comply with the requirements of Division 36 of the Act.
• take reasonable steps to identify residents, or the legal representatives of their estate, and when directed by the Secretary, refund fees or charges to care recipients who paid accommodation charges while they were charge-exempt residents.

See legislative reference - section 56-1, Aged Care Act 1997.

ACCOUNTABILITY REQUIREMENTS
Approved residential care providers must:
• keep and maintain records that enable claims for payments of subsidies to be verified and proper assessments to be made of whether the approved provider is complying with its responsibilities
• cooperate with anyone exercising the powers of an authorised officer under Part 6.4 of the Act and comply with the obligations in that Part in relation to the officer’s exercise of those powers.
• notify the Department of Social Services (DSS) of any change of key personnel or change of circumstances that materially affects the provider’s suitability to be a provider of aged care within 28 days after the change occurs and respond within 28 days to any request by the Secretary for information about the provider’s suitability, payments made to the provider or information relating to accommodation payments
• comply with any conditions on the allocation of any places in the aged care service, for example:
  – people with special needs
  – supported, concessional and assisted residents
  – people needing a particular level of care
  – people receiving respite care
  – other people specified in the notice of allocation of places to the provider
• provide records or copies of records to another approved provider in accordance with section 16-10 of the Act, for any places transferred to that provider See legislative reference - section 16-10, Aged Care Act 1997.
• if the provider has relinquished any places:
  – notify DSS at least 60 days before the proposed date of relinquishment
  – comply with any proposal accepted, modified or set out by the Secretary to ensure that the care needs of residents in those places are appropriately met
• allow people authorised by the Secretary access to the aged care service to assess the care needs of any person provided with care at the service
• conduct appraisals or reappraisals of the care required by residents in a proper way
• comply with the conditions under which extra service status was granted or renewed
• allow people authorised by the Secretary access to the aged care service to review the service’s certification
- comply with any agreement the approved provider undertakes in lieu of revocation of approved provider status imposed as a sanction, or any undertaking they give to the Secretary, to remedy non-compliance with the provider’s responsibilities
- allow representatives from the Quality Agency access to the aged care service to assess compliance with the Accreditation Standards through accreditation site visits, review audits, support contacts and spot checks.


POLICE CHECKS (NATIONAL CRIMINAL HISTORY RECORD CHECKS)

Police checks (formally known as national criminal history record checks) are intended to complement robust recruitment practices and are part of an approved provider’s responsibilities to ensure all staff and volunteers are suitable to provide care to the aged.

Approved providers must ensure that all staff and unsupervised volunteers who are likely to have access to residents have a current police certificate. Approved providers are required to ensure that all staff and unsupervised volunteers* undergo a police check every three years to reassess their suitability to work in aged care.

What is a national criminal history record check?

State or territory police, or the Australian Federal Police, can conduct a national criminal history record check to determine if a person has been charged with and/or convicted of a criminal offence which has not been removed from their record under a spent conviction scheme.

Who is required to have a national criminal history record check?

All people who are employed, hired, retained or contracted by an approved provider, whether directly or through an employment or recruitment agency, to provide care or services within an aged care service, who are reasonably likely to have access to residents, are required to have a national criminal history record check. See legislative reference - section 1.18, Accountability Principles 1998.

This covers people over the age of 16 who work or provide services at the aged care service, including:
- key personnel of the approved provider
- employees and contractors of the approved provider who provide care
- allied health professionals contracted by the approved provider to provide care
- kitchen, laundry, garden and office personnel employed by the approved provider
- consultants, trainers and advisors for accreditation support or systems improvement who are under the control of the approved provider
- staff who are not directly engaged by the approved provider but who are under the control of the approved provider, for example, agency staff
  - where an approved provider has a contract with an agency that provides staff, the contract should include the requirement for police checks. The contract should state that any staff provided must have had a national criminal history record check, and that the check does not preclude them from working in aged care
• volunteers who are organised by the provider and who have, or are reasonably likely to have, unsupervised access to a resident
• volunteers visiting residents under the Community Visitors Scheme (CVS).

This excludes:
• volunteers who are under the age of 16 or under the age of 18 if they are a fulltime school student
• visiting people who attend the service at the invitation of a resident
• visiting medical practitioners, pharmacists and other allied health care personnel who are requested by, or on behalf of, the resident but not contracted by the approved provider
• tradespeople and independent contractors - for example, plumbers electricians, delivery people - who provide services on an ad hoc basis
• volunteers who only have supervised access to residents

**What are the consequences for staff and volunteers whose police checks reveal a criminal offence?**

Approved providers must be satisfied that the police certificate does not record that the person has been:
• convicted for murder or sexual assault; or
• convicted of, and sentenced to imprisonment for, any other form of assault.

If the approved provider cannot be satisfied of this, the person is not permitted to work within an aged care service. *See legislative reference - section 1.19 and section 1.21(2), Accountability Principles 1998.*

For convictions for other offences it is up to the approved provider to determine whether the individual is suitable to be engaged in the service. Approved providers should consider the seriousness and relevance of the conviction, the level of access the person has to care recipients and the length of time since the conviction. There are a range of factors to weigh up, and approved providers should consult the Police Certificate Guidelines for Aged Care Approved Providers when making their decision. However, the overriding responsibility that providers should bear in mind is the health, safety and well-being of care recipients.

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

**When should a statutory declaration be made?**

There are limited circumstances in which a staff member or unsupervised volunteer, who does not have a police check in place, will be required to make a statutory declaration.
• where, prior to receiving a police certificate, a new staff member commences working in the service as their work is deemed to be essential they will be required to make a statutory declaration: stating that they have never been convicted of murder or sexual assault, or convicted of, and sentenced to imprisonment for, any other form of assault. The application for a police certificate must have been made and until the certificate is received, the person must be subject to appropriate supervision. *See legislative reference - section 1.22, Accountability Principles 1998.*
• if a staff member or volunteer was a citizen or permanent resident of any country other than Australia after turning 16, they are required to make a statutory declaration stating
that they have never been convicted of murder or sexual assault, or convicted of, and sentenced to imprisonment for, any other form of assault in Australia or another country. See legislative reference - section 1.20, Accountability Principles 1998.

**Maintaining and renewing police checks**
Approved providers have a responsibility to take reasonable measures to require each of their staff members and volunteers to notify the approved provider if they are convicted of a precluding offence in the three year period between obtaining and renewing their police check.

Where an approved provider is satisfied on reasonable grounds that a staff member or volunteer has been convicted of a precluding offence they must ensure that person does not continue as a staff member or volunteer. See legislative reference – sections 1.21(3) and (4), Accountability Principles 1998.

Approved providers have a continuing responsibility to ensure that for each person who is a staff member or unsupervised volunteer there is a police certificate that is not more than three years old. See legislative reference - section 1.21(1), Accountability Principles 1998.

**Keeping staff and volunteers’ police checks on file**
Approved providers are required to retain records demonstrating that police checks not more than three years old have been undertaken for all staff and relevant volunteers. See legislative reference - section 19.5A, Records Principles 1997.

In the case of CVS volunteers, a copy of the ‘letter of introduction’ which states that the police check has not expired is sufficient. Storage of personal information about staff and volunteers must be in accordance with the Privacy Act 1988.


To help approved providers complete and assess records for staff and volunteers, there are two templates at Appendices 3 and 4 of the Police Certificate Guidelines for Aged Care Providers.

For a link to the Guidelines and for a link to the office of the Privacy Commissioner, see References at the end of this chapter.

**MONITORING COMPLIANCE**
Both DSS and the Quality Agency are responsible for monitoring aged care services’ compliance with their responsibilities under the Act.

**Role of the Department of Social Services (DSS)**
DSS is required to take appropriate action when an approved provider is not complying with their responsibilities in relation to quality of care, user rights and accountability under the
Act. See legislative reference - Part 4.1, 4.2, 4.3, Aged Care Act 1997. This includes taking into account an approved provider’s compliance with the Accreditation Standards.

DSS monitors approved providers’ broad responsibilities under the Act. The Quality Agency’s monitoring focuses on a provider’s compliance with the Accreditation Standards.

In order to monitor compliance by approved providers, the Secretary can appoint authorised officers who can conduct spot checks - or unannounced visits - on aged care services. See legislative reference - Part 6.4, Aged Care Act 1997.

Authorised officers can also conduct site visits. For a site visit, an authorised officer will notify an approved provider of the intended visit and agree on a time for the visit. At all times, an authorised officer must be able to produce an identity card verifying their authority to conduct a compliance monitoring visit.

The authorised officer must obtain the consent of the occupier of the premises before entering the service. An approved provider can also withdraw its consent at any time. See legislative reference - section 91-1, Aged Care Act 1997. However, if an approved provider fails to cooperate with an authorised officer, for example, by denying access or refusing to provide reasonable assistance, DSS may take compliance action.

If an approved provider does not comply with its responsibilities under the Act, DSS can start compliance action. This can include issuing a notice of non-compliance to the approved provider or imposing sanctions. Different sanctions can be imposed depending on the type of non-compliance.

**Role of the Australian Aged Care Quality Agency**

The Quality Agency manages the process of accreditation of residential aged care services in accordance with the Quality Agency Principles 2013. It assesses and monitors Government-subsidised aged care services against the Accreditation Standards.

If the Quality Agency finds that a service fails to meet the Accreditation Standards and its other responsibilities under the Act, but the failure to meet the Accreditation Standards has not placed the safety, health or well-being of the residents at serious risk, it will write to the service informing them of:

- areas in which improvements must be made to meet the Accreditation Standards and
- the timetable for making the improvements; and
- the arrangements for assessment contacts to assess progress in making the necessary improvements.

See legislative reference - Part 1, 2.23(2)(e) and (f), Quality Agency Principles 2013.

If the level of care provided at the end of the timetable for improvements does not meet the Accreditation Standards, the Quality Agency must give the approved provider and DSS information and evidence about the way in which the level of care is not satisfactory. See legislative reference - Part 5, section 2.64, Quality Agency Principles 2013.
If the Quality Agency finds that an aged care service does not meet the Accreditation Standards or other responsibilities under the Act and is putting the safety, health or well-being of residents at serious risk, then the Quality Agency must inform DSS of this in writing. See legislative reference - Part 5, section 2.63, Quality Agency Principles 2013, Part 2, section 13, Quality Agency Reporting Principles 2013.

The Quality Agency may decide to vary or revoke a service’s period of accreditation. DSS can take compliance action, consistent with the Act and appropriate to the nature and level of the failure to meet the Accreditation Standards. See the Compliance Action section following.

For more information on the Quality Agency, see chapter on Accreditation and Quality of Care in this Manual.

**COMPLIANCE ACTION**

The Act sets out a series of formal steps leading to sanctions DSS can take if an approved provider is not complying with its responsibilities. See legislative reference - Part 4.4, Aged Care Act 1997.

**When can sanctions be imposed?**

Sanctions can be imposed on an approved provider if:

- the approved provider is not complying with one or more of its responsibilities in relation to quality of care, prudential requirements, user rights and/or accountability
- the Secretary is satisfied that it is appropriate to impose sanctions.


In deciding whether or not to impose sanctions, the Secretary will consider:

- whether the non-compliance is minor or serious
- whether the non-compliance has occurred before, and if so, how often
- whether the non-compliance threatens the health, welfare or interests of the residents or of future residents
- whether the approved provider has failed to comply with any undertaking to remedy the non-compliance
- the desirability of deterring any future non-compliance
- any other matters specified in the Sanctions Principles.


Sanctions can be imposed in two ways:

- immediately, if the Secretary believes there is an immediate and severe risk to the safety, health or well-being of residents as a result of the approved provider’s non-compliance
- if there is no immediate and severe risk to the safety, health or well-being of residents, the Secretary must first issue a series of notices, starting with a notice of non-compliance, before imposing sanctions.

See legislative reference - section 67-1, Aged Care Act 1997
**Notice of non-compliance**

*See legislative reference - section 67-2, Aged Care Act 1997.*

If the approved provider is not complying with its responsibilities under the Act in relation to quality of care, prudential requirements, user rights or accountability, and the risks to residents are not immediate and severe, the Secretary can issue a notice of non-compliance, informing:

- details of the non-compliance
- broadly what action the Secretary requires the approved provider to take to remedy the non-compliance
- the timeframe in which the approved provider must make a written submission to DSS
- what sanctions can be imposed.

The approved provider will be invited to make a written submission within 14 days of receiving the notice, including what action will be taken to address the non-compliance.

After considering any submissions made by the approved provider, and assuming that the approved provider has not established that the non-compliance did not occur, the Secretary can decide to:

- issue a notice of intention to impose sanctions
- issue a notice to remedy the non-compliance; or
- issue a combination of these.

*See legislative reference - section 67-2(2)(e), Aged Care Act 1997.*

See also section on Publishing Sanctions and Notices of Non-compliance further in this chapter of this Manual.

**Notice to remedy non-compliance**

*See legislative reference - section 67-4, Aged Care Act 1997.*

If the Secretary thinks the approved provider’s submission in response to a notice of non-compliance:

- proposes appropriate action to remedy the non-compliance
- provides sufficient reason for the non-compliance; or
- is otherwise satisfactory,

The Secretary can give the provider a notice to remedy the non-compliance. The notice will require the approved provider to give a written undertaking within 14 days of receiving the notice to remedy the non-compliance. The notice will also inform the approved provider that failure to either give, or fulfil, the undertaking can lead to sanctions being imposed.

The undertaking that the provider must sign will set out:

- a description and acknowledgement of the approved provider’s non-compliance with its responsibilities
- the action which the approved provider proposes to take to remedy the non-compliance
- the timetable for carrying out the action
an acknowledgment that failure to fulfil the undertaking may lead to sanctions being imposed.


**Notice of intention to impose sanctions**

*See legislative reference - section 67-3, Aged Care Act 1997.*

If the approved provider does not make a submission in response to a notice of non-compliance or if the Secretary thinks the submission:

- does not propose appropriate action to remedy the non-compliance
- fails to establish that the non-compliance did not occur or is not occurring
- fails to provide a sufficient reason for the non-compliance; or
- is otherwise unsatisfactory

the Secretary can give the approved provider a notice of intention to impose sanctions.

The notice will set out in writing:

- a description of the approved provider’s non-compliance with its responsibilities
- the reasons for proposing to impose sanctions; and
- the consequences of imposing the proposed sanctions.

The approved provider will be invited to make a submission in writing in relation to the matter within 14 days of receiving the notice.

The notice will also state that the Secretary may, after considering the approved provider’s submissions, impose sanctions on the approved provider.

**Notice of decision on whether to impose sanctions**

*See legislative reference - section 67-5, Aged Care Act 1997.*

After considering any submissions from an approved provider in response to a notice of intention to impose sanctions, the Secretary will decide whether or not to impose sanctions and inform the approved provider accordingly.

If the decision is to impose sanctions, the Secretary will give the approved provider a notice of decision to impose sanctions. See the following section on What Sanctions can be Imposed. If the Secretary decides not to impose sanctions, the Secretary will give the approved provider a notice of the decision not to impose sanctions, including reasons for this decision.

A notice to impose sanctions will set out:

- a description of the provider’s non-compliance
- the sanction to be imposed
- the consequences of imposing the sanction
- when the sanction commences
- where applicable, the sanction period; and
- the reasons for imposing the sanction.
What sanctions can be imposed?
The Secretary can impose one or more of the following sanctions, by notice in writing:
- revoking or suspending approval as a provider of aged care services. See the following section on Agreeing to Certain Matters in lieu of Revoking Approved Provider Status
- restricting approval to existing services or places
- restricting funding to existing residents
- revoking or suspending the existing allocation of places
- varying the conditions of approval for allocated places
- prohibiting the further allocation of places
- revoking or suspending extra service status
- prohibiting granting of approval for extra service status
- revoking or suspending certification
- prohibiting the charging of accommodation charges or accommodation bonds
- requiring repayment of grants
- other sanctions as specified in the Sanctions Principles.

Agreeing to certain matters in lieu of revoking approved provider status

If an approved provider’s approval is revoked, the approved provider can agree to certain matters to ensure that the revocation does not take effect. If the sanction notice specifies that this is an option, the approved provider can agree to:
- provide, at its expense, training for officers, employees and agents
- provide security for a debt owed to the Commonwealth
- appoint an adviser or an administrator, approved by the Commonwealth
- and/or transfer some or all of its allocated places to another approved provider.

DSS has established adviser and administrator panels and the Sanctions Principles sets out the timetable for nominating and appointing people from those panels for sanctions purposes.

Duration of sanctions
Some sanctions are for an indefinite period of time - for example, revocation of approved provider status. Other sanctions can be applied progressively, for example, an approved provider may no longer have approval for high care residents or may be imposed for a specific period of time.

Sanctions no longer apply when the sanction period set out in the notice expires.

An approved provider can also apply to have sanctions lifted before the specified expiry date. See legislative reference - section 68-4, Aged Care Act 1997. An application must provide the following details:
- what the approved provider has done to remedy the non-compliance
• where relevant, any assessments of the aged care service made against the Accreditation Standards while the sanction was in effect
• any consultations with staff, residents, residents’ relatives or representatives about the non-compliance
• the approved provider’s proposals for sustaining its compliance with its responsibilities. See legislative reference - section 22.20, Sanctions Principles 1997.

The Secretary must notify the approved provider of the decision within 28 days of receiving the application or if the Secretary requests the provider to submit further information, within 28 days of that information being provided. See legislative reference - section 68-6(1), Aged Care Act 1997.

The following sanctions cannot be lifted, but may be reconsidered if the approved provider applies for a review of the decision to impose sanctions:
• the revocation of approved provider status
• the revocation of the allocation of places
• the revocation of extra service status
• the revocation of certification
• requiring the approved provider to repay grants, where the approved provider has not complied with responsibilities related to those grants. See legislative reference - Division 85, Aged Care Act 1997.

REVIEW RIGHTS
A decision to impose a sanction can be reviewed. If the Secretary refuses to lift a sanction, this is also a reviewable decision. See legislative reference - section 85-1, Aged Care Act 1997.

Broadly, if an approved provider considers that the Secretary has made an invalid decision in terms of imposing or refusing to lift a sanction, they can apply DSS for these decisions to be reconsidered. After reconsideration, the decision will either be confirmed, varied or set aside. If the approved provider still believes that the decision is invalid, they can seek a review of the decision at the Administrative Appeals Tribunal. See References at the end of this chapter for a link to the Administrative Appeals Tribunal.

However, giving an approved provider a notice of non-compliance, a notice to remedy or a notice of intention to impose sanctions are not reviewable decisions.

CASE MANAGEMENT AND CONSUMER INFORMATION
A key element in managing sanctions action is an early meeting between DSS and the approved provider to establish the provider’s plans for the future. DSS also requests that the approved provider arrange a meeting for residents and their nominated representatives to outline the current situation and the approved provider’s plans for improvement in order to achieve and maintain compliance.

When sanctions are imposed, DSS writes to all residents and their representatives to ensure that they are kept well informed. Information about the sanctions may also be sent to other
relevant stakeholders including Aged Care Assessment Teams, advocacy services, peak industry organisations, and the Quality Agency.

**PUBLISHING SANCTIONS AND NOTICES OF NON-COMPLIANCE**

Information about current and archived sanctions imposed on approved providers is available on the website. Published online are:

- the names and addresses of aged care services where sanctions are in place
- the names of the approved providers of the aged care services
- sanctions action taken under the Act and the reasons for that action
- the status of the sanction action.

The site is updated with information about new sanctions, as they are applied. Information on sanctions which have expired or have been lifted is archived on the website. See References at the end of this chapter for a link.

Information relating to notices of non-compliance (NNCs) issued in the last two years is available on the My Aged Care website at [www.myagedcare.gov.au/service-finders](http://www.myagedcare.gov.au/service-finders).

The information about current NNCs includes the name and address of the service, the name of the approved provider, the date the NNC was issued, and general information on the non-compliance. This information is only made available online after the delegate has considered any submission made by the due date specified in the NNC.

Information about the NNC is moved from the current NNCs page to an archived NNCs page following confirmation by DSS that the non-compliance has been addressed. Additional information on the archived page will indicate whether the provider had addressed the non-compliance, or was issued with a sanctions notice.

The NNC site is updated weekly to reflect the current status of NNCs. Any change of provider status is also amended in cases where this may apply to archived information.

If a sanction notice is issued following failure to comply with the requirements of a NNC, it will appear on the sanctions page of the website. See References following, for a link.

Approved providers are encouraged to inform residents, or their representatives, about the issuing of a NNC and the action taken to address the non-compliance. Approved providers may also wish to include specific information on their own websites regarding any non-compliance and action taken to address the matter.

Concerns about information regarding a previous or current NNC issued should be emailed to DSS’s compliance email address. See the References section following, for the address.
REFERENCES

Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Accreditation - for information about accreditation or accreditation reports
www.aacqa.gov.au

Administrative Appeals Tribunal
www.aat.gov.au

Aged Care Complaints Scheme
Ph 1800 550 552 (a free call from fixed lines calls from mobiles may be charged)

The Scheme operates:
Weekdays - 9am to 5pm (AEST)
Weekends - 10am to 5pm (AEST)
Outside of these hours (including on public holidays), a message can be left on the Scheme’s answering machine requesting an officer to return the call during business hours.

People can also write to the Scheme at:
Department of Social Services
GPO Box 9848
(In your capital city)

An online complaints form is available at:

Crimtrac

Forms - all
All Departmental forms are available on the following website
Legislation - other
Go to ComLaw to access other legislation mentioned in this chapter, including the Privacy Act 1988.
www.comlaw.gov.au

National Criminal History Record Checks - Australian Federal Police

National Criminal History Record Check - consent, fees, form and guidelines

Notice of non-compliance - concerns about
Concerns about information in regard to a previous or current notice of non-compliance should be emailed to Aged.Care.Compliance@health.gov.au

Notice of non-compliance - current and archived
Information about notices of non-compliance (NNCs) is available on the My Aged Care website
www.myagedcare.gov.au/service-finders

Police Certificate Guidelines for Aged Care Providers

Privacy - Office of the Privacy Commissioner
www.privacy.gov.au

Sanctions - current and archived sanctions
COMPULSORY REPORTING

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

OVERVIEW

TO MAKE A COMPULSORY REPORT, TELEPHONE THE AGED CARE COMPLAINTS SCHEME ON 1800 550 552.

An aged care staff member may be the first person to suspect or become aware that a resident has allegedly been assaulted, or that a resident is absent without explanation (also known as a ‘missing resident’).

To help protect residents, the Aged Care Act 1997 has compulsory reporting provisions. This means that an approved provider must report suspicions or allegations of assaults to local police and to the Department of Social Services (DSS).

The Act also requires service providers to report missing residents in certain circumstances. This legal requirement ensures that those affected receive timely help and support, and that strategies are put in place to prevent the situation from occurring again. These strategies help maintain a safe and secure environment for residents.

This chapter includes information about:
- what constitutes an unexplained absence
- what constitutes a reportable assault
- how to make a report to DSS
- the discretion not to report alleged or suspected assaults
- protecting the identity of informants
- record keeping and privacy.
UNEXPLAINED ABSENCES (OR MISSING RESIDENTS)
A resident is considered missing when they are absent and the service is unaware of any reasons for the absence.

Reporting an unexplained absence (missing resident)
To make a compulsory report about an unexplained absence or missing resident, telephone the Aged Care Complaints Scheme on 1800 550 552.

DSS must be informed within 24 hours by approved providers about missing residents in circumstances where:
- a resident is absent from a residential care service; and
- the absence is unexplained; and
- the absence has been reported to police.

DSS must also be notified where the approved provider was unaware that a resident was missing and the police returned the resident to the service before the approved provider had the opportunity to lodge a report.

These requirements are part of an approved provider’s responsibility under the Act to provide a safe and secure environment. These requirements do not override the right of residents to move freely inside and outside the service without undue restriction.

REPORTABLE ASSAULTS
A reportable assault means:
- unreasonable use of force on a resident, ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force
- unlawful sexual contact, meaning any sexual contact with residents where there has been no consent.

See legislative reference section 63-1AA(9), Aged Care Act 1997.

Unreasonable use of force
Unreasonable use of force ranges from what could be considered less serious (for example, use of force that does not cause injury) to more serious situations including hitting, punching or kicking a resident.

There may be circumstances where a staff member could be genuinely trying to assist a resident, and despite their best intentions, the resident is injured. This can occur because the resident may bruise easily or have fragile skin.

An injury is not necessarily an indication of unreasonable use of force, nor is the absence of injury an indication that there was not an unreasonable use of force.

It is up to key personnel, in the first instance, to make a decision about what constitutes unreasonable use of force.
**Unlawful sexual contact**

Unlawful sexual contact refers to non-consensual sexual activity involving residents in aged care facilities. Reporting requirements under the law are designed to protect vulnerable residents, not restrict their sexual freedoms.

Residents have the right to select and maintain personal, intimate and sexual relationships with others without fear, criticism or restriction. This includes residents with a mental or cognitive impairment. Approved providers must balance their responsibilities in providing a safe environment for vulnerable residents by ensuring residents’ rights to maintain these relationships are not compromised.

Deciding whether a resident has the capacity to consent to sexual activity is a decision that may be based on an assessment by a health professional, which should be considered on a case-by-case basis. Mental or cognitive impairment may only affect a resident’s ability to consent to sexual activity at times, however this may not be all the time.

When faced with making this decision about a sexual incident, it can be useful for you to consider the following questions:

- Does the resident have capacity to consent to this particular contact, at this time?
- Does the resident have the capacity to refuse participation in this activity?
- Does the resident have the capacity to agree to participating in this activity?
- Does the resident show signs of distress?

**Reporting an allegation or suspicion of assault**

When an aged care staff member first has a suspicion of a reportable assault or becomes aware of an allegation of a reportable assault, they should report it immediately to the most senior member of staff on duty. An approved provider is required to make a report to DSS on any suspicion or allegation of assault. **Within 24 hours**, the service must report the incident to local police and DSS (via the Aged Care Complaints Scheme on 1800 550 552). *See legislative reference - section 63-1AA, Aged Care Act 1997.*

It does not matter whether the approved provider believes that an assault has occurred - this is a matter for police to determine.

An allegation or suspicion can be made by anyone including staff, residents and visitors.

Reporting suspicions allows reports to be made where there is no allegation or where the suspected assault may not have been witnessed. Approved providers must have internal policies and processes in place aimed at creating a culture of reporting and responding to alleged or suspected assaults on residents.

An approved provider is responsible for taking reasonable measures to require each staff member to report any reasonable suspicion as soon as practicable. *See legislative reference - section 63-1AA(5), Aged Care Act 1997.*
A staff member can report the incident to one or more of the following:
- the approved provider
- one of the approved provider’s key personnel
- another person authorised by the approved provider to receive reports of suspected reportable assaults
- local police
- DSS (via the Scheme).

The Act allows staff members to report incidents directly to the local police or DSS (via the Scheme). This may occur if a staff member does not feel comfortable reporting alleged incidents involving the service’s personnel or the approved provider.

**Discretion not to report suspected or alleged assaults**

There are limited circumstances where an approved provider has discretion not to report a suspected or alleged assault.

These relate to alleged assaults by residents with a previously assessed cognitive or mental impairment, and assaults that have been previously reported to the police and DSS. *See legislative reference - Part 5, Accountability Principles 1998.*

In these cases, approved providers are expected to review care provision to minimise the incidence of assaults by residents with a previously diagnosed or assessed cognitive or mental impairment.

Strategies for such a resident must be developed, documented and regularly reviewed by a suitably qualified health professional and must include information regarding:
- environmental factors which could contribute to or cause the behaviour
- possible health or medical factors which could contribute to or cause the behaviour
- possible communication needs of the person which may be contributing to the behaviour
- interventions being trialled or used to manage the behaviour, including alternatives to restraint.

The discretion not to report does not prevent an approved provider from reporting a suspected or alleged assault to the police or DSS if this is the appropriate response. Depending on the severity of an assault, and in cases where a resident is seriously harmed, DSS strongly encourages approved providers to report.

Approved providers must keep records in relation to the above circumstances and in accordance with the Records Principles. *See legislative reference - section 19.5AA, Records Principles 1997.*

**Staff Education and Training**

Approved providers have a responsibility to ensure their staff are provided with education and trained in how to recognise a situation that may require a report to DSS, the police or both, and how to respond and make reports within their own aged care service.
This includes awareness of:

- the option to report to the department if they are concerned about anonymity where the manager or approved provider may be the subject of the allegation and
- the protections in place and the circumstances in which they would qualify for protection.


**PROTECTING THE IDENTITY OF INFORMANTS**

There are a range of protections for staff and approved providers that report alleged or suspected assaults. See legislative reference - sections 63-1AA(7), 96-8, Aged Care Act 1997.

A disclosure of information regarding a suspected reportable assault by a person qualifies for protection if:

- the person is an approved provider of an aged care service or a staff member of an approved provider
- the disclosure is made to:
  - a police officer
  - DSS
  - the approved provider
  - one of the approved provider’s key personnel
  - another person authorised by the approved provider to receive such reports
- the discloser informs the person to whom the disclosure is made of their name before making the disclosure
- the discloser has reasonable grounds to suspect that the information indicates that a reportable assault has occurred.
- the discloser makes the disclosure in good faith.


The approved provider or staff member who makes a protected disclosure is protected in a number of different ways, as outlined below.

- The discloser, who qualifies for protection in line with the above, is protected from any civil or criminal liability for making the disclosure. See legislative reference - section 96-8(2)(a), Aged Care Act 1997.
- The discloser is protected from someone enforcing a contractual or other remedy against that person based on the disclosure. See legislative reference - section 96-8(2)(b), Aged Care Act 1997.
- The discloser has qualified privilege in proceedings for defamation relating to the disclosure and is not liable to an action for defamation relating to the disclosure. See legislative reference— section 96-8(3)(a), Aged Care Act 1997.
- This provision does not affect any other right, privilege or immunity the discloser has as a defendant in proceedings, or an action, for defamation. See legislative reference— section 96-8(4) Aged Care Act 1997. For example, if a person assaulted a resident and
then informed DSS of this fact, they would not be protected from prosecution for the assault. The person is only protected from liability in disclosing the information.

- The discloser is protected from a contract to which they are a party being terminated, on the basis that the disclosure constitutes a breach of the contract. See legislative reference - section 96-8(2)(b), Aged Care Act 1997. For example, if a staff member has a contract of employment that specifies that they must not discuss issues that arise in an aged care service with anyone outside the service, a disclosure by the staff member under these provisions would not give the employer the right to terminate the contract. If a court is satisfied that an employee made a protected disclosure and the employer - either an approved provider or a recruitment agency who employs the person on behalf of the approved provider - terminates the employee’s contract because of the disclosure, the court can order that the employee be reinstated or that compensation be paid to them. See legislative reference - section 96-8(5), Aged Care Act 1997.

- The discloser is protected from victimisation. A person must not cause detriment or threaten the discloser on the grounds that a disclosure was made or may be made. See legislative reference - section 96-8(6), Aged Care Act 1997. The approved provider has a responsibility to ensure that all staff comply with this requirement. Compliance action may be taken where an approved provider does not comply with this responsibility.

Residents of aged care services, their families and advocates, visiting medical practitioners, other allied health professionals, volunteers and visitors are not compelled to report assaults and are not afforded statutory protection under the legislation.

However, these people are strongly encouraged to report incidents of abuse or neglect of an aged care resident to the DSS’s Aged Care Complaints Scheme (the Scheme). The person providing information may do so openly, anonymously or ask the Scheme to keep their identity confidential. See References at the end of this chapter for contact information.

These people also have access to common law protections from defamation action. As these people can often identify if an assault of a resident is reasonably likely to have occurred, an approved provider should consider establishing visitor policies and protocols encouraging reporting where it is in the best interests of the residents.

**RECORD KEEPING AND PRIVACY**

Approved providers must keep consolidated records of all incidents involving allegations or suspicions of reportable assaults. See legislative reference - section 19.5AA(1), Records Principles 1997.

These records will be monitored by DSS and must:

- be distinguishable from other incident records; and
- be retained in one central place; and
- be accessible to DSS when required.

The record for each incident must include:

- the date the approved provider received the allegation, or started to suspect on reasonable grounds, that a reportable assault had occurred; and
- a brief description of the allegation or the circumstances that gave rise to the suspicion; and
- information about whether a report of the allegation or suspicion has been made to a police officer and DSS; or
- information about the approved provider exercising their discretion not to make a compulsory report, and why.


Approved providers must also have in place systems and procedures which will allow them to:
- comply with requirements relating to protection of personal information. See legislative reference - section 62-1, Aged Care Act 1997
- comply with all relevant legislation and regulatory requirements in relation to privacy issues, including state, territory or Commonwealth legislation such as the Privacy Act 1988. See References at the end of this chapter for a link to ComLaw for this Act.
RECORD KEEPING

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

OVERVIEW
An approved provider must keep records so that:
- claims for payment of Government subsidies can be verified
- and approved providers can be assessed to see if they are meeting their responsibilities under Chapter 4 of the Act
  - to provide quality care
  - in relation to user rights
  - to be accountable for the care they provide. See legislative reference - section 88-1(1)(a), Aged Care Act 1997.

Approved providers must keep these records for three years after the end of the financial year:
- in which the record was made. See legislative reference - section 88-1(1)(b), Aged Care Act 1997.

Approved providers will have to decide if they will need to keep records for longer than a three year period in order to comply with taxation regulations, state government legislation or possible medical or legal matters.

A record may be kept or retained in written or electronic form. See legislative reference - section 88-1(3), Aged Care Act 1997.

KINDS OF RECORDS
An approved provider must keep the following records relating to residents see legislative reference - section 19.5, Records Principles 1997:
- resident assessments
- appraisal and reappraisal records in the form of Answer Appraisal Packs
- copies of applications for classification for residents that are not provided to the Department of Social Services in electronic form
- individual care plans for residents
- medical records, progress notes and other clinical records of residents
- schedules of fees and charges (including retention amounts relating to accommodation bonds and/or accommodation charges) for previous and current residents
- agreements between residents and the approved provider
- residents’ accounts
• records relating to the approved provider’s compliance with prudential requirements for accommodation bonds
• records about the payment and repayment of accommodation bonds (including periodic payments)
• records about the payment of accommodation charges
• records about a resident’s entry, departure and leave arrangements, including death certificates where appropriate
• records about a financial hardship determination for a resident
• records about the amount of accommodation charge refunded to residents who were charge-exempt residents
• up-to-date records of the name and contact details of at least one representative of each resident and the name and contact details of any other representative of a resident, both according to information given to the approved provider by the resident, or by the representative.

An approved provider that permanently ceases to provide care must retain these records in relation to residents for a period of three years commencing on the day that the person ceased to be an approved provider. See legislative reference - section 89-1, Aged Care Act 1997, section 19.6, Records Principles 1997.

An approved provider must also keep:
• consolidated records of all incidents involving allegations of or suspicions about reportable assaults. See also sections on Record Keeping and Privacy in chapters on Providers Responsibilities and Non-compliance, and Compulsory Reporting in this Manual.
• records showing compliance regarding police certificate requirements for staff members and volunteers. See also section on Police Checks in chapter on Providers’ Responsibilities and Non-compliance in this Manual.

The requirements referred to in this chapter relate to Australian Government requirements only. Approved providers may also be required to keep records to meet state or territory requirements.

**False or misleading records**
A person who makes a false or misleading record may be guilty of an offence punishable by a fine. See legislative reference - section 88-3(2), Aged Care Act 1997. Sanctions can also be imposed on an approved provider that makes a record that is false or misleading. See legislative reference - section 88-3(1), Aged Care Act 1997.
REFERENCES

Addresses, contact numbers and website links are correct as at 1 January 2014.

The Aged Care Act 1997 is now administered by the Minister for Social Services, and matters relating to aged care are now the responsibility of the Department of Social Services. Until further notice, all web content (forms, guidelines, etc) referred to in this Manual will sit on the Department of Health’s website at www.health.gov.au

Department of Social Services
www.health.gov.au

Aged Care Provider Line
For providers of aged care services.
ph 1800 057 616 (national)

Aged Care Complaints Scheme
Ph 1800 550 552 (a free call from fixed lines calls from mobiles may be charged)

The Scheme operates:
Weekdays - 9am to 5pm (AEST)
Weekends - 10am to 5pm (AEST)
Outside of these hours (including on public holidays), a message can be left on the Scheme’s answering machine requesting an officer to return the call during business hours.

Compulsory Reporting Guidelines (DSS)

Legislation - other
See ComLaw for a link to the Privacy Act 1988.
www.comlaw.gov.au