Aged Care Act 1997

No. 112, 1997

An Act relating to aged care, and for other purposes

Contents

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[*Assented to 7 July 1997*]

The Parliament of Australia enacts:

Chapter 1—Introduction

Division 1—Preliminary matters

1-1 Short title

This Act may be cited as the *Aged Care Act 1997*.

1-2 Commencement

(1) This Division commences on the day on which this Act receives the Royal Assent.

(2) Subject to subsection (3), the provisions of this Act (other than the provisions of this Division) commence on a day or days to be fixed by Proclamation.

(3) If a provision of this Act does not commence under subsection (2) within the period of 6 months beginning on the day on which this Act receives the Royal Assent, it commences on the first day after the end of that period.

1-3 Identifying defined terms

(1) Many of the terms in this Act are defined in the Dictionary in Schedule 1.

(2) Most defined terms are identified by an asterisk appearing at the start of the term: as in "*aged care service". The footnote that goes with the asterisk contains a signpost to the Dictionary.

(3) An asterisk usually identifies the first occurrence of a term in a subsection, note or definition. Later occurrences of the term in the same subsection, note or definition are not asterisked.

(4) Terms are not asterisked in headings, tables or diagrams.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(5) The following basic terms used throughout the Act are not identified with an asterisk:

Terms that are not identified		
Item	**This term:**	**is defined in:**
1	approved provider	Schedule 1
2	care	Schedule 1
3	community care	section 45-3
4	community care service	Schedule 1
5	flexible care	section 49-3
6	flexible care service	Schedule 1
7	provide	section 96-4
8	residential care	section 41-3
9	residential care service	Schedule 1
10	Secretary	Schedule 1

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 2—Objects

2-1 The objects of this Act

(1) The objects of this Act are as follows:

(a) to provide for funding of *aged care that takes account of:

(i) the quality of the care; and

(ii) the *type of care and level of care provided; and

(iii) the need to ensure access to care that is affordable by, and appropriate to the needs of, people who require it; and

(iv) appropriate outcomes for recipients of the care; and

(v) accountability of the providers of the care for the funding and for the outcomes for recipients;

(b) to promote a high quality of care and accommodation for the recipients of *aged care services that meets the needs of individuals;

(c) to protect the health and well-being of the recipients of aged care services;

(d) to ensure that aged care services are targeted towards the people with the greatest needs for those services;

(e) to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location;

(f) to provide respite for families, and others, who care for older people;

(g) to encourage diverse, flexible and responsive aged care services that:

(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and

(ii) facilitate the independence of, and choice available to, those recipients and carers;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(h) to help those recipients to enjoy the same rights as all other people in Australia;

(i) to plan effectively for the delivery of aged care services that:

(i) promote the targeting of services to areas of the greatest need and people with the greatest need; and

(ii) avoid duplication of those services; and

(iii) improve the integration of the planning and delivery of aged care services with the planning and delivery of related health and community services;

(j) to promote ageing in place through the linking of care and support services to the places where older people prefer to live.

(2) In construing the objects, due regard must be had to:

(a) the limited resources available to support services and programs under this Act; and

(b) the need to consider equity and merit in accessing those resources.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 3—Overview of this Act

3-1 General

This Act provides for the Commonwealth to give financial support:

(a) through payment of subsidies for the provision of *aged care; and

(b) through payment of grants for other matters connected with the provision of aged care.

Subsidies are paid under Chapter 3 (but Chapters 2 and 4 are also relevant to subsidies), and grants are paid under Chapter 5.

3-2 Preliminary matters relating to subsidies (Chapter 2)

Before the Commonwealth can pay subsidy to a provider of *aged care under Chapter 3, a number of approvals and similar decisions may need to have been made under Chapter 2. These may relate to:

(a) the provider (for example, the requirement that the provider be an approved provider); or

(b) the *aged care service in question (for example, the requirement that *places have been allocated in respect of the service); or

(c) the recipient of aged care (for example, the requirement that the recipient has been approved as a recipient of the type of aged care that is provided).

3-3 Subsidies (Chapter 3)

A number of different kinds of subsidy can be paid under Chapter 3. They are paid for *aged care that has been provided. Eligibility for a subsidy depends on:

(a) particular approvals and similar decisions having been made under Chapter 2; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the circumstances in which the care is provided (for example, whether the care is provided in a residential care service that meets its *accreditation requirement).

3-4 Responsibilities of approved providers (Chapter 4)

Approved providers have certain responsibilities under Chapter 4. These responsibilities relate to:

(a) the quality of care they provide; and

(b) user rights for the people to whom care is provided; and

(c) accountability for the care that is provided.

Failure to meet these responsibilities can lead to the imposition of sanctions that affect the status of approvals and similar decisions under Chapter 2 (and therefore may affect amounts of subsidy payable to an approved provider).

3-5 Grants (Chapter 5)

The Commonwealth makes grants under Chapter 5 to contribute to costs associated with:

(a) the establishment or enhancement of *aged care services (for example, *residential care grants); or

(b) assessments or approvals related to *aged care (for example, *assessment grants); or

(c) support services related to the provision of aged care (for example, *advocacy grants).

The grants are (in most cases) payable under agreements with the recipients of the grants, and may be subject to conditions.

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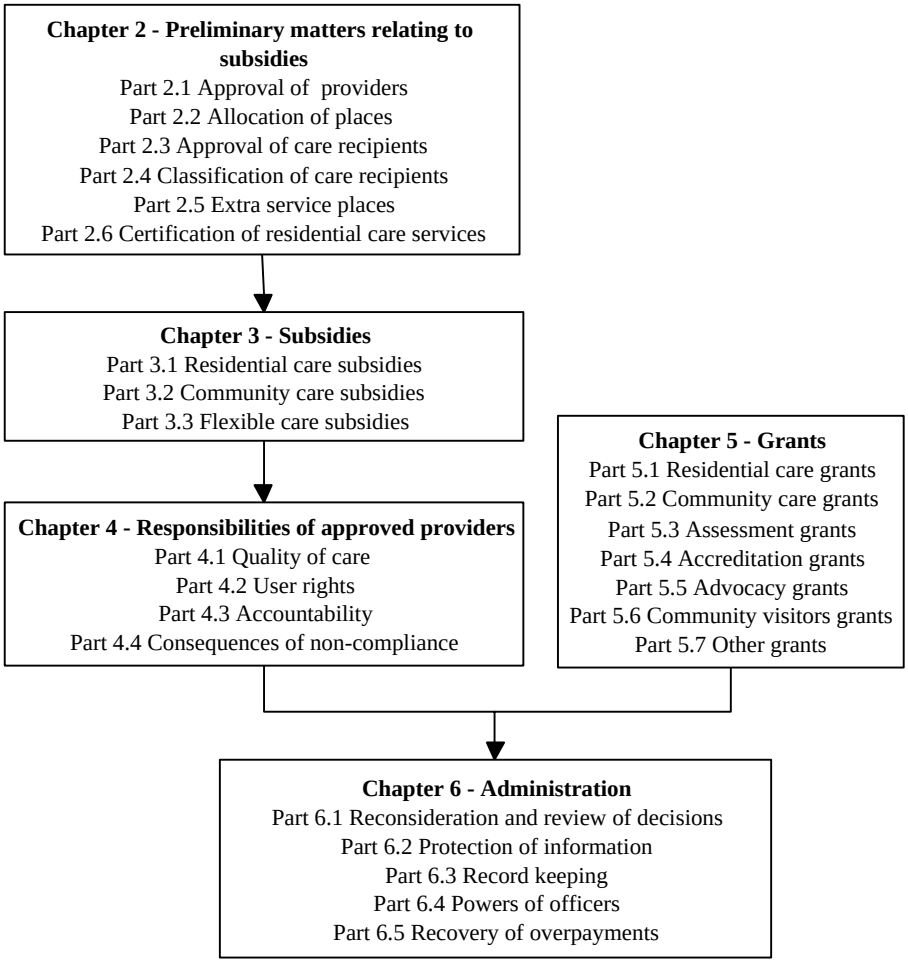
*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

3-6 The structure of this Act

This diagram sets out the basic structure of this Act.



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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 4—Application of this Act

4-1 Application of this Act

(1) This Act applies in all the States and Territories.

(2) However, this Act does not apply in any external Territory.

4-2 Binding the Crown

(1) This Act binds the Crown in each of its capacities.

(2) This Act does not make the Crown liable to be prosecuted for an offence.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 2—Preliminary matters relating to subsidies

Division 5—Introduction

5-1 What this Chapter is about

Before the Commonwealth can pay a subsidy under Chapter 3 for the provision of care, a number of approvals and similar decisions may need to have been made. These relate to:

- the provider of the service—the provider must be an approved provider (see Part 2.1);
- the *aged care service in question—*places must have been allocated in respect of the service (see Part 2.2). In addition, decisions can be made under Part 2.5 allowing places in a residential care service to become *extra service places (enabling higher fees to be charged for those places), and a residential care service can become certified under Part 2.6 (enabling *accommodation bonds to be charged);
- the recipient of the care—the recipient must (in most cases) be approved in respect of the type of *aged care provided (see Part 2.3), and (in the case of residential care or flexible care) can be classified in respect of the level of care that is required (see Part 2.4).

Note: Not all of these approvals and decisions are needed in respect of each kind of subsidy under Chapter 3.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

5-2 Which approvals etc. may be relevant

The following table shows, in respect of each kind of payment under Chapter 3, which approvals and similar decisions under this Chapter may be relevant.

Which approvals etc. may be relevant

	Approvals or decisions	Kind of payment		
		Residential care subsidy	**Community care subsidy**	**Flexible care subsidy**
1	Approval of providers	Yes	Yes	Yes
2	Allocation of places	Yes	Yes	Yes
3	Approval of care recipients	Yes	Yes	Yes
4	Classification of care recipients	Yes	No	Yes
5	Decisions relating to extra service places	Yes	No	No
6	Certification of residential care services	Yes	No	No

Note 1: Classification of care recipients is relevant to *flexible care subsidy only in respect of some kinds of flexible care services.

Note 2: Allocation of funding for *residential care grants and *community care grants is dealt with in Parts 5.1 and 5.2 respectively, and not in this Chapter.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 2.1—Approval of providers

Division 6—Introduction

6-1 What this Part is about

Regardless of what type of *aged care is to be provided, approval under this Part is a precondition to a provider of aged care receiving subsidy under Chapter 3 for the provision of the care.

Table of Divisions

6-2 The Approved Provider Principles

Approval of providers of *aged care is also dealt with in the Approved Provider Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Approved Provider Principles are made by the Minister under section 96-1.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 7—What is the significance of approval as a provider of aged care?

7-1 Providers of aged care must be approved to receive subsidy

Payments of subsidy cannot be made under Chapter 3 to a person for providing *aged care unless the person is approved under this Part as a provider of aged care, and:

(a) the approval is in respect of all types of aged care; or

(b) the approval is in respect of a type of aged care that includes the aged care in question; or

(c) if the approval is in respect of one or more *aged care services—the aged care in question is provided through that aged care service, or one of those aged care services, as the case requires; or

(d) if the approval is in respect of one or more specified types of aged care and one or more specified aged care services:

(i) the specified type or types of aged care includes the aged care in question; and

(ii) the aged care in question is provided through that aged care service or one of those aged care services, as the case requires.

7-2 Approvals may be restricted

(1) If a restriction on the approved provider's approval is in force under paragraph 66-1(b) limiting the approval to certain *aged care services, subsidy can only be paid under Chapter 3 in respect of care provided through those services.

(2) If a restriction on the approved provider's approval is in force under paragraph 66-1(c) limiting the approval to certain care recipients, subsidy can only be paid under Chapter 3 in respect of care provided to those care recipients.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 7-2

Note: Subsections (1) and (2) will apply together if restrictions on the approved provider's approval are in force under both paragraph 66-1(b) and paragraph 66-1(c).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 8—How does a person become an approved provider?

8-1 Approval as a provider of aged care

(1) The Secretary must, in writing, approve a person as a provider of *aged care if:

(a) the person (the ***applicant***) makes an application under section 8-2; and

(b) the Secretary is satisfied that the applicant is a *corporation; and

(c) the Secretary is satisfied that the applicant is suitable to provide aged care (see section 8-3).

Note 1: Under Part 4.4, the Secretary may restrict a person's approval as a provider of *aged care to certain *aged care services, or to certain care recipients.

Note 2: Rejections of applications are reviewable under Part 6.1.

(2) The approval is in respect of all types of *aged care, unless the Secretary specifies in the instrument of approval that the approval is limited to:

(a) one or more specified types of aged care; or

(b) one or more specified *aged care services; or

(c) one or more specified types of aged care and one or more specified aged care services.

A decision to limit the approval must comply with any requirements set out in the Approved Provider Principles relating to the grounds on which such a limitation may be imposed.

(3) The approval is not subject to any limitation relating to the period for which it is in force, unless the instrument of approval is limited to a specified period.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

8-2 Applications for approval

(1) A person may apply in writing to the Secretary to be approved as a provider of *aged care.

(2) The application must be in a form approved by the Secretary, and must be accompanied by:
   (a) any documents that are required by the Secretary to be provided; and
   (b) the application fee (if any) specified in, or worked out in accordance with, the Approved Provider Principles.

(3) The amount of any application fee:
   (a) must be reasonably related to the expenses incurred or to be incurred by the Commonwealth in relation to the application; and
   (b) must not be such as to amount to taxation.

(4) An application that contains information that is, to the applicant's knowledge, false or misleading in a material particular is taken not to be an application under this section.

8-3 Suitability of people to provide aged care

(1) In deciding whether the applicant is suitable to provide *aged care, the Secretary must consider:
   (a) the suitability and experience of the applicant's key personnel; and
   (b) the applicant's ability to provide, and its experience (if any) in providing, aged care; and
   (c) the applicant's ability to meet (and, if the applicant has been a provider of aged care, its record of meeting) relevant standards for the provision of aged care (see Part 4.1); and
   (d) the applicant's commitment to (and, if the applicant has been a provider of aged care, its record of commitment to) the rights of the recipients of aged care; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(e) the applicant's record of financial management, and the methods that the applicant uses, or proposes to use, in order to ensure sound financial management; and

(f) if the applicant has been a provider of aged care—its record of financial management relating to the provision of that aged care; and

(g) if the applicant has been a provider of aged care—its conduct as a provider, and its compliance with its responsibilities as a provider and its obligations arising from the receipt of any payments from the Commonwealth for providing that aged care; and

(h) any other matters specified in the Approved Provider Principles.

(2) In considering a matter referred to in paragraphs (1)(b) to (h), the Secretary may also consider the matter in relation to any or all of the applicant's key personnel.

(3) For the purposes of paragraph (1)(a) and subsection (2), each of the following is one of the applicant's ***key personnel***:

(a) a member of the group of people who are responsible for the executive decisions of the applicant;

(b) any other person who is concerned in, or takes part in, the management of the applicant;

(c) any person who is responsible for the nursing services provided, or to be provided, by the *aged care service conducted, or to be conducted, by the applicant;

(d) any person who is responsible for the day-to-day operations of an *aged care service conducted by the applicant, whether or not the person is employed by the applicant;

(e) any person who is likely to be responsible for the day-to-day operations of an *aged care service that the applicant proposes to conduct, whether or not the person is employed by the applicant.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(4) A person referred to in paragraph (3)(c) must hold a recognised qualification in nursing.

(5) The Approved Provider Principles may specify the matters to which the Secretary must have regard in considering any of the matters set out in paragraphs (1)(a) to (h).

(6) The references in paragraphs (1)(b), (c), (d), (f) and (g) to aged care include references to any care for the aged, whether provided before or after the commencement of this section, in respect of which any payment was or is payable under a law of the Commonwealth.

8-4 Requests for further information

(1) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requiring the applicant to give the further information within 28 days after receiving the notice, or within such shorter period as is specified in the notice.

(2) The application is taken to be withdrawn if the applicant does not give the further information within the 28 days, or within the shorter period, as the case requires. However, this does not stop the applicant from reapplying.

Note: The period for giving the further information can be extended—see section 96-7.

(3) The notice must contain a statement setting out the effect of subsection (2).

(4) The Approved Provider Principles may limit the Secretary's power to specify a shorter period in the notice by setting out one or both of the following:

(a) the circumstances in which the power may be exercised;

(b) the length of the shorter period, either generally or in respect of particular circumstances.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

8-5 Notification of Secretary's determination

(1) The Secretary must notify the applicant, in writing, whether or not the applicant is approved as a provider of *aged care. The notice must be given:

(a) within 90 days after receiving the application; or

(b) if the Secretary has requested further information under section 8-4—within 90 days after receiving the information.

(2) If the applicant is approved, the notice must include statements setting out the following matters:

(a) the applicant's obligations under Division 9;

(b) whether the approval is in respect of all types of *aged care and all *aged care services and, if it is not:

(i) the one or more specified types of aged care; or

(ii) the one or more specified aged care services; or

(iii) the one or more specified types of aged care and the one or more specified aged care services;

in respect of which the applicant is approved as an approved provider; and

(c) the circumstances in which the approval may be restricted under Part 4.4 and the effect of such a restriction (see section 7-2);

(d) if the approval is for a specified period—the date on which the period ends;

(e) the circumstances in which the approval will lapse (see section 10-2);

(f) the circumstances in which the approval may be suspended or revoked (see sections 10-3, 10-4 and Part 4.4).

8-6 States, Territories and local government taken to be approved providers

(1) Each of the following is taken to have been approved under this Part as a provider of *aged care:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) a State or Territory;
(b) an *authority of a State or Territory;
(c) a *local government authority.

The approval is taken to be in respect of all types of aged care.

(2) Subsection (1) ceases to apply in relation to a State, Territory, *authority of a State or Territory or *local government authority if the approval:
(a) lapses under section 10-2; or
(b) is revoked under section 10-3 or 10-4; or
(c) is revoked or suspended under Part 4.4.

(3) If a State, Territory, *authority of a State or Territory or *local government authority to which subsection (1) has ceased to apply subsequently applies under section 8-2 for approval as a provider of *aged care, for the purposes of the application:
(a) the applicant is taken to be a *corporation; and
(b) if the applicant is a State or Territory—paragraphs 8-3(3)(a) and (b) do not apply.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 9—What obligations arise from being an approved provider?

9-1 Obligation to notify certain changes

(1) An approved provider must notify the Secretary of any of the following changes within 28 days after the change occurs:

(a) a change of circumstances that materially affects the approved provider's suitability to be a provider of *aged care (see section 8-3);

(b) a change of any of the approved provider's key personnel.

Note: Approved providers have a responsibility under Part 4.3 to comply with this obligation. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(2) For the purposes of paragraph (1)(b), each of the following is one of an approved provider's ***key personnel***:

(a) a member of the group of people who are responsible for the executive decisions of the approved provider;

(b) any other person who is concerned in, or takes part in, the management of the approved provider;

(c) any person who is responsible for the overall nursing care provided, or to be provided, by the *aged care service conducted, or to be conducted, by the applicant;

(d) any person who is responsible for the day-to-day operations of an *aged care service conducted by the approved provider, whether or not the person is employed by the approved provider.

However, paragraphs (a) and (b) of this subsection do not apply if the approved provider is a State or Territory.

(3) A person referred to in paragraph (2)(c) must hold a recognised qualification in nursing.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(4) An approved provider that is a *corporation is guilty of an offence if the approved provider fails to notify the Secretary of such a change within the 28 day period.

Penalty: 30 penalty units.

(5) Strict liability applies to subsection (4).

Note 1: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

Note 2: For ***strict liability***, see section 6.1 of the *Criminal Code*.

9-2 Obligation to give information relevant to an approved provider's status when requested

(1) The Secretary may, at any time, request an approved provider to give the Secretary such information, relevant to the approved provider's suitability to be a provider of *aged care (see section 8-3), as is specified in the request. The request must be in writing.

(2) The approved provider must comply with the request within 28 days after the request was made, or within such shorter period as is specified in the notice.

Note: Approved providers have a responsibility under Part 4.3 to comply with this obligation. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(3) An approved provider that is a *corporation is guilty of an offence if it fails to comply with the request within the period referred to in subsection (2).

Penalty: 30 penalty units.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

(4) The request must contain a statement setting out the effect of subsections (2) and (3).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

9-3 Obligation to give information relevant to payments under this Act

(1) The Secretary may, at any time, request an approved provider to give to the Secretary such information relating to payments made under this Act as is specified in the request. The request must be in writing.

(2) The approved provider must comply with the request within 28 days after the request was made, or within such shorter period as is specified in the notice.

Note: Approved providers have a responsibility under Part 4.3 to comply with this obligation. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(3) The request must contain a statement setting out the effect of subsection (2).

9-4 Obligations while approval is suspended

If a person's approval under section 8-1 is suspended for a period under Part 4.4, the obligations under this Division apply to the person as if the person were an approved provider during that period.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 10—When does an approval cease to have effect?

10-1 Cessation of approvals

(1) An approval as a provider of *aged care ceases to have effect if:
  (a) the approval lapses under section 10-2; or
  (b) the approval is revoked under section 10-3 or 10-4; or
  (c) the period (if any) to which the approval is limited under subsection 8-1(3) expires; or
  (d) the approval is revoked under Part 4.4.

(2) If an approval as a provider of *aged care is suspended under Part 4.4, the approval ceases to have effect until the suspension ceases to apply (see Division 68).

10-2 Approval lapses if services not provided for 6 months

(1) If an approved provider does not provide any *aged care during a continuous period of 6 months, the approval lapses on the day after the end of that period. However, any period during which the operation of this subsection is waived under subsection (3) is not to be counted towards the 6 months.

(2) For the purposes of subsection (1), an approved provider is taken to be providing *aged care at all times while there is in force an allocation of *places to the approved provider that, under Division 15, has the status of a *provisional allocation.

(3) The Secretary may waive the operation of subsection (1) for a specified period in relation to the approved provider if:
  (a) the approved provider has applied to the Secretary, in writing, for a waiver; and
  (b) there is in force an allocation of *places to the approved provider that has taken effect under section 15-1; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(c) the Secretary is satisfied that the approved provider intends, and will have the capacity, to provide *aged care by the end of the period of the waiver.

(4) The application for the waiver must be made at least 28 days before the end of the 6 months referred to in subsection (1).

(5) The Secretary must, at least 14 days before the end of the 6 months referred to in subsection (1):

(a) waive the operation of subsection (1) for a specified period; or

(b) reject the application;

and notify the approved provider accordingly.

Note: Rejections of applications are reviewable under Part 6.1.

10-3 Revocation of approval

(1) The Secretary must revoke an approval if:

(a) the Secretary is satisfied that the approved provider has ceased to be a *corporation; or

(b) the Secretary is satisfied that the approved provider has ceased to be suitable for approval (see section 8-3); or

(c) the Secretary is satisfied that the approved provider's application for approval contained information that was false or misleading in a material particular.

Note 1: Revocation of approvals are reviewable under Part 6.1.

Note 2: Approvals may also be revoked as a sanction under Part 4.4.

(2) However, the Secretary must not revoke the approval unless the Secretary is satisfied that such arrangements as are appropriate have been made to ensure that the care recipients to whom the approved provider was providing care before the revocation will continue to be provided with care after the revocation.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) Before deciding to revoke the approval, the Secretary must notify the approved provider that revocation is being considered. The notice must be in writing and must:
   (a) include the Secretary's reasons for considering the revocation; and
   (b) invite the approved provider to make submissions, in writing, to the Secretary within 28 days after receiving the notice; and
   (c) inform the approved provider that if no submission is made within that period, any revocation will take effect on the day after the last day for making submissions.

(4) In deciding whether to revoke the approval, the Secretary must consider any submissions given to the Secretary within that period.

(5) The Secretary must notify the approved provider, in writing, of the decision.

(6) The notice must be given to the approved provider within 28 days after the end of the period for making submissions. If the notice is not given within this period, the Secretary is taken to have decided not to revoke the approval.

(7) A revocation takes effect:
   (a) if no submission was made under subsection (3)—on the day after the last day for making submissions; or
   (b) if such a submission was made—7 days after the day on which the notice under subsection (5) was given.

(8) Paragraph (1)(a) does not apply if the approved provider is a State, Territory, *authority of a State or Territory or *local government authority.

10-4 Revocation of approval on request of approved provider

(1) The Secretary must revoke an approval if the approved provider requests the Secretary in writing to revoke its approval.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) The request must be given to the Secretary:

(a) at least 60 days before the day on which the revocation is requested to take effect; or

(b) before such other time as the Secretary determines in accordance with any requirements specified in the Approved Provider Principles.

(3) The Secretary must notify the approved provider of the revocation. The notice must be in writing and must be given to the approved provider at least 14 days before the day on which the revocation is to take effect.

(4) The revocation has effect on the day requested, unless another day is specified in the notice under subsection (3).

(5) The revocation is subject to such conditions (if any) as are specified in the notice.

Note: Decisions to impose conditions on revocations under this section are reviewable under Part 6.1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 2.2—Allocation of places

Division 11—Introduction

11-1 What this Part is about

An approved provider can only receive subsidy under Chapter 3 for providing *aged care in respect of which a *place has been allocated. The Commonwealth plans the distribution between *regions of the available places in respect of the types of subsidies. It then invites applications and allocates the places to approved providers.

Table of Divisions

11-2 The Allocation Principles

Allocation of *places is also dealt with in the Allocation Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: The Allocation Principles are made by the Minister under section 96-1.

11-3 Meaning of *people with special needs*

For the purposes of this Act, the following people are ***people with special needs***:

(a) people from Aboriginal and Torres Strait Islander communities;

(b) people from non-English speaking backgrounds;

(c) people who live in rural or remote areas;

(d) people who are financially or socially disadvantaged;

(e) people of a kind (if any) specified in the Allocation Principles.

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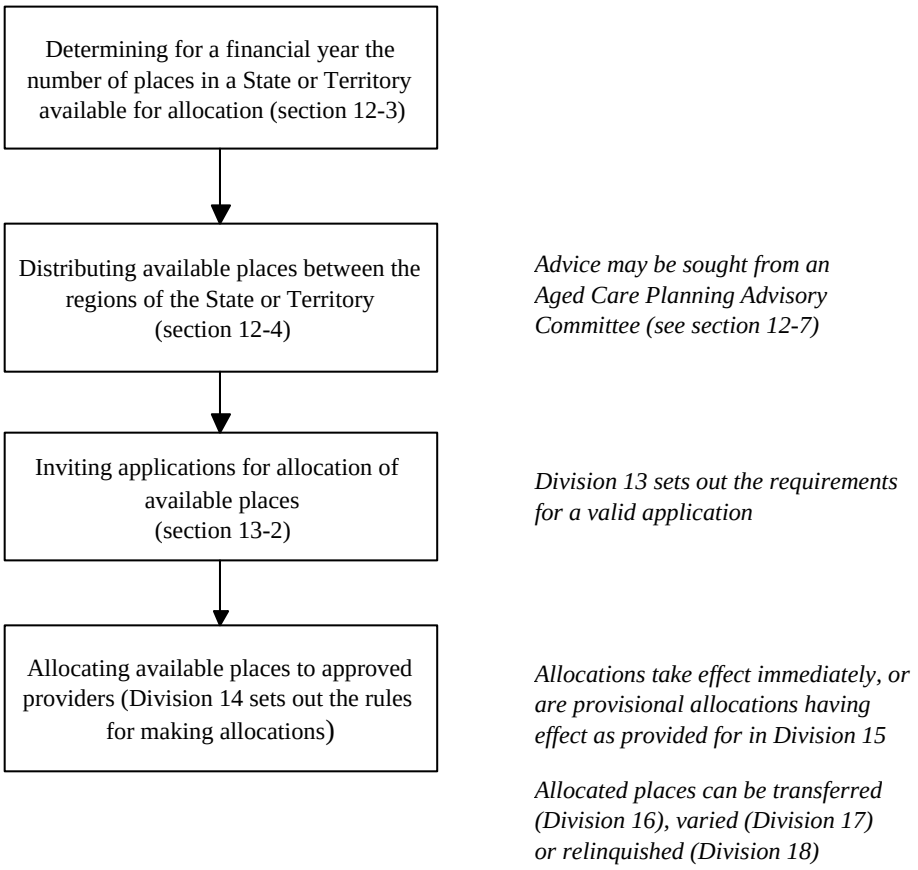
*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

11-4 Explanation of the allocation process

This diagram sets out the steps that the Commonwealth takes in allocating *places to an approved provider under this Part in respect of a type of subsidy under Chapter 3.



*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 12—How does the Commonwealth plan its allocations of places?

12-1 The planning process

(1) The Secretary must, for each financial year, carry out the planning process under this Division for each type of subsidy under Chapter 3.

(2) In carrying out the planning process, the Secretary:
  (a) must have regard to the objectives set out in section 12-2; and
  (b) must comply with the Minister's determination under section 12-3; and
  (c) may comply with sections 12-4 to 12-7.

12-2 Objectives of the planning process

The objectives of the planning process are:
  (a) to provide an open and clear planning process; and
  (b) to identify community needs, particularly in respect of *people with special needs; and
  (c) to allocate *places in a way that best meets the identified needs of the community.

12-3 Minister to determine the number of places available for allocation

(1) The Minister must, in respect of each type of subsidy under Chapter 3, determine for the financial year how many *places are available for allocation in each State or Territory.

(2) The determination must be published in the *Gazette*.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

12-4 Distributing available places among regions

(1) The Secretary may, in respect of each type of subsidy, distribute for the financial year the *places *available for allocation in a State or Territory among the *regions within the State or Territory.

Note: *Regions are determined under section 12-6.

(2) In distributing the places, the Secretary must comply with any requirements specified in the Allocation Principles.

(3) If, in respect of a type of subsidy:

(a) the Secretary does not, under subsection (1), distribute for the financial year the *places *available for allocation in the State or Territory; or

(b) the whole of the State or Territory comprises one *region;

the Secretary is taken to have distributed for that year the places to the whole of the State or Territory as one region.

12-5 Determining proportion of care to be provided to certain groups of people

(1) The Secretary may, in respect of each type of subsidy, determine for the *places *available for allocation the proportion of care that must be provided to one or more of the following:

(a) *people with special needs;

(b) *concessional residents and *assisted residents;

(c) recipients of *respite care;

(d) people needing a particular level of care;

(e) people of kinds specified in the Allocation Principles.

(2) In determining the proportion, the Secretary must consider any criteria specified in the Allocation Principles.

(3) The following are examples of the matters with which the criteria specified in the Allocation Principles may deal:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the likely number of places that would be included in the *aged care services that would provide the care in relation to the *places to be allocated;

(b) whether those aged care services have been, or are likely to be, granted *extra service status;

(c) the particular kinds of care that are likely to be provided in relation to the places;

(d) the proportion of people receiving that care who are likely:

(i) to be *people with special needs; or

(ii) to be *concessional residents or *assisted residents; or

(iii) to be recipients of *respite care; or

(iv) to need a particular level of care; or

(v) to be included in the kinds of people specified in the Allocation Principles;

(e) in the case of places in respect of *residential care subsidy—whether the residential care services through which the care is likely to be provided are likely to be *certified.

12-6 Regions

(1) The Secretary may, in respect of each type of subsidy, determine for each State and Territory the regions within the State and Territory.

(2) If the Secretary does not determine the regions within a State or Territory in respect of a particular type of subsidy, the whole of the State or Territory comprises the region.

(3) The determination must be published in the *Gazette*.

12-7 Aged Care Planning Advisory Committees

(1) The Secretary may establish Aged Care Planning Advisory Committees.

(2) The Secretary may request advice from a Committee about:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the distribution of *places among *regions under section 12-4; and

(b) the making of determinations under section 12-5.

If the Secretary requests advice, the Committee must advise the Secretary accordingly.

(3) The Allocation Principles may specify:

(a) the Committees' functions; and

(b) the Committees' membership; and

(c) any other matter relevant to the Committees' operations.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 13—How do people apply for allocations of places?

13-1 Applications for allocations of places

A person may apply in writing for an allocation of *places. However, the application is valid only if:

(a) it is in response to an invitation to apply for allocation of places published by the Secretary under section 13-2; and

(b) it is made on or before the closing date specified in the invitation; and

(c) it is in a form approved by the Secretary; and

(d) it is accompanied by the application fee (see section 13-3); and

(e) the applicant complies with any requests for information under section 13-4.

Note: These requirements can be waived under section 14-4.

13-2 Invitation to apply

(1) If:

(a) *places are *available for allocation for a financial year; and

(b) those places have been distributed, or taken to have been distributed, to a *region under section 12-4;

the Secretary may, during or before that financial year, invite applications for allocations of those places.

(2) The invitation may relate to more than one type of subsidy under Chapter 3, and to *places in respect of more than one *region.

(3) The invitation must specify the following:

(a) all of the *regions in respect of which allocations will be considered;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the types of subsidy in respect of which allocations will be considered;
(c) the number of *places *available for allocation in respect of each type of subsidy;
(d) the closing date after which applications will not be accepted;
(e) the proportion of care (if any), in respect of the places available for allocation, that must be provided to each of the following:
(i) *people with special needs;
(ii) *concessional residents and *assisted residents;
(iii) recipients of *respite care;
(iv) people needing a particular level of care;
(v) people of kinds specified in the Allocation Principles.

(4) The invitation must be:
(a) published in such newspapers; or
(b) published or notified by such other means;
as the Secretary thinks appropriate.

13-3 Application fee

(1) The Allocation Principles may specify:
(a) the application fee; or
(b) the way the application fee is to be worked out.

(2) The amount of any application fee:
(a) must be reasonably related to the expenses incurred or to be incurred by the Commonwealth in relation to the application; and
(b) must not be such as to amount to taxation.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

13-4 Requests for further information

(1) If the Secretary needs further information for a purpose connected with making an allocation under Division 14, the Secretary may give an applicant a notice requesting the applicant to give the further information within 28 days after receiving the notice, or within such shorter period as is specified in the notice.

(2) The application is taken to be withdrawn if the applicant does not give the further information within 28 days, or within the shorter period, as the case requires. However, this does not stop the applicant from reapplying, either:

(a) in response to the invitation in question (on or before the closing date); or

(b) in response to a later invitation to apply for allocation of places.

Note: The period for giving the further information can be extended—see section 96-7.

(3) The Secretary's request must contain a statement setting out the effect of subsection (2).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 14—How are allocations of places decided?

14-1 Allocation of places

(1) The Secretary may allocate *places, in respect of a particular type of subsidy under Chapter 3, to a person to provide *aged care services for a *region, but only if the person is an approved provider.

(2) However, the *places must not be allocated to the approved provider if:

(a) under Division 7, subsidy could not be paid to the approved provider for care provided in respect of the places; or

(b) a sanction imposed under Part 4.4 is in force prohibiting allocation of places to the approved provider.

(3) The allocation:

(a) must be the one that the Secretary is satisfied would best meet the needs of the aged care community in the *region (see section 14-2); and

(b) may be made subject to conditions (see sections 14-5 and 14-6).

(4) In order for an allocation to be made to an approved provider:

(a) the approved provider must have made a valid application in respect of the allocation (see Division 13); and

(b) the allocation must comply with the terms of an invitation published under Division 13 (see section 14-3);

except so far as the Secretary waives these requirements under section 14-4.

Note: However, paragraph (3)(a) and subsection (4) will not apply to an allocation of *places in a situation of emergency (see section 14-9).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

14-2 Competitive assessment of applications for allocations

(1) In deciding which allocation of *places would best meet the needs of the aged care community in the *region, the Secretary must consider, in relation to each application:

(a) whether the people who manage, or propose to manage, the *aged care service that is providing or would provide the care to which the places relate have the necessary expertise and experience to do so; and

(b) if applicable, whether the premises used, or intended to be used, to provide the care to which the places relate are suitably planned and located for the provision of *aged care; and

(c) the ability of the applicant to provide the appropriate level of care; and

(d) if the applicant has been a provider of aged care—its conduct as such a provider, and its compliance with its responsibilities as such a provider and its obligations arising from the receipt of any payments from the Commonwealth for providing that aged care; and

(e) the measures to protect the rights of care recipients; and

(f) the provision of appropriate care for care recipients who are *people with special needs; and

(g) any matters set out in the Allocation Principles.

(2) The reference in paragraph (1)(d) to aged care includes a reference to any care for the aged, whether provided before or after the commencement of this section, in respect of which any payment was or is payable under a law of the Commonwealth.

14-3 Compliance with the invitation

The allocation complies with the terms of the invitation if:

(a) *places that are specified in the invitation as being *available for allocation in respect of a particular type of subsidy under

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3 have been allocated only in respect of that type of subsidy; and

(b) places that are specified in the invitation as being available for allocation in respect of a particular *region have been allocated only in that region; and

(c) the total number of places that have been allocated does not exceed the number of places specified in the invitation as being available for allocation; and

(d) the Secretary has considered all valid applications made in respect of the allocation, together with any further information given under section 13-4 in relation to those applications; and

(e) the allocation was made after the closing date.

14-4 Waiver of requirements

(1) The Secretary may waive the requirement under paragraph 14-1(4)(a) that each approved provider who is allocated *places must have made a valid application in respect of the allocation if:

(a) each of the approved providers made an application in respect of the allocation; and

(b) the Secretary is satisfied that there are exceptional circumstances justifying the waiver.

(2) The Secretary may waive:

(a) the requirement under paragraph 14-1(4)(a) that each approved provider who is allocated *places must have made a valid application in respect of the allocation; and

(b) the requirement under paragraph 14-1(4)(b) that the allocation must comply with the terms of an invitation published under Division 13;

if the places being allocated are places that have been *relinquished under section 18-2 or that were included in an allocation, or a part of an allocation, revoked under Part 4.4.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: If, because of this subsection, an allocation does not have to comply with the terms of an invitation published under Division 13, it will not be limited to places that are determined by the Minister under section 12-3 to be available for allocation.

(3) The Secretary may waive:

(a) the requirement under paragraph 14-1(4)(a) that each approved provider who is allocated *places must have made a valid application in respect of the allocation; and

(b) the requirement under paragraph 14-1(4)(b) that the allocation must comply with the terms of an invitation published under Division 13;

if the Secretary is satisfied that there are exceptional circumstances justifying the waiver, and that only places that are *available for allocation are allocated.

14-5 Conditions relating to particular allocations

(1) The Secretary may make an allocation of *places to an approved provider subject to such conditions as the Secretary specifies in writing.

(2) The Secretary may specify which of the conditions (if any) must be met before a determination can be made under section 15-1.

Note: An allocation takes effect when a determination is made under section 15-1. Until an allocation takes effect, it is a *provisional allocation.

(3) It is a condition of every allocation of a *place that:

(a) the place is allocated in respect of a specified location; and

(b) the place is allocated in respect of a particular *aged care service; and

(c) any care provided, in respect of the place, must be provided at that location and through that service.

(4) The following are examples of the matters with which the conditions may deal:

(a) the proportion of care to be provided to:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(i) *people with special needs; or
(ii) *concessional residents and *assisted residents; or
(iii) recipients of *respite care; or
(iv) people needing a particular level of care; or
(v) people of kinds specified in the Allocation Principles;

through the *aged care service in which the place is, or will be, included;

(b) the period within which the aged care service is to be operational;

(c) the period within which the premises to be used by the approved provider to provide care are required to be built;

(d) the professional planning of the aged care service.

Note: Approved providers have a responsibility under Part 4.3 to comply with the conditions to which the allocation is subject. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

14-6 Conditions relating to allocations generally

(1) An allocation of *places to an approved provider is also subject to such conditions as are from time to time determined by the Secretary, in writing, in respect of:

(a) allocations of places generally; or

(b) allocations of places of a specified kind that includes the allocation of places in question.

(2) In making a determination under subsection (1), the Secretary must have regard to any matters specified in the Allocation Principles.

(3) Conditions determined under this section apply to allocations that occurred before or after the determination is made, unless the determination specifies otherwise.

Note: Approved providers have a responsibility under Part 4.3 to comply with the conditions to which the allocation is subject. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

14-7 Allocation of places to services with extra service status

(1) The Secretary must not approve the allocation of *places to a residential care service that has, or a *distinct part of which has, *extra service status unless subsection (2) or (3) applies to the allocation.

(2) The Secretary may approve the allocation if satisfied that the *places other than the allocated places could, after the allocation, form one or more *distinct parts of the residential care service concerned.

Note: The allocated places would not have *extra service status because of the operation of section 31-3.

(3) The Secretary may approve the allocation if satisfied that:

(a) granting the allocation would be reasonable, having regard to the criteria set out in section 32-4; and

(b) granting the allocation would not result in the maximum proportion of *extra service places under section 32-7, for the State, Territory or region concerned, being exceeded; and

(c) any other requirements set out in the Allocation Principles are satisfied.

Note: These *places would have *extra service status because of the operation of section 31-1. (Section 31-3 would not apply.)

14-8 Notification of allocation

(1) The Secretary must notify each applicant in writing whether or not any *places have been allocated to the applicant.

(2) If *places have been allocated to an applicant, the notice must set out:

(a) the number of places that have been allocated; and

(b) the types of subsidy under Chapter 3 in respect of which the places have been allocated; and

(c) the *region for which the places have been allocated; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(d) if the Secretary determines that the allocation takes effect immediately—a statement of the consequences of the allocation taking effect immediately; and

(e) if the allocation is a *provisional allocation—a statement of the effect of the allocation being a provisional allocation; and

(f) the conditions to which the allocation is subject; and

(g) if the allocation is a provisional allocation—which of those conditions (if any) must be met before the allocation can take effect.

14-9 Allocations in situations of emergency

(1) The Secretary may declare that an allocation of *places to an approved provider is made in a situation of emergency.

(2) Paragraph 14-1(3)(a) and subsection 14-1(4) do not apply to an allocation that is the subject of such a declaration.

Note: The effect of subsection (2) is that the process of inviting applications under Division 13 does not apply, valid applications for the allocation are not required, and there is no competitive assessment of applications.

(3) The Secretary must not make such a declaration unless the Secretary is satisfied that:

(a) a situation of emergency exists that could result in, or has resulted in, *aged care ceasing to be provided to a group of care recipients; and

(b) an allocation of *places under this Division would ensure that the provision of that care did not cease, or would resume; and

(c) there is insufficient time, in making the allocation, to comply with paragraph 14-1(3)(a) and subsection 14-1(4).

(4) A declaration must specify a period at the end of which the allocation in question is to cease to have effect.

Note: If, because of this section, an allocation does not have to comply with the terms of an invitation published under Division 13, it will not be

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

limited to places that are determined by the Minister under section 12-3 to be available for allocation.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 15—When do allocations of places take effect?

15-1 When allocations take effect

(1) An allocation of *places to an approved provider takes effect when the Secretary determines that the approved provider is in a position to provide care, in respect of those places, for which subsidy under Chapter 3 may be paid.

(2) The Secretary may so determine at the same time that the allocation is made. If the Secretary does not do so, the allocation is taken to be a ***provisional allocation***.

Note: Subsidy cannot be paid in respect of places covered by an allocation that is only a provisional allocation.

(3) If the allocation was made subject to conditions under section 14-5 that must be met before a determination is made, the Secretary must not make the determination unless he or she is satisfied that all of those conditions have been met.

(4) In deciding whether to make the determination, the Secretary must have regard to any matters specified in the Allocation Principles.

15-2 Provisional allocations

A *provisional allocation remains in force until the end of the *provisional allocation period (see section 15-7) unless, before then:

(a) a determination is made under section 15-1 relating to the provisional allocation; or

(b) the provisional allocation is revoked under section 15-4; or

(c) the provisional allocation is surrendered under section 15-6.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

15-3 Applications for determinations

(1) The approved provider may, at any time before the end of the *provisional allocation period, apply to the Secretary for a determination under section 15-1.

(2) The application must be in the form approved by the Secretary.

(3) The Secretary must, within 28 days after receiving the application:
   (a) make a determination under section 15-1; or
   (b) reject the application;
   and, within that period, notify the approved provider accordingly.

   Note: Rejections of applications are reviewable under Part 6.1.

(4) Rejection of the application does not prevent the approved provider making a fresh application at a later time during the *provisional allocation period.

15-4 Variation or revocation of provisional allocations

(1) The Secretary may vary or revoke a *provisional allocation if the Secretary is satisfied that a condition to which the provisional allocation is subject under section 14-5 or 14-6 has not been met.

   Note: Variations or revocations of *provisional allocations are reviewable under Part 6.1.

(2) A variation of the *provisional allocation must be a variation of a condition to which the allocation is subject under section 14-5 or 14-6.

(3) Before deciding to vary or revoke the *provisional allocation, the Secretary must notify the approved provider that variation or revocation is being considered. The notice:
   (a) must be in writing; and
   (b) must invite the approved provider to make written submissions to the Secretary, within 28 days after receiving

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

the notice, as to why the provisional allocation should not be varied or revoked; and

(c) must inform the approved provider that, if no submissions are made within that period, the variation or revocation takes effect on the day after the last day for making submissions.

(4) In deciding whether to vary or revoke the *provisional allocation, the Secretary must consider any submissions made within that period.

(5) The Secretary must notify, in writing, the approved provider of the decision.

(6) The notice must be given to the approved provider within 28 days after the end of the period for making submissions. If the notice is not given within this period, the Secretary is taken to have decided not to vary or revoke the *provisional allocation.

(7) If the Secretary has decided to vary the *provisional allocation, the notice must include details of the variation.

(8) A variation or revocation has effect:

(a) if no submissions were made under subsection (3)—on the day after the last day for making submissions; or

(b) if such a submission was made—on the day after the approved provider receives a notice under subsection (5).

15-5 Variation of provisional allocations on application of approved provider

(1) If the allocation is a *provisional allocation, the approved provider may apply to the Secretary for a variation of the provisional allocation.

(2) A variation of the *provisional allocation may be:

(a) a reduction in the number of *places to which the provisional allocation relates; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) a variation of any of the conditions to which the provisional allocation is subject under section 14-5.

(3) The application must:
(a) be in the form approved by the Secretary; and
(b) be made before the end of the *provisional allocation period.

(4) The Secretary must, within 28 days after receiving the application:
(a) make the variation; or
(b) reject the application;
and, within that period, notify the approved provider accordingly.

Note: Rejections of applications are reviewable under Part 6.1.

(5) If the Secretary has decided to vary the *provisional allocation, the notice must include details of the variation.

(6) Rejection of the application does not prevent the approved provider making a fresh application at a later time during the *provisional allocation period.

15-6 Surrendering provisional allocations

If the allocation is a *provisional allocation, the approved provider may, at any time before the end of the *provisional allocation period, surrender the allocation by notice in writing to the Secretary.

15-7 Provisional allocation periods

(1) The ***provisional allocation period*** is the period of 2 years after the day on which the allocation is made.

(2) However, the *provisional allocation period:
(a) may be extended; and
(b) if an application under section 15-3 is pending at the end of the 2 years, or the 2 years as so extended—continues until the

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Secretary makes a determination under section 15-1 or rejects the application.

(3) The Secretary must extend the *provisional allocation period if:

(a) the approved provider applies to the Secretary, in accordance with subsection (4), for an extension; and

(b) the approved provider has not already been granted an extension; and

(c) the Secretary is satisfied that the extension is justified in the circumstances; and

(d) the Secretary is satisfied that granting the extension meets any requirements specified in the Allocation Principles.

(4) The application:

(a) must be in the form approved by the Secretary; and

(b) must be made at least 60 days, or such lesser number of days as the Secretary allows, before what would be the end of the *provisional allocation period if it were not extended.

(5) The Secretary must, within 28 days after receiving an application for an extension:

(a) grant an extension; or

(b) reject the application;

and, within that period, notify the approved provider accordingly.

Note: Extending provisional allocation periods and rejections of applications for extensions are reviewable under Part 6.1.

(6) The period of the extension is 12 months unless the Secretary is satisfied that the applicant meets the criteria in the Allocation Principles for increasing or decreasing the period of the extension. The Secretary must specify the period of the extension in the notice of the granting of the extension.

(7) The following are examples of the matters with which the Allocation Principles may deal:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the extent to which the approved provider has made reasonable progress towards being in a position to provide the care for which subsidy may be paid under Chapter 3;

(b) circumstances in which delays in being in a position to provide that care are justified;

(c) circumstances in which the period of the extension can be increased or decreased.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 16—How are allocated places transferred from one person to another?

16-1 Transfer of places

(1) A transfer of an allocated *place from one person to another is of no effect unless it is approved by the Secretary.

(2) The Secretary must approve the transfer of a *place if, and only if:
  (a) an allocation of that place has taken effect under Division 15; and
  (b) an application for transfer is made under section 16-2; and
  (c) the Secretary is satisfied under subsection 16-4(1) that the transfer is justified in the circumstances; and
  (d) the transferee is an approved provider when the transfer is completed; and
  (e) the transfer would not have the effect of the care to which the place relates being provided in a different State or Territory.

(3) If the transfer is approved:
  (a) the transferee is taken, from the transfer day (see section 16-7), to be the person to whom the *place is allocated under this Division; and
  (b) if, as part of the transfer, approval is sought for one or more variations of the conditions to which the allocation is subject under section 14-5—the Secretary is taken to have made such variation of the conditions as is specified in the instrument of approval.

16-2 Applications for transfer of places

(1) An approved provider to whom a *place has been allocated under Division 14 may apply in writing to the Secretary for approval to transfer the place to another person.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) The application must:

(a) be in a form approved by the Secretary; and

(b) include the information referred to in subsection (3); and

(c) be signed by the transferor and the transferee; and

(d) set out any variation of the conditions to which the allocation is subject under section 14-5, for which approval is being sought as part of the transfer; and

(e) if, after the transfer, the *place would relate to a different *aged care service—set out the proposals for ensuring that care needs are appropriately met for care recipients who are being provided with care in respect of those places.

(3) The information to be included in the application is as follows:

(a) the transferor's name;

(b) the number of *places to be transferred;

(c) the *aged care service to which the places currently relate, and its location;

(d) the proposed transfer day;

(e) the name of the transferee;

(f) if, after the transfer, the places would relate to a different aged care service—that aged care service, and its location;

(g) whether any of the places are:

(i) places included in a residential care service, or a *distinct part of a residential care service, that has *extra service status; or

(ii) *adjusted subsidy places; or

(iii) places in respect of which one or more *residential care grants have been paid; or

(iv) places in respect of which one or more grants under the *Aged or Disabled Persons Care Act 1954* have been paid;

(h) if the places are included in a residential care service and, after the transfer, the places would relate to a different

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

residential care service—whether that service, or a *distinct part of that service, has *extra service status;

(i) such other information as is specified in the Allocation Principles.

(4) The application must be made:

(a) if the transferee is an approved provider—no later than 60 days, or such other period as the Secretary determines under subsection (5), before the proposed transfer day; or

(b) if the transferee is not an approved provider—no later than 90 days, or such other period as the Secretary determines under subsection (5), before the proposed transfer day.

(5) The Secretary may, at the request of the transferor and the transferee, determine another period under paragraph (4)(a) or (b) if the Secretary is satisfied that it is justified in the circumstances.

(6) In deciding whether to make a determination, and in determining another period, the Secretary must consider any matters set out in the Allocation Principles.

(7) The Secretary must give written notice of his or her decision under subsection (5) to the transferor and the transferee.

(8) If the information included in an application changes, the application is taken not to have been made under this section unless the transferor and the transferee give the Secretary written notice of the changes.

16-3 Requests for further information

(1) If the Secretary needs further information to determine the application, the Secretary may give to the transferor and the transferee a notice requesting that:

(a) either the transferor or the transferee give the further information; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the transferor and the transferee jointly give the further information;

within 28 days after receiving the notice.

(2) The application is taken to be withdrawn if the further information is not given within the 28 days.

Note: The period for giving the further information can be extended—see section 96-7.

(3) The notice must contain a statement setting out the effect of subsection (2).

16-4 Consideration of applications

In deciding whether the transfer is justified in the circumstances, the Secretary must consider the following:

(a) whether the transfer would meet the objectives of the planning process set out in section 12-2;

(b) if the places were allocated to meet the needs of *people with special needs—whether those needs would continue to be met after the transfer;

(c) if the places were allocated to provide a particular type of *aged care—whether that type of aged care would continue to be provided after the transfer;

(d) the suitability of the transferee to provide the aged care to which the places to be transferred relate;

(e) if, after the transfer, the *places would relate to a different *aged care service:

(i) the financial viability, if the transfer were to occur, of the aged care service in which the places are currently included; and

(ii) the financial viability, if the transfer were to occur, of the aged care service in which the places would be included; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(iii) the suitability of the premises being used, or proposed to be used, to provide care through that aged care service; and

(iv) the standard of care, accommodation and other services provided, or proposed to be provided, by that aged care service; and

(v) whether the proposals set out in the application, for ensuring that care needs are appropriately met for care recipients who are being provided with care in respect of those places, are satisfactory;

(f) any other matters set out in the Allocation Principles.

16-5 Time limit for decisions on applications

(1) Subject to this section, the Secretary must, at least 14 days before the proposed transfer day:

(a) approve the transfer; or

(b) reject the application;

and notify the transferor and transferee accordingly.

Note: Rejections of applications are reviewable under Part 6.1.

(2) The Secretary may make a decision under subsection (1) on a later day if the transferor and the transferee agree. However, the later day must not occur on or after the proposed transfer day.

(3) If:

(a) the Secretary is given written notice (the ***alteration notice***) under subsection 16-2(8) of changes to the information contained in the application; and

(b) the alteration notice is given on or after the day occurring 30 days before the day by which the Secretary must act under subsection (1) of this section;

the Secretary is not obliged to act under subsection (1) until the end of the 30 day period following the day on which the alteration notice was given by the Secretary.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

16-6 Notice of decision on transfer

If the transfer is approved, the notice must include statements setting out the following matters:

(a) the number of *places to be transferred;

(b) the proposed transfer day;

(c) the *aged care service to which the places currently relate, and its location;

(d) if, after the transfer, the places will relate to a different aged care service:

(i) that aged care service, and its location; and

(ii) the proposals for ensuring that care needs are appropriately met for care recipients who are being provided with care in respect of those places, including the timetable for the proposals;

(e) the proportion of care, in respect of the places to be transferred, to be provided to:

(i) *people with special needs; or

(ii) *concessional residents and *assisted residents; or

(iii) recipients of *respite care; or

(iv) people needing a particular level of care; or

(v) people of the kinds specified in the Allocation Principles;

(f) such other information as is specified in the Allocation Principles.

16-7 Transfer day

(1) The transfer day is the proposed transfer day specified in the application if the transfer is completed on or before that day.

(2) If the transfer is not completed on or before the proposed transfer day, the transferor and the transferee may apply, in writing, to the Secretary to approve a day as the transfer day.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: Because the proposed transfer day must be specified in the application for transfer, the Secretary must be notified if the transfer is not completed on or before the proposed transfer day (see subsection 16-2(8)).

(3) The Secretary must, within 28 days after receiving the application under subsection (2):

(a) approve a day as the transfer day; or

(b) reject the application;

and, within that period, notify the transferor and the transferee accordingly.

Note: Approvals of days and rejections of applications are reviewable under Part 6.1.

(4) However, the day approved by the Secretary as the transfer day must not be earlier than the day on which the transfer is actually completed.

16-8 Transfer of places to service with extra service status

(1) The Secretary must not approve the transfer of a *place from one person to another if:

(a) the transfer would result in residential care in respect of the place being provided through a residential care service in a different location; and

(b) that residential care service has, or a *distinct part of that service has, *extra service status;

unless subsection (2) or (3) applies to the transfer.

(2) The Secretary may approve the transfer if satisfied that the *places other than transferred places could, after the allocation, form one or more *distinct parts of the residential care service concerned.

Note: The transferred places would not have *extra service status because of the operation of section 31-3.

(3) The Secretary may approve the transfer if satisfied that:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) granting the transfer would be reasonable, having regard to the criteria set out in section 32-4; and

(b) granting the transfer would not result in the maximum proportion of *extra service places under section 32-7, for the State, Territory or region concerned, being exceeded; and

(c) any other requirements set out in the Allocation Principles are satisfied.

Note: These *places would have *extra service status because of the operation of section 31-1. (Section 31-3 would not apply.)

16-9 Information to be given to transferee

(1) The Secretary may give to the transferee information specified in the Allocation Principles at such times as are specified in those Principles.

(2) The following are examples of matters that may be specified in the Allocation Principles:

(a) the types of subsidies paid under Chapter 3 to the transferor in respect of the *aged care service in which *places being transferred are included;

(b) the likely future adjustments to those payments;

(c) where applicable, the current *classification levels of care recipients receiving care from the service and their classification histories;

(d) the financial status of those care recipients;

(e) if the aged care service in which the places being transferred are included is a residential care service:

(i) matters relating to the *certification of the aged care service; and

(ii) matters relating to whether the aged care service meets its *accreditation requirement;

(f) matters relating to the *residential care grants (if any) that have been made in respect of that aged care service;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(g) matters relating to any grants under the *Aged or Disabled Persons Care Act 1954*, or Part VAB of the *National Health Act 1953*, that have been made in respect of that aged care service;

(h) compliance by the transferor with the transferor's responsibilities under Chapter 4 in relation to that aged care service, including any action that has been taken or is proposed to be taken, under Part 4.4, in relation to the transferor.

(3) The Allocation Principles must not specify information that would, or would be likely to, disclose the identity of any care recipient.

16-10 Transferors to provide transferee with certain records

(1) If the transfer is completed, the transferor must give to the transferee such records, or copies of such records, as are necessary to ensure that the transferee can provide care in respect of the *places being transferred.

(2) These records must include the following:

(a) the assessment and classification records of care recipients receiving care from the *aged care service to which the *places being transferred relate;

(b) the individual care plans of those care recipients;

(c) the medical records, progress notes and other clinical records of those care recipients;

(d) the schedules of fees and charges (including, where applicable, retention amounts relating to *accommodation bonds) for those care recipients;

(e) any agreements between those care recipients and the transferor;

(f) the accounts of those care recipients;

(g) where applicable, the prudential requirements for accommodation bonds for that aged care service;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(h) the records specified in the Allocation Principles.

Note: Approved providers have a responsibility under Part 4.3 to comply with this obligation. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

16-11 Effect of transfer on certain matters

On the transfer day:

(a) any entitlement of the transferor to an amount of subsidy under Chapter 3, in respect of the *place being transferred, that is payable but has not been paid passes to the transferee; and

(b) any responsibilities under Part 4.2 that the transferor had, immediately before that transfer day, in relation to an *accommodation bond balance connected with the place become responsibilities of the transferee under Part 4.2; and

(c) the transferee is subject to any obligations to which the transferor was subject, immediately before that day, under a *resident agreement or *community care agreement entered into with a care recipient provided with care in respect of the place.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 17—How are the conditions for allocations of places varied?

17-1 Variation of allocations

(1) The Secretary must approve a variation of the conditions to which the allocation of a *place is subject under section 14-5 if and only if:

(a) the allocation has taken effect under Division 15; and

(b) an application for variation is made under section 17-2; and

(c) the Secretary is satisfied under section 17-4 that the variation is justified in the circumstances; and

(d) the variation would not have the effect of the care to which the place relates being provided in a different State or Territory.

Note: An allocation of a place can also be varied under Division 16 as part of a transfer of the allocation from one person to another.

(2) If the variation is approved, it takes effect on the variation day (see section 17-7).

17-2 Applications for variation of allocations

(1) An approved provider to whom a *place has been allocated under Division 14 may apply in writing to the Secretary to vary the conditions to which the allocation is subject under section 14-5.

(2) The application must:

(a) be in a form approved by the Secretary; and

(b) include such information as is specified in the Allocation Principles.

(3) The following are examples of the matters that may be specified in the Allocation Principles for the purposes of paragraph (2)(b):

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the applicant's name;

(b) the *aged care service to which the allocation being varied relates, and its location;

(c) the number of *places to which the variation relates;

(d) whether any of the places to which the variation relates are:

(i) *adjusted subsidy places; or

(ii) places included in a residential care service, or a *distinct part of a residential care service, that has *extra service status;

(e) if, after the variation, care provided in respect of the places would be provided at a different location:

(i) the address of that location; and

(ii) the proposals for ensuring that care needs are appropriately met for care recipients who are being provided with care in respect of those places;

(f) the conditions of the allocation to be varied.

(4) The application must be made no later than 60 days, or such other period as the Secretary determines under subsection (5), before the proposed variation day.

(5) The Secretary may determine, at the applicant's request, another period under subsection (4) if the Secretary is satisfied that it is justified in the circumstances.

Note: Determinations of periods and refusals to determine periods are reviewable under Part 6.1.

(6) In deciding whether to make a determination, and in determining another period, the Secretary must consider any matters set out in the Allocation Principles.

(7) The Secretary must give written notice of the decision under subsection (5) to the applicant.

(8) If the information that an applicant has included in an application changes, the application is taken not to have been made under this

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

section unless the applicant gives the Secretary written notice of the changes.

17-3 Requests for further information

(1) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the applicant to give the further information within 28 days after receiving the notice.

(2) The application is taken to be withdrawn if the applicant does not give the further information within 28 days.

Note: The period for giving the further information can be extended—see section 96-7.

(3) The notice must contain a statement setting out the effect of subsection (2).

17-4 Consideration of applications

In deciding whether the variation is justified in the circumstances, the Secretary must consider:

(a) whether the variation will meet the objectives of the planning process set out in section 12-2; and

(b) the financial viability of the *aged care service to which the allocation being varied relates; and

(c) if the *places have been allocated to meet the needs of a particular group—whether those needs would continue to be met after the variation; and

(d) if the places have been allocated to provide a particular type of *aged care—whether that type of aged care would continue to be provided after the variation; and

(e) if, after the variation, the places would be included in a different aged care service—the financial viability of the aged care service; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(f) if, after the variation, care provided in respect of the places would be provided at a different location:
  (i) the suitability of the premises used, or proposed to be used, to provide care through that aged care service; and
  (ii) the proposals for ensuring that care needs are appropriately met for care recipients who are being provided with care in respect of those places; and
(g) any other matters set out in the Allocation Principles.

17-5 Time limit for decisions on applications

The Secretary must, at least 14 days before the proposed variation day:

(a) approve the variation; or
(b) reject the application;

and, within that period, notify the applicant accordingly.

Note: Rejections of applications are reviewable under Part 6.1.

17-6 Notice of decisions

If the variation is approved, the notice must include statements setting out the following matters:

(a) the number of *places to which the variation relates;
(b) details of the variation of the conditions to which the allocation in question is subject;
(c) if, after the variation, care provided in respect of the places would be provided at a different location:
  (i) the address of that location; and
  (ii) the proposals for ensuring that care needs are appropriately met for care recipients who are being provided with care in respect of those places;
(d) any other matters specified in the Allocation Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

17-7 Variation day

(1) The variation day is the proposed variation day specified in the application if the variation is made on or before that day.

(2) If the variation is not made on or before the proposed variation day, the applicant may apply, in writing, to the Secretary to approve a day as the variation day.

(3) The Secretary must, within 28 days after receiving the application:

(a) approve a day as the variation day; or

(b) reject the application;

and, within that period, notify the applicant accordingly.

Note: Approvals of days and rejections of applications are reviewable under Part 6.1.

(4) However, the day approved by the Secretary as the variation day must not be earlier than the day on which the variation is made.

17-8 Variation involving relocation of places to service with extra service status

(1) The Secretary must not approve the variation of the conditions to which an allocation of places is subject, if:

(a) the variation would result in residential care in respect of the *places being provided through a residential care service in a different location; and

(b) that residential care service has, or a *distinct part of that service has, *extra service status;

unless subsection (2) or (3) applies to the variation.

(2) The Secretary may approve the variation if the Secretary is satisfied that the *places other than the places to which the variation relates could, after the variation, form one or more *distinct parts of the residential care service concerned.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: The places to which the variation relates would not have *extra service status because of the operation of section 31-3.

(3) The Secretary may approve the variation if the Secretary is satisfied that:

(a) granting the variation would be reasonable, having regard to the criteria set out in section 32-4; and

(b) granting the variation would not result in the maximum proportion of *extra service places under section 32-7, for the State, Territory or region concerned, being exceeded; and

(c) any other requirements set out in the Allocation Principles are satisfied.

Note: These places would have *extra service status because of the operation of section 31-1. (Section 31-3 would not apply.)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 18—When do allocations cease to have effect?

18-1 Cessation of allocations

(1) The allocation of a *place that has taken effect under Division 15 ceases to have effect if either of the following happens:

(a) the place is relinquished (see section 18-2);

(b) the allocation is revoked under section 18-5 or Part 4.4.

(2) Without limiting subsection (1), if the allocation of a *place is the subject of a declaration under section 14-9, the allocation ceases to have effect at the end of the period specified, under subsection 14-9(4), in the declaration.

(3) If the allocation of a place that has taken effect under Division 15 is suspended under Part 4.4, the allocation ceases to have effect until the suspension ceases to apply (see Division 68).

18-2 Relinquishing places

(1) If an allocation of *places has taken effect under Division 15, the approved provider to whom the places are allocated may *relinquish all or some of the places by notice in writing to the Secretary.

(2) The notice must include the following information:

(a) the approved provider's name;

(b) the *aged care service in which the *places to be *relinquished are included, and its location;

(c) the date of the proposed relinquishment of the places;

(d) the number of places to be relinquished;

(e) the approved provider's proposals for ensuring that care needs are appropriately met for those care recipients (if any)

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

who are being provided with care in respect of the places to be relinquished.

(3) The proposals referred to in paragraph (2)(e) must deal with the matters specified in the Allocation Principles.

(4) An approved provider must not *relinquish a *place that has taken effect under Division 15 without giving a notice of the relinquishment under this section at least 60 days before the proposed date of relinquishment.

Note: Approved providers have a responsibility under Part 4.3 to comply with this obligation. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(5) If an approved provider that is a *corporation fails to comply with subsection (4), the approved provider is guilty of an offence punishable, on conviction, by a fine not exceeding 30 penalty units.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

18-3 Proposals relating to the care needs of care recipients

(1) The Secretary must decide whether any proposals for ensuring that care needs are appropriately met for care recipients who are being provided with care in respect of the*places being *relinquished, set out in the notice under subsection 18-2(1), are satisfactory.

(2) In deciding if the proposals are satisfactory, the Secretary must take into account any matters specified in the Allocation Principles.

(3) The Secretary must give notice to the approved provider, in writing, of the Secretary's decision within 14 days after receiving the notice under subsection 18-2(1).

(4) If the Secretary decides that the proposals are not satisfactory, the Secretary may, in the notice given under subsection (3), request the approved provider to modify the proposals as specified in the notice within the period specified in the notice.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(5) If the approved provider does not, within the period specified in the notice, modify the proposals in accordance with the request, the Secretary may give notice, in writing, to the approved provider:
   (a) rejecting the proposals set out in the notice under subsection 18-2(1); and
   (b) setting out new proposals acceptable to the Secretary for ensuring that care needs are appropriately met for care recipients who are being provided with care in respect of the *places being *relinquished.

18-4 Approved providers' obligations relating to the care needs of care recipients

(1) An approved provider must not *relinquish *places in respect of which care recipients are being provided with care without complying with any proposal, for ensuring that care needs are appropriately met for those care recipients, that was:
   (a) accepted by the Secretary under section 18-3; or
   (b) modified by the approved provider as requested by the Secretary under subsection 18-3(4); or
   (c) set out by the Secretary in a notice under subsection 18-3(5).

Note: Approved providers have a responsibility under Part 4.3 to comply with this obligation. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(2) If an approved provider that is a *corporation fails to comply with this section, the approved provider is guilty of an offence punishable, on conviction, by a fine not exceeding 1,000 penalty units.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

18-5 Revocation of unused allocations of places

(1) The Secretary may revoke the allocation of a *place if the approved provider to whom the place is allocated has not, for a continuous

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

period of 12 months, or such other period as is set out in the Allocation Principles:

(a) if the allocation is in respect of residential care subsidy—provided residential care in respect of the place; or

(b) if the allocation is in respect of community care subsidy—provided community care in respect of the place; or

(c) if the allocation is in respect of flexible care subsidy—provided flexible care in respect of the place.

Note: Revocations of allocations are reviewable under Part 6.1.

(2) Before deciding to revoke the allocation, the Secretary must notify the approved provider that revocation is being considered. The notice must be in writing and must:

(a) include the Secretary's reasons for considering the revocation; and

(b) invite the approved provider to make written submissions to the Secretary within 28 days after receiving the notice; and

(c) inform the approved provider that if no submission is made within that period, any revocation will take effect on the day after the last day for making submissions.

(3) In deciding whether to revoke the allocation, the Secretary must consider:

(a) any submissions given to the Secretary within that period; and

(b) any matters specified in the Allocation Principles.

(4) The Secretary must notify, in writing, the approved provider of the decision.

(5) The notice must be given to the approved provider within 28 days after the end of the period for making submissions. If the notice is not given within this period, the Secretary is taken to have decided not to revoke the allocation.

(6) A revocation has effect:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) if no submission was made under subsection (2)—on the day after the last day for making submissions; or

(b) if such a submission was made—7 days after the day on which the notice was given under subsection (4).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 2.3—Approval of care recipients

Division 19—Introduction

19-1 What this Part is about

A person must be approved under this Part to receive either residential care or community care before an approved provider can be paid *residential care subsidy or *community care subsidy for providing that care. In some cases, approval under this Part to receive flexible care is required before *flexible care subsidy can be paid.

Table of Divisions

19-2 The Approval of Care Recipients Principles

Approval of care recipients is also dealt with in the Approval of Care Recipients Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Approval of Care Recipients Principles are made by the Minister under section 96-1.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 20—What is the significance of approval as a care recipient?

20-1 Care recipients must be approved before subsidy can be paid

(1) Subsidy cannot be paid under Chapter 3 to an approved provider for providing residential care to a person unless the person is approved under this Part as a recipient of residential care.

(2) Subsidy cannot be paid under Chapter 3 to an approved provider for providing community care to a person unless the person is approved under this Part as a recipient of community care.

(3) Subsidy cannot be paid under Chapter 3 to an approved provider for providing flexible care unless:

(a) the person is approved under this Part as a recipient of that kind of flexible care; or

(b) the person is included in a class of people who, under the Flexible Care Subsidy Principles made for the purposes of subparagraph 50-1(1)(b)(ii), do not need approval in respect of flexible care.

(4) For the purposes of this Act, if a particular kind of flexible care also constitutes residential care or community care, a person who is approved under this Part as a recipient of residential care or community care (as the case requires) is also taken to be approved under this Part as a recipient of that kind of flexible care.

20-2 Effect of limitation of approvals

If a person's approval as a recipient of a type of *aged care is limited under section 22-2, payments cannot be made under Chapter 3 to an approved provider for providing care to the person unless the care was provided in accordance with the limitation.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 21—Who is eligible for approval as a care recipient?

21-1 Eligibility for approval

A person is eligible to be approved under this Part if the person is eligible to receive:

(a) residential care (see section 21-2); or

(b) community care (see section 21-3); or

(c) flexible care (see section 21-4).

21-2 Eligibility to receive residential care

A person is eligible to receive ***residential care*** if:

(a) the person has physical, medical, social or psychological needs that require the provision of care; and

(b) those needs cannot be met more appropriately through non-residential care services; and

(c) the person meets the criteria (if any) specified in the Approval of Care Recipient Principles as the criteria that a person must meet in order to be eligible to be approved as a recipient of residential care.

21-3 Eligibility to receive community care

A person is eligible to receive ***community care*** if:

(a) the person has physical, social or psychological needs that require the provision of care; and

(b) those needs can be met appropriately through non-residential care services; and

(c) the person meets the criteria (if any) specified in the Approval of Care Recipients Principles as the criteria that a

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

person must meet in order to be eligible to be approved as a recipient of community care.

21-4 Eligibility to receive flexible care

A person is eligible to receive ***flexible care*** if:

(a) the person has physical, social or psychological needs that require the provision of care; and

(b) those needs can be met appropriately through flexible care services; and

(c) the person meets the criteria (if any) specified in the Approval of Care Recipients Principles as the criteria that a person must meet in order to be eligible to be approved as a recipient of flexible care.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 22—How does a person become approved as a care recipient?

22-1 Approval as a care recipient

(1) A person can be approved as a recipient of one or more of the following:
   (a) residential care;
   (b) community care;
   (c) flexible care.

(2) The Secretary must approve a person as a recipient of one or more of those types of *aged care if:
   (a) an application is made under section 22-3; and
   (b) the Secretary is satisfied that the person is eligible to receive that type of aged care (see Division 21).

Note: Rejections of applications are reviewable under Part 6.1.

22-2 Limitation of approvals

(1) The Secretary may limit an approval to one or more of the following:
   (a) care provided by an *aged care service of a particular kind;
   (b) care provided during a specified period starting on the day after the approval was given;
   (c) the provision of *respite care for the period specified in the limitation;
   (d) any other matter or circumstance specified in the Approval of Care Recipients Principles.

The Secretary is taken to have limited an approval to the provision of care other than *respite care, unless the approval expressly covers the provision of respite care.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: Limitations of approvals are reviewable under Part 6.1.

(2) A period specified under paragraph (1)(b) must not exceed the period (if any) specified in the Approval of Care Recipients Principles.

(3) If an approval is for residential care, the Secretary may limit the approval to one or more levels of care corresponding to the *classification levels (see section 25-2).

Note: Limitations of approvals to one or more levels of care are reviewable under Part 6.1.

(4) The Secretary may, at any time, vary any limitation under this section of an approval, including any limitation varied under this subsection.

Note: Variations of limitations are reviewable under Part 6.1.

(5) Any limitation of an approval under this section, including any limitation as varied under subsection (4), must be consistent with the care needs of the person to whom the approval relates.

22-3 Applications for approval

(1) A person may apply in writing to the Secretary for the person to be approved as a recipient of one or more types of *aged care.

(2) However, the fact that the application is for approval of a person as a recipient of one or more types of *aged care does not stop the Secretary from approving the person as a recipient of one or more other types of aged care.

(3) The application must be in a form approved by the Secretary. It may be made on the person's behalf by another person.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

22-4 Assessments of care needs

(1) Before deciding whether to approve a person under this Part, the Secretary must ensure the care needs of the person have been assessed.

(2) The Secretary may limit the assessment to assessing the person in relation to:

(a) the person's eligibility to receive one or more specified types of *aged care; or

(b) in the case of residential care—the person's eligibility to receive specified levels of residential care.

(3) However, the Secretary may make the decision without the person's care needs being assessed if the Secretary is satisfied that there are exceptional circumstances that justify making the decision without an assessment.

(4) A person to whom the Secretary's function of deciding whether to approve the person is delegated may be the same person who assessed the person.

22-5 Date of effect of approval

(1) An approval takes effect on the day on which the Secretary approves the person as a care recipient.

(2) However, an approval of a person who is provided with care before being approved as a recipient of that type of *aged care is taken to have had effect from the day on which the care started if:

(a) the application for approval is made within 5 *business days (or that period as extended under subsection (3)) after the day on which the care started; and

(b) the Secretary is satisfied, in accordance with the Approval of Care Recipients Principles, that the person urgently needed the care when it started, and that it was not practicable to apply for approval beforehand.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: Decisions about when a person urgently needed care are reviewable under Part 6.1.

(3) A person may apply in writing to the Secretary for an extension of the period referred to in subsection (2). The Secretary must, by written notice given to the person:

(a) grant an extension of a duration determined by the Secretary; or

(b) reject the application.

Note: Determinations of periods and rejections of applications are reviewable under Part 6.1.

22-6 Notification of decisions

(1) The Secretary must notify, in writing, the person who applied for approval whether that person, or the person on whose behalf the application was made, is approved as a recipient of one or more specified types of *aged care.

(2) If the person is approved, the notice must include statements setting out the following matters:

(a) the day from which the approval takes effect (see section 22-5);

(b) any limitations on the approval under subsection 22-2(1);

(c) if the approval is for residential care—whether the approval is limited to a specified level of care (see subsection 22-2(3));

(d) when the approval will expire (see section 23-2);

(e) when the approval will lapse (see section 23-3);

(f) the circumstances in which the approval may be revoked (see section 23-4).

(3) The Secretary must notify, in writing, a person who is already approved as a recipient of one or more types of *aged care if the Secretary:

(a) limits the person's approval under subsection 22-2(1) or (3); or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) varies a limitation on the person's approval under subsection 22-2(4).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 23—When does an approval cease to have effect?

23-1 Expiration, lapse or revocation of approvals

An approval as a recipient of residential care, community care or flexible care ceases to have effect if any of the following happens:

(a) the approval expires under section 23-2;

(b) the approval lapses under section 23-3;

(c) the approval is revoked under section 23-4.

23-2 Expiration of time limited approvals

If a person's approval is limited to a specified period under paragraph 22-2(1)(b), the approval expires when that period ends.

23-3 Approval lapses if care not received within a certain time

(1) A person's approval lapses if the person is not provided with the care in respect of which he or she is approved within:

(a) the entry period specified in the Approval of Care Recipients Principles; or

(b) if no such period is specified—the period of 12 months starting on the day after the approval was given.

(2) For the purposes of paragraph (1)(a), the Approval of Care Recipients Principles may specify different entry periods for all or any of the following:

(a) residential care (other than residential care provided as *respite care);

(b) residential care provided as respite care;

(c) community care;

(d) flexible care.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) A person's approval lapses if the person ceases, in the circumstances specified in the Approval of Care Recipients Principles, to be provided with the care in respect of which he or she is approved.

(4) For the purposes of subsection (3), a person is not taken to cease to be provided with residential care merely because he or she is on *leave under section 42-2.

23-4 Revocation of approvals

(1) The Secretary may revoke a person's approval if, after ensuring that the person's care needs have been assessed, the Secretary is satisfied that the person has ceased to be eligible to receive a type of *aged care in respect of which he or she is approved.

Note 1: Revocations of approval are reviewable under Part 6.1.

Note 2: For eligibility to receive types of *aged care, see Division 21.

(2) In deciding whether to revoke the person's approval, the Secretary must consider the availability of such alternative care arrangements as the person may need if the care currently being provided to the person ceases.

(3) Before deciding to revoke the approval, the Secretary must notify the person, and the approved provider (if any) providing care to the person, that revocation is being considered. The notice must be in writing and must:

(a) include the Secretary's reasons for considering the revocation; and

(b) invite the person and the approved provider (if any) to make submissions, in writing, to the Secretary within 28 days after receiving the notice; and

(c) inform them that if no submissions are made within that period, any revocation will take effect on the day after the last day for making submissions.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(4) In deciding whether to revoke the approval, the Secretary must consider any submissions given to the Secretary within that period.

(5) The Secretary must notify, in writing, the person and the approved provider (if any) of the decision.

(6) The notice must be given to the person and the approved provider (if any) within 28 days after the end of the period for making submissions. If the notice is not given within this period, the Secretary is taken to have decided not to revoke the approval.

(7) A revocation has effect:
  (a) if no submission was made under subsection (3)—on the day after the last day for making submissions; or
  (b) if such a submission was made, and the person and the approved provider (if any) received notice under subsection (5) on the same day—the day after that day; or
  (c) if such a submission was made, and they received the notice on different days—the day after the later of those days.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 2.4—Classification of care recipients

Division 24—Introduction

24-1 What this Part is about

Care recipients approved under Part 2.3 for residential care, or for some kinds of flexible care, are classified according to the level of care they need. The classifications may affect the amounts of *residential care subsidy or *flexible care subsidy payable to approved providers for providing care.

Note: Care recipients who are approved under Part 2.3 for community care only are not classified under this Part.

Table of Divisions

24-2 The Classification Principles

The classification of care recipients is also dealt with in the Classification Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Classification Principles are made by the Minister under section 96-1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 25—How are care recipients classified?

25-1 Classification of care recipients

(1) If the Secretary receives an appraisal under section 25-3 in respect of:

(a) a care recipient who is approved under Part 2.3 for residential care; or

(b) a care recipient who is approved under Part 2.3 for flexible care and whose flexible care is of a kind specified in the Classification Principles;

the Secretary must classify the care recipient according to the level of care the care recipient needs, relative to the needs of other care recipients.

(2) The classification must specify the appropriate *classification level for the care recipient (see section 25-2).

(3) In classifying the care recipient, the Secretary:

(a) must take into account the appraisal made in respect of the care recipient under section 25-3; and

(b) must not exceed the level (if any) specified by the Secretary under subsection 22-2(3) in relation to the care recipient; and

(c) must take into account any other matters specified in the Classification Principles.

(4) If there is no classification of the care recipient, the care recipient is taken to be classified at the *lowest applicable classification level under the Classification Principles (see subsection 25-2(3)).

(5) The Classification Principles may exclude a class of care recipients from classification under this Part. A care recipient who is in such a class cannot be classified under this Part for the period specified in the Classification Principles in relation to that class.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

25-2 Classification levels

(1) The Classification Principles may set out the *classification levels for care recipients being provided with residential care or flexible care.

(2) The Classification Principles may provide for any of the following:
  (a) for only some of the *classification levels to be available when care is provided as *respite care;
  (b) for different classification levels to apply when residential care is provided as respite care;
  (c) for different classification levels to apply in respect of flexible care.

(3) The Classification Principles may specify the *lowest applicable classification level. They may provide that a different level is the lowest applicable classification level when care is provided as *respite care.

(4) The Classification Principles may specify the criteria, in respect of each *classification level, for determining which level applies to a care recipient.

(5) The following are examples of matters the Classification Principles may deal with in specifying the criteria:
  (a) a care recipient's clinical needs;
  (b) the assistance a care recipient requires with the activities of daily living;
  (c) the assistance a care recipient requires with personal care;
  (d) the assistance a care recipient requires with communication or sensory processes;
  (e) the care recipient's need for social or emotional support.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

25-3 Appraisals of the level of care needed

(1) An appraisal of the level of care needed by a care recipient, relative to the needs of other care recipients, must be made by:

(a) the approved provider that is providing care to the care recipient, or a person acting on the approved provider's behalf; or

(b) if the approved provider has been suspended under section 25-4 from making appraisals—a person authorised under section 25-5 to make those appraisals.

However, this subsection does not apply if the care recipient is being provided with care as *respite care.

(2) The appraisal must be made over a continuous period of at least 21 days. However, in the circumstances (if any) specified in the Classification Principles, the appraisal may be made over the shorter period specified in the Classification Principles in relation to those circumstances.

(3) The appraisal must be in a form approved by the Secretary, and must be made in accordance with the procedures (if any) specified in the Classification Principles.

(4) If a care recipient is being, or is to be, provided with care as *respite care, an assessment of the care recipient's care needs made under section 22-4 is taken:

(a) to be an appraisal of the level of care needed by the care recipient; and

(b) to have been received by the Secretary under subsection 25-1(1) as such an appraisal.

25-4 Suspending approved providers from making appraisals

(1) The Secretary may suspend an approved provider from making appraisals under section 25-3 if:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the Secretary is satisfied that the approved provider, or a person acting on the approved provider's behalf, gave false, misleading or inaccurate information in a substantial number of appraisals reviewed under subsection 29-1(3); and

(b) the classifications made in connection with those appraisals were changed under section 29-1; and

(c) the Secretary is satisfied that, after those classifications were changed, the approved provider continued to give false, misleading or inaccurate information in other appraisals.

Note: Suspensions of approved providers from making assessments are reviewable under Part 6.1.

(2) In considering whether a number of appraisals in which false, misleading or inaccurate information was given is substantial, the Secretary must apply the criteria (if any) specified in the Classification Principles.

(3) Before deciding to suspend an approved provider from making appraisals, the Secretary must notify the approved provider that suspension is being considered. The notice must be in writing and must:

(a) specify the period proposed for the suspension; and

(b) invite the approved provider to make submissions, in writing, to the Secretary within 28 days after receiving the notice; and

(c) inform the approved provider that if no submissions are made within that period, any suspension will take effect on the day after the last day for making submissions.

(4) In making the decision whether to suspend the approved provider, the Secretary must consider any submissions given to the Secretary within that period.

(5) The Secretary must notify the approved provider, in writing, of the decision.

(6) The notice must be given to the approved provider within 28 days after the end of the period for making submissions. If the notice is

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

not given within this period, the Secretary is taken to have decided not to suspend the approved provider.

(7) A suspension takes effect:

(a) if no submission was made under subsection (3)—on the day after the last day for making submissions; or

(b) if such a submission was made—7 days after the day on which the notice under subsection (5) was given.

25-5 Authorisation of another person to make appraisals

(1) If the Secretary suspends an approved provider from making appraisals, the Secretary must, in writing, authorise another person to make appraisals of care recipients to whom the approved provider provides care.

(2) The Secretary must inform the approved provider, in writing, of the name of the person who has been authorised to make appraisals of care recipients to whom the approved provider provides care.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 26—When do classifications take effect?

26-1 Appraisals received within the appropriate period—care other than respite care

A classification of a care recipient (other than a classification in relation to care provided as *respite care) is taken to have had effect from the day on which provision of the level of care specified in an appraisal to the care recipient began, if the appraisal is received by the Secretary:

(a) within the period specified in the Classification Principles; or

(b) if no such period is so specified—within 2 months after the day on which provision of the care to the care recipient began.

26-2 Assessments not received within the appropriate period—care other than respite care

(1) A classification of a care recipient (other than a classification in relation to care provided as *respite care) takes effect from the day an appraisal of the care recipient is received by the Secretary if the appraisal is received outside the period in paragraph 26-1(a) or (b) (whichever is applicable).

(2) However, if the Secretary is satisfied that the appraisal was sent in sufficient time to be received by the Secretary, in the ordinary course of events, within that period, the classification is taken to have had effect from the day the care recipient began being provided with the level of care specified in the appraisal.

Note: A decision that the Secretary is not satisfied an appraisal was sent in sufficient time is reviewable under Part 6.1.

(3) In considering whether an appraisal received outside that period was sent in sufficient time, the Secretary may have regard to any

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

information, relevant to that question, that the approved provider gives to the Secretary.

(4) The Secretary must notify the approved provider, in writing, if the Secretary is not satisfied that the appraisal received outside that period was sent in sufficient time.

26-3 When respite care classifications take effect

A classification of a care recipient in relation to care provided as *respite care takes effect on a day specified in the Classification Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 27—When do classifications cease to have effect?

27-1 Expiry dates for classifications

(1) A classification ceases to have effect on its expiry date, unless it is renewed under Division 28.

(2) Subject to sections 27-2 and 27-3, the ***expiry date*** of a classification (other than a classification in relation to residential care provided as *respite care) is:

(a) the day that occurs 12 months after the classification took effect; or

(b) such other day as is specified in the Classification Principles.

(3) The ***expiry date*** for a classification for care provided to a care recipient as *respite care is the earlier of the following:

(a) the day on which the period during which the care recipient was provided with the respite care ends;

(b) the expiry date specified in the Classification Principles.

(4) A reference in this section to a classification includes a reference to a classification renewed under Division 28.

27-2 Cessation of care

(1) If a care recipient departs from a residential care service or a flexible care service, the ***expiry date*** for a classification in respect of the care recipient that was in force immediately before the day of departure is:

(a) the day of departure; or

(b) such other day as is specified in the Classification Principles.

(2) This section does not apply if the care in question was being provided as *respite care.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

27-3 Extended hospital leave

If a care recipient:

(a) takes *extended hospital leave that begins and ends before what would, apart from this section, have been the *expiry date under section 27-1; and

(b) is provided with residential care (other than residential care provided as *respite care) by an approved provider immediately after the end of that leave;

the ***expiry date*** is the day on which that leave ended.

Note: If a care recipient takes *extended hospital leave, this may result in a lower *classification level applying to the care recipient for the purpose of working out amounts of *residential care subsidy (see section 44-4).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 28—How are classifications renewed?

28-1 Renewing classifications

(1) The Secretary may renew the classification of a care recipient (other than a classification in relation to residential care provided as *respite care), if the approved provider notifies the Secretary of a reappraisal of the level of care needed by the care recipient (see section 28-2).

Note: Refusals to renew the classifications of care recipients are reviewable under Part 6.1.

(2) The renewal of the classification must specify the appropriate *classification level for the care recipient (see section 28-2).

(3) In renewing the classification, the Secretary:

(a) must take into account the reappraisal made in respect of the care recipient under section 28-2; and

(b) must not exceed the level (if any) specified by the Secretary under subsection 22-2(3) in relation to the care recipient; and

(c) must take into account any other matters specified in the Classification Principles.

(4) A reference in this section to a classification includes a reference to a renewed classification.

28-2 Reappraisal of the level of care needed

(1) A reappraisal of the level of care needed by a care recipient must be made in accordance with the Classification Principles applying to an appraisal under Division 25.

(2) The reappraisal must be made by:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the approved provider that is providing care to the care recipient, or a person acting on the approved provider's behalf; or

(b) if the approved provider has been suspended under section 25-4 from making appraisals—a person authorised to make those appraisals under section 25-5.

(3) The reappraisal must be in a form approved by the Secretary.

(4) Subject to subsection (5), the reappraisal must be made during the reappraisal period for the classification set out in section 28-3.

(5) If the care needs of the care recipient have changed significantly during the period during which the classification has effect, the reappraisal may be made at any time during that period.

(6) The Classification Principles may specify the circumstances in which the care needs of a care recipient are taken to have changed significantly.

28-3 Reappraisal period for classifications

(1) The reappraisal period for the classification is:

(a) the period:

(i) beginning one month before the *expiry date of the classification; and

(ii) ending one month after the expiry date; or

(b) such other period as is specified in the Classification Principles.

(2) However, if the *expiry date of the classification occurs:

(a) while the care recipient is on *leave from a residential care service; or

(b) within one month after the residential care service recommenced providing residential care to the care recipient after that leave ended;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

the reappraisal period is:

(c) the period of one month beginning on the day on which the provision of residential care to the care recipient through the residential care service recommenced; or

(d) such other period as is specified in the Classification Principles.

28-4 Date of effect of renewal

(1) Subject to subsections (2) and (3) and section 28-5, the renewal of the classification has effect from the *expiry date of the classification.

(2) If:

(a) a reappraisal of the classification is given to the Secretary before the start of the reappraisal period; and

(b) the reappraisal concludes that the care needs of the care recipient have changed significantly (within the meaning of subsection 28-2(5)) during the period during which the classification has effect;

the renewal of the classification takes effect from the day the reappraisal is received by the Secretary.

(3) Subject to section 28-5, if the *expiry date of the classification occurs:

(a) while the care recipient is on *leave from a residential care service; or

(b) within one month after the residential care service recommenced providing residential care to the care recipient after that leave ended;

a renewal of the classification takes effect from the day on which provision of residential care to the care recipient through the residential care service recommenced.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

28-5 Reappraisal given to the Secretary after the reappraisal period

(1) If a reappraisal of a classification is given to the Secretary after the end of the reappraisal period, the renewal of the classification takes effect from the day the reappraisal is received by the Secretary.

(2) However, if the Secretary is satisfied that the reappraisal was sent in sufficient time to be received by the Secretary, in the ordinary course of events, within that period, the renewal is taken to have had effect from the day the care recipient began being provided with the level of care in question.

Note: A decision that the Secretary is not satisfied a reappraisal was sent in sufficient time is reviewable under Part 6.1.

(3) In considering whether a reappraisal received outside that period was sent in sufficient time, the Secretary may have regard to any information, relevant to that question, that the approved provider gives to the Secretary.

(4) The Secretary must notify the approved provider, in writing, if the Secretary is not satisfied that a reappraisal received outside that period was sent in sufficient time.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 29—How are classifications changed?

29-1 Changing classifications

(1) The Secretary must change a classification if the Secretary is satisfied that:

(a) the classification was based on an incorrect or inaccurate appraisal under section 25-3 or reappraisal under section 28-2; or

(b) the classification was, for any other reason, made incorrectly.

Note: Changes of classifications are reviewable under Part 6.1.

(2) A classification cannot be changed in any other circumstances, except when classifications are renewed under Division 28.

(3) Before changing a classification under subsection (1), the Secretary must review it by examining:

(a) the material on which the classification was based; and

(b) any other material or information of a kind specified in the Classification Principles;

and considering whether the material supports the classification.

(4) If the Secretary changes the classification under subsection (1), the Secretary must give written notice of the change to the approved provider that is providing care to the care recipient.

29-2 Date of effect of change

A change of a classification is taken to have had effect:

(a) if the classification took effect less than 6 months before the Secretary gives written notice of the change to the approved provider—from the day on which the classification took effect; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) in any other case—from the day that occurred 6 months before the day on which the Secretary gives the notice.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 2.5—Extra service places

Division 30—Introduction

30-1 What this Part is about

A *place in respect of which residential care is provided may become an extra service place. Extra service places involve providing a significantly higher standard of accommodation, food and services to care recipients. Extra service places can attract higher resident fees, but a lower amount of *residential care subsidy is payable.

Note 1: For resident fees, see Division 58.

Note 2: For the lower amount of *residential care subsidy, see section 44-18, and also sections 44-6, 44-29 and 44-30. Further amounts may be deducted to recover capital payments (see section 43-6).

Note 3: *Extra service status also affects an approved provider's future entitlement for capital payments (see subsection 72-1(4)).

Note 4: The rules for various matters relating to allocations of places are also affected by *extra service status (see sections 14-7, 16-8 and 17-8).

Table of Divisions

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

30-2 The Extra Service Principles

Extra service places are also dealt with in the Extra Service Principles. The provisions of this Part indicate where a particular matter is or may be dealt with in these Principles.

Note: The Extra Service Principles are made by the Minister under section 96-1.

30-3 Meaning of *distinct part*

(1) For the purposes of this Part, ***distinct part***, in relation to a residential care service, means a specific area of the service that:

(a) is physically identifiable as separate from all the other *places included in the service; and

(b) includes sufficient living space for the care recipients to whom residential care is provided in respect of the places in the area; and

(c) meets any other requirements specified in the Extra Service Principles.

Example: A wing of a service with a separate living and dining area for residents living in the wing might constitute a "distinct part" of the service.

Note: If the Secretary approves an application for *extra service status for a distinct part of a service, all the places in that distinct part will be extra service places at a particular time as long as the requirements of section 31-1 are met.

(2) The Extra Service Principles may specify characteristics that must be present in order for an area to be physically identifiable as separate for the purposes of paragraph (1)(a).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 31—When is a place an extra service place?

31-1 Extra service place

A *place is an ***extra service place*** on a particular day if, on that day:

(a) the place is included in a residential care service, or a *distinct part of a residential care service, which has *extra service status (see Divisions 32 to 34); and

(b) an extra service fee is in force for the place (see Division 35); and

(c) residential care is provided, in respect of the place, to a care recipient on an extra service basis (see Division 36); and

(d) the place meets any other requirements set out in the Extra Service Principles.

31-2 Extra service status may continue after cessation in limited circumstances

(1) However, if:

(a) a *place is included in a residential care service, or a *distinct part of a residential care service, for which *extra service status has expired under section 33-2; and

(b) immediately before the extra service status expired, residential care was being provided, in respect of that place, to a care recipient on an extra service basis (see Division 36);

the Secretary may, on written application by the approved provider conducting the residential care service, determine that the place is an extra service place during the period:

(c) starting on the *expiry date; and

(d) finishing at the end of the last day on which the care recipient is provided with residential care in respect of the place.

Note: Refusals to make determinations are reviewable under Part 6.1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) If a determination under subsection (1) is made in respect of a *place or places, the conditions of *extra service status under section 32-8, as in force immediately before the determination took effect, continue in force in respect of the place or places.

(3) A determination under subsection (1) must not be made unless the requirements set out in the Extra Service Principles are met. The requirements may relate to, but are not limited to, the following matters:

(a) the form of applications for determinations;

(b) time limits in relation to applications;

(c) criteria to be considered by the Secretary in making decisions on applications;

(d) notification requirements.

(4) The Secretary must notify the applicant, in writing, of the Secretary's decision on the application. The notice must be given:

(a) within 28 days after receiving the application; or

(b) if another period is specified in the Extra Service Principles —within that period.

31-3 Effect of allocation or transfer of places to services with extra service status

(1) If:

(a) *places are allocated or transferred to a service that has *extra service status, or a *distinct part of which has extra service status; and

(b) the allocation or transfer was in accordance with subsection 14-7(2) or 16-8(2);

the allocated or transferred places are taken, for the purposes of this Part, not to have extra service status.

(2) If:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the Secretary approves a variation, under Division 17, of the conditions to which an allocation of *places is subject; and

(b) as a result of the variation, care in respect of the places is provided through a residential care service in a different location; and

(c) the variation was in accordance with subsection 17-8(2);

the places are taken, for the purposes of this Part, not to have *extra service status.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 32—How is extra service status granted?

32-1 Grants of extra service status

(1) An application may be made to the Secretary in accordance with section 32-3 for *extra service status in respect of a residential care service, or a *distinct part of a residential care service. The application must be in response to an invitation under section 32-2.

(2) The Secretary must, by notice in writing, grant *extra service status in respect of the residential care service, or a distinct part of the residential care service, if:

(a) the Secretary is satisfied, having considered the application in accordance with sections 32-4 and 32-5, that extra service status should be granted; and

(b) the application is accompanied by the application fee (see section 32-6); and

(c) granting the extra service status would not result in the number of extra service places exceeding the maximum proportion (if any) determined by the Minister under section 32-7 for the State, Territory or region in which the residential care service is located.

(3) The grant of *extra service status is subject to such conditions as are set out by the Secretary in the notice given to the applicant under subsection 32-9(1). The conditions may include conditions that must be satisfied before the extra service status becomes effective.

32-2 Invitations to apply

(1) The Secretary may invite applications for *extra service status in respect of residential care services, or *distinct parts of residential care services, in a particular State or Territory, or in a particular region within a State or Territory.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) The invitation must specify:

(a) the closing date; and

(b) if the Minister has determined under section 32-7 a maximum proportion of the total number of *places allocated in the State, Territory or region that may be extra service places—the maximum proportion.

(3) The invitation must be:

(a) published in such newspapers; or

(b) published or notified by such other means;

as the Secretary thinks appropriate.

(4) In this section:

region means a region determined by the Secretary under subsection 12-6(1) for a State or Territory in respect of residential care subsidy.

32-3 Applications for extra service status

(1) A person may make an application for *extra service status in respect of a residential care service, or a *distinct part of a residential care service, if the person:

(a) has the allocation under Part 2.2 for the *places included in the residential care service; or

(b) has applied under Part 2.2 for such an allocation.

(2) The application must:

(a) be in response to an invitation to apply for *extra service status published by the Secretary under section 32-2; and

(b) be made on or before the closing date specified in the invitation; and

(c) be in a form approved by the Secretary; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(d) state the number of *places to be included in the residential care service, or the *distinct part, for which extra service status is sought; and

(e) specify the standard of accommodation, services and food in relation to each such place; and

(f) include an application for approval under Division 35 of the extra service fee in respect of each place; and

(g) meet any requirements specified in the Extra Service Principles.

(3) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the applicant to give the further information within 14 days after receiving the notice.

(4) The application is taken to be withdrawn if the applicant does not give the further information within 14 days.

Note: The period for giving the further information can be extended—see section 96-7.

(5) The Secretary may, for a purpose connected with considering an application under this section, request the applicant to agree to an assessment of the residential care service concerned, conducted by a person authorised by the Secretary to conduct the assessment.

(6) If the applicant does not agree to the assessment within 28 days of the request, the application is taken to be withdrawn.

(7) A request under subsection (3) or (5) must contain a statement setting out the effect of subsection (4) or (6), as the case requires.

32-4 Criteria to be considered by Secretary

(1) The Secretary must not grant an application unless the following criteria are satisfied:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) granting the *extra service status sought would not unreasonably reduce access to residential care by people living in the State, Territory or region concerned who:

(i) are *concessional residents; or

(ii) are included in a class of people specified in the Extra Service Principles;

(b) the proposed standard of accommodation, services and food in respect of each *place that would be covered by the extra service status is, in the Secretary's opinion, at the time of the application, significantly higher than the average standard in residential care services that do not have extra service status;

(c) if the applicant has been a provider of aged care—the applicant has a very good record of:

(i) conduct as such a provider; and

(ii) compliance with its responsibilities as such a provider, and meeting its obligations arising from the receipt of any payments from the Commonwealth for providing aged care;

(d) if, at the time of the application, residential care is being provided through the residential care service:

(i) the service is *certified; and

(ii) if the application is made on or after the *accreditation day—the service meets its accreditation requirement (within the meaning of subsection 42-4(1)); and

(e) any other matters specified in the Extra Service Principles.

(2) The Extra Service Principles may specify the matters to which the Secretary must have regard in considering, or how the Secretary is to determine:

(a) whether granting *extra service status would unreasonably reduce access as mentioned in paragraph (1)(a); and

(b) whether the proposed standard referred to in paragraph (1)(b) is significantly higher than the average standard referred to in that paragraph; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(c) whether an applicant has a very good record of conduct, compliance or meeting its obligations, for the purposes of paragraph (1)(c).

(3) The reference in paragraph (1)(c) to aged care includes a reference to any care for the aged, whether provided before or after the commencement of this section, in respect of which any payment was or is payable under a law of the Commonwealth.

32-5 Competitive assessment of applications

(1) The Secretary must consider an application in accordance with this section if:

(a) more than one application in respect of a State or Territory, or a particular region within a State or Territory, is made in response to an invitation under section 32-2; and

(b) the Secretary is satisfied that to grant the *extra service status sought in each application that would (apart from this section) succeed would:

(i) unreasonably reduce access as mentioned in paragraph 32-4(1)(a); or

(ii) result in the number of extra service places exceeding the maximum proportion (if any) set by the Minister under section 32-7.

(2) The Secretary must grant *extra service status in respect of the applications in a way that ensures that the extra service status granted will not:

(a) unreasonably reduce access as mentioned in paragraph 32-4(1)(a); or

(b) result in the number of extra service places exceeding the maximum proportion (if any) set by the Minister under section 32-7.

(3) The Secretary must, in deciding which applications will succeed:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) give preference to those applications that best meet the criteria in section 32-4; and

(b) have regard to the level of the extra service fees (see Division 35) proposed in each application.

(4) The Extra Service Principles may set out matters to which the Secretary is to have regard in determining which applications best meet the criteria set out in section 32-4.

32-6 Application fee

(1) The Extra Service Principles may specify:

(a) the application fee; or

(b) the way the application fee is to be worked out.

(2) The amount of any application fee:

(a) must be reasonably related to the expenses incurred or to be incurred by the Commonwealth in relation to the application; and

(b) must not be such as to amount to taxation.

32-7 Maximum proportion of places

(1) The Minister may determine, in respect of any State or Territory, or any region within a State or Territory, the maximum proportion of the total number of *places allocated in the State, Territory or region that may be extra service places.

(2) The determination must be published in the *Gazette*.

32-8 Conditions of grant of extra service status

(1) *Extra service status is subject to the terms and conditions set out in the notice given to the applicant under subsection 32-9(1).

(2) The conditions are taken to include any conditions set out in this Act and any conditions specified in the Extra Service Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) Without limiting the conditions to which a grant of *extra service status in respect of a residential care service, or *distinct part, may be subject, such a grant is subject to the following conditions:

(a) if the Extra Service Principles specify standards that must be met by a residential care service, or a distinct part of a residential care service, that has extra service status—the service, or distinct part, must meet those standards;

(b) residential care may not be provided other than on an extra service basis through the residential care service, or distinct part, except to a care recipient who was being provided with residential care through the service, or distinct part, immediately before extra service status became effective.

Note: Paragraph (b) is to protect residents already in a service when it is granted extra service status. See also paragraph 36-1(1)(b), which provides that an *extra service agreement is necessary in order for residential care to be provided on an extra service basis. A person cannot be forced to enter such an agreement, and section 36-4 contains additional protection for existing residents.

(4) A notice under subsection (1) must:

(a) specify that the *extra service status granted is in respect of a particular location; and

(b) specify that location.

(5) Without limiting the conditions to which a grant of *extra service status may be subject, conditions may be included that relate to the following:

(a) the minimum standard of accommodation, services and food;

(b) entering into an agreement relating to *capital repayment deductions (see section 43-6);

(c) agreements with care recipients setting out the terms on which they will receive care on an extra service basis;

(d) the level of the extra service fee.

(6) Conditions, other than those under this Act or the Extra Service Principles, may be varied, in accordance with any requirements set

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

out in those Principles, by agreement between the Secretary and the approved provider.

Note: Approved providers have a responsibility under Part 4.3 to comply with the conditions to which a grant of extra service status is subject. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

32-9 Notification of extra service status

(1) The Secretary must notify each applicant in writing whether the *extra service status sought in the application has been granted. The notice must be given:

(a) within 90 days of receiving the application; or

(b) if the Secretary has requested further information under subsection 32-3(3)—within 90 days after receiving the information.

(2) If *extra service status has been granted, the notice must specify:

(a) the conditions to which the grant is subject; and

(b) when the extra service status will become effective (see subsection (3); and

(c) when the extra service status ceases to have effect (see Division 33).

(3) The day on which the *extra service status becomes effective must not be:

(a) before the day on which the notice is given; or

(b) before the day on which the residential care service concerned is *certified.

The day may be specified by reference to conditions that must be satisfied in order for extra service status to become effective.

Example: Extra service status might not become effective until specified building works are completed.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 33—When does extra service status cease?

33-1 Cessation of extra service status

*Extra service status for a residential care service, or a *distinct part of a residential care service, ceases to have effect at a particular time if any of the following happens:

(a) the extra service status expires under section 33-2;

(b) the extra service status lapses under section 33-3;

(c) the extra service status is revoked or suspended under section 33-4 or Part 4.4;

(d) the residential care service does not meet its *accreditation requirement (if any) at that time;

(e) the residential care service ceases to be *certified;

(f) if the Extra Service Principles specify that extra service status ceases to have effect on the occurrence of a particular event—that event occurs.

33-2 Extra service status expires on expiry date

(1) *Extra service status for a residential care service, or a *distinct part of a residential care service, expires on its expiry date, unless it is renewed under Division 34.

(2) Subject to subsection (3), the ***expiry date*** of *extra service status for a residential care service, or a *distinct part of a residential care service, is the day occurring:

(a) 5 years; or

(b) such other period as is specified in the Extra Service Principles;

after the latest day on which extra service status took effect, or was renewed, in respect of the residential care service or the distinct part of the residential care service, as the case requires.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) The Secretary may, by notice in writing, determine that the expiry date of *extra service status for a residential care service, or a *distinct part of a residential care service, is a day occurring not more than 12 months after the day that would otherwise be the expiry date under subsection (2) (the ***notional expiry date***).

(4) A notice under subsection (3) must be given to the approved provider concerned not later than 60 days before the notional expiry date.

33-3 Lapsing of extra service status

(1) *Extra service status for a residential care service, or a *distinct part of a residential care service, lapses if:

(a) an allocation made under Division 14 in respect of all of the *places included in that service, or distinct part, is *relinquished or revoked; or

(b) the allocation is a *provisional allocation and the provisional allocation does not take effect under section 15-1 before the end of the *provisional allocation period; or

(c) the approval of the person as a provider of *aged care services ceases to have effect under Division 10.

(2) The Extra Service Principles may specify other circumstances in which *extra service status for a residential care service, or a *distinct part of a residential care service, lapses.

33-4 Revocation or suspension of extra service status at approved provider's request

(1) The Secretary must revoke, or suspend for a specified period, the *extra service status of a residential care service, or a *distinct part of a residential care service, if the approved provider concerned requests the Secretary in writing to do so.

Note: *Extra service status can also be revoked or suspended as a sanction under Part 4.4 (see paragraph 66-1(g)).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 33-4

(2) Subject to subsection (3), a revocation or suspension under this section has effect on the date requested by the approved provider, unless the Secretary specifies otherwise.

(3) However, the date of effect must not be earlier than 60 days after the day on which the request is received by the Secretary.

(4) The Secretary must notify the approved provider, in writing, of the day on which the revocation or suspension will take effect and, in the case of a suspension, the day on which it will cease to have effect.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 34—How is extra service status renewed?

34-1 Renewal of extra service status

(1) An approved provider who provides residential care through a residential care service, or a *distinct part of a residential care service, that has *extra service status, may apply to the Secretary in accordance with section 34-2 for renewal of the extra service status.

(2) The Secretary must renew the *extra service status if:
  (a) the Secretary is satisfied as to the matters in section 34-3; and
  (b) the application is accompanied by the application fee (see section 34-4).

(3) The Secretary must notify the approved provider whether or not the extra service status is renewed. The notice must be given:
  (a) within 90 days of receiving the application; or
  (b) if the Secretary has requested further information under subsection 34-2(2)—within 90 days after receiving the information.

(4) The renewal of the *extra service status:
  (a) has effect from the *expiry date for the extra service status; and
  (b) is subject to such conditions as are specified in the notice under subsection (3).

34-2 Applications for renewal of extra service status

(1) An application for renewal of *extra service status must:
  (a) be in a form approved by the Secretary; and
  (b) be made at least 90 days before the *expiry date; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(c) meet any requirements specified in the Extra Service Principles.

(2) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the applicant to give the further information within 28 days after receiving the notice.

(3) The application is taken to be withdrawn if the applicant does not give the further information within 28 days.

Note: The period for giving the further information can be extended—see section 96-7.

(4) The Secretary may, for a purpose connected with considering an application under this section, request the applicant to agree to an assessment of the residential care service concerned, conducted by a person authorised by the Secretary to conduct the assessment.

(5) If the applicant does not agree to the assessment within 28 days of the request, the application is taken to be withdrawn.

(6) A request under subsection (2) or (4) must contain a statement setting out the effect of subsection (3) or (5), as the case requires.

34-3 Criteria to be considered by Secretary

(1) In considering an application, the Secretary must have regard to the following:

(a) whether the applicant has complied with the conditions to which the *extra service status is subject;

(b) whether the applicant would be able to comply with the conditions to which the renewal of extra service status would be subject;

(c) the conduct of the applicant as a provider of *aged care, and its compliance with its responsibilities as such a provider and its obligations arising from the receipt of any payments from the Commonwealth for providing aged care;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(d) the matters specified in section 32-4;

(e) any other matters specified in the Extra Service Principles.

(2) The reference in paragraph (1)(c) to aged care includes a reference to any care for the aged, whether provided before or after the commencement of this section, in respect of which any payment was or is payable under a law of the Commonwealth.

34-4 Application fee

(1) The Extra Service Principles may specify:

(a) the application fee for the renewal of *extra service status; or

(b) the way the application fee is to be worked out.

(2) The amount of any application fee:

(a) must be reasonably related to the expenses incurred or to be incurred by the Commonwealth in relation to the application; and

(b) must not be such as to amount to taxation.

34-5 Conditions of renewal of extra service status

(1) A renewal of *extra service status is subject to the conditions set out in the notice given to the approved provider concerned under subsection 34-1(3).

(2) The conditions are taken to include any conditions set out in this Act and any conditions specified in the Extra Service Principles.

(3) Without limiting the conditions to which a renewal of *extra service status may be subject, the notice must:

(a) specify that the extra service status renewal is in respect of a particular location; and

(b) specify that location.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(4) Without limiting the conditions to which a renewal of *extra service status may be subject, conditions may be included that relate to the following:

(a) the minimum standard of accommodation, services and food;

(b) agreements with care recipients setting out the terms on which they will receive care on an extra service basis;

(c) the level of the extra service fee.

(5) Conditions, other than those required by this Act, or by the Extra Service Principles, may be varied, in accordance with the requirement set out in those Principles, by agreement between the Secretary and the approved provider.

Note: Approved providers have a responsibility under Part 4.3 to comply with the conditions to which a grant of extra service status is subject. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

34-6 When renewals cease to have effect

A renewed *extra service status ceases to have effect in accordance with Division 33 as if it had been granted under Division 32.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 35—How are extra service fees approved?

35-1 Approval of extra service fees

(1) An approved provider who:

(a) has applied for *extra service status to be granted in respect of a residential care service, or a *distinct part of a residential care service; or

(b) who has been granted such extra service status;

may apply to the Secretary, in accordance with section 35-2, for extra service fees to be approved for one or more *places included in that residential care service or distinct part.

(2) The Secretary must approve the extra service fees proposed in the application if:

(a) the proposed fees meet the requirements of section 35-3; and

(b) the proposed fees meet any requirements (whether as to amount or otherwise) set out in the Extra Service Principles; and

(c) in a case where the application is not included in an application under Division 32 or 34—the Secretary is satisfied that any requirements specified in the Extra Service Principles in relation to standards, *certification or accreditation have been met; and

(d) fees for those places have not been approved during the 12 months immediately before the date on which the application is given to the Secretary.

Note: Rejections of applications are reviewable under Part 6.1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

35-2 Applications for approval

(1) The application must be in a form approved by the Secretary, and must satisfy any requirements set out in the Extra Service Principles.

(2) If the applicant has not been granted *extra service status for the residential care service, or the *distinct part of the residential care service, in which the *places concerned are located, the application must be included in an application under Division 32 for such extra service status.

35-3 Rules about amount of extra service fee

(1) The Secretary must not approve a nil amount as the extra service fee for a *place.

(2) The Secretary must not approve extra service fees for the *places in that residential care service, or *distinct part, if the average of the extra service fees for all those places, worked out on a daily basis, would be less than:

(a) $10.00; or

(b) such other amount as is specified in the Extra Service Principles.

(3) The Secretary must not approve extra service fees for *places in respect of which residential care is provided if:

(a) the care is provided through a particular residential care service; and

(b) extra service fees have previously been approved in respect of places in respect of which residential care is provided through that aged care service; and

(c) 12 months, or such other period specified in the Extra Service Principles, has not yet elapsed since the date on which the last approval took effect.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(4) The Secretary must not approve an application for an extra service fee for a *place if:

(a) an extra service fee for the place (the ***current fee***) is in force at the time the application is made; and

(b) the application proposes to increase the current fee by an amount that exceeds the maximum amount specified in, or worked out in accordance with, the Extra Service Principles.

35-4 Notification of Secretary's decision

The Secretary must notify the applicant, in writing, of the Secretary's decision on the application. The notice must be given within 28 days after receiving the application.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 36—When is residential care provided on an extra service basis?

36-1 Provision of residential care on extra service basis

(1) Residential care is provided, in respect of a *place, to a care recipient on an extra service basis on a particular day if:

(a) the care is provided in accordance with the conditions applying to the *extra service status for the residential care service, or the *distinct part of a residential care service, through which the care is provided; and

(b) there is in force on that day an *extra service agreement, between the care recipient and the approved provider providing the service, that was entered into in accordance with section 36-2 and that meets the requirements of section 36-3; and

(c) the care meets any other requirements set out in the Extra Service Principles.

(2) For the purposes of paragraph (1)(b), a care recipient is taken to have entered an *extra service agreement if the care recipient has entered an agreement which contains the provisions specified in section 36-3.

Example: These conditions may be included in a *resident agreement.

36-2 Extra service agreements not to be entered under duress etc.

(1) An *extra service agreement must not be entered into in circumstances under which the care recipient is subject to duress, misrepresentation, or threat of disadvantage or detriment.

(2) An *extra service agreement must not be entered into in a way that contravenes the Extra Service Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) Without limiting subsection (1), a threat to cease providing care to a care recipient through a particular residential care service unless the care recipient signs an *extra service agreement is taken to be a threat of disadvantage for the purposes of that subsection.

36-3 Contents of extra service agreements

(1) An *extra service agreement must specify:

(a) the level of the extra service amount (within the meaning of section 58-5) in respect of the *place concerned; and

(b) how the extra service amount may be varied; and

(c) the standard of the accommodation, services and food to be provided to the care recipient.

Note: The notice under subsection 34-1(3) will specify minimum standards, but care recipients and approved providers may make agreements to provide more than the minimum.

(2) An *extra service agreement must also:

(a) contain the provisions (if any) set out in the Extra Service Principles; and

(b) deal with the matters (if any) specified in the Extra Service Principles.

36-4 Additional protection for existing residents

An *extra service agreement entered into with a care recipient who was being provided with care in a residential care service, or a *distinct part of a residential care service, immediately before *extra service status became effective under Division 32 must provide that the care recipient may terminate the agreement:

(a) at any time during the 3 months after the date of effect of the agreement; and

(b) without penalty of any kind.

Note: Under paragraph 56-1(f), an approved provider has a responsibility to comply with this Division. A failure to comply may lead to sanctions being imposed under Part 4.4.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 2.6—Certification of residential care services

Division 37—Introduction

37-1 What this Part is about

An approved provider can only charge *accommodation bonds or receive concessional resident supplements in respect of a residential care service if the service has been certified under this Part.

Table of Divisions

37-2 The Certification Principles

The *certification of residential care services is also dealt with in the Certification Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Certification Principles are made by the Minister under section 96-1.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 38—How is a residential care service certified?

38-1 Certification of residential care services

(1) An application may be made to the Secretary in accordance with section 38-2 for *certification of a residential care service.

(2) The Secretary must, in writing, *certify the residential care service if:

(a) the Secretary is satisfied, having considered the application in accordance with sections 38-3 and 38-4 (if applicable), that the service should be certified; and

(b) the application is accompanied by the application fee (see section 38-7).

Note 1: *Certification of a residential care service may affect entitlement to a Commonwealth benefit under Part VAB or VAC of the *National Health Act 1953*, and may reduce an amount of *residential care subsidy that would otherwise be payable (see section 43-7).

Note 2: Rejections of applications are reviewable under Part 6.1.

38-2 Applications for certification

(1) The application for *certification of a residential care service must be made by the approved provider who has the allocation under Part 2.2 for the *places included in the residential care service for which certification is sought.

(2) The application must:

(a) be in a form approved by the Secretary; and

(b) be accompanied by any documents that are required by the Secretary to be provided; and

(c) meet any requirements specified in the Certification Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) If residential care is provided at different locations through the same residential care service, only one application may be made for the certification of the service (in respect of all those locations).

(4) An application cannot be made:
   (a) for certification of a part of a residential care service; or
   (b) for certification of more than one residential care service, even if the residential care services are conducted in the same premises.

38-3 Suitability of residential care service for certification

(1) In considering an application, the Secretary must have regard to:
   (a) the standard of the buildings and equipment that are being used by the residential care service in providing residential care; and
   (b) the standard of the residential care being provided by the residential care service; and
   (c) if the applicant has been a provider of *aged care—its conduct as such a provider, and its compliance with its responsibilities as such a provider and its obligations arising from the receipt of any payments from the Commonwealth for providing aged care; and
   (d) any other matters specified in the Certification Principles.

(2) The reference in paragraph (1)(c) to aged care includes a reference to any care for the aged, whether provided before or after the commencement of this section, in respect of which any payment was or is payable under a law of the Commonwealth.

(3) The Certification Principles may specify the matters to which the Secretary must have regard in considering any of the matters set out in paragraphs (1)(a), (b) and (c).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

38-4 Secretary may require service to be assessed

(1) For the purpose of deciding whether to *certify a residential care service, the Secretary may require the service to be assessed by a person or body authorised by the Secretary.

(2) The assessment may relate to any aspect of the residential care service that the Secretary considers relevant to the suitability of the service for *certification.

38-5 Requests for further information

(1) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the further information:

(a) within the period specified in the notice; or

(b) if no period is specified in the notice—within 14 days after receiving the notice.

(2) The application is taken to be withdrawn if the applicant does not give the further information within whichever of those periods applies.

Note: The period for giving the further information can be extended—see section 96-7.

(3) The notice must contain a statement setting out the effect of subsection (2).

38-6 Notification of Secretary's determination

(1) The Secretary must notify the applicant, in writing, whether the residential care service has been *certified. The notice must be given:

(a) within 90 days of receiving the application; or

(b) if the Secretary has requested further information under section 38-5—within 90 days after receiving the information.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) If the Secretary decides to *certify the residential care service, the notice must include statements setting out:

(a) when the certification takes effect; and

(b) how the certification can be reviewed (see section 39-4); and

(c) when the certification ceases to have effect (see Division 39); and

(d) the consequences of failure by the approved provider to comply with the responsibilities relating to *accommodation bonds set out in Division 57, in particular, that such a failure may lead to the revocation or suspension under Part 4.4 of the certification of the residential care service; and

(e) such other matters as are specified in the Certification Principles.

38-7 Application fee

(1) The Certification Principles may specify:

(a) the application fee; or

(b) the way the application fee is to be worked out.

(2) The amount of any application fee:

(a) must be reasonably related to the expenses incurred or to be incurred by the Commonwealth in relation to the application; and

(b) must not be such as to amount to taxation.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 39—When does certification cease to have effect?

39-1 Certifications ceasing to have effect

The *certification of a residential care service ceases to have effect if any of the following happens:

(a) the certification lapses under section 39-2;

(b) the certification is revoked under section 39-3 or 39-5;

(c) the certification is revoked or suspended under Part 4.4;

(d) if the Certification Principles specify that a certification ceases to have effect on the occurrence of a particular event—that event occurs.

39-2 Lapse of certification on change of location of residential care service

The certification of a residential care service lapses if, after the residential care service has been *certified, there is a change in the location at which residential care is provided through the service.

39-3 Revocation of certification

(1) The Secretary must revoke the *certification of a residential care service if:

(a) the Secretary is satisfied that the service has ceased to be suitable for certification; or

(b) the Secretary is satisfied that the approved provider's application for certification of the service contained information that was false or misleading in a material particular.

Note 1: *Certification may also be revoked as a sanction under Part 4.4.

Note 2: Revocations of *certifications are reviewable under Part 6.1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) Before deciding to revoke the *certification, the Secretary must notify the approved provider that revocation is being considered. The notice must be in writing and must:

(a) include the Secretary's reasons for considering the revocation; and

(b) invite the approved provider to make submissions, in writing, to the Secretary within 28 days after receiving the notice; and

(c) inform the approved provider that if no submission is made within that period, any revocation will take effect on the day after the last day for making submissions.

(3) In deciding whether to revoke the certification, the Secretary must:

(a) consider any submissions given to the Secretary within that period; and

(b) consider any review of the certification under section 39-4.

(4) The Secretary must notify the approved provider, in writing, of the decision.

(5) The notice must be given to the approved provider within 28 days after the end of the period for making submissions. If the notice is not given within this period, the Secretary is taken to have decided not to revoke the certification.

(6) A revocation takes effect:

(a) if no submission was made under subsection (4)—on the day after the last day for making submissions; or

(b) if such a submission was made—7 days after the day on which the notice under subsection (4) was given.

39-4 Review of certification

(1) The Secretary may, at any time, review the *certification of a residential care service.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) The Secretary must give notice, in writing, to the approved provider of the review at least 5 *business days before the review commences.

(3) For the purposes of the review, the Secretary may require the residential care service to be assessed by a person or body authorised by the Secretary.

(4) The assessment may relate to any aspect of the residential care service that the Secretary considers relevant to the ongoing suitability of the service for *certification.

(5) The Secretary must, within 28 days after completing the review, notify the approved provider, in writing, of the result of the review.

39-5 Revocation of certification on request of approved provider

(1) The Secretary must revoke the *certification of a residential care service if the approved provider who has the allocation under Part 2.2 for the *places included in the residential care service requests the Secretary in writing to revoke the certification.

(2) The request must be given to the Secretary:
  (a) at least 60 days before the day on which the revocation is requested to take effect; or
  (b) at or before such other later time as is determined by the Secretary in accordance with any requirements specified in the Certification Principles.

(3) The Secretary must notify the approved provider of the revocation. The notice must be in writing and must be given to the approved provider at least 14 days before the day on which the revocation is to take effect.

(4) The revocation has effect on the day requested, unless another day is specified in the notice under subsection (3).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(5) The revocation is subject to such conditions (if any) as are specified in the notice.

Note: Decisions to impose conditions on revocations under this section are reviewable under Part 6.1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 3—Subsidies

Division 40—Introduction

40-1 What this Chapter is about

The Commonwealth pays subsidies to approved providers for *aged care that has been provided. These subsidies are:

- *residential care subsidy (see Part 3.1);
- *community care subsidy (see Part 3.2);
- *flexible care subsidy (see Part 3.3).

A number of approvals and other decisions may need to have been made under Chapter 2 before a particular kind of payment can be made (see section 5-2). Receipt of payments under this Chapter gives rise to certain responsibilities, that are dealt with in Chapter 4.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 3.1—Residential care subsidy

Division 41—Introduction

41-1 What this Part is about

The *residential care subsidy is a payment by the Commonwealth to approved providers for providing residential care to care recipients.

Table of Divisions

41-2 The Residential Care Subsidy Principles

*Residential care subsidy is also dealt with in the Residential Care Subsidy Principles. The provisions in this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Residential Care Subsidy Principles are made by the Minister under section 96-1.

41-3 Meaning of *residential care*

(1) ***Residential care*** is personal care or nursing care, or both personal care and nursing care, that:

(a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(i) appropriate staffing to meet the nursing and personal care needs of the person; and

(ii) meals and cleaning services; and

(iii) furnishings, furniture and equipment for the provision of that care and accommodation; and

(b) meets any other requirements specified in the Residential Care Subsidy Principles.

(2) However, residential care does not include any of the following:

(a) care provided to a person in the person's private home;

(b) care provided in a hospital or in a psychiatric facility;

(c) care provided in a facility that primarily provides care to people who are not frail and aged.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 42—Who is eligible for residential care subsidy?

42-1 Eligibility for residential care subsidy

(1) An approved provider is eligible for *residential care subsidy in respect of a day if the Secretary is satisfied that, during that day:

(a) the approved provider holds an allocation of *places for residential care subsidy that is in force under Part 2.2 (not being a *provisional allocation); and

(b) the approved provider provides residential care to a care recipient in respect of whom an approval is in force under Part 2.3 as a recipient of residential care; and

(c) the residential care service through which the care is provided meets its *accreditation requirement (if any) applying at that time (see section 42-4).

Note 1: A care recipient can be taken to be provided with residential care while he or she is on *leave from that care (see section 42-2).

Note 2: If the care recipient's approval under Part 2.3 is not in force, subsidy will not be payable. (For example, the approval may have been given only for a limited period.)

(2) However, the approved provider is not eligible in respect of residential care provided to the care recipient during that day if:

(a) it is excluded because the approved provider exceeds the approved provider's allocation of *places for residential care subsidy (see section 42-7); or

(b) the approved provider stopped providing residential care to the person during that day; or

(c) subject to subsections (3) and (4), another approved provider would, but for this paragraph, also be eligible for *residential care subsidy in respect of residential care provided to the same care recipient during that day.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) Paragraph (2)(c) does not apply if the approved provider started providing residential care to the care recipient before the other approved provider.

(4) Paragraph (2)(c) does not apply if:

(a) the care recipient is on *leave under section 42-2 from the residential care service through which the approved provider provides residential care to the care recipient at a level that is not a *high level of residential care; and

(b) the care recipient's approval under Part 2.3 is not limited under subsection 22-2(3) so as to preclude any high level of residential care; and

(c) the other approved provider is providing to the care recipient, on a temporary basis, a high level of residential care; and

(d) the approved provider referred to in paragraph (a) is unable to provide that high level of residential care.

Note: Eligibility may also be affected by Division 7 (relating to a person's approval as a provider of aged care services) or Division 20 (relating to a person's approval as a recipient of residential care).

42-2 Leave from residential care services

(1) On each day during which a care recipient is on *leave under this section from a residential care service, the care recipient is taken, for the purposes of this Part (other than section 42-3), to be provided with residential care by the approved provider operating the residential care service.

(2) A care recipient is on *leave under this section from a residential care service on all the days of any period during which the care recipient attends a hospital for the purpose of receiving hospital treatment.

Note: Attending a hospital for a period of *extended hospital leave may result in a lower *classification level applying to the care recipient (see section 44-4) for the purpose of working out the amount of subsidy.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) A care recipient is on *leave under this section from a residential care service on a day if:

(a) during the whole of that day, the care recipient is absent from the residential care service; and

(b) the care recipient does not, during that day, attend a hospital for the purpose of receiving hospital treatment; and

(c) the number of days on which the care recipient has previously been on leave under this subsection, during the current financial year, is less than 52.

Note: If a care recipient is taken not to have been provided with care because the maximum number of days has been exceeded, subsidy will not be payable in respect of those days. However, the care recipient may agree to pay a fee to the approved provider to reserve the care recipient's *place in the service. The maximum amount in such a case is set by section 58-6.

(4) Despite subsections (2) and (3), a care recipient cannot be on *leave under this section from a residential care service during any period during which the residential care in question would have been *respite care.

42-3 Working out periods of leave

(1) In working out the days on which a care recipient is on *leave under section 42-2:

(a) include the day on which the period commenced; and

(b) do not include the day on which the approved provider recommenced, or commenced, providing residential care to the care recipient.

Note: Absences that do not include an overnight absence from a residential care service are not counted as *leave because of paragraph (b).

(2) Subject to subsection (3), a care recipient cannot be on *leave under section 42-2 from a residential care service before he or she *enters the service.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) A care recipient may be on leave under section 42-2 on the days during the period starting on the later of:

(a) the day on which he or she was notified that there was a vacancy in the residential care service in question; or

(b) the day that is 7 days, or such other period as is specified in the Residential Care Subsidy Principles, before the day on which the person *enters the residential care service;

and ending on the day of entry.

42-4 Accreditation requirement

(1) On or after the *accreditation day, a residential care service meets its accreditation requirement at all times during which:

(a) there is in force an accreditation of the service by an *accreditation body; or

(b) there is in force a determination under section 42-5 that the service is taken, for the purposes of this Division, to meet its accreditation requirement.

(2) The ****accreditation day*** is:

(a) the day specified in the Residential Care Subsidy Principles; or

(b) if no such day is specified in the Residential Care Subsidy Principles—1 January 2001.

(3) Subject to subsection (6), a residential care service meets its accreditation requirement at all times during the application period if the approved provider conducting the service had, before the start of the application period, applied to an *accreditation body for accreditation of the service.

(4) The ***application period*** is the period starting:

(a) on the day specified in the Residential Care Subsidy Principles; or

(b) if no such day is specified in the Residential Care Subsidy Principles—1 January 2000;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

and finishing at the end of the day before the *accreditation day.

(5) The Residential Care Subsidy Principles may specify a day, occurring before the *accreditation day, on and after which all residential care services must comply with standards, or other requirements, set out in those Principles in order to meet their *accreditation requirements.

(6) A residential care service does not meet its accreditation requirement on a particular day if:

(a) the day is a day specified in the Residential Care Subsidy Principles as mentioned in subsection (5), or a later day; and

(b) there is in force a determination by an *accreditation body that the service does not comply with the standards specified in respect of that specified day.

42-5 Determinations allowing for exceptional circumstances

(1) The Secretary may determine, in accordance with the Residential Care Subsidy Principles, that a residential care service is taken, for the purposes of this Division, to meet its *accreditation requirement. However, the Secretary must first be satisfied that exceptional circumstances apply to the service.

Note: Refusals to make determinations are reviewable under Part 6.1.

(2) The following are examples of the matters that the Residential Care Subsidy Principles may require the Secretary to take into account:

(a) the reasons for a residential care service not meeting the standards required for accreditation;

(b) the action that the approved provider conducting a residential care service must take for the service to meet those standards;

(c) the impact of a residential care service not meeting those standards on the residential care, accommodation and other services provided through the service to care recipients.

(3) The Secretary must not make a determination if:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) there is an immediate or severe risk to the safety or well-being of care recipients to whom residential care is being provided through the residential care service; or

(b) the approved provider has not applied for accreditation of the service; or

(c) a determination under this section has previously been made in relation to the service and the service has not subsequently met its *accreditation requirement as set out in section 42-4; or

(d) any circumstances specified in the Residential Care Subsidy Principles for the purposes of this paragraph apply.

(4) A determination ceases to be in force on the earlier of:

(a) the end of 6 months, or such shorter period as is specified in the determination, after the determination is made; or

(b) the occurrence of a specified event, if the determination so provides.

Note: Determinations specifying periods or events are reviewable under Part 6.1.

(5) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the applicant to give the further information within 28 days after receiving the notice.

(6) The application is taken to be withdrawn if the applicant does not give the further information within 28 days.

Note: The period for giving the further information can be extended—see section 96-7.

(7) The notice must contain a statement setting out the effect of subsection (6).

(8) The Secretary must notify the approved provider, in writing, of the Secretary's decision on whether to make the determination. If the Secretary makes the determination, the notice must inform the approved provider of:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the period at the end of which; and
(b) any event on the occurrence of which;

the determination will cease to be in force.

(9) A notice under subsection (8) must be given to the approved provider:
(a) within 28 days after receiving the application; or
(b) if the Secretary has requested further information under subsection (5)—within 28 days after receiving the information.

42-6 Revocation of determinations

(1) The Secretary must revoke a determination under section 42-5 if satisfied that:
(a) the exceptional circumstances that applied to the residential care service in question at the time the determination was made no longer apply; or
(b) circumstances have changed such that one or more of the circumstances referred to in subsection 42-5(3) now applies.

Note: Revocations of determinations are reviewable under Part 6.1.

(2) The Secretary must, in writing, notify the approved provider conducting the service of the Secretary's decision to revoke the determination. The notice must be given within 7 days after the decision is made.

42-7 Exceeding the number of places for which there is an allocation

(1) For the purposes of a person's eligibility for *residential care subsidy, residential care provided to a particular care recipient on a particular day is excluded if:
(a) the number of care recipients provided with residential care by the approved provider during that day exceeds the number

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

of *places included in the approved provider's allocation of places for residential care subsidy; and

(b) the Secretary decides, in accordance with subsection (2), that the residential care provided to that particular care recipient on that day is to be excluded.

(2) In deciding under paragraph (1)(b) which residential care is to be excluded, the Secretary must:

(a) make the number of exclusions necessary to ensure that the number of *places for which *residential care subsidy will be payable does not exceed the number of places included in the approved provider's allocation of places for residential care subsidy; and

(b) exclude the residential care in the reverse order in which the care recipients *entered the residential care service for the provision of residential care.

42-8 Notice of refusal to pay residential care subsidy

If:

(a) an approved provider has claimed *residential care subsidy in respect of a person; and

(b) the approved provider is not eligible for residential care subsidy in respect of that person;

the Secretary must notify the approved provider, in writing, accordingly.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 43—How is residential care subsidy paid?

43-1 Payment of residential care subsidy

(1) Residential care subsidy is payable by the Commonwealth to an approved provider in respect of each *payment period (see section 43-2) during which the approved provider is eligible under section 42-1. However, it is not payable in respect of any days during that period on which the approved provider is not eligible.

(2) Residential care subsidy is separately payable by the Commonwealth in respect of each residential care service through which the approved provider provides residential care.

(3) The Secretary may, in accordance with the Residential Care Subsidy Principles, deduct from the amount of residential care subsidy otherwise payable in respect of a *payment period such of the following amounts as apply to the residential care service in question:

(a) deductions for fees (see section 43-5);

(b) *capital repayment deductions (see section 43-6);

(c) deductions for additional recurrent funding (see section 43-7);

(d) non-compliance deductions (see section 43-8).

43-2 Meaning of *payment period*

A ***payment period*** is:

(a) a calendar month; or

(b) such other period as is set out in the Residential Care Subsidy Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

43-3 Advances

(1) Subject to subsection 43-4(2), *residential care subsidy is payable by the Commonwealth in advance, in respect of a *payment period, at such times as the Secretary thinks fit.

(2) The Secretary must work out the amount of an advance to be paid to an approved provider in respect of the first *payment period or the second payment period for a residential care service by estimating the amount of *residential care subsidy that will be payable for the days in that period.

(3) The Secretary must work out the amount of an advance to be paid to an approved provider in respect of subsequent *payment periods for a residential care service by:

(a) estimating the amount of *residential care subsidy that will be payable (taking into account any deductions under subsection 43-1(3)) for the days in the period; and

(b) increasing or reducing that amount to make any adjustments that the Secretary reasonably believes are necessary to take account of likely underpayments or overpayments in respect of advances previously paid under this section.

(4) The amounts of advances must be worked out in accordance with any requirements set out in the Residential Care Subsidy Principles.

(5) The Secretary may, in deciding whether to reduce the amount of an advance under paragraph (3)(b), take into account the likelihood of the Commonwealth's right to recover a particular overpayment being waived under section 95-6.

Note: Subsection (5) allows the Secretary to take account of waivers in respect of overpayments caused, for example, by some cases of incorrect determinations of the *ordinary incomes of care recipients.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

43-4 Claims for residential care subsidy

(1) For the purpose of obtaining payment of *residential care subsidy in respect of a residential care service through which an approved provider provides residential care, the approved provider must, as soon as practicable after the end of each *payment period, give to the Secretary:

(a) a claim, in the form approved by the Secretary, for residential care subsidy that is payable in respect of the residential care service for that payment period; and

(b) any information relating to the claim that is stated in the form to be required, or that the Secretary requests; and

(c) copies of any documents relating to the claim, or to the payment of *residential care subsidy, that are stated in the form to be required, or that the Secretary requests.

(2) An advance of *residential care subsidy is not payable in respect of a *payment period for the residential care service if the approved provider has not given to the Secretary under subsection (1) a claim relating to the second last preceding payment period for the service.

Example: An advance of subsidy is not payable for March if the Secretary has not been given a claim for January of the same year (assuming the *payment periods are all calendar months—see section 43-2).

(3) Subsection (2) does not apply to the first *payment period or the second payment period for a residential care service.

(4) If all the places in a residential care service are transferred from one person to another, subsection (2) does not apply to the first 2 *payment periods for the residential care service that occur after the transfer took effect.

(5) If:

(a) apart from this subsection, the operation of paragraph (1)(c) would result in the acquisition of property from a person otherwise than on just terms; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the acquisition would be invalid because of paragraph (xxxi) of the Constitution;

the Commonwealth is liable to pay compensation of a reasonable amount to the person in respect of the acquisition.

43-5 Deductions for fees

The Secretary may, on behalf of the Commonwealth, enter into an agreement with an approved provider, under which:

(a) amounts equal to the fees payable by the approved provider for applications made under this Act are to be deducted from amounts of *residential care subsidy otherwise payable to the approved provider in respect of the residential care service specified in the agreement; and

(b) so far as amounts are so deducted, the approved provider ceases to be liable to the Commonwealth for payment of the fees.

43-6 Capital repayment deductions

(1) Capital repayment deductions apply in respect of a residential care service if:

(a) the approved provider is granted *extra service status under Division 32 in respect of the service, or in respect of a *distinct part of the service; and

(b) the Commonwealth has previously made capital payments in respect of the service, whether or not the payments were made to that approved provider; and

(c) the payments have not been repaid to the Commonwealth.

The capital repayment deductions are applied in accordance with an agreement entered into under this section.

(2) The Secretary may, on behalf of the Commonwealth, enter into an agreement with the approved provider, under which:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) amounts equal to the capital payments made in respect of the service are to be deducted from amounts of *residential care subsidy otherwise payable to the approved provider in respect of the service; and

(b) so far as amounts are so deducted, the approved provider ceases to be liable to the Commonwealth for repayment in respect of the capital payments.

Note: Entering into such an agreement may be a condition of the granting of *extra service status (see paragraph 32-8(5)(b)).

(3) However, only a proportion of the amounts equal to the capital payments made in respect of the service are to be deducted under the agreement if:

(a) *extra service status is granted only in respect of a *distinct part of the service; or

(b) some or all of the capital payments were made more than 5 years before the first of the deductions is to be made; or

(c) the circumstances (if any) specified in the Residential Care Subsidy Principles apply.

The proportion is to be worked out in accordance with the Residential Care Subsidy Principles.

(4) The agreement must provide for the deductions to be completed within 3 years after the making of the first deduction.

(5) In this section:

capital payment means:

(a) a *residential care grant; or

(b) financial assistance by way of a grant under Part II, or Division 3 of Part III, of the *Aged or Disabled Persons Care Act 1954*; or

(c) a grant of a Commonwealth benefit under Part VAB or VAC of the *National Health Act 1953*; or

(d) a grant under the *Aged or Disabled Persons Hostels Act 1972*; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(e) a grant approved on or after 1 July 1989 under the program known as the Residential Aged Care Upgrading Program; or

(f) capital funding approved on or after 1 July 1989 under the program known as the Small Homes Capital Funding Initiative; or

(g) a payment of a kind specified in the Residential Care Subsidy Principles.

43-7 Deductions for additional recurrent funding

(1) Deductions for additional recurrent funding apply in respect of a residential care service that is *certified if an amount of Commonwealth benefit is payable, to a person other than the approved provider, under Part VAB or VAC of the *National Health Act 1953* in respect of:

(a) eligible premises (within the meaning of Part VAB of that Act) that correspond to the residential care service; or

(b) an eligible nursing home (within the meaning of Part VAC of that Act) that corresponds to the residential care service.

(2) The amount of the deductions for additional recurrent funding in respect of a *payment period is the sum of all the amounts of Commonwealth benefit referred to in subsection (1) that the Commonwealth paid during that payment period.

43-8 Non-compliance deductions

(1) Subject to subsection (2), non-compliance deductions apply in respect of a residential care service if conditions, to which the allocation of the *places included in the service are subject under section 14-5 or 14-6, relating to:

(a) the proportion of care to be provided to *concessional residents and *assisted residents; or

(b) the proportion of care to be provided to recipients of *respite care;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

have not been met.

(2) The Residential Care Subsidy Principles may specify circumstances in which non-compliance deductions do not apply even if the conditions referred to in subsection (1) have not been met.

(3) The Secretary must notify the approved provider conducting a residential care service if, in respect of a *payment period, non-compliance deductions apply in respect of the residential care service. The notice must be in writing and must set out why non-compliance deductions apply.

(4) The amount of a non-compliance deduction is the amount worked out in accordance with the Residential Care Subsidy Principles.

Note: Non-compliance deductions do not affect the maximum fees payable by residents (see Division 58).

43-9 Recovery of overpayments

This Division does not affect the Commonwealth's right to recover overpayments under Part 6.5.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 44—What is the amount of residential care subsidy?

44-1 What this Division is about

Amounts of *residential care subsidy payable under Division 43 to an approved provider are worked out under this Division in respect of each residential care service. The amount in respect of a residential care service is determined by adding together amounts worked out, using the residential care subsidy calculator in section 44-2, in respect of individual care recipients in the service.

Table of Subdivisions

Subdivision 44-A—Working out the amount of residential care subsidy

44-2 Amount of residential care subsidy

(1) The amount of *residential care subsidy payable to an approved provider for a residential care service in respect of a *payment period is the amount worked out by adding together the amounts of residential care subsidy for each care recipient:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) to whom the approved provider provided residential care through the residential care service during the period; and

(b) in respect of whom the approved provider was eligible for residential care subsidy during the period.

(2) This is how to work out the amount of *residential care subsidy for a care recipient in respect of the *payment period.

Residential care subsidy calculator

Step 1. Work out the ***basic subsidy amount*** using Subdivision 44-B.

Step 2. Add to this amount the amounts of any ***primary supplements*** worked out using Subdivision 44-C.

Step 3. Subtract the amounts of any ***reductions in subsidy*** worked out using Subdivision 44-D.

Step 4. Subtract any further reduction worked out by applying the ***income test*** under Subdivision 44-E.

Step 5. Add the amounts of any ***other supplements*** worked out using Subdivision 44-F.

The result is the ***amount of residential care subsidy*** for the care recipient in respect of the payment period.

Subdivision 44-B—The basic subsidy amount

44-3 The basic subsidy amount

(1) The basic subsidy amount for the care recipient in respect of the *payment period is the sum of all the basic subsidy amounts for the days during the period on which the care recipient was provided

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

with residential care through the residential care service in question.

(2) The basic subsidy amount for a day is the amount determined by the Minister in writing.

(3) The Minister may determine different amounts (including nil amounts) based on any one or more of the following:

(a) the *classification levels for care recipients being provided with residential care;

(b) whether the residential care being provided is *respite care;

(c) the times at which a care recipient *entered a residential care service;

(d) the State or Territory in which a residential care service is located;

(e) any other matters specified in the Residential Care Subsidy Principles;

(f) any other matters determined by the Minister.

44-4 Effect on classification levels of long periods in hospital

(1) For the purposes only of working out the basic subsidy amount, the care recipient's *classification level for a particular day is taken to be reduced, as provided in subsection (2) or (3), if, on that day:

(a) the care recipient is on *extended hospital leave; and

(b) the care recipient's classification level at the time the care recipient started that period of leave (his or her ***normal classification level***) is not the *lowest applicable classification level.

(2) If the care recipient's normal classification level is one level above the *lowest applicable classification level, the care recipient's classification level for that day is taken to be reduced to the lowest applicable classification level.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) If the care recipient's normal *classification level is 2 or more levels above the *lowest applicable classification level, the care recipient's classification level for that day is taken to be reduced by 2 classification levels.

Subdivision 44-C—Primary supplements

44-5 Primary supplements

The primary supplements for the care recipient under step 2 of the residential care subsidy calculator in section 44-2 are such of the following supplements as apply to the care recipient in respect of the *payment period:

(a) the concessional resident supplement (see section 44-6);
(b) the respite supplement (see section 44-12);
(c) the oxygen supplement (see section 44-13);
(d) the enteral feeding supplement (see section 44-14);
(e) any additional primary supplements (see section 44-16).

Note: The supplements under this Subdivision are taken into account in applying the income test under Subdivision 44-E. (The supplements under Subdivision 44-F are not taken into account in applying the income test.)

44-6 The concessional resident supplement

(1) The concessional resident supplement for the care recipient in respect of the *payment period is the sum of all the concessional resident supplements for the days during the period on which:

(a) the care recipient was provided with residential care (other than *respite care) through the residential care service in question; and
(b) the care recipient was eligible for a *concessional resident supplement.

(2) The care recipient is eligible for a concessional resident supplement on a particular day if, on that day:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) subject to subsection (3), the care recipient's *classification level is not the *lowest applicable classification level; and

(b) the care recipient is a *concessional resident or an *assisted resident; and

(c) the residential care service is *certified; and

(d) the residential care provided to the care recipient is not provided on an extra service basis for the purposes of Division 36.

However, the care recipient must have *entered the residential care service after the residential care service was certified.

(3) Paragraph (2)(a) is not to be taken to affect a care recipient's eligibility for concessional resident supplement on a particular day if, on that day, the care recipient's classification level is the *lowest applicable classification level only because of the operation of section 44-4 (which deals with long periods in hospital).

(4) The concessional resident supplement for a particular day is the amount determined by the Minister in writing.

(5) Subject to subsection (6), the Minister may determine different amounts (including nil amounts) based on any one or more of the following:

(a) the amount of *accommodation bond paid by a care recipient for *entry to a residential care service;

(b) the value of assets held by a care recipient;

(c) whether the residential care with which a care recipient is provided is *respite care;

(d) any other matters specified in the Residential Care Subsidy Principles.

(6) The Minister must determine lower amounts in respect of *assisted residents than the Minister determines in respect of *concessional residents.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

44-7 Meaning of *concessional resident*

(1) A person is a ***concessional resident*** if the person is being provided with residential care (other than *respite care) through a residential care service and, at the applicable time under subsection (2):

(a) the person was receiving an *income support payment; and

(b) the person had not been a *homeowner for 2 years or more, or owned a home that was occupied by:

(i) the *partner or a *dependent child of the person; or

(ii) a carer, or a *close relation, of the person who had occupied the home for the past 5 years and, at the applicable time, was eligible to receive an income support payment; and

(c) the value of the person's assets was less than:

(i) the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 2.5 times the *basic age pension amount at the time in question; or

(ii) such other amount as is specified in, or worked out in accordance with, the Residential Care Subsidy Principles.

Note: A *concessional resident cannot be required to pay an accommodation bond—see section 57-12.

(2) The applicable time for the purposes of subsection (1) is:

(a) if:

(i) the person had, within 28 days prior to *entry to the residential care service, been provided with residential care through another residential care service; and

(ii) the person had paid an *accommodation bond for entry to that other service;

the time that was, under this subsection, the applicable time in respect of that other service; or

(b) in any other case—the time at which the person entered the residential care service.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) A person is also a ***concessional resident*** if a determination is in force under section 57-14 in respect of the person.

44-8 Meaning of *assisted resident*

(1) A person is an ***assisted resident*** if the person is being provided with residential care (other than *respite care) through a residential care service and, at the applicable time under subsection (2):

(a) the person was receiving an *income support payment; and

(b) the person had not been a *homeowner for 2 years or more, or owned a home that was occupied by:

(i) the *partner or a *dependent child of the person; or

(ii) a carer, or a *close relation, of the person who had occupied the home for the past 5 years and, at the applicable time, was eligible to receive an income support payment; and

(c) the value of the person's assets was less than:

(i) the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 4 times the *basic age pension amount at the time in question; or

(ii) such other amount as is specified in, or worked out in accordance with, the Residential Care Subsidy Principles;

but more than:

(iii) the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 2.5 times the *basic age pension amount at the time in question; or

(iv) such other amount as is specified in, or worked out in accordance with, the Residential Care Subsidy Principles.

Note: An *assisted resident may be required to pay an accommodation bond.

(2) The applicable time for the purposes of subsection (1) is:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) if:

(i) the person had, within 28 days prior to *entry to the residential care service, been provided with residential care through another residential care service; and

(ii) the person had paid an *accommodation bond for entry to that other service;

the time that was, under this subsection, the applicable time in respect of that other service; or

(b) in any other case—the time at which the person entered the residential care service.

44-9 Person taken not to be a concessional resident or an assisted resident if asset information not provided

If:

(a) a care recipient is provided with residential care through a residential care service at a particular time; and

(b) at that time, the care recipient has not given to the approved provider conducting the residential care service sufficient information about the care recipient's assets for the approved provider to determine whether the care recipient is an *assisted resident or a *concessional resident;

the person is taken, for the purposes of this Act, not to be a concessional resident or an assisted resident at that time.

44-10 How to work out the value of a person's assets

(1) Subject to this section, the value of a person's assets for the purposes of section 44-7 or 44-8 is to be worked out in accordance with the Residential Care Subsidy Principles.

(2) If the care recipient is a *homeowner, the value of the home owned by the care recipient is to be disregarded in working out the value of the care recipient's assets if, at the time of the care recipient's *entry to the residential care service, the home was occupied by:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the *partner or a *dependent child of the care recipient; or

(b) a carer or a *close relation of the care recipient, who:

(i) had occupied the home for the past 5 years; and

(ii) was eligible to receive an *income support payment at the time of the care recipient's entry to the residential care service.

(3) The value of the assets of a person who is a *member of a couple is taken to be 50% of the sum of:

(a) the value of the person's assets; and

(b) the value of the assets of the person's *partner.

(4) A reference to the value of the assets of a person is, in relation to an asset owned by the person jointly or in common with one or more other people, a reference to the value of the person's interest in the asset.

44-11 Definitions relating to *concessional residents* and *assisted residents*

(1) In sections 44-7, 44-8, and 44-10 and in this section:

close relation, in relation to a person, means:

(a) the father or mother of the person; or

(b) a sister, brother or child of the person; or

(c) a person included in a class of persons specified in the Residential Care Subsidy Principles.

dependent child has the meaning given by subsection (2).

homeowner has the meaning given by the Residential Care Subsidy Principles.

member of a couple means:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) a person who is legally married to another person, and is not living separately and apart from the person on a permanent basis; or

(b) a person who lives with another person in a marriage-like relationship, although not legally married to the other person.

partner, in relation to a person, means the other *member of a couple of which the person is also a member.

(2) A young person (see subsection (3)) is a ***dependent child*** of a person (in this subsection referred to as the ***adult***) if:

(a) the adult is legally responsible (whether alone or jointly with another person) for the day-to-day care, welfare and development of the young person; and

(b) the young person is not:

(i) in full-time employment; or

(ii) in receipt of a social security pension (within the meaning of the *Social Security Act 1991*) or a social security benefit (within the meaning of that Act); or

(iii) included in a class of people specified in the Residential Care Subsidy Principles.

(3) A reference in subsection (2) to a ***young person*** is a reference to any of the following:

(a) a person under 16 years of age;

(b) a person who:

(i) has reached 16 years of age, but is under 25 years of age; and

(ii) is receiving full-time education at a school, college or university;

(c) a person included in a class of people specified in the Residential Care Subsidy Principles.

(4) The reference in paragraph (2)(a) to care does not have the meaning given in the Dictionary in Schedule 1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

44-12 The respite supplement

(1) The respite supplement for the care recipient in respect of the *payment period is the sum of all the respite supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) the care recipient was eligible for a respite supplement.

(2) The care recipient is eligible for a respite supplement on a particular day if, on that day:

(a) the residential care provided through the residential care service:

(i) was provided as *respite care; and

(ii) meets any requirements specified in the Residential Care Subsidy Principles; and

(b) the care recipient's approval under Part 2.2 was not limited so as to preclude the provision of respite care; and

(c) the number of days on which the care recipient had previously been provided with residential care as respite care during the financial year in which the day occurred does not equal or exceed the number specified, for the purposes of this paragraph, in the Residential Care Subsidy Principles; and

(d) immediately before that day, the number of successive days on which the care recipient had been provided with residential care as respite care does not equal the number specified, for the purposes of this paragraph, in the Residential Care Subsidy Principles.

(3) The respite supplement for a particular day is the amount determined by the Minister in writing.

(4) The Minister may determine different amounts (including nil amounts) based on any one or more of the following:

(a) the different levels of care at which a care recipient may be assessed under section 22-4;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) whether a residential care service is *certified;

(c) whether a care recipient *enters a residential care service, for provision of *respite care, before or after the service is certified;

(d) whether a care recipient continues to be provided with residential care through a residential care service immediately after ceasing to be provided with *respite care through that service;

(e) whether a care recipient is a *member of a couple;

(f) any other matters specified in the Residential Care Subsidy Principles.

44-13 The oxygen supplement

(1) The oxygen supplement for the care recipient in respect of the *payment period is the sum of all the oxygen supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) a determination was in force under subsection (2) in relation to the care recipient; and

(c) the residential care provided through the residential care service included administering oxygen to the care recipient in circumstances of a kind specified in the Residential Care Subsidy Principles.

(2) The Secretary may determine that a care recipient is eligible for an oxygen supplement.

Note: Refusals to make determinations are reviewable under Part 6.1.

(3) In deciding whether to make a determination, the Secretary must comply with any requirements, and have regard to any matters, specified in the Residential Care Subsidy Principles.

(4) An approved provider that is providing, or is to provide, residential care to a care recipient may apply to the Secretary, in the form

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

approved by the Secretary, for a determination under subsection (2) in respect of the care recipient.

(5) The Secretary must notify the applicant, in writing, of the Secretary's decision on whether to make the determination. The notice must be given within 28 days after the decision is made.

(6) The oxygen supplement for a particular day is the amount:
  (a) determined by the Minister in writing; or
  (b) worked out in accordance with a method determined by the Minister in writing.

(7) The Minister may determine different amounts (including nil amounts) based on any matters determined by the Minister in writing.

44-14 The enteral feeding supplement

(1) The enteral feeding supplement for the care recipient in respect of the *payment period is the sum of all the enteral feeding supplements for the days during the period on which:
  (a) the care recipient was provided with residential care through the residential care service in question; and
  (b) a determination was in force under subsection (2) in relation to the care recipient; and
  (c) the residential care provided through the residential care service included providing enteral feeding to the care recipient in circumstances of a kind specified in the Residential Care Subsidy Principles.

(2) The Secretary may determine that a care recipient is eligible for an enteral feeding supplement.

Note: Refusals to make determinations are reviewable under Part 6.1.

(3) In deciding whether to make a determination, the Secretary must comply with any requirements, and have regard to any matters, specified in the Residential Care Subsidy Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(4) An approved provider that is providing, or is to provide, residential care to a care recipient may apply to the Secretary, in the form approved by the Secretary, for a determination under subsection (2) in respect of the care recipient.

(5) The Secretary must notify the applicant, in writing, of the Secretary's decision on whether to make the determination. The notice must be given within 28 days after the decision is made.

(6) The enteral feeding supplement for a particular day is the amount:
  (a) determined by the Minister in writing; or
  (b) worked out in accordance with a method determined by the Minister in writing.

(7) The Minister may determine different amounts (including nil amounts) based on any matters determined by the Minister in writing.

44-15 Requests for further information

(1) If the Secretary needs further information to determine an application under section 44-13 or 44-14, the Secretary may give to the applicant a notice requesting the further information:
  (a) within the period specified in the notice; or
  (b) if no period is specified in the notice—within 14 days after receiving the notice.

(2) The application is taken to be withdrawn if the applicant does not give the further information within whichever of those periods applies.

Note: The period for giving further information can be extended—see section 96-7.

(3) The notice must contain a statement setting out the effect of subsection (2).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

44-16 Additional primary supplements

(1) The Residential Care Subsidy Principles may provide for additional primary supplements.

(2) The Residential Care Subsidy Principles may specify, in respect of each such supplement, the circumstances in which the supplement will apply to a care recipient in respect of a *payment period.

(3) The Minister may determine in writing, in respect of each such supplement, the amount of the supplement, or the way in which the amount of the supplement is to be worked out.

Subdivision 44-D—Reductions in subsidy

44-17 Reductions in subsidy

The reductions in subsidy for the care recipient under step 3 of the residential care subsidy calculator in section 44-2 are such of the following reductions as apply to the care recipient in respect of the *payment period:

(a) the extra service reduction (see section 44-18);

(b) the adjusted subsidy reduction (see section 44-19);

(c) the compensation payment reduction (see section 44-20).

44-18 The extra service reduction

(1) The extra service reduction for the care recipient in respect of the *payment period is the sum of all the extra service reductions for days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) the care is provided in respect of a place that is an *extra service place (see Division 31), or the care is required, under a condition of a kind specified in paragraph 32-8(3)(b), to be provided on an extra service basis.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) The extra service reduction for a particular day is an amount equal to 25% of the daily rate of the extra service fee in force for the *place under Division 35.

44-19 The adjusted subsidy reduction

(1) The adjusted subsidy reduction for the care recipient in respect of the *payment period is the sum of all the adjusted subsidy reductions for days during the period on which:

(a) the care recipient is provided with residential care through the residential care service in question; and

(b) the residential care service, or the part of the residential care service through which the care is provided, is determined by the Minister in writing to be an adjusted subsidy residential care service.

(2) The adjusted subsidy reduction for a particular day is the amount determined by the Minister in writing.

(3) The Minister may determine different amounts based on any matters determined by the Minister in writing.

44-20 The compensation payment reduction

(1) The compensation payment reduction for the care recipient in respect of the *payment period is the sum of all compensation payment reductions for days during the period:

(a) on which the care recipient is provided with residential care through the residential care service in question; and

(b) that are covered by a compensation entitlement.

(2) For the purposes of this section, a day is covered by a compensation entitlement if:

(a) the care recipient is entitled to compensation under a judgment, settlement or reimbursement arrangement; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the compensation takes into account the cost of providing residential care to the care recipient on that day; and

(c) the application of compensation payment reductions to the care recipient for preceding days has not resulted in reductions in subsidy that, in total, exceed or equal the part of the compensation that relates, or is to be treated under subsection (5) or (6) as relating, to future costs of providing residential care.

(3) The compensation payment reduction for a particular day is an amount equal to the amount of *residential care subsidy that would be payable for the care recipient in respect of the *payment period if:

(a) the care recipient was provided with residential care on that day only; and

(b) this section and Subdivision 44-F did not apply.

(4) However, if:

(a) the compensation payment reduction arises from a judgment or settlement that fixes the amount of compensation on the basis that liability should be apportioned between the care recipient and the compensation payer; and

(b) as a result, the amount of compensation is less than it would have been if liability had not been so apportioned; and

(c) the compensation is not paid in a lump sum;

the amount of the compensation payment reduction under subsection (3) is reduced by the proportion corresponding to the proportion of liability that is apportioned to the care recipient by the judgment or settlement.

(5) If a care recipient is entitled to compensation under a judgment or settlement that does not take into account the future costs of providing residential care to the care recipient, the Secretary may, in accordance with the Residential Care Subsidy Principles, determine:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) that, for the purposes of this section, the judgment or settlement is to be treated as having taken into account the cost of providing that residential care; and

(b) the part of the compensation that, for the purposes of this section, is to be treated as relating to the future costs of providing residential care.

Note: Determinations are reviewable under Part 6.1.

(6) If:

(a) a care recipient is entitled to compensation under a settlement; and

(b) the settlement takes into account the future costs of providing residential care to the recipient; and

(c) the Secretary is satisfied that the settlement does not adequately take into account the future costs of providing residential care to the care recipient;

the Secretary may, in accordance with the Residential Care Subsidy Principles, determine the part of the compensation that, for the purposes of this section, is to be treated as relating to the future costs of providing residential care.

Note: Determinations are reviewable under Part 6.1.

(7) A determination under subsection (5) or (6) must be in writing and notice of it must be given to the care recipient.

(8) A reference in this section to the costs of providing residential care does not include a reference to an amount that is or may be payable as an *accommodation bond, except to the extent provided in the Residential Care Subsidy Principles.

(9) In this section, the following terms have the same meanings as in the *Health and Other Services (Compensation) Act 1995*:

compensation

compensation payer

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

judgment
reimbursement arrangement
settlement

Subdivision 44-E—The income test

44-21 The income test

(1) The income test for the care recipient under step 4 of the residential care subsidy calculator in section 44-2 is applied by working out the amount (if any) of the income tested reduction in respect of the *payment period.

(2) The income tested reduction in respect of the *payment period is the sum of all the *daily income tested reductions for days during the period on which the care recipient is provided with residential care through the residential care service in question.

(3) The *daily income tested reduction for a particular day is worked out as follows:

Income tested reduction calculator

Step 1. Work out the care recipient's *ordinary income on a yearly basis (see section 44-24).

Step 2. Work out the care recipient's *ordinary income free area (see section 44-26).

Step 3. If the care recipient's *ordinary income does not exceed the care recipient's *ordinary income free area, the income tested reduction is zero.

Step 4. If the care recipient's *ordinary income exceeds the care recipient's *ordinary income free area, the smallest of the

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

following amounts (rounded down to the nearest cent) is the **daily income tested reduction***:

(a) the amount equal to 25% of that excess (worked out on a per day basis);

(b) the amount worked out by subtracting the care recipient's *standard resident contribution from an amount equal to 3 times the *standard pensioner contribution;

(c) the amount worked out in respect of the *payment period using steps 1, 2 and 3 of the residential care subsidy calculator in section 44-2 (worked out on a per day basis).

Note: In some circumstances, a different *daily income tested reduction will apply under section 44-22 or 44-23.

44-22 Daily income tested reduction taken to be zero in some circumstances

(1) The *daily income tested reduction in respect of the care recipient is taken to be zero for each day, during the *payment period, on which one or more of the following applies:

(a) the care recipient was provided with *respite care;

(b) a determination was in force under subsection (2) in relation to the care recipient;

(c) the care recipient was included in a class of people specified in the Residential Care Subsidy Principles.

(2) The Secretary may, in accordance with the Residential Care Subsidy Principles, determine that the *daily income tested reduction in respect of the care recipient is to be taken to be zero.

Note: Refusals to make determinations are reviewable under Part 6.1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) The determination ceases to be in force at the end of the period (if any) specified in the determination.

Note: Decisions specifying periods are reviewable under Part 6.1.

(4) In deciding whether to make a determination, the Secretary must have regard to the matters specified in the Residential Care Subsidy Principles.

(5) Application may be made to the Secretary, in the form approved by the Secretary, for a determination under subsection (2) in respect of a care recipient. The application may be made by:

(a) the care recipient; or

(b) an approved provider that is providing, or is to provide, residential care to the care recipient.

(6) The Secretary must notify the care recipient and the approved provider, in writing, of the Secretary's decision on whether to make the determination. The notice must be given:

(a) if an application for a determination was made under subsection (5)—within 28 days after the application was made, or, if the Secretary requested further information in relation to the application, within 28 days after receiving the information; or

(b) if such an application was not made—within 28 days after the decision is made.

44-23 Effect on daily income tested reduction of failure to give requested information

(1) If the care recipient fails to give to the Secretary information, within the time specified in a notice under subsection 44-24(5), that the Secretary requests for the purpose of determining the care recipient's *ordinary income under section 44-24, the *daily income tested reduction in respect of the care recipient, for each day during the period:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) starting on the day on which the care recipient failed to give the information; and

(b) finishing at the end of the day before the day on which the care recipient gives to the Secretary the information requested;

is the amount worked out under subsection (4) of this section.

(2) If the care recipient elects, by a written notice given to the Secretary, not to give any information to the Secretary for the purpose of determining the care recipient's *ordinary income under section 44-24, the *daily income tested reduction in respect of the care recipient, for each day during the period:

(a) starting on the day on which the care recipient made the election; and

(b) finishing at the end of, the day before the day on which the care recipient gives to the Secretary a written notice revoking the election;

is the amount worked out under subsection (4) of this section.

(3) The Secretary must not, while the election is in force, request the care recipient to give information for the purpose of determining the care recipient's *ordinary income under section 44-24.

(4) For the purpose of subsections (1) and (2), the *daily income tested reduction in respect of the care recipient is whichever is the lesser of the following amounts (rounded down to the nearest cent):

(a) the amount worked out by subtracting the care recipient's *standard resident contribution from an amount equal to 3 times the *standard pensioner contribution;

(b) the amount worked out in respect of the *payment period using steps 1, 2 and 3 of the residential care subsidy calculator in section 44-2 (worked out on a per day basis).

Note: Care recipients are not obliged to give information to the Secretary. However, if they do not, the amount of residential care subsidy paid for their care may be reduced, and the amount of resident fees that they are liable to pay may therefore increase (see Division 58).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

44-24 The care recipient's ordinary income

(1) If the care recipient is not entitled to a *service pension or an *income support supplement, his or her *ordinary income is the amount the Secretary determines to be the amount that would be worked out as that ordinary income for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991*.

Note: Determinations are reviewable under Part 6.1.

(2) If the care recipient is entitled to a *service pension, his or her *ordinary income is the amount the Secretary determines to be the amount that would be worked out as that ordinary income for the purpose of applying Module D of the Rate Calculator at the end of section 41 of the *Veterans' Entitlements Act 1986*.

Note: Determinations are reviewable under Part 6.1.

(3) If the care recipient is entitled to an *income support supplement, his or her *ordinary income is the amount the Secretary determines to be the amount that would be worked out as the care recipient's adjusted income for the purpose of applying Module E of the Rate Calculator at the end of section 45X of the *Veterans' Entitlements Act 1986*.

Note: Determinations are reviewable under Part 6.1.

(4) The Residential Care Subsidy Principles may specify other amounts that are to be taken to be excluded from determinations under this section of the *ordinary incomes of specified kinds of care recipients.

(5) The Secretary may, by notice in writing, request one of more of the following:

(a) the care recipient;

(b) a person acting for or on behalf of the care recipient;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(c) any other person whom the Secretary believes has information that would assist the Secretary in making the determination;

to give to the Secretary such information as is specified in the notice for the purposes of making the determination.

Note: A person is not obliged to provide the information.

(6) A determination of a care recipient's *ordinary income takes effect on the day specified by the Secretary. The day may be earlier than the day on which the determination is made.

(7) The Secretary must notify, in writing, the care recipient of any determination of the care recipient's *ordinary income.

(8) The notice must include such matters as are specified in the Residential Care Subsidy Principles.

Note: The Secretary can delegate functions related to determinations of *ordinary income to the Secretary to the Department of Social Security and to the Secretary to the Department of Veterans' Affairs.

44-25 Ordinary income of war widows and war widowers

If:

(a) a person is receiving a pension under Part II or IV of the *Veterans' Entitlements Act 1986* at a rate determined under or by reference to subsection 30(1) of that Act; and

(b) the person is also receiving an *income support payment, the rate of which is reduced to take account of the pension referred to in paragraph (a);

the person's *ordinary income under section 44-24 is taken to be reduced by an amount equal to 2 times the difference between:

(c) the rate that would have been the rate of the income support payment if the person was not receiving the pension referred to in paragraph (a) but was receiving an additional amount of other income equal to the rate of that pension; and

(d) the rate of the income support payment.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

44-26 The care recipient's ordinary income free area

(1) If the care recipient is not entitled to a *service pension or an *income support supplement, his or her *ordinary income free area is the amount worked out by applying points 1064-E4 to 1064-E9 of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991*.

(2) If the care recipient is entitled to a *service pension, his or her *ordinary income free area is the amount worked out by applying points 41-D3 and 41-D4 of the Rate Calculator at the end of section 41 of the *Veterans' Entitlements Act 1986*.

(3) If the care recipient is entitled to an *income support supplement, his or her *ordinary income free area is the amount worked out by applying points 45X-E4 and 45X-E5 of the Rate Calculator at the end of section 45X of the *Veterans' Entitlements Act 1986*.

Subdivision 44-F—Other supplements

44-27 Other supplements

The other supplements for the care recipient under step 5 of the residential care subsidy calculator in section 44-2 are such of the following supplements as apply to the care recipient in respect of the *payment period:

(a) the pensioner supplement (see section 44-28);

(b) the viability supplement (see section 44-29);

(c) the hardship supplement (see section 44-30).

Note: The supplements under this Subdivision are not taken into account in applying the income test under Subdivision 44-E. (The supplements under Subdivision 44-C are taken into account in applying the income test.)

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

44-28 The pensioner supplement

(1) The pensioner supplement for the care recipient in respect of the *payment period is the sum of all the pensioner supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) the care recipient was eligible for a pensioner supplement.

(2) Subject to subsections (3), (5) and (6), the care recipient is eligible for a pensioner supplement on a particular day if, on that day, the care recipient:

(a) was receiving an *income support payment; or

(b) had a *dependent child; or

(c) was provided with *respite care; or

(d) was included in a class of people specified in the Residential Care Subsidy Principles.

(3) The care recipient is not eligible for a pensioner supplement on a particular day if:

(a) an *accommodation bond was paid, or agreed to be paid, by the care recipient for *entry to the residential care service; and

(b) at the time of the care recipient's entry, that accommodation bond exceeded the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 10 times the *basic age pension amount;

unless, on that day, the care recipient had a dependent child.

(4) For the purposes of subsection (3), if the care recipient elects under subsection 57-17(1) to pay an *accommodation bond by periodic payments, the amount of the accommodation bond is taken to be what would have been payable by the care recipient in accordance with Subdivision 57-D had the care recipient paid it as a lump sum.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(5) If the care recipient has failed to give to the Secretary information that the Secretary requests for the purpose of determining the care recipient's *ordinary income under section 44-24, the care recipient is not eligible for a pensioner supplement for any of the days during the period:

(a) starting on the day on which the care recipient failed to give to the Secretary that information; and

(b) finishing at the end of the day before the day on which the care recipient gave to the Secretary that information.

(6) If the care recipient has elected not to give any information to the Secretary for the purpose of determining the care recipient's *ordinary income under section 44-24, the care recipient is not eligible for a pensioner supplement for any of the days during the period:

(a) starting on the day on which the care recipient made the election; and

(b) finishing at the end of the day before the day on which the care recipient gives to the Secretary a written notice revoking the election.

Note: Care recipients are not obliged to give the Secretary the information. They can choose not to give the information, but, in addition to the effect this has on the income test (see section 44-23), a pensioner supplement will not apply.

(7) The pensioner supplement for a particular day is the amount determined by the Minister in writing.

(8) The Minister may determine different amounts (including nil amounts) based on any matters determined by the Minister in writing.

44-29 The viability supplement

(1) The viability supplement for the care recipient in respect of the *payment period is the sum of all the viability supplements for the days during the period on which:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) the service was the subject of a determination under subsection (2).

(2) The Secretary may, in accordance with the Residential Care Subsidy Principles, make a determination under this subsection in respect of a residential care service if satisfied that the determination should be made having regard to:

(a) how small the service is, and the size of the population that it serves; and

(b) the degree of isolation of the service's location; and

(c) any other matters specified in the Residential Care Subsidy Principles.

Note: Refusals to make determinations are reviewable under Part 6.1.

(3) The Secretary must not make a determination under subsection (2) in respect of a residential care service if the residential care service, or a *distinct part of the residential care service, has *extra service status.

(4) A person may apply to the Secretary, in the form approved by the Secretary, for a determination under subsection (2) in respect of a residential care service.

(5) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the further information:

(a) within the period specified in the notice; or

(b) if no period is specified in the notice—within 14 days after receiving the notice.

(6) The application is taken to be withdrawn if the applicant does not give the further information within whichever of those periods applies. The notice must contain a statement setting out the effect of this subsection.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: The period for giving the further information can be extended—see section 96-7.

(7) The Secretary must notify the person, in writing, of the Secretary's decision on whether to make the determination. The notice must be given:

(a) if an application for a determination was made under subsection (4)—within 28 days after the application was made, or, if the Secretary requested further information under subsection (5), within 28 days after receiving the information; or

(b) if such an application was not made—within 28 days after the decision is made.

(8) The viability supplement for a particular day is the amount:

(a) determined by the Minister in writing; or

(b) worked out in accordance with a method determined by the Minister in writing.

(9) The Minister may determine different amounts based upon:

(a) the number of *places included in residential care services; and

(b) the size of the population served by residential care services; and

(c) the degree of isolation of residential care services; and

(d) whether residential care services are, or could be, co-located with other residential care services; and

(e) any other matters determined by the Minister in writing.

44-30 The hardship supplement

(1) The hardship supplement for the care recipient in respect of the *payment period is the sum of all the hardship supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the care recipient was eligible for a hardship supplement.

(2) Subject to subsection (4), the care recipient is eligible for a hardship supplement on a particular day if:

(a) the Residential Care Subsidy Principles specify one or more classes of care recipients to be care recipients for whom paying the maximum daily amount of resident fees worked out under section 58-2 would cause financial hardship; and

(b) on that day, the care recipient is included in such a class.

(3) Subject to subsection (4), the care recipient is also eligible for a hardship supplement on a particular day if a determination is in force under section 44-31 in relation to the care recipient.

(4) The care recipient is not eligible for a hardship supplement in respect of a day if, on that day, the care recipient is being provided with residential care on an extra service basis (see Division 36).

(5) The hardship supplement for a particular day is the amount:

(a) determined by the Minister in writing; or

(b) worked out in accordance with a method determined by the Minister in writing.

(6) The Minister may determine different amounts (including nil amounts) based on any matters determined by the Minister in writing.

44-31 Determining cases of financial hardship

(1) The Secretary may, in accordance with the Residential Care Subsidy Principles, determine that the care recipient is eligible for a hardship supplement if the Secretary is satisfied that paying the maximum daily amount of resident fees worked out under section 58-2 would cause the care recipient financial hardship.

Note: Refusals to make determinations are reviewable under Part 6.1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) In deciding whether to make a determination under this section, and in determining a lesser amount, the Secretary must have regard to the matters (if any) specified in the Residential Care Subsidy Principles.

(3) A determination under this section ceases to be in force at the end of a specified period, or on the occurrence of a specified event, if the determination so provides.

Note: Decisions to specify periods or events are reviewable under Part 6.1.

(4) Application may be made to the Secretary, in the form approved by the Secretary, for a determination under this section. The application may be made by:

(a) the care recipient; or

(b) an approved provider who is providing, or is to provide, residential care to the care recipient.

(5) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the applicant to give the further information:

(a) within 28 days after receiving the notice; or

(b) within such other period as is specified in the notice.

(6) The application is taken to have been withdrawn if the information is not given within whichever of those periods applies. The notice must contain a statement setting out the effect of this subsection.

Note: The period for giving the further information can be extended—see section 96-7.

(7) The Secretary must notify the care recipient and the approved provider, in writing, of the Secretary's decision on whether to make the determination. The notice must be given:

(a) within 28 days after receiving the application; or

(b) if the Secretary has requested further information under subsection (5)—within 28 days after receiving the information.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(8) If the Secretary makes the determination, the notice must set out:
  (a) any period at the end of which; or
  (b) any event on the occurrence of which;
the determination will cease to be in force.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 3.2—Community care subsidy

Division 45—Introduction

45-1 What this Part is about

The *community care subsidy is a payment by the Commonwealth to approved providers for providing community care to care recipients.

Table of Divisions

45-2 The Community Care Subsidy Principles

*Community care subsidy is also dealt with in the Community Care Subsidy Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Community Care Subsidy Principles are made by the Minister under section 96-1.

45-3 Meaning of *community care*

(1) ***Community care*** is care consisting of a package of personal care services and other personal assistance provided to a person who is not being provided with residential care.

(2) The Community Care Subsidy Principles may specify care that:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) constitutes community care for the purposes of this Act; or
(b) does not constitute community care for the purposes of this Act.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 46—Who is eligible for community care subsidy?

46-1 Eligibility for community care subsidy

(1) An approved provider is eligible for *community care subsidy in respect of a day if the Secretary is satisfied that, during that day:

(a) the approved provider holds an allocation of *places for community care subsidy that is in force under Part 2.2 (other than a *provisional allocation); and

(b) there is in force a *community care agreement under which a care recipient approved under Part 2.3 in respect of community care is to be provided with community care by the approved provider, whether or not the care is to be provided on that day; and

(c) the approved provider provides the care recipient with such community care (if any) as is required under the community care agreement.

Note: A care recipient can be taken to be provided with community care while the provision of that care is temporarily suspended (see section 46-2).

(2) However, the approved provider is not eligible for *community care subsidy if the *community care agreement is excluded on that day because the approved provider exceeds the approved provider's allocation of *places for community care subsidy (see section 46-3).

Note: Eligibility may also be affected by Division 7 (relating to a person's approval as a provider of *aged care services) or Division 20 (relating to a person's approval as a recipient of community care).

46-2 Suspension of community care services

(1) A care recipient who is being provided with community care by an approved provider in accordance with a *community care agreement may request the approved provider to suspend, on a

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

temporary basis, the provision of that community care, commencing on a date specified in the request.

(2) The approved provider must comply with the request.

(3) For the purposes of this Part:

(a) the *community care agreement as in force on that date is taken to remain in force during the period for which the provision of care is suspended; and

(b) the care recipient is to be taken (subject to subsection (4)) to have been provided with community care as required by the community care agreement:

(i) on each day of any period during which the care recipient attends a hospital for the purpose of receiving hospital treatment; and

(ii) on each day of any period during which the care recipient is provided with care (other than by the approved provider) of a type, and at a level, specified in the Community Care Subsidy Principles; and

(iii) on each day of any other period specified in the Community Care Subsidy Principles as a period during which a care recipient is to be taken to be provided with community care for the purposes of this section.

(4) The Community Care Subsidy Principles may specify a maximum number of days, in respect of each period or all periods referred to in subsection (3), for which a care recipient may be taken to have been provided with community care under that subsection during a particular year.

Note: If a care recipient is taken not to have been provided with care because the maximum number of days has been exceeded, subsidy will not be payable in respect of those days. However, it would be open to the care recipient to agree, in accordance with paragraph 61-1(1)(e), to pay a fee to the approved provider to reserve the care recipient's place in the service.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(5) In working out the days on which the provision of community care is suspended under this section:

(a) include the day on which the period commenced; and

(b) do not include the day on which the approved provider recommenced, or commenced, providing community care to the care recipient.

46-3 Exceeding the number of places for which there is an allocation

(1) For the purposes of an approved provider's eligibility for *community care subsidy, a *community care agreement to provide community care to a particular care recipient on a particular day is excluded if:

(a) the number of care recipients in respect of whom the approved provider has, during that day, community care agreements to provide community care exceeds the number of *places included in the approved provider's allocation of places for community care subsidy; and

(b) the Secretary decides, in accordance with subsection (2), that the community care agreement is to be excluded on that day.

(2) In deciding under paragraph (1)(b) which *community care agreements are to be excluded, the Secretary must:

(a) make the number of exclusions necessary to ensure that the number of *places for which *community care subsidy will be payable does not exceed the number of places included in the approved provider's allocation of places for community care subsidy; and

(b) exclude the community care agreements in the reverse order in which the care recipients in question *entered the community care service for the provision of community care.

46-4 Notice of refusal to pay community care subsidy

If:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) an approved provider has claimed *community care subsidy in respect of a person; and

(b) the approved provider is not eligible for community care subsidy in respect of that person;

the Secretary must, within 28 days after receiving the claim, notify the approved provider in writing accordingly.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 47—On what basis is community care subsidy paid?

47-1 Payability of community care subsidy

(1) *Community care subsidy is payable by the Commonwealth to an approved provider in respect of each *payment period (see section 47-2) during which the approved provider is eligible under section 46-1. However, it is not payable in respect of any days during that period on which the approved provider is not eligible.

(2) *Community care subsidy is separately payable by the Commonwealth in respect of each community care service through which an approved provider provides community care.

47-2 Meaning of *payment period*

A ***payment period*** is:

(a) a calendar month; or

(b) such other period as is set out in the Community Care Subsidy Principles.

47-3 Advances

(1) Subject to subsection 47-4(2), *community care subsidy is payable by the Commonwealth in advance, in respect of a *payment period, at such times as the Secretary thinks fit.

(2) The Secretary must work out the amount of an advance to be paid to an approved provider in respect of the first *payment period for a community care service by estimating the amount of *community care subsidy that will be payable for the days in that period and in the following payment period.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) The Secretary must work out the amount of an advance to be paid to an approved provider in respect of subsequent *payment periods for a community care service by:

(a) estimating the amount of *community care subsidy that will be payable for the days in the period; and

(b) increasing or reducing that amount to make any adjustments that the Secretary reasonably believes are necessary to take account of likely underpayments or overpayments in respect of advances previously paid under this section.

(4) The amounts of advances must be worked out in accordance with any requirements set out in the Community Care Subsidy Principles.

47-4 Claims for community care subsidy

(1) For the purpose of obtaining payment of *community care subsidy in respect of a community care service through which an approved provider provides community care, the approved provider must, as soon as practicable after the end of each *payment period, give to the Secretary:

(a) a claim, in the form approved by the Secretary, for community care subsidy that is, or may become, payable in respect of the service for that payment period; and

(b) any information relating to the claim that is stated in the form to be required, or that the Secretary requests.

(2) An advance of *community care subsidy is not payable in respect of a *payment period for the community care service if the approved provider has not given to the Secretary, under subsection (1), a claim relating to the second last preceding payment period for the service.

Example: An advance of subsidy is not payable for March if the Secretary has not been given a claim for January of the same year (assuming the *payment periods are all calendar months—see section 47-2).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) Subsection (2) does not apply to the first *payment period or the second payment period for a community care service.

47-5 Recovery of overpayments

This Division does not affect the Commonwealth's right to recover overpayments under Part 6.5.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 48—What is the amount of community care subsidy?

48-1 Amount of community care subsidy

(1) The amount of *community care subsidy that is payable to an approved provider in respect of a *payment period for a community care service is the sum of the amounts of community care subsidy payable to the approved provider in respect of each care recipient:

(a) in respect of whom there is in force a *community care agreement for provision of community care provided through the service during the period; and

(b) in respect of whom the approved provider was eligible under section 46-1 for community care subsidy during the period.

(2) The amount of *community care subsidy that is payable to an approved provider in respect of a care recipient is the sum of the amounts of community care subsidy payable in respect of each day, during the *payment period, on which there is in force a *community care agreement for provision of community care to the care recipient.

(3) The amount of *community care subsidy that is payable in respect of a day is the amount:

(a) determined by the Minister in writing; or

(b) worked out in accordance with a method determined by the Minister in writing.

(4) The Minister may determine rates of *community care subsidy based on any matters determined by the Minister in writing.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 3.3—Flexible care subsidy

Division 49—Introduction

49-1 What this Part is about

The *flexible care subsidy is a payment by the Commonwealth to approved providers for providing flexible care to care recipients.

Table of Divisions

49-2 The Flexible Care Subsidy Principles

*Flexible care subsidy is also dealt with in the Flexible Care Subsidy Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Flexible Care Subsidy Principles are made by the Minister under section 96-1.

49-3 Meaning of *flexible care*

Flexible care means care provided in a residential or community setting through an *aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and community care services.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 50—Who is eligible for flexible care subsidy?

50-1 Eligibility for flexible care subsidy

(1) An approved provider is eligible for *flexible care subsidy in respect of a day if the Secretary is satisfied that, during that day:

(a) the approved provider holds an allocation of *places for flexible care subsidy that is in force under Part 2.2 (other than a *provisional allocation); and

(b) the approved provider provides flexible care to a care recipient who:

(i) is approved under Part 2.3 in respect of flexible care; or

(ii) is included in a class of people who, under the Flexible Care Subsidy Principles, do not need approval under Part 2.3 in respect of flexible care; and

(c) the flexible care is of a kind for which flexible care subsidy may be payable (see section 50-2).

(2) However, the approved provider is not eligible in respect of flexible care provided to the care recipient if the care is excluded because the approved provider exceeds the approved provider's allocation of *places for *flexible care subsidy (see section 50-3).

Note: Eligibility may also be affected by Division 7 (relating to a person's approval as a provider of *aged care services) or Division 20 (relating to a person's approval as a recipient of flexible care).

50-2 Kinds of care for which flexible care subsidy may be payable

(1) The Flexible Care Subsidy Principles may specify kinds of care for which *flexible care subsidy may be payable.

(2) Kinds of care may be specified by reference to one or more of the following:

(a) the nature of the care;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the circumstances in which the care is provided;
(c) the nature of the locations in which it is provided;
(d) the groups of people to whom it is provided;
(e) the period during which the care is provided;
(f) any other matter.

Note: Examples of the kinds of care that might be specified are:

(a) care for *people with special needs;

(b) care provided in small or rural communities;

(c) care provided through a pilot program for alternative means of providing care;

(d) care provided as part of co-ordinated service and accommodation arrangements directed at meeting several health and community service needs.

50-3 Exceeding the number of places for which there is an allocation

(1) For the purposes of an approved provider's eligibility for *flexible care subsidy, flexible care provided to a particular care recipient on a particular day is excluded if:
(a) the number of care recipients provided with flexible care by the approved provider during that day exceeds the number of *places included in the approved provider's allocation of places for flexible care subsidy; and
(b) the Secretary decides, in accordance with subsection (2), that the flexible care provided to that particular care recipient on that day is to be excluded.

(2) In deciding under paragraph (1)(b) which flexible care is to be excluded, the Secretary must:
(a) make the number of exclusions necessary to ensure that the number of *places for which *flexible care subsidy will be payable does not exceed the number of places included in the approved provider's allocation of places for flexible care subsidy; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) exclude the flexible care in the reverse order in which the care recipients in question *entered the flexible care service for the provision of flexible care.

50-4 Notice of refusal to pay flexible care subsidy

If:

(a) an approved provider has claimed *flexible care subsidy in respect of a person; and

(b) the approved provider is not eligible for flexible care subsidy in respect of that person;

the Secretary must notify the approved provider, in writing, accordingly.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 51—On what basis is flexible care subsidy paid?

51-1 Payment of flexible care subsidy

(1) *Flexible care subsidy in respect of a particular kind of flexible care is payable in accordance with the Flexible Care Subsidy Principles.

(2) The Flexible Care Subsidy Principles may, in relation to each kind of flexible care, provide for one or more of the following:

(a) the periods in respect of which *flexible care subsidy is payable;

(b) the payment of flexible care subsidy in advance;

(c) the way in which claims for flexible care subsidy are to be made;

(d) any other matter relating to the payment of flexible care subsidy.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 52—What is the amount of flexible care subsidy?

52-1 Amounts of flexible care subsidy

(1) The amount of *flexible care subsidy that is payable in respect of a day is the amount:

(a) determined by the Minister in writing; or

(b) worked out in accordance with a method determined by the Minister in writing.

(2) The Minister may determine rates of *flexible care subsidy based on any matters determined by the Minister in writing.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 4—Responsibilities of approved providers

Division 53—Introduction

53-1 What this Chapter is about

Approved providers have responsibilities in relation to *aged care they provide through their *aged care services. These responsibilities relate to:

- the quality of care they provide (see Part 4.1);
- user rights for the people to whom the care is provided (see Part 4.2);
- accountability for the care that is provided (see Part 4.3).

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

Note: An approved provider's responsibilities cover all the care recipients in an *aged care service who are approved under Part 2.3 as recipients of the type of *aged care provided through the service, as well as those in respect of whom a subsidy is payable under Chapter 3.

53-2 Failure to meet responsibilities does not have consequences apart from under this Act

(1) If:

(a) an approved provider fails to meet a responsibility under this Chapter; and

(b) the failure does not give rise to an offence;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

the failure has no consequences under any law other than this Act.

(2) However, if the act or omission that constitutes that failure also constitutes a breach of an obligation under another law, this section does not affect the operation of any law in relation to that breach of obligation.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 4.1—Quality of care

Division 54—Quality of care

54-1 Responsibilities of approved providers

(1) The responsibilities of an approved provider in relation to the quality of the *aged care that the approved provider provides are as follows:

(a) to provide such care and services as are specified in the Quality of Care Principles in respect of aged care of the type in question;

(b) to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;

(c) to provide care and services of a quality that is consistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles for the purposes of paragraph 56-1(l), 56-2(i) or 56-3(j);

(d) if the care is provided through a residential care service after the *accreditation day—to comply with the Accreditation Standards made under section 54-2;

(e) if the care is provided through a residential care service before the accreditation day—to comply with the Residential Care Standards made under section 54-3;

(f) if the care is provided through a community care service—to comply with the Community Care Standards made under section 54-4;

(g) if the care is provided through a flexible care service—to comply with the Flexible Care Standards (if any), made under section 54-5, that apply to a flexible care service of that kind;

(h) such other responsibilities as are specified in the Quality of Care Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: The Quality of Care Principles are made by the Minister under section 96-1.

(2) The responsibilities under this subsection apply in relation to matters concerning a person to whom the approved provider provides, or is to provide, care through an *aged care service only if:

(a) subsidy is payable under Chapter 3 for the provision of the care to the person; or

(b) the person is approved under Part 2.3 as a recipient of the type of *aged care provided through the service.

54-2 Accreditation Standards

(1) The Quality of Care Principles may set out Accreditation Standards. Accreditation Standards are standards for quality of care and quality of life for the provision of residential care on and after the *accreditation day.

(2) The following are examples of matters with which the Accreditation Standards may deal:

(a) health and personal care of care recipients;

(b) the lifestyle of care recipients;

(c) safe practices and the physical environment in which residential care is provided;

(d) management systems, staffing and organisational development relating to the provision of residential care.

54-3 Residential Care Standards

(1) The Quality of Care Principles may set out Residential Care Standards. Residential Care Standards are standards for quality of care and quality of life for the provision of residential care before the *accreditation day.

(2) The following are examples of matters with which the Residential Care Standards may deal:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) health and personal care of care recipients;
(b) the lifestyle of care recipients;
(c) safe practices and the physical environment in which residential care is provided.

54-4 Community Care Standards

(1) The Quality of Care Principles may set out Community Care Standards. Community Care Standards are standards for quality of care and quality of life for the provision of community care.

(2) The following are examples of matters with which the Community Care Standards may deal:
(a) the information and consultation requirements applicable to the provision of community care;
(b) the assessment and review of care needs of care recipients;
(c) the planning and co-ordination of the delivery of community care.

54-5 Flexible Care Standards

(1) The Quality of Care Principles may set out Flexible Care Standards. Flexible Care Standards are standards for quality of care and quality of life for the provision of flexible care of particular kinds.

(2) The Flexible Care Standards may set out different standards for different kinds of flexible care.

(3) The following are examples of matters with which the Flexible Care Standards may deal:
(a) health and personal care of care recipients;
(b) the lifestyle of care recipients;
(c) safe practices and the physical environment in which flexible care is provided;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(d) the information and consultation requirements applicable to the provision of flexible care;

(e) the assessment and review of care needs of care recipients;

(f) the planning and co-ordination of the delivery of flexible care.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 4.2—User rights

Division 55—Introduction

55-1 What this Part is about

Approved providers have general responsibilities to users, and proposed users, of their *aged care services who are approved as care recipients of the type of *aged care in question. Failure to meet those responsibilities may lead to sanctions being imposed under Part 4.4.

Table of Divisions

55-2 The User Rights Principles

User rights are also dealt with in the User Rights Principles. The provisions of this Part indicate where a particular matter is or may be dealt with in these Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 55-2

Note: The User Rights Principles are made by the Minister under section 96-1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 56—What are the general responsibilities relating to user rights?

56-1 Responsibilities of approved providers—residential care

The responsibilities of an approved provider in relation to a care recipient to whom the approved provider provides, or is to provide, residential care are as follows:

(a) to comply with the requirements of Division 57 in relation to any *accommodation bond charged for the care recipient's *entry to the residential care service through which the care is, or is to be, provided;

(b) to charge no more than the amount permitted under Division 58 for provision of the care and services that it is the approved provider's responsibility under paragraph 54-1(1)(a) to provide;

(c) to charge no more than the amount permitted under the User Rights Principles by way of a booking fee for *respite care;

(d) to charge no more for any other care or services than an amount agreed beforehand with the care recipient, and to give the care recipient an itemised account of the other care or services;

(e) to provide such security of tenure for the care recipient's *place in the service as is specified in the User Rights Principles;

(f) to comply with the requirements of Division 36 in relation to *extra service agreements; and

(g) to offer to enter into a *resident agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement (see Division 59);

(h) to comply with the requirements of Division 62 in relation to *personal information relating to the care recipient;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(i) to comply with the requirements of section 56-4 in relation to resolution of complaints;

(j) to allow people acting for care recipients to have such access to the service as is specified in the User Rights Principles;

(k) to allow people acting for bodies that have been paid *advocacy grants under Part 5.5, or *community visitors grants under Part 5.6, to have such access to the service as is specified in the User Rights Principles;

(l) not to act in a way which is inconsistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles;

(m) such other responsibilities as are specified in the User Rights Principles.

56-2 Responsibilities of approved providers—community care

The responsibilities of an approved provider in relation to a care recipient to whom the approved provider provides, or is to provide, community care are as follows:

(a) not to charge for the care recipient's *entry to the service through which the care is, or is to be, provided;

(b) to charge no more than the amount permitted under Division 60 for provision of the care and services that it is the approved provider's responsibility under paragraph 54-1(1)(a) to provide;

(c) to charge no more for any other care or services than an amount agreed beforehand with the care recipient, and to give the care recipient an itemised account of the other care or services;

(d) to provide such security of tenure for the care recipient's *place in the service as is specified in the User Rights Principles;

(e) to offer to enter into a *community care agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement (see Division 61);

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(f) to comply with the requirements of Division 62 in relation to *personal information relating to the care recipient;

(g) to comply with the requirements of section 56-4 in relation to resolution of complaints;

(h) to allow people acting for bodies that have been paid *advocacy grants under Part 5.5 to have such access to the service as is specified in the User Rights Principles;

(i) not to act in a way which is inconsistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles;

(j) such other responsibilities as are specified in the User Rights Principles.

56-3 Responsibilities of approved providers—flexible care

The responsibilities of an approved provider in relation to a care recipient to whom the approved provider provides, or is to provide, flexible care are as follows:

(a) to comply with the requirements of the User Rights Principles in relation to any *accommodation bond charged for the care recipient's *entry to the flexible care service through which the care is, or is to be, provided;

(b) to charge no more than the amount specified in, or worked out in accordance with, the User Rights Principles, for provision of the care and services that it is the approved provider's responsibility under paragraph 54-1(1)(a) to provide;

(c) to charge no more for any other care or services than an amount agreed beforehand with the care recipient, and to give the care recipient an itemised account of the other care or services;

(d) to provide such security of tenure for the care recipient's *place in the service as is specified in the User Rights Principles;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(e) to comply with any requirements of the User Rights Principles relating to:
  (i) offering to enter into an agreement with the care recipient relating to the provision of care to the care recipient; or
  (ii) entering into such an agreement if the care recipient wishes;
(f) to comply with the requirements of Division 62 in relation to *personal information relating to the care recipient;
(g) to comply with the requirements of section 56-4 in relation to resolution of complaints;
(h) to allow people acting for care recipients to have such access to the service as is specified in the User Rights Principles;
(i) to allow people acting for bodies that have been paid *advocacy grants under Part 5.5 to have such access to the service as is specified in the User Rights Principles;
(j) not to act in a way which is inconsistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles;
(k) such other responsibilities as are specified in the User Rights Principles.

56-4 Complaints resolution mechanisms

(1) The approved provider must:
  (a) establish a complaints resolution mechanism for the *aged care service; and
  (b) use the complaints resolution mechanism to address any complaints made by or on behalf of a person to whom care is provided through the service; and
  (c) advise the person of any other mechanisms that are available to address complaints, and provide such assistance as the person requires to use those mechanisms; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(d) allow people authorised by the Secretary to investigate and assist in the resolution of complaints such access to the service as is specified in the User Rights Principles; and

(e) comply with any determination made, in respect of the approved provider, by a committee of the kind referred to in subsection 96-3(2).

(2) If the *aged care service is a residential care service, the complaints resolution mechanism must be the complaints resolution mechanism provided for in the *resident agreements entered into between the care recipients provided with care through the service and the approved provider (see paragraph 59-1(1)(g)).

(3) If the *aged care service is a community care service, the complaints resolution mechanism must be the complaints resolution mechanism provided for in the *community care agreements entered into between the care recipients provided with care through the service and the approved provider (see paragraph 61-1(1)(f)).

56-5 Extent to which responsibilities apply

The responsibilities under this Division apply in relation to matters concerning any person to whom the approved provider provides, or is to provide, care through an *aged care service only if:

(a) subsidy is payable under Chapter 3 for the provision of care to that person; or

(b) the person is approved under Part 2.3 as a recipient of the type of *aged care provided through the service.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 57—What are the responsibilities relating to accommodation bonds?

57-1 What this Division is about

If an approved provider charges an *accommodation bond for the *entry of a care recipient to a residential care service, several rules must be followed. These relate particularly to prudential arrangements, *accommodation bond agreements, the amount of the bond and its payment, treatment of income derived from the bond, deductions from the bond and refunding the bond.

Table of Subdivisions

Subdivision 57-A—The basic rules

57-2 Basic rules about accommodation bonds

The rules relating to charging an *accommodation bond for the *entry of a person to a residential care service as a care recipient are as follows:

(a) the residential care service must be *certified for the accommodation bond to become payable;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the entry must not be for the purpose of the provision of *respite care;

(c) the approved provider conducting the residential care service must comply with the prudential requirements (see section 57-3);

(d) the approved provider must, before the recipient enters the service, provide the care recipient with such information about the accommodation bond as is specified in the User Rights Principles;

(e) the approved provider must have entered into an *accommodation bond agreement (see section 57-9) with the care recipient before, or within 7 days after, the care recipient entered the service;

(f) another person must not be required to pay the accommodation bond as a condition of the care recipient entering the residential care service;

(g) the accommodation bond must not exceed the maximum amount under section 57-12 or 57-13, as the case requires, and the care recipient must not be charged more than one accommodation bond in respect of entering the service;

(h) the accommodation bond must not be charged if a determination is in force under section 57-14 that paying an accommodation bond would cause the care recipient financial hardship;

(i) payment of the accommodation bond can only be required during a period specified in section 57-16;

(j) payment of the accommodation bond by periodic payments must meet the requirements set out in section 57-17;

(k) the approved provider must not use the accommodation bond for a purpose that is not related to providing *aged care to care recipients, or that does not comply with the prudential requirements (see section 57-3);

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(l) the approved provider is entitled to income derived from investing the *accommodation bond balance (see section 57-18);

(m) amounts must not be deducted from the accommodation bond balance, except for amounts deducted under section 57-19;

(n) the approved provider must use the income derived from the accommodation bond and the retention amount in the following ways:

(i) to meet capital works costs relating to residential care;

(ii) to retire debt relating to residential care; or

(iii) where no capital expenditure is reasonably necessary to comply with matters specified in the certification principles for the purposes of 38-3(3) and meeting accreditation requirements – to improve the quality and range of *aged care services;

(o) the approved provider must not charge an accommodation bond if prohibited under Part 4.4 from doing so (see paragraph 66-1(j));

(p) any other rules specified in the User Rights Principles.

Subdivision 57B—Prudential requirements

57-3 Compliance with prudential requirements

An approved provider complies with prudential requirements if the approved provider complies with:

(a) the general prudential requirements under section 57-4; or

(b) specific prudential requirements approved, in relation to an organisation operating a specific prudential arrangement, under section 57-5.

57-4 General prudential requirements

(1) The User Rights Principles may specify the general prudential requirements for the purpose of:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) protecting the *accommodation bond balances of care recipients; and

(b) enabling accommodation bond balances owed to care recipients and former care recipients to be refunded in a timely way.

(2) Without limiting subsection (1), the general prudential requirements may deal with all or any of the following matters:

(a) requiring approved providers to maintain a specified proportion of *accommodation bond balances in a liquid and secure form;

(b) creation of a contributory fund for holding accommodation bond balances, and the appointment of people or organisations to operate the fund;

(c) requiring approved providers to maintain a specified proportion of accommodation bond balances in the contributory fund;

(d) ensuring the viability of the contributory fund through insurance or other arrangements;

(e) requiring approved providers to provide information of specified kinds to the contributory fund as required by the fund;

(f) requiring approved providers and the fund to provide information about the general prudential requirements to care recipients.

57-5 Approval of prudential requirements

(1) The User Rights Principles may specify the criteria for the approval of prudential requirements relating to specific prudential arrangements.

(2) The Secretary must, on an organisation seeking to operate a specific prudential arrangement making an application under section 57-6, approve prudential requirements proposed by the organisation if the Secretary is satisfied that the prudential

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

requirements meet the criteria specified in the User Rights Principles for the purposes of subsection (1).

Note: Rejections of applications are reviewable under Part 6.1.

(3) The Secretary must not approve specific prudential requirements that are in any respect less stringent than the general prudential requirements under section 57-4.

(4) In considering whether to approve the application, the Secretary must:

(a) have regard to the purposes referred to in subsection 57-4(1) in relation to the general prudential requirements; and

(b) comply with any requirements specified in the User Rights Principles.

57-6 Applications for approval of specific prudential requirements

(1) An organisation seeking to operate a specific prudential arrangement may apply in writing to the Secretary for approval of specific prudential requirements.

(2) The application must be in a form approved by the Secretary, and must be accompanied by:

(a) a copy of the proposed prudential requirements; and

(b) any documents that are required by the Secretary to be provided; and

(c) the application fee (if any) specified in, or worked out in accordance with, the User Rights Principles.

(3) The amount of any application fee:

(a) must be reasonably related to the expenses incurred or to be incurred by the Commonwealth in relation to the application; and

(b) must not be such as to amount to taxation.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

57-7 Requests for further information

(1) If the Secretary needs further information to determine the application, the Secretary may give to the organisation a notice requiring the organisation to give the further information within 28 days after receiving the notice, or within such shorter period as is specified in the notice.

(2) The application is taken to be withdrawn if the organisation does not give the further information within the 28 days, or within the shorter period, as the case requires. However, this does not stop the organisation from reapplying.

Note: The period for giving the further information can be extended—see section 96-7.

(3) The notice must contain a statement setting out the effect of subsection (2).

57-8 Notification of Secretary's decision

(1) The Secretary must notify, in writing, the organisation whether or not the specific prudential requirements have been approved. The notice must be given:

(a) within 60 days after receiving the application; or

(b) if the Secretary has requested further information under section 57-7—within 60 days after receiving the information.

(2) If the specific prudential requirements are not approved, the notice must include a copy of the Secretary's decision.

Subdivision 57-C—Accommodation bond agreements

57-9 Contents of accommodation bond agreements

(1) An agreement between an approved provider and a person proposing to *enter, or having entered, as a care recipient to a residential care service through which the approved provider

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

provides care is an ***accommodation bond agreement*** if it sets out the following:

(a) the amount of the *accommodation bond that:
  (i) will be payable if the care recipient enters the residential care service; or
  (ii) if the care recipient has already entered the residential care service—is payable;

(b) the care recipient's proposed date of entry, or date of entry, to the residential care service;

(c) how the accommodation bond is to be paid, and if the accommodation bond is to be paid by periodic payments, the conditions relating to the periodic payments (which must comply with the requirements of section 57-17);

(d) when the accommodation bond is payable;

(e) the amount of each retention amount (within the meaning of section 57-20) that will be deducted from the *accommodation bond balance;

(f) when retention amounts and other amounts permitted by section 57-19 to be deducted from the accommodation bond balance will be deducted;

(g) unless the care recipient has already entered the residential care service—the conditions that will apply if the care recipient agrees to pay the accommodation bond but then does not enter the residential care service (including the conditions that will apply if the person chooses not to enter the service);

(h) whether agreeing to pay the accommodation bond entitles the care recipient to specific accommodation or additional services within the residential care service;

(i) if the accommodation bond is such an amount that, under subsection 44-28(3), the care recipient would not be eligible for a *pensioner supplement—any additional resident fees that will be payable by the care recipient as a result of not being so eligible;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(j) any financial hardship provisions that apply to the care recipient;

(k) the circumstances in which the accommodation bond balance must be refunded and the way the amount of the refund will be worked out;

(l) such other matters as are specified in the User Rights Principles.

(2) The User Rights Principles may specify, but are not limited to, matters relating to the following:

(a) the specific entitlements of care recipients arising from entering into an *accommodation bond agreement;

(b) prudential requirements with which an approved provider must comply to safeguard the *accommodation bond balance;

(c) the provision of information to third parties about accommodation bonds and related matters;

(d) a care recipient's obligations;

(e) alleviating financial hardship.

57-10 Accommodation bond agreements may be incorporated into other agreements

For the purposes of this Division, a person is taken to have entered into an *accommodation bond agreement if the person has entered into an agreement that contains the provisions required by section 57-9.

Example: These provisions may be included in a *resident agreement.

57-11 Agreements cannot affect requirements of this Division

The requirements of this Division apply despite any provision of an *accommodation bond agreement, or any other agreement, to the contrary.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Subdivision 57-D—Amounts of accommodation bonds

57-12 Maximum amount of accommodation bond

(1) Subject to subsection (2) and section 57-13, the maximum amount of an *accommodation bond for the *entry of a person as a care recipient to a residential care service is whichever is the lowest of the following:

(a) the amount of the accommodation bond specified in the *accommodation bond agreement;

(b) an amount that, when subtracted from an amount equal to the value of the care recipient's assets at the time of the care recipient's entry to the residential care service, leaves an amount at least equal to the care recipient's minimum permissible asset value (see subsection (3));

(c) such amount as is specified in, or worked out in accordance with, the User Rights Principles.

(2) If:

(a) a care recipient proposes to *enter a residential care service conducted by an approved provider; and

(b) the care recipient does not, before entering an *accommodation bond agreement, give to the approved provider sufficient information about the care recipient's assets for the approved provider to be able to determine the amounts referred to in paragraph (1)(b);

the maximum amount of an *accommodation bond for the entry of the person as a care recipient to the residential care service is the lesser of the amounts referred to in paragraphs (1)(a) and (c).

(3) A care recipient's ***minimum permissible asset value*** is:

(a) the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 2.5 times the *basic age pension amount at the time of the care recipient's *entry to the residential care service; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) such higher amount as is specified in, or worked out in accordance with, the User Rights Principles.

(4) The value of a care recipient's assets is to be worked out in the same way as it would be worked out under section 44-10 for the purposes of section 44-7 or 44-8.

57-13 Maximum amount of accommodation bond if care recipient moves between residential care services

If:

(a) an *accommodation bond has been paid by a care recipient for *entry to a residential care service (the ***original service***); and

(b) the care recipient ceases being provided with residential care through the original service (other than because the care recipient is on *leave); and

(c) the care recipient enters another residential care service within 28 days after the day on which the care recipient ceased being provided with care by the original service;

the maximum amount of the accommodation bond for the entry of the care recipient to the other service is the amount of the accommodation bond balance that was refunded or is payable to the care recipient under section 57-21 in respect of the accommodation bond referred to in paragraph (a).

57-14 Accommodation bond not payable in cases of financial hardship

(1) The Secretary may determine, in accordance with the User Rights Principles, that a person must not be charged an *accommodation bond because payment of an accommodation bond would cause the person financial hardship.

Note: Refusals to make determinations are reviewable under Part 6.1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) Without limiting the circumstances that constitute financial hardship for the purposes of this section, such circumstances include any circumstances specified in the User Rights Principles.

(3) The determination ceases to be in force at the end of a specified period or on the occurrence of a specified event, if the determination so provides.

Note: Decisions to specify periods or events are reviewable under Part 6.1.

(4) Application may be made to the Secretary, in the form approved by the Secretary, for a determination under subsection (1) that payment of an *accommodation bond would cause the person financial hardship. The application may be made by:

(a) the person; or

(b) an approved provider to which the accommodation bond would otherwise be paid.

(5) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requiring the applicant to give the further information:

(a) within 28 days after receiving the notice; or

(b) within such other period as is specified in the notice.

The application is taken to have been withdrawn if the information is not given within whichever of those periods applies. The notice must contain a statement setting out the effect of this subsection.

Note: The period for giving the further information can be extended—see section 96-7.

(6) The Secretary must notify the person and the approved provider, in writing, of the Secretary's decision on whether to make the determination. The notice must be given:

(a) within 28 days after receiving the application; or

(b) if the Secretary has requested further information under subsection (5)—within 28 days after receiving the information.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(7) If the Secretary makes the determination, the notice must set out:
   (a) any period at the end of which; or
   (b) any event on the occurrence of which;
the determination will cease to be in force.

57-15 Revocation of determinations of financial hardship

(1) The Secretary may, in accordance with the User Rights Principles, revoke a determination made under section 57-14.

Note: Revocations of determinations are reviewable under Part 6.1.

(2) Before deciding to revoke the determination, the Secretary must notify the person, and an approved provider who is providing or is to provide residential care to the person, that revocation is being considered. The notice must be in writing and must:
   (a) invite the person and the approved provider to make submissions, in writing, to the Secretary within 28 days after receiving the notice; and
   (b) inform them that if no submissions are made within that period, the revocation takes effect on the day after the last day for making submissions.

(3) In making the decision whether to revoke the determination, the Secretary must consider any submissions received within the period for making submissions. The Secretary must make the decision within 28 days after the end of that period.

(4) The Secretary must notify, in writing, the person and the approved provider of the decision.

(5) The notice must be given to the person and the approved provider within 28 days after the end of the period for making submissions. If the notice is not given within that period, the Secretary is taken to have decided not to revoke the determination.

(6) A revocation has effect:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) if the person and the approved provider received notice under subsection (4) on the same day—the day after that day; or

(b) if they received the notice on different days—the day after the later of those days.

Subdivision 57-E—Payment of accommodation bonds

57-16 Period for payment of accommodation bond

(1) A care recipient must not be required to pay an *accommodation bond:

(a) before the end of such period as is specified in the User Rights Principles; or

(b) if no period is specified—before the end of 6 months;

after *entry to the residential care service.

(2) If the residential care service was not *certified at the time of the care recipient's *entry to the service, the care recipient must not be required to pay the *accommodation bond:

(a) before the end of such period as is specified in the User Rights Principles; or

(b) if no period is specified—before the end of 6 months;

following the certification of the residential care service.

Note 1: However, under sections 57-18 and 57-20, amounts representing income derived and retention amounts are payable from the date a care recipient *enters the residential care service, or the date on which the service was *certified.

Note 2: Paragraph 57-2(e) requires the *accommodation bond agreement to have been entered into before, or within 7 days after, the care recipient's *entry—this applies even if the residential care service was not *certified at that time.

57-17 Payment of an accommodation bond by periodic payments

(1) A care recipient may elect that an *accommodation bond is to be paid, in whole or in part, by periodic payments.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) The User Rights Principles may specify:

(a) the frequency of periodic payments; and

(b) the method for working out amounts of periodic payments (including a method where only part of the *accommodation bond is to be paid by periodic payments); and

(c) any other matters relating to periodic payments.

(3) The method specified in the User Rights Principles for working out amounts of periodic payments must have regard to:

(a) the income that the approved provider could be expected to have derived; and

(b) the retention amounts that would have been permitted to be deducted under section 57-20;

if the *accommodation bond had been paid as a lump sum.

Subdivision 57-F—Rights of approved providers

57-18 Approved provider may retain income derived

(1) An approved provider may retain income derived from the investment of an *accommodation bond balance in respect of an *accommodation bond paid to the approved provider.

(2) Despite section 57-16, if a care recipient pays an *accommodation bond to an approved provider after the due date (see subsection (6)), the care recipient may be required to pay to the approved provider an amount representing the income the approved provider could be expected to have derived, through investing the *accommodation bond balance, during the period:

(a) beginning on the due date; and

(b) ending on the day on which the *accommodation bond was paid.

(3) If the care recipient is provided with care for 2 months or less, the care recipient may be required to pay to the approved provider an amount representing the income the approved provider could be

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

expected to have derived, through investing the *accommodation bond balance, during:

(a) the whole of the month in which the care recipient *entered the residential care service; and

(b) the 2 following months;

unless the User Rights Principles specify that a lesser amount is payable.

Example: If a care recipient *entered a residential care service on 20 January and left on 3 March, the amount would be the amount the approved provider could have been expected to have derived if the care recipient received care for the whole of January, February and March.

(4) The User Rights Principles may specify a method for working out the amounts referred to in subsections (2) and (3).

(5) The User Rights Principles may provide that, in the circumstances specified in the User Rights Principles, an approved provider must not retain income derived, from the investment of an *accommodation bond balance, in respect of periods specified in the User Rights Principles.

(6) In this section:

due date, in relation to an *accommodation bond payable by a care recipient for *entry to a residential care service, means whichever of the following days is applicable:

(a) the day on which the care recipient entered the residential care service;

(b) if the residential care service was not *certified on that day—the day on which the residential care service was certified.

57-19 Amounts to be deducted from accommodation bond balance

(1) An approved provider to whom an *accommodation bond was paid by a care recipient may deduct from the *accommodation bond balance:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) retention amounts in respect of the accommodation bond (see section 57-20); and

(b) amounts owed to the approved provider by the care recipient under an *accommodation bond agreement, a *resident agreement or an *extra service agreement; and

(c) amounts, worked out in accordance with the User Rights Principles, representing interest on the amounts referred to in paragraph (b).

(2) The approved provider must not deduct any other amounts from the *accommodation bond balance.

57-20 Retention amounts

(1) A retention amount must not exceed the amount specified in, or worked out in accordance with, the User Rights Principles.

(2) The User Rights Principles may provide that, in the circumstances specified in the User Rights Principles, an approved provider must not deduct any amounts from an *accommodation bond balance in respect of periods specified in the User Rights Principles.

(3) Subject to subsections (4) and (5), a retention amount may be deducted from an *accommodation bond balance for each month, or part of a month, during which the care recipient concerned is provided with residential care through the residential care service in respect of which the *accommodation bond was paid.

(4) Subject to subsection (5), retention amounts may only be deducted during the period of 5 years, or such other period specified in the User Rights Principles, starting on the latest of the following days:

(a) the day on which the care recipient *entered the residential care service;

(b) if the service is not *certified on that day—the day on which the service became certified;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(c) if a determination under section 57-14 is in force in respect of the care recipient—the day after the day on which the determination ceases to be in force;

(d) such other day as is worked out in accordance with the User Rights Principles.

(5) If, before the *accommodation bond was paid, amounts had already been deducted from an *accommodation bond balance in respect of another accommodation bond previously paid by the care recipient, the period of 5 years referred to in subsection (4) is reduced by each month in respect of which a retention amount was so deducted.

Note: The effect of this subsection is that all periods spent in residential care after an *accommodation bond is first paid will count towards the 5 year maximum under subsection (4) for deducting retention amounts.

Example: If a care recipient initially spends 6 weeks in residential care and then moves to another residential care service, retention amounts can be deducted for 3 months in respect of the 6 weeks of care (see subsection (6)), but after that only for up to 4 years and 9 months.

(6) For the purposes of this section, if the care recipient is provided with care for 2 months or less, the care recipient is taken, for the purposes of working out retention amounts payable, to have received that care during:

(a) the whole of the month in which the care recipient *entered the residential care service; and

(b) the 2 following months;

unless the User Rights Principles specify that care is taken to have been provided for a shorter period.

Example: A care recipient who *entered a residential care service on 20 January and left on 3 March would be taken to have received care for the whole of January, February and March. Therefore, retention amounts could be deducted for each of these months.

(7) Deduction of retention amounts must comply with any other requirements specified in the User Rights Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Subdivision 57-G—Refunds

57-21 Refunding of accommodation bond balance

(1) The *accommodation bond balance in respect of an *accommodation bond paid by a care recipient for *entry to a residential care service must be refunded by the approved provider conducting the service if:

(a) the care recipient dies; or

(b) the care recipient ceases to be provided with residential care by a residential care service conducted by the approved provider (other than because the care recipient is on *leave); or

(c) the residential care service ceases to be *certified.

(2) The *accommodation bond balance must be refunded to the care recipient in the way specified in the User Rights Principles.

(3) The *accommodation bond balance must be refunded:

(a) if the care recipient is to *enter another residential care service:

(i) if the care recipient has notified the approved provider of the move more than 7 days before the day on which the approved provider ceased providing care to the care recipient—on the day on which the approved provider ceased providing that care; or

(ii) if the care recipient so notified the approved provider within 7 days before the day on which the approved provider ceased providing that care—within 7 days after the day on which the notice was given; or

(iii) if the care recipient did not notify the approved provider before the day on which the approved provider ceased providing that care—within 7 days after the day on which the approved provider ceased providing that care; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) in any other case—within 2 months after the day on which the event referred to in paragraph (1)(a), (b) or (c) (whichever is applicable) happened.

57-22 Delaying refunds to secure re-entry

(1) If a care recipient ceases to be provided with residential care by a residential care service (other than because the care recipient is on *leave), the care recipient may agree with the approved provider to delay refunding the *accommodation bond balance on condition that, if the care recipient requests re-entry to the service:

(a) the approved provider must allow *entry to the care recipient, if:

(i) there are any *places vacant in the service; and

(ii) the care recipient has been approved under Part 2.3 as a recipient of residential care; and

(b) an *accommodation bond is not payable in respect of that re-entry.

(2) If an agreement is made as mentioned in subsection (1):

(a) retention amounts must not be deducted in respect of the period:

(i) beginning on the day when the care recipient ceased to be provided with residential care; and

(ii) ending when the care recipient re-enters the service; and

(b) the period of 5 years referred to in subsection 57-20(4) is to be worked out excluding the period referred to in paragraph (a) of this subsection.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 58—What are the responsibilities relating to resident fees?

58-1 Responsibilities relating to resident fees

The responsibilities relating to resident fees charged for, or in connection with, the provision to a care recipient of care and services that it is the approved provider's responsibility under paragraph 54-1(1)(a) to provide, are as follows:

(a) subject to section 58-6, the resident fee in respect of any day must not exceed the sum of:
  (i) the maximum daily amount set under section 58-2; and
  (ii) such other amounts as are specified in, or worked out in accordance with, the User Rights Principles;

(b) the care recipient must not be required to pay resident fees more than one month in advance;

(c) the care recipient must not be required to pay resident fees for any period prior to *entry to the residential care service, other than for a period in which the care recipient is, because of subsection 42-3(3), taken to be on *leave under section 42-2;

(d) if the care recipient dies or departs from the service—any fees paid in advance in respect of a period occurring after the care recipient dies or leaves must be refunded in accordance with the User Rights Principles.

58-2 Maximum daily amount of resident fees

The maximum daily amount of resident fees payable by the care recipient is the amount worked out as follows:

Resident fee calculator

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Step 1.	Work out the *standard resident contribution for the care recipient using section 58-3 or 58-4 (whichever is applicable).
Step 2.	Add the compensation payment reduction (if any) applicable to the care recipient on the day in question (see section 44-20).
Step 3.	Add the *daily income tested reduction (if any) applicable to the care recipient on that day (see sections 44-21 to 44-23).
Step 4.	Subtract the amount of any hardship supplement (expressed as a daily amount) applicable to the care recipient on the day in question under section 44-30.
Step 5.	Add any other amounts agreed between the care recipient and the approved provider in accordance with the User Rights Principles.
Step 6.	If, on the day in question, the *place in respect of which residential care is provided to the care recipient has *extra service status, add the extra service amount in respect of the place worked out under section 58-5.

The result is the ***maximum daily amount of resident fees*** for the care recipient.

58-3 Standard resident contribution—people not receiving income support payments

(1) The ***standard resident contribution*** for a care recipient who is not receiving an *income support payment is:

(a) $26.40; or

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) that amount as indexed from time to time in the same way that it would be indexed under the *Social Security Act 1991* if it were the annual maximum basic rate under section 1064-B1 of that Act applying to a person who is not a member of a couple (within the meaning of that section);

whichever is the larger amount.

(2) However, the ***standard resident contribution*** for a care recipient who:

(a) has a *dependent child; or

(b) is being provided with *respite care;

is an amount equal to the *standard pensioner contribution.

58-4 Standard resident contribution—people receiving income support payments

(1) The ***standard resident contribution*** for a care recipient who is receiving an *income support payment is an amount equal to the *standard pensioner contribution.

(2) However, the ***standard resident contribution*** for a care recipient who is receiving an *income support payment and who does not have a *dependent child is the amount worked out under section 58-3 if:

(a) for *entry to the residential care service in question, the care recipient paid an *accommodation bond that exceeded the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 10 times the *basic age pension amount at the time of entry; or

(b) the *daily income tested reduction in respect of the care recipient is an amount worked out under section 44-23.

(3) For the purposes of paragraph (2)(a), if the care recipient has elected under subsection 57-17(1) to pay an *accommodation bond by periodic payments, the amount of the accommodation bond is taken to be what would have been payable by the care recipient in

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

accordance with Subdivision 57-E had the care recipient paid it as a lump sum.

58-5 Extra service amount

The ***extra service amount*** in respect of the *place referred to in step 6 of the resident fee calculator in section 58-2 is the sum of:

(a) the extra service fee in force for the place on the day in question (see Division 35); and

(b) an amount equal to 25% of that extra service fee.

58-6 Maximum daily amount of resident fees for reserving a place

If:

(a) a care recipient is absent from a residential care service on a particular day; and

(b) the person is not on *leave from the residential care service on that day because of the operation of paragraph 42-2(3)(c);

the maximum fee in respect of a day that can be charged for reserving a place in the residential care service for that day is the sum of the following amounts:

(c) the maximum daily amount under section 58-2 that would have been payable by the care recipient if the care recipient had been provided with residential care through the residential care service on that day;

(d) the amount that would have been the amount of *residential care subsidy under Division 44 for the care recipient in respect of that day, if the care recipient had been provided with residential care through the residential care service on that day.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 59—What are the requirements for resident agreements?

59-1 Requirements for resident agreements

(1) A resident agreement entered into between a care recipient and an approved provider must specify:

(a) the residential care service in which the approved provider will provide care to the care recipient; and

(b) the levels of care and services that the approved provider has the capacity to provide to the care recipient while the care recipient is being provided with care through the residential care service; and

(c) the policies and practices that the approved provider will follow in setting the fees that the care recipient will be liable to pay to the approved provider for the provision of the care and services; and

(d) if the care recipient is not to *enter the residential care service on a permanent basis—the period for which the care and services will be provided, and (if applicable) any *respite care booking fee; and

(e) the circumstances in which the care recipient may be asked to depart from the residential care service; and

(f) the assistance that the approved provider will provide to the care recipient to obtain alternative accommodation if the care recipient is asked to depart from the residential care service; and

(g) the complaints resolution mechanism that the approved provider will use to address complaints made by or on behalf of the care recipient; and

(h) the care recipient's responsibilities as a resident in the residential care service.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 59-1

(2) In addition, a *resident agreement must comply with any requirements specified in the User Rights Principles relating to:

(a) the way in which, and the process by which, the agreement is to be entered into; or

(b) the period within which the agreement is to be entered into; or

(c) any provisions that the agreement must contain; or

(d) any other matters with which the agreement must deal.

(3) A *resident agreement must not contain any provision that would have the effect of the care recipient being treated less favourably in relation to any matter than the care recipient would otherwise be treated, under any law of the Commonwealth, in relation to that matter.

Note: A residential care agreement can incorporate the terms of an *extra service agreement (see paragraph 36-1(1)(b), and an *accommodation bond agreement (see section 57-10).

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 60—What are the responsibilities relating to community care fees?

60-1 Responsibilities relating to community care fees

The responsibilities relating to community care fees charged, for the provision to a care recipient of care and services that it is the approved provider's responsibility under paragraph 54-1(1)(a) to provide, are as follows:

(a) the fee in respect of any day must not exceed the maximum daily amount under section 60-2;

(b) the care recipient must not be required to pay community care fees more than one month in advance;

(c) the care recipient must not be required to pay community care fees for any period prior to being provided with the community care;

(d) if the care recipient dies or provision of community care ceases—any fees paid in advance in respect of a period occurring after the care recipient's death, or the cessation of community care, must be refunded in accordance with the User Rights Principles.

60-2 Maximum daily amount of community care fees

(1) The maximum daily amount of community care fees payable by the care recipient is the amount specified in, or determined in accordance with, the User Rights Principles.

(2) The User Rights Principles may specify different levels of maximum daily amounts of community care fees having regard to any or all of the following:

(a) the income of a care recipient;

(b) the nature and level of the care and services to which the community care fees relate;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(c) reduced levels of community care fees for a care recipient who would suffer financial hardship if required to pay the amount of community care fees that would otherwise be payable.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 61—What are the requirements for community care agreements?

61-1 Requirements for community care agreements

(1) A community care agreement entered into between a care recipient and an approved provider must specify:

(a) the community care service through which the approved provider will provide care to the care recipient; and

(b) the levels of care and services that the approved provider has the capacity to provide to the care recipient while the care recipient is being provided with care through the community care service; and

(c) the policies and practices that the approved provider will follow in setting the fees that the care recipient will be liable to pay to the approved provider for the provision of the care and services; and

(d) if the care recipient is not to be provided with the community care service on a permanent basis—the period for which the care and services will be provided; and

(e) the circumstances in which provision of the community care may be suspended or terminated by either party, and the amounts that the care recipient will be liable to pay to the approved provider for any period of suspension; and

(f) the complaints resolution mechanism that the approved provider will use to address complaints made by or on behalf of the person; and

(g) the care recipient's responsibilities as a recipient of the community care.

(2) In addition, a *community care agreement must comply with any requirements specified in the User Rights Principles relating to:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 61-1

(a) the way in which, and the process by which, the agreement is to be entered into; or

(b) the period within which the agreement is to be entered into; or

(c) any provisions that the agreement must contain; or

(d) any other matters with which the agreement must deal.

(3) A *community care agreement must not contain any provision that would have the effect of the care recipient being treated less favourably in relation to any matter than the care recipient would otherwise be treated, under any law of the Commonwealth, in relation to that matter.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 62—What are the responsibilities relating to protection of personal information?

62-1 Responsibilities relating to protection of personal information

The responsibilities relating to protection of *personal information, relating to a person to whom the approved provider provides *aged care, are as follows:

(a) the personal information must not be used other than:
  (i) for a purpose connected with the provision of aged care to the person by the approved provider; or
  (ii) for a purpose for which the personal information was given by or on behalf of the person to the approved provider;

(b) except with the written consent of the person, the personal information must not be disclosed to any other person other than:
  (i) for a purpose connected with the provision of aged care to the person by the approved provider; or
  (ii) for a purpose connected with the provision of aged care to the person by another approved provider, but only so far as the disclosure relates to the person's *accommodation bond balance or the period for which retention amounts may be deducted under section 57-20; or
  (iii) for a purpose for which the personal information was given by or on behalf of the person;

(c) the personal information must be protected by security safeguards that it is reasonable in the circumstances to take against the loss or misuse of the information.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 62-2

62-2 Giving personal information to courts etc.

This Division does not prevent *personal information being given to a court, or to a tribunal, authority or person having the power to require the production of documents or the answering of questions, in accordance with a requirement of that court, tribunal, authority or person.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 4.3—Accountability

Division 63—Accountability

63-1 Responsibilities of approved providers

(1) The responsibilities of an approved provider in relation to accountability for the *aged care provided by the approved provider through an *aged care service are as follows:

(a) to comply with Part 6.3 in relation to keeping and retaining records relating to the service;

(b) to co-operate with any person who is exercising powers under Part 6.4 in relation to the service, and to comply with that Part in relation to the person's exercise of those powers;

(c) to notify any change of circumstances under subsection 9-1(1), and to provide information under subsections 9-2(2) and 9-3(2);

(d) to comply with any conditions to which the allocation of any of the *places included in the service is subject under section 14-5 or 14-6;

(e) if the approved provider has transferred places to another person—to provide records, or copies of records, to that person in accordance with section 16-10;

(f) if the approved provider has *relinquished places—to comply with the obligations under subsections 18-2(4) and 18-4(1);

(g) to allow people authorised by the Secretary access to the service, as required under the Accountability Principles, in order to assess, for the purposes of section 22-4, the care needs of any person provided with care through the service;

(h) to conduct in a proper manner any appraisals under section 25-3, or reappraisals under section 28-2, of the care needs of care recipients provided with care through the service;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(i) if the service, or a *distinct part of the service, has *extra service status—to comply with any conditions to which the grant or renewal of extra service status is subject under section 32-8 or 34-5;

(j) to allow people authorised by the Secretary access to the service, as required under the Accountability Principles, in order to review the *certification of the service under section 39-4;

(k) to comply with any agreement the approved provider makes under paragraph 66-2(1)(b), and with any undertaking the approved provider gives for the purposes of section 67-4;

(l) to allow people acting for *accreditation bodies to have such access to the service as is specified in the Accountability Principles;

(m) such other responsibilities as are specified in the Accountability Principles.

Note: The Accountability Principles are made by the Minister under section 96-1.

(2) The responsibilities under this section apply in relation to matters concerning a person to whom the approved provider provides, or is to provide, care through an *aged care service only if:

(a) subsidy is payable under Chapter 3 for provision of the care to that person; or

(b) the person is approved under Part 2.3 as the recipient of the type of *aged care provided through the service.

63-2 Annual report on the operation of the Act

(1) The Minister must, as soon as practicable after 30 June but before 30 September in each year, cause to be laid before each House of the Parliament a report on the operation of this Act during the year ending on 30 June of that year.

(2) A report under subsection (1) must include information about the following matters:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the extent of unmet demand for places; and

(b) the adequacy of the Commonwealth subsidies provided to meet the care needs of residents; and

(c) the extent to which providers are complying with their responsibilities under the Act; and

(d) the amounts of accommodation bonds charged; and

(e) the duration of waiting periods for entry to residential care; and

(f) the extent of building, upgrading and refurbishment of aged care facilities; and

(g) the imposition of any sanctions for non-compliance under Part 4.4, including details of the nature of the non-compliance and the sanctions imposed;

but is not limited to information about those matters.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 4.4—Consequences of non-compliance

Division 64—Introduction

64-1 What this Part is about

Sanctions can be imposed on an approved provider that does not comply with its responsibilities under Part 4.1, 4.2 or 4.3. Certain procedures must be followed if sanctions are to be imposed.

Table of Divisions

64-2 The Sanctions Principles

The imposition of sanctions on approved providers is also dealt with in the Sanctions Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Sanctions Principles are made by the Minister under section 96-1.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 65—When can sanctions be imposed?

65-1 Imposition of sanctions

The Secretary may impose sanctions (see Division 66) on an approved provider if:

(a) the approved provider has not complied, or is not complying, with one or more of its responsibilities under Part 4.1, 4.2 or 4.3; and

(b) the Secretary is satisfied that it is appropriate to impose sanctions on the approved provider (see section 65-2); and

(c) the Secretary complies with the requirements of Division 67.

Note: Decisions to impose sanctions are reviewable under Part 6.1.

65-2 Appropriateness of imposing sanctions

In deciding whether it is appropriate to impose sanctions on an approved provider for non-compliance with one or more of its responsibilities under Part 4.1, 4.2 or 4.3, the Secretary must consider the following:

(a) whether the non-compliance is of a minor or serious nature;

(b) whether the non-compliance has occurred before and, if so, how often;

(c) whether the non-compliance threatens the health, welfare or interests of care recipients;

(d) whether the approved provider has failed to comply with any undertaking to remedy the non-compliance;

(e) any other matters specified in the Sanctions Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 66—What sanctions can be imposed?

66-1 Sanctions that may be imposed

The Secretary may, by notice in writing, impose one or more of the following sanctions on an approved provider that has not complied, or is not complying, with one or more of its responsibilities under Part 4.1, 4.2 or 4.3:

(a) revoking or suspending the approved provider's approval under Part 2.1 approval under Part 2.1 as a provider of *aged care services;

(b) restricting the approved provider's approval under Part 2.1 as a provider of aged care services to aged care services that are being conducted by the approved provider at the time the sanction is imposed;

(c) restricting the approved provider's approval under Part 2.1 as a provider of aged care services to either:

(i) care recipients to whom the approved provider is providing care at the time the sanction is imposed; or

(ii) care recipients other than those to whom the approved provider commenced providing care, through one or more specified aged care services, after the time the sanction is imposed;

(d) revoking or suspending the allocation of some or all of the *places allocated to the approved provider under Part 2.2;

(e) varying the conditions to which the allocation of some or all of those places is subject under section 14-5;

(f) prohibiting the further allocation of places under Part 2.2 to the approved provider;

(g) revoking or suspending the *extra service status of a residential care service, or a *distinct part of a residential care service, conducted by the approved provider;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(h) prohibiting the granting of extra service status in respect of residential care services, or distinct parts of residential care services, conducted by the approved provider;

(i) revoking or suspending the *certification of a residential care service in respect of which the approved provider has not complied with its responsibilities;

(j) prohibiting the charging of *accommodation bonds for the *entry of care recipients to one or more specified residential care services, or all residential care services, conducted by the approved provider;

(k) requiring repayment of some or all of any grants paid to the approved provider under Chapter 5 in respect of an aged care service in respect of which the approved provider has not complied with its responsibilities;

(l) such other sanctions as are specified in the Sanctions Principles.

66-2 Agreement to certain matters in lieu of revocation of approved provider status

(1) If revocation of the approved provider's approval under Part 2.1 as a provider of *aged care services is imposed as a sanction, the revocation does not take effect if:

(a) the Secretary specifies, in the notice of imposition of the sanction under section 67-5, that the revocation will not take effect if, within the period specified in the notice, the approved provider agrees to whichever one or more of the following is specified in the notice:

(i) providing, at its expense, such training as is specified in the notice for its officers, employees and agents;

(ii) providing such security as is specified in the notice for any debts owed by the approved provider to the Commonwealth;

(iii) appointment by the approved provider, in accordance with the Sanctions Principles, of an adviser approved by

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

the Commonwealth to assist the approved provider to comply with its responsibilities;

(iv) appointment by the approved provider, in accordance with the Sanctions Principles, of an administrator approved by the Commonwealth to administer an aged care service in respect of which the approved provider has not complied with its responsibilities;

(v) transferring some or all of the *places allocated to the approved provider under Part 2.2 to another approved provider;

(vi) such other matters as are specified in the Sanctions Principles; and

(b) within that period, the approved provider agrees accordingly.

Note: Approved providers have a responsibility under paragraph 63-1(1)(k) to comply with an agreement. Failure to comply with this responsibility can result in a further sanction being imposed under this Part.

(2) The reference in subparagraph (1)(a)(iii) to appointment of an adviser does not include appointment of the Commonwealth as an adviser.

(3) The reference in subparagraph (1)(a)(iv) to appointment of an administrator does not include appointment of the Commonwealth as an administrator.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 67—How are sanctions imposed?

67-1 Procedure for imposing sanctions

(1) The Secretary must not impose sanctions on an approved provider for not complying with one or more of its responsibilities under Part 4.1, 4.2 or 4.3 unless the Secretary has completed each of the following steps:

(a) giving to the approved provider a notice of non-compliance (see section 67-2);

(b) giving to the approved provider:

(i) a notice of intention to impose sanctions (see section 67-3); or

(ii) a notice to remedy the non-compliance (see section 67-4); or

(iii) a notice of intention to impose sanctions in respect of a specified part of the non-compliance (see section 67-3) and a notice to remedy the remainder of the non-compliance (see section 67-4);

(c) giving to the approved provider notice of the Secretary's decision on whether to impose sanctions (see section 67-5).

(2) However, paragraphs (1)(a) and (b) do not apply if the Secretary is satisfied that, because of the approved provider's non-compliance, there is an immediate and severe risk to the safety, health or well-being of care recipients to whom the approved provider is providing care.

67-2 Notice of non-compliance

(1) If the Secretary is satisfied that an approved provider has not complied, or is not complying, with one or more of its responsibilities under Part 4.1, 4.2 or 4.3, the Secretary may give to the approved provider a notice of non-compliance.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) The notice must be in writing and must:

(a) set out details of the non-compliance by the approved provider; and

(b) set out broadly what action the Secretary requires the approved provider to take to remedy the non-compliance; and

(c) set out what sanctions under this Part can be imposed on the approved provider; and

(d) invite the approved provider to make submissions, in writing, to the Secretary addressing the matter within 14 days after receiving the notice, or within such shorter period as is specified in the notice; and

(e) inform the approved provider that the Secretary may, after considering the submissions (if any), give to the approved provider:

(i) a notice of intention to impose sanctions; or

(ii) a notice to remedy the non-compliance; or

(iii) a notice of intention to impose sanctions in respect of a specified part of the non-compliance and a notice to remedy the remainder of the non-compliance.

(3) The Secretary must consider any submissions made by the approved provider.

67-3 Notice of intention to impose sanctions

(1) The Secretary may give to the approved provider a notice of intention to impose sanctions in respect of non-compliance by the approved provider with its responsibilities under Part 4.1, 4.2 or 4.3 if the approved provider:

(a) has not made any submissions addressing the matter in response to a notice under section 67-2; or

(b) has made such submissions, but the Secretary thinks the submissions:

(i) do not propose appropriate action to remedy the non-compliance; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(ii) fail to establish that the non-compliance did not occur, or is not occurring; or

(iii) do not set out sufficient reason for the non-compliance; or

(iv) are otherwise unsatisfactory.

(2) The notice must be in writing and must:

(a) set out the nature of the approved provider's non-compliance; and

(b) set out the reasons for proposing to impose sanctions on the approved provider; and

(c) set out the consequences under this Act of imposing the proposed sanctions on the approved provider; and

(d) invite the approved provider to make submissions, in writing, to the Secretary within 14 days after receiving the notice, or within such shorter period as is specified in the notice; and

(e) inform the approved provider that the Secretary may, after considering the submissions (if any), impose sanctions on the approved provider.

(3) The Secretary must consider any submissions made by the approved provider.

67-4 Notice to remedy non-compliance

(1) The Secretary may give to the approved provider a notice to remedy non-compliance by the approved provider with its responsibilities under Part 4.1, 4.2 or 4.3 if:

(a) the approved provider has made submissions addressing the non-compliance in response to a notice under section 67-2; and

(b) the Secretary thinks the submissions:

(i) propose appropriate action to remedy the non-compliance; or

(ii) set out sufficient reason for the non-compliance; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(iii) are otherwise satisfactory.

(2) The notice must be in writing and must:

(a) inform the approved provider that, within 14 days after receiving the notice, or within such shorter period as is specified in the notice, the approved provider must give a written undertaking to the Secretary to remedy the non-compliance; and

(b) inform the approved provider that the Secretary may impose sanctions on the approved provider if the approved provider does not give, or comply with, the undertaking.

(3) The undertaking must:

(a) be in a form approved by the Secretary; and

(b) contain a description and acknowledgment of the approved provider's non-compliance with its responsibilities under Part 4.1, 4.2 or 4.3; and

(c) set out what action the approved provider proposes to take to remedy the non-compliance; and

(d) set out the period within which such action is required to be taken; and

(e) contain an acknowledgment that a failure by the approved provider to comply with the undertaking may lead to sanctions being imposed under this Part; and

(f) meet any requirements specified in the Sanctions Principles.

Note: Approved providers have a responsibility under paragraph 63-1(1)(k) to comply with an undertaking. Failure to comply with this responsibility can result in a sanction being imposed under this Part.

67-5 Notice of decision on whether to impose sanctions

(1) The Secretary must notify the approved provider, in writing, of the Secretary's decision on whether to impose a sanction on the approved provider in respect of non-compliance by the approved provider with its responsibilities under Part 4.1, 4.2 or 4.3.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) If the Secretary decides to impose a sanction, the notice must set out:

(a) the nature of the approved provider's non-compliance; and

(b) the sanction to be imposed on the approved provider; and

(c) the consequences under this Act of imposing the sanction on the approved provider; and

(d) where applicable, the sanction period (see section 68-2); and

(e) the reasons for imposing the sanction.

(3) If the Secretary decides not to impose a sanction, the notice must:

(a) specify the nature of the approved provider's non-compliance; and

(b) the reasons for not imposing the sanction.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 68—When do sanctions cease to apply?

68-1 Sanctions cease to apply

(1) A sanction that has been imposed on an approved provider for non-compliance with its responsibilities under Part 4.1, 4.2 or 4.3 ceases to apply if:

(a) its sanction period ends (see section 68-2); or

(b) the Secretary decides under section 68-3 that it is appropriate for the sanction to be lifted.

(2) However, this Division does not apply to any of the following sanctions:

(a) revoking the approved provider's approval under Part 2.1 as a provider of *aged care services;

(b) revoking the allocation of some or all of the *places allocated to the approved provider under Part 2.2;

(c) revoking the *extra service status of a residential care service, or a *distinct part of a residential care service, conducted by the approved provider;

(d) revoking the *certification of the residential care service in respect of which the approved provider has not complied with its responsibilities;

(e) requiring repayment of some or all of any grants paid to the approved provider under Chapter 5 in respect of an aged care service in respect of which the approved provider has not complied with its responsibilities.

68-2 Sanction period

(1) The sanction period for a sanction is the period fixed by the Secretary in respect of that sanction and specified in the notice under subsection 67-5(2).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) In deciding on the length of the sanction period, the Secretary must have regard to any matters specified in the Sanctions Principles.

68-3 Lifting of sanctions

In deciding whether it is appropriate for the sanction to be lifted, the Secretary must have regard to:

(a) whether the approved provider is complying with its responsibilities under Parts 4.1, 4.2 and 4.3; and

(b) any other matter specified in the Sanctions Principles.

Note: Refusals to lift sanctions are reviewable under Part 6.1.

68-4 Applications for lifting of sanctions

(1) If a sanction has been imposed on an approved provider, the approved provider may apply, in writing, to the Secretary for the sanction to be lifted.

(2) The application must:

(a) be in a form approved by the Secretary; and

(b) meet any requirements specified in the Sanctions Principles.

68-5 Requests for further information

(1) If the Secretary needs further information to decide the application, the Secretary may give the applicant a written notice requiring the applicant to give the further information within 14 days after receiving the notice, or within such shorter period as is specified in the notice.

(2) The application is taken to be withdrawn if the applicant does not give the further information within the 14 days, or within the shorter period, as the case requires. However, this does not stop the applicant from reapplying.

Note: The period for giving the further information can be extended—see section 96-7.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) The notice must contain a statement setting out the effect of subsection (2).

68-6 Notification of Secretary's decision

(1) The Secretary must notify the approved provider, in writing, of the Secretary's decision whether to lift the sanction. The notice must be given:
   (a) within 28 days after receiving the application; or
   (b) if the Secretary has requested further information under section 68-5—within 28 days after receiving the information.

(2) If the Secretary decides that the sanction is to be lifted, the notice must:
   (a) inform the approved provider when the sanction will cease to apply; and
   (b) set out such other matters as are specified in the Sanctions Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 5—Grants

Division 69—Introduction

69-1 What this Chapter is about

The Commonwealth makes grants to contribute to costs associated with the establishment or enhancement of *aged care services, with assessments or approvals related to *aged care or with support services related to the provision of aged care. These grants are:

- *residential care grants (see Part 5.1);
- *community care grants (see Part 5.2);
- *assessment grants (see Part 5.3);
- *accreditation grants (see Part 5.4);
- *advocacy grants (see Part 5.5);
- *community visitors grants (see Part 5.6);
- other grants (see Part 5.7).

Grants are (in most cases) payable under agreements with the recipients of the grants, and may be subject to conditions.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 5.1—Residential care grants

Division 70—Introduction

70-1 What this Part is about

The Commonwealth makes *residential care grants to contribute towards the *capital works costs associated with some projects undertaken by approved providers to establish residential care services or to enhance their capacity to provide residential care.

Table of Divisions

70-2 The Residential Care Grant Principles

*Residential care grants are also dealt with in the Residential Care Grant Principles. The provisions in this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Residential Care Grant Principles are made by the Minister under section 96-1.

70-3 Meaning of *capital works costs*

(1) The ***capital works costs*** relating to residential care include, but are not limited to, the following:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the cost of acquiring land on which are, or are to be built, the premises needed for providing that care;
(b) the cost of acquiring, erecting, altering or extending those premises;
(c) the cost of acquiring furniture, fittings or equipment for those premises;
(d) the cost of altering or installing furniture, fittings or equipment on those premises.

(2) However, if:
(a) those premises are, or will be, part of larger premises; and
(b) another part of the larger premises is not, or will not be, connected with the provision of residential care;

any costs that the Secretary is satisfied are attributable to the other part of the larger premises are taken not to be capital works costs relating to the residential care in question.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 71—How do people apply for allocations of residential care grants?

71-1 Applications for residential care grants

A person may apply in writing for the allocation of a *residential care grant. However, the application is valid only if:

(a) it is in response to an invitation to apply for the allocation of residential care grants published by the Secretary under section 71-2; and

(b) it is made on or before the closing date specified in the invitation; and

(c) it is in a form approved by the Secretary.

Note: An applicant who is not an approved provider must become an approved provider for a residential care grant to be allocated (see subsection 72-1(1)).

71-2 Invitation to apply

(1) The Secretary may invite applications for the allocation of *residential care grants.

(2) The invitation must:

(a) specify the amount of money that is available for allocation as *residential care grants; and

(b) specify the criteria for allocations of residential care grants (see section 72-2); and

(c) specify the closing date after which applications will not be accepted; and

(d) specify all of the matters, of the kind referred to in subsection 72-3(1), that will be taken into account in allocating the residential care grants; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(e) state that there may be conditions that approved providers must meet before payments of residential care grants are made.

(3) The invitation must be published or notified by such means as the Secretary thinks appropriate.

71-3 Requests for further information

(1) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the applicant to give the further information within 14 days after receiving the notice, or within such shorter period as is specified in the notice.

(2) The application is taken to be withdrawn if the applicant does not give the further information within 14 days, or within the shorter period, as the case requires.

Note: The period for giving the further information can be extended—see section 96-7.

(3) The notice must contain a statement setting out the effect of subsection (2).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 72—How are residential care grants allocated?

72-1 Allocation of residential care grants

(1) The Secretary may allocate *residential care grants to approved providers in respect of the *capital works costs of projects for the provision of residential care.

(2) The allocation must:
  (a) meet the criteria for allocations (see section 72-2); and
  (b) be the one that best meets the needs of *people with special needs (see section 72-3).

(3) However:
  (a) each of the approved providers must have made a valid application in respect of the allocation (see Division 71); and
  (b) the allocation must comply with the terms of an invitation published under that Division (see section 72-4);

except so far as the Secretary waives these requirements under section 72-5.

(4) A *residential care grant can only be allocated to an approved provider:
  (a) whose approval under Part 2.1 includes *residential care (see subsection 8-1(2)); and
  (b) who holds an allocation of places for *residential care subsidy under Part 2.2 (whether or not it is a *provisional allocation), being places that are, or are to be, included in the residential care service in respect of which the grant is payable; and
  (c) in relation to a residential care service that does not have, and no *distinct part of which has, *extra service status.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

72-2 Criteria for allocations

The criteria for allocation of a *residential care grant are:

(a) a majority of the care recipients who receive, or who will receive, the care to which the grant relates must be either *concessional residents or *assisted residents; and

(b) a majority of care recipients who receive, or who will receive, that care must be *people with special needs or people of a kind specified in the Residential Care Grant Principles; and

(c) such other criteria as are specified in the Residential Care Grant Principles.

72-3 Meeting the needs of people with special needs

(1) In deciding which allocation of *residential care grants best meets the needs of *people with special needs, the Secretary must consider, in relation to each grant:

(a) the proportion of the care recipients, to whom the care to which the grant would relate is or will be provided, who are *concessional residents or *assisted residents; and

(b) the location of the *aged care service, or proposed aged care service, to which the grant would relate, particularly whether it is, or will be, in a rural or remote area; and

(c) the availability of other aged care services in the area in which the aged care service is, or will be, located; and

(d) the need for the grant in order to assist in establishing or upgrading the service or proposed service, particularly the building or upgrading of premises; and

(e) whether there is an urgent need for the grant because of unforeseen circumstances; and

(f) such other matters as are specified in the Residential Care Grant Principles.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) In considering the matters referred to in subsection (1), the Secretary must comply with the requirements of the Residential Care Grant Principles.

72-4 Compliance with the invitation

The allocation complies with the terms of the invitation if:

(a) the sum of the amounts allocated as *residential care grants does not exceed the amount specified in the invitation as being available for allocation as residential care grants; and

(b) the Secretary has considered all valid applications made in respect of the allocation, together with any further information given under section 71-3 in relation to those applications; and

(c) the allocation was made after the closing date specified in the invitation.

72-5 Waiver of requirements

The Secretary may waive:

(a) the requirement under paragraph 72-1(3)(a) that each approved provider who is allocated a *residential care grant must have made a valid application in respect of the allocation; or

(b) that requirement and the requirement under paragraph 72-1(3)(b) that the allocation must comply with the terms of an invitation published under Division 71;

if the Secretary is satisfied that:

(c) the provision of residential care to care recipients is being seriously affected by the condition of the premises used for providing the care, being premises to which the residential care grant would relate; or

(d) the premises used for providing care, being premises to which the residential care grant would relate, have been so

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

damaged by a disaster that they are unsuitable for the provision of residential care; or

(e) there is a high need for the provision of residential care that would not be met unless the residential care grant is allocated, and it would not be practicable to allocate the grant without the waiver; or

(f) there are other exceptional circumstances for justifying the waiver.

72-6 Notification of allocation

(1) The Secretary must notify, in writing, each applicant to whom a *residential care grant has been allocated. The notice must be given within 14 days after the Secretary's decision under section 72-1 is made.

(2) The notice must specify:

(a) the amount of the grant (see Division 74); and

(b) the project to which the grant relates; and

(c) when the grant, or the instalments of the grant, will be paid (see Division 73); and

(d) if the grant is to be paid in more than one instalment—the amounts of the instalments or how they will be worked out (see Division 73); and

(e) the conditions on which the grant is payable (see Division 73).

72-7 Notice to unsuccessful applicants

(1) The Secretary must notify, in writing, each applicant to whom a *residential care grant has not been allocated. The notice must be given within 14 days after the Secretary's decision under section 72-1 is made.

(2) The notice must set out the reasons for the applicant not being allocated a grant.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 73—On what basis are residential care grants paid?

73-1 Basis on which residential care grants are paid

(1) A *residential care grant is payable to an approved provider:

(a) at such time as the Secretary determines in writing; and

(b) in full or in such instalments as the Secretary determines in writing.

(2) The grant is subject to such conditions (if any) as the Secretary determines in writing (see section 73-2).

(3) The grant is not payable unless the approved provider enters into an agreement with the Commonwealth under which the approved provider agrees to comply with the conditions to which the grant is subject.

73-2 Conditions of residential care grants

The following are examples of matters with which the conditions of a *residential care grant may deal:

(a) the kinds of people who are to be provided with care when the project, in respect of which the grant is payable, is completed;

(b) the number of *concessional residents and *assisted residents who are to be provided with care when the project, in respect of which the grant is payable, is completed;

(c) the period within which one or more conditions must be complied with by the approved provider;

(d) the period within which the residential care service in respect of which the grant is payable is to be operational;

(e) the period within which the project is required to be completed;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(f) the amount of money to be provided by the approved provider for the project;

(g) information to be given to the Commonwealth by the approved provider;

(h) the approved provider's compliance with:

(i) any responsibilities of the approved provider under Chapter 4; and

(ii) conditions imposed in respect of other payments made under this Chapter to the approved provider;

(i) certificates about the fulfilment of conditions;

(j) certificates about the completion of premises;

(k) the circumstances in which the grant must be repaid;

(l) giving security to the Commonwealth for repayment of the grant;

(m) the vesting of property used to conduct the *aged care service in respect of which the grant is made;

(n) giving security to the Commonwealth for payment of amounts (whether or not their total exceeds the amount of the grant) that, under the conditions, are to be taken to represent the Commonwealth's interest in anything acquired or improved as a result (wholly or partly) of the grant;

(o) the use and the recovery of amounts (whether or not their total exceeds the amount of the grant) that under the conditions are to be taken to represent the Commonwealth's interest in anything acquired or improved as a result (wholly or partly) of the grant.

73-3 Grants payable only if certain conditions met

(1) The Secretary may specify which of the conditions of a *residential care grant must be met before the grant is payable.

(2) The grant is not payable unless the approved provider complies with those conditions.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) However, payment of the grant to the approved provider does not affect the approved provider's obligation to comply with any other conditions to which the grant is subject.

73-4 Variation or revocation of allocations

(1) The Secretary may vary or revoke an allocation of a *residential care grant if the Secretary is satisfied that a condition to which the allocation is subject has not been met.

Note: Variations or revocations of allocations are reviewable under Part 6.1.

(2) A variation of the allocation may be either or both of the following:
(a) a reduction of the amount of the grant;
(b) a variation of any of the conditions to which the allocation is subject.

(3) Before deciding to vary or revoke the allocation, the Secretary must notify the approved provider that it is being considered. The notice:
(a) must be in writing; and
(b) must invite the approved provider to make submissions, in writing, to the Secretary within 28 days after receiving the notice; and
(c) must inform the approved provider that, if no submissions are made within that period, the variation or revocation takes effect on the day after the last day for making submissions.

(4) In making the decision whether to vary or revoke the allocation, the Secretary must consider any submissions made within that period.

(5) The Secretary must notify, in writing, the approved provider of the decision.

(6) The notice must be given to the approved provider within 28 days after the end of the period for making submissions. If the notice is

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

not given within that period, the Secretary is taken to have decided not to vary or revoke the allocation, as the case requires.

(7) A variation or revocation has effect:

(a) if no submissions were made within the 28 day period—on the day after the last day for making submissions; or

(b) if submissions were made within that period—on the day after the approved provider receives a notice under subsection (5).

73-5 Variation of allocations on application of approved provider

(1) An approved provider may at any time apply to the Secretary for a variation of an allocation of a *residential care grant to the approved provider.

(2) A variation of the allocation may be either or both of the following:

(a) a reduction of the amount of the grant;

(b) a variation of any of the conditions to which the allocation is subject.

(3) The application must be in the form approved by the Secretary.

(4) The Secretary must, within 28 days after receiving the application:

(a) make a variation; or

(b) reject the application;

and, within that period, notify the approved provider accordingly.

Note: Variations of allocations and rejections of applications are reviewable under Part 6.1.

73-6 Agreement taken to be varied

If the Secretary varies, under section 73-4 or 73-5, one or more of the conditions of an allocation, the agreement entered into under subsection 73-1(3) is taken to be varied accordingly.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

73-7 Appropriation

Payments by the Commonwealth under this Part are to be made out of money appropriated by the Parliament for the purpose.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 74—How much is a residential care grant?

74-1 The amount of a residential care grant

(1) The amount of a *residential care grant is the amount specified in, or worked out in accordance with, the Residential Care Grant Principles.

(2) However, the amount of a grant to an approved provider must not exceed the difference between:
   (a) the *capital works costs of the project in respect of which the grant is payable; and
   (b) the sum of the money (if any) spent, and the money presently available for expenditure, by the approved provider towards the capital works costs of the project.

(3) The following are examples of matters with which the Residential Care Grant Principles may deal in relation to the amounts of *residential care grants:
   (a) the purpose for which the grant is required;
   (b) the cost of the project, including any cost of acquiring and developing land;
   (c) the capacity of the approved provider to borrow money for the project;
   (d) the capacity of the approved provider, or the proposed care recipients of the residential care when the project is completed, to contribute to funding the project;
   (e) the kind of people who are to be care recipients of the residential care;
   (f) limits on the amounts of residential care grants.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 5.2—Community care grants

Division 75—Introduction

75-1 What this Part is about

The Commonwealth makes *community care grants to contribute towards the costs associated with some projects undertaken by approved providers to establish community care services or to enhance their capacity to provide community care.

Table of Divisions

75-2 The Community Care Grant Principles

*Community care grants are also dealt with in the Community Care Grant Principles. The provisions in this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Community Care Grant Principles are made by the Minister under section 96-1.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 76—How are community care grants allocated?

76-1 Allocation of community care grants

(1) The Secretary may allocate *community care grants to approved providers in respect of the costs of projects for:

(a) establishing new community care services; or

(b) extending existing community care services to cover additional areas.

(2) The allocation must meet the criteria for allocations (see section 76-2).

(3) A person may apply for an allocation of *community care grants (see section 76-3).

Note: An applicant who is not an approved provider must become an approved provider for a community care grant to be allocated (see subsection (1)).

(4) A *community care grant can only be allocated to an approved provider:

(a) whose approval under Part 2.1 includes community care (see subsection 8-1(2)); and

(b) who holds an allocation of places for *community care subsidy under Part 2.2 (whether or not it is a *provisional allocation), being places that are, or are to be, included in the community care service in respect of which the grant is payable.

76-2 Criteria for allocations

The criteria for allocation of a *community care grant are as follows:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) whether there is a need for the community care service, or proposed community care service, to which the grant would relate;

(b) whether the grant would assist:

(i) people in rural or remote areas; or

(ii) Aboriginal and Torres Strait Islander communities;

(c) such other criteria as are specified in the Community Care Grant Principles.

76-3 Applications for community care grants

(1) An application for the allocation of a *community care grant must be in a form approved by the Secretary.

(2) If the Secretary needs further information to determine the application, the Secretary may give to the applicant a notice requesting the further information:

(a) within the period specified in the notice; or

(b) if no period is specified in the notice—within 14 days after receiving the notice.

(3) The application is taken to be withdrawn if the applicant does not give the further information within whichever of those periods applies.

Note: The period for giving the further information can be extended—see section 96-7.

(4) The notice must contain a statement setting out the effect of subsection (3).

76-4 Notification of allocation

(1) The Secretary must notify, in writing, each applicant to whom a *community care grant has been allocated. The notice must be given within 14 days after the Secretary's decision under section 76-1 is made.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) The notice must specify:

(a) the amount of the grant (see Division 78); and

(b) the project to which the grant relates; and

(c) when the grant, or the instalments of the grant, will be paid (see Division 77); and

(d) if the grant is to be paid in more than one instalment—the amounts of the instalments or how they will be worked out (see Division 77); and

(e) the conditions on which the grant is payable (see Division 77).

76-5 Notice to unsuccessful applicants

(1) The Secretary must notify, in writing, each applicant to whom a *community care grant has not been allocated. The notice must be given within 14 days after the Secretary's decision under section 76-1 is made.

(2) The notice must set out the reasons for the applicant not being allocated a grant.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 77—On what basis are community care grants paid?

77-1 Basis on which community care grants are paid

(1) A *community care grant is payable to an approved provider:

(a) at such time as the Secretary determines in writing; and

(b) in full or in such instalments as the Secretary determines in writing.

(2) The grant is subject to such conditions (if any) as the Secretary determines in writing (see section 77-2).

(3) The grant is not payable unless the approved provider enters into an agreement with the Commonwealth under which the approved provider agrees to comply with the conditions to which the grant is subject.

77-2 Conditions of community care grants

The following are examples of matters with which the conditions of a *community care grant may deal:

(a) the kinds of people who are to be provided with care when the project, in respect of which the grant is payable, is completed;

(b) the period within which one or more conditions must be complied with by the approved provider;

(c) the period within which the community care service in respect of which the grant is payable is to be operational;

(d) the amount of money to be provided by the approved provider for the project;

(e) information to be given to the Commonwealth by the approved provider;

(f) the approved provider's compliance with:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(i) any responsibilities of the approved provider under Chapter 4; and

(ii) conditions imposed in respect of other payments made under this Chapter to the approved provider;

(g) the circumstances in which the grant must be repaid.

77-3 Grants payable only if certain conditions met

(1) The Secretary may specify which of the conditions of a *community care grant must be met before the grant is payable.

(2) The grant is not payable unless the approved provider complies with those conditions.

(3) However, payment of the grant to the approved provider does not affect the approved provider's obligation to comply with any other conditions to which the grant is subject.

77-4 Variation or revocation of allocations

(1) The Secretary may vary or revoke an allocation of a *community care grant if the Secretary is satisfied that a condition to which the allocation is subject has not been met.

Note: Variations or revocations of allocations are reviewable under Part 6.1.

(2) A variation of the allocation may be either or both of the following:

(a) a reduction of the amount of the grant;

(b) a variation of any of the conditions to which the allocation is subject.

(3) Before deciding to vary or revoke the allocation, the Secretary must notify the approved provider that it is being considered. The notice:

(a) must be in writing; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) must invite the approved provider to make submissions, in writing, to the Secretary within 28 days after receiving the notice; and

(c) must inform the approved provider that, if no submissions are made within that period, the variation or revocation takes effect on the day after the last day for making submissions.

(4) In making the decision whether to vary or revoke the allocation, the Secretary must consider any submissions made within that period.

(5) The Secretary must notify, in writing, the approved provider of the decision.

(6) The notice must be given to the approved provider within 28 days after the end of the period for making submissions. If the notice is not given within that period, the Secretary is taken to have decided not to vary or revoke the allocation, as the case requires.

(7) A variation or revocation has effect:

(a) if no submissions were made within the 28 day period—on the day after the last day for making submissions; or

(b) if submissions were made within that period—on the day after the approved provider receives a notice under subsection (5).

77-5 Variation of allocations on application of approved provider

(1) An approved provider may at any time apply to the Secretary for a variation of an allocation of a *community care grant to the approved provider.

(2) A variation of the allocation may be either or both of the following:

(a) a reduction of the amount of the grant;

(b) a variation of any of the conditions to which the allocation is subject.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) The application must be in the form approved by the Secretary.

(4) The Secretary must, within 28 days after receiving the application:

(a) make a variation; or

(b) reject the application;

and, within that period, notify the approved provider accordingly.

Note: Variations of allocations and rejections of applications are reviewable under Part 6.1.

77-6 Agreement taken to be varied

If the Secretary varies, under section 77-4 or 77-5, one or more of the conditions of an allocation, the agreement entered into under subsection 77-1(3) is taken to be varied accordingly.

77-7 Appropriation

Payments by the Commonwealth under this Part are to be made out of money appropriated by the Parliament for the purpose.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 78—How much is a community care grant?

78-1 The amount of a community care grant

(1) The amount of a *community care grant is the amount specified in, or worked out in accordance with, the Community Care Grant Principles.

(2) The following are examples of matters with which the Community Care Grant Principles may deal in relation to the amounts of *community care grants:

(a) the circumstances of approved providers to which the grants are payable;

(b) the purposes for which the grants are payable;

(c) the locations of the community care services to which the grants relate;

(d) the kinds of people who will be provided with community care through the services;

(e) limits on the amounts of the grants.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 5.3—Assessment grants

Division 79—Assessment grants

79-1 Assessment grants

(1) The Minister may, on behalf of the Commonwealth, make one or more grants of money to a State, Territory or another body for some or all of the following purposes:

(a) assessment of the care needs of people seeking approval under Part 2.3 as recipients of residential care, community care or flexible care;

(b) helping people to obtain the types of care and services that best meet their needs;

(c) monitoring and evaluating the effectiveness of the assessment services that are provided;

(d) conducting research relevant to the care needs of people, and the approval of people as recipients of residential care, community care or flexible care;

(e) such other purposes as are determined by the Minister.

A grant of money under this subsection is an ***assessment grant***.

(2) An *assessment grant is payable to a State, Territory or body:

(a) at such time as the Minister determines in writing; and

(b) in full or in such instalments as the Minister determines in writing.

79-2 Conditions of assessment grants

An *assessment grant is subject to:

(a) such conditions (if any) as are set out in the Assessment Grant Principles; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) conditions that relate to the matters (if any) specified in the Assessment Grant Principles as matters to which conditions of an assessment grant must relate; and

(c) such other conditions as are determined by the Secretary.

Note: The Assessment Grant Principles are made by the Minister under section 96-1.

79-3 Appropriation

Payments by the Commonwealth under this Part are to be made out of money appropriated by the Parliament for the purpose.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 5.4—Accreditation grants

Division 80—Accreditation grants

80-1 Accreditation grants

(1) The Secretary may, on behalf of the Commonwealth, enter into a written agreement with a body corporate under which the Commonwealth makes one or more grants of money to the body for the following purposes:

(a) accreditation of residential care services in accordance with the Accreditation Grant Principles;

(b) any other purposes specified in the Accreditation Grant Principles, including the performance of any of the functions of the Secretary under this Act that are specified in the Accreditation Grant Principles.

A grant of money under this subsection is an ***accreditation grant***.

Note: The Accreditation Grant Principles are made by the Minister under section 96-1.

(2) The following are examples of matters with which the Accreditation Grant Principles may deal:

(a) the procedures to be followed in deciding whether to accredit a residential care service, including the reconsideration of decisions on accreditation;

(b) the matters to be taken into account in making, or reconsidering, those decisions;

(c) the procedures to be followed in revoking or suspending the accreditation of a residential care service;

(d) the matters to be taken into account in deciding to revoke or suspend the accreditation of a residential care service;

(e) the accreditation of a residential care service before it commences operation;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(f) the interim accreditation of a new residential care service pending a full assessment for the purposes of accreditation;

(g) the effect on the accreditation of a residential care service if places included in the service are transferred under Division 16.

(3) An *accreditation grant is payable to a body:

(a) at such time as is specified in the agreement; and

(b) in full or in such instalments as are specified in the agreement.

80-2 Conditions of accreditation grants

(1) An *accreditation grant is subject to:

(a) such conditions (if any) as are set out in the Accreditation Grant Principles; and

(b) conditions, set out in the agreement under which the grant is payable, that relate to matters specified in the Accreditation Grant Principles as matters to which conditions of an accreditation grant must relate; and

(c) such other conditions as are set out in the agreement.

(2) The following are examples of matters to which such conditions may relate:

(a) the administration and monitoring of the grant;

(b) the circumstances in which the grant is repayable;

(c) giving security to the Commonwealth for repayment of the grant;

(d) reports and other information to be given to the Commonwealth relating to:

(i) the extent to which the Accreditation Standards are being complied with; and

(ii) any other matters dealt with in the conditions.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

80-3 Appropriation

Payments by the Commonwealth under this Part are to be made out of money appropriated by the Parliament for the purpose.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 5.5—Advocacy grants

Division 81—Advocacy grants

81-1 Advocacy grants

(1) The Secretary may, on behalf of the Commonwealth, enter into a written agreement with a body corporate under which the Commonwealth makes one or more grants of money to the body for the following purposes:

(a) encouraging understanding of, and knowledge about, the rights of recipients and potential recipients of *aged care services on the part of people who are, or may become:

(i) care recipients; or

(ii) people caring for care recipients; or

(iii) people who provide aged care services;

or on the part of the general community;

(b) enabling care recipients to exercise those rights;

(c) providing free, independent and confidential advocacy services in relation to those rights to people:

(i) who are, or may become, care recipients; or

(ii) who are representatives of care recipients.

A grant of money under this subsection is an ***advocacy grant***.

(2) An *advocacy grant is payable to a body:

(a) at such time as is specified in the agreement; and

(b) in full or in such instalments as are specified in the agreement.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

81-2 Applications for advocacy grants

(1) A body corporate, other than a body mentioned in subsection (3), may apply to the Secretary for an *advocacy grant.

(2) The application must be:
  (a) in writing; and
  (b) in a form approved by the Secretary.

(3) A body may not make an application under subsection (1) if it is:
  (a) an approved provider; or
  (b) a body that is directly associated with an approved provider.

81-3 Deciding whether to make advocacy grants

(1) In deciding whether to make a grant under subsection 81-1(1), the Secretary must take into account the criteria (if any) set out in the Advocacy Grant Principles.

Note: The Advocacy Grant Principles are made by the Minister under section 96-1.

(2) The following are examples of matters to which criteria set out in the Advocacy Grant Principles may relate:
  (a) consistency of an application with the purposes set out in paragraphs 81-1(1)(a) to (c)*;*
  (b) the experience, skills and infrastructure of the applicant;
  (c) the ability of the applicant to meet the special needs of particular groups.

81-4 Conditions of advocacy grants

(1) An *advocacy grant is subject to:
  (a) such conditions (if any) as are set out in the Advocacy Grant Principles; and
  (b) conditions, set out in the agreement under which the grant is payable, that relate to matters specified in the Advocacy

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Grant Principles as matters to which conditions of an advocacy grant must relate; and

(c) such other conditions as are set out in the agreement.

(2) Without limiting the conditions to which an *advocacy grant may be subject under paragraphs (1)(a) to (c), the following are examples of matters to which such conditions may relate:

(a) the administration and monitoring of the grant;

(b) the circumstances in which the grant is repayable;

(c) giving security to the Commonwealth for repayment of the grant;

(d) reports and other information to be given to the Commonwealth relating to matters dealt with in the conditions;

(e) compliance with conditions imposed in respect of other payments made under this Act.

81-5 Appropriation

Payments by the Commonwealth under this Part are to be made out of money appropriated by the Parliament for the purpose.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 5.6—Community visitors grants

Division 82—Community visitors grants

82-1 Community visitors grants

(1) The Secretary may, on behalf of the Commonwealth, enter into a written agreement with a body corporate under which the Commonwealth makes one or more grants of money to the body for the following purposes:

(a) facilitating frequent and regular contact with the community by care recipients to whom residential care is provided;

(b) helping such care recipients to maintain independence through contact with people in the community;

(c) assisting such care recipients from particular linguistic or cultural backgrounds to maintain contact with people from similar backgrounds.

A grant of money under this subsection is a ***community visitors grant***.

(2) A *community visitors grant is payable to a body:

(a) at such time as is specified in the agreement; and

(b) in full or in such instalments as are specified in the agreement.

82-2 Applications for community visitors grants

(1) A body corporate, other than a body mentioned in subsection (3), may apply to the Secretary for a *community visitors grant.

(2) The application must be:

(a) in writing; and

(b) in a form approved by the Secretary.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(3) A body is not eligible to make an application under subsection (1) if it is:

(a) an approved provider; or

(b) a body that is directly associated with an approved provider;

except in the circumstances specified in the Community Visitors Grant Principles.

Note: The Community Visitors Grant Principles are made by the Minister under section 96-1.

82-3 Deciding whether to make community visitors grants

(1) In deciding whether to make a grant under subsection 82-1(1), the Secretary must take into account the criteria (if any) set out in the Community Visitors Grant Principles.

(2) The following are examples of matters to which criteria set out in the Community Visitors Grant Principles may relate:

(a) the consistency of an application with the purposes set out in paragraphs 82-1(1)(a) to (c);

(b) the experience, skills and infrastructure of the applicant;

(c) the ability of the applicant to meet the special needs of particular groups.

82-4 Conditions of community visitors grants

(1) A *community visitors grant is subject to:

(a) such conditions (if any) as are set out in the Community Visitors Grant Principles; and

(b) conditions, set out in the agreement under which the grant is payable, that relate to the matters (if any) specified in the Community Visitors Grant Principles as matters to which conditions of a community visitors grant must relate; and

(c) such other conditions as are set out in the agreement.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) Without limiting the conditions to which a *community visitors grant may be subject under paragraphs (1)(a) to (c), the following are examples of matters to which such conditions may relate:

(a) the administration, co-ordination and monitoring of the community visitors grant;

(b) recruitment and approval of community visitors;

(c) training and support for community visitors;

(d) the circumstances in which the grant is repayable;

(e) giving security to the Commonwealth for repayment of the grant;

(f) reports and other information to be given to the Commonwealth relating to matters dealt with in the conditions;

(g) compliance with conditions imposed in respect of other payments made under this Act.

82-5 Appropriation

Payments by the Commonwealth under this Part are to be made out of money appropriated by the Parliament for the purpose.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 5.7—Other grants

Division 83—Other grants

83-1 Other grants

(1) The Secretary may, on behalf of the Commonwealth, enter into a written agreement with a body corporate under which the Commonwealth makes one or more grants of money to the body for the purposes specified in the agreement. The purposes must, in the Secretary's opinion, further the objects of this Act.

(2) A grant under this Part is payable to a body:
  (a) at such time as is specified in the agreement; and
  (b) in full or in such instalments as are specified in the agreement.

(3) The Other Grants Principles may specify requirements with which the Secretary must comply in exercising powers under this Part.

Note: The Other Grants Principles are made by the Minister under section 96-1.

83-2 Conditions of other grants

A grant under this Part is subject to:
  (a) such conditions (if any) as are set out in the Other Grants Principles; and
  (b) conditions, set out in the agreement under which the grant is payable, that relate to the matters (if any) specified in the Other Grants Principles as matters to which conditions of a grant under this Part must relate; and
  (c) such other conditions as are set out in the agreement.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

83-3 Appropriation

Payments by the Commonwealth under this Part are to be paid out of money appropriated by the Parliament for the purpose.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 6—Administration

Division 84—Introduction

84-1 What this Chapter is about

This Chapter deals with a number of aspects relating to the administration of the Act, namely:

- reconsideration and administrative review of decisions (see Part 6.1);
- protection of information (see Part 6.2);
- record keeping obligations of approved providers (see Part 6.3);
- powers of officers in relation to monitoring compliance and offences (see Part 6.4);
- recovery of overpayments by the Commonwealth (see Part 6.5).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 6.1—Reconsideration and review of decisions

Division 85—Reconsideration and review of decisions

85-1 Reviewable decisions

Each of the following decisions is a **reviewable decision*:

Reviewable decisions

Item	Decision	Provision under which decision is made
1	To reject an application for approval as an approved provider	subsection 8-1(1)
2	To reject an application for a waiver of the operation of subsection 10-2(1)	subsection 10-2(5)
3	To revoke an approval as an approved provider	subsection 10-3(1)
4	To impose conditions on revocation of an approval as an approved provider	subsection 10-4(5)
5	To reject an application for a determination under section 15-1 (when allocations take effect)	subsection 15-3(3)
6	To vary or revoke a provisional allocation of places to an approved provider if a condition has not been met	subsection 15-4(1)
7	To reject an application for a variation of a provisional allocation of places	subsection 15-5(4)
8	To extend a provisional allocation period	subsection 15-7(5)
9	To reject an application for extension of a provisional allocation period	subsection 15-7(5)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 85-1

Reviewable decisions

Item	Decision	Provision under which decision is made
10	To reject an application for transfer of allocated places	subsection 16-5(1)
11	To approve a day as a transfer day for the transfer of allocated places	subsection 16-7(3)
12	To reject an application to approve a day as a transfer day	subsection 16-7(3)
13	To determine a period for making an application to vary the conditions to which an allocation is subject	subsection 17-2(5)
14	To refuse to determine a period for making an application to vary the conditions to which an allocation is subject	subsection 17-2(5)
15	To reject an application for variation of conditions to which an allocation of places is subject	section 17-5
16	To approve a day as a variation day for conditions to which an allocation of places is subject	subsection 17-7(3)
17	To reject an application to approve a day as a variation day	subsection 17-7(3)
18	To revoke an unused allocation of a place	subsection 18-5(1)
19	To reject an application to approve a person as a care recipient	subsection 22-1(2)
20	To limit a person's approval as a care recipient	subsection 22-2(1)
21	To limit a person's approval as a care recipient to one or more levels of care	subsection 22-2(3)
22	To vary a limitation on a person's approval as a care recipient	subsection 22-2(4)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Reviewable decisions

Item	Decision	Provision under which decision is made
23	As to when a person urgently needed care and when it was practicable to apply for approval	paragraph 22-5(2)(b)
24	To extend the period during which an application for approval as a care recipient can be made	subsection 22-5(3)
25	To reject an application to extend the period during which an application for approval as a care recipient can be made	subsection 22-5(3)
26	To revoke an approval of a person as a care recipient	subsection 23-4(1)
27	To suspend an approved provider from making appraisals under section 25-3 (appraisals of the level of care needed)	subsection 25-4(1)
28	That the Secretary is not satisfied an appraisal under section 25-3 (appraisals of the level of care needed) was sent in sufficient time	subsection 26-2(2)
29	To refuse to renew the classification of a care recipient	subsection 28-1(1)
30	That the Secretary is not satisfied that a reappraisal under section 28-2 (reappraisal of the level of care needed) was sent in sufficient time	subsection 28-5(2)
31	To change the classification of a care recipient	subsection 29-1(1)
32	To refuse to make a determination to extend extra service status	subsection 31-2(1)
33	To reject an application for approval of extra service fees	subsection 35-1(2)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Reviewable decisions

Item	Decision	Provision under which decision is made
34	To reject an application for certification of a residential care service	subsection 38-1(2)
35	To revoke the certification of a residential care service	subsection 39-3(1)
36	To impose conditions on revocation of the certification of a residential care service	subsection 39-5(5)
37	To refuse to make a determination that a residential care service is taken to meet its accreditation requirement	subsection 42-5(1)
38	To specify a period or event at the end of which, or on the occurrence of which, a determination under subsection 42-5(1) ceases to be in force.	subsection 42-5(4)
39	To revoke a determination that exceptional circumstances apply	subsection 42-6(1)
40	To refuse to make a determination that a care recipient is eligible for an oxygen supplement	subsection 44-13(2)
41	To refuse to make a determination that a care recipient is eligible for an enteral feeding supplement	subsection 44-14(2)
42	To determine that a judgment or settlement is to be treated as having taken into account the cost of providing residential care	subsection 44-20(5)
43	To determine that a part of the compensation under a settlement is to be treated as relating to the future costs of providing residential care	subsection 44-20(6)
44	To refuse to make a determination that the daily income tested reduction is zero	subsection 44-22(2)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Reviewable decisions

Item	Decision	Provision under which decision is made
45	To specify a period at the end of which a determination that the daily income tested reduction is zero ceases to be in force	subsection 44-22(3)
46	To determine a care recipient's ordinary income	subsection 44-24(1), (2) or (3)
47	To refuse to make a determination about viability supplement	subsection 44-29(2)
48	To refuse to make a determination that a care recipient is eligible for a hardship supplement	subsection 44-31(1)
49	To specify a period or event at the end of which, or on the occurrence of which, a determination under section 44-31 will cease to be in force	subsection 44-31(3)
50	To reject an application for approval of prudential requirements	subsection 57-5(1)
51	To refuse to make a determination that paying an accommodation bond would cause financial hardship	subsection 57-14(1)
52	To specify, in a determination that paying an accommodation bond would cause financial hardship, a period or event at the end of which or, on the occurrence of which, the determination will cease to be in force	subsection 57-14(3)
53	To revoke a determination that paying an accommodation bond would cause financial hardship	subsection 57-15(1)
54	To impose a sanction on an approved provider	section 65-1
55	To refuse to lift a sanction	section 68-3

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Reviewable decisions		
Item	**Decision**	**Provision under which decision is made**
56	To vary or revoke an allocation of a residential care grant	subsection 73-4(1)
57	To vary an allocation of a residential care grant	subsection 73-5(4)
58	To reject an application to vary an allocation of a residential care grant	subsection 73-5(4)
59	To vary or revoke an allocation of a community care grant	subsection 77-4(1)
60	To vary an allocation of a community care grant	subsection 77-5(4)
61	To reject an application to vary an allocation of a community care grant	subsection 77-5(4)

85-2 Deadlines for making reviewable decisions

If:

(a) this Act provides for a person to apply to the Secretary to make a *reviewable decision; and

(b) a period is specified under this Act for giving notice of the decision to the applicant; and

(c) the Secretary has not notified the applicant of the Secretary's decision within that period;

the Secretary is taken, for the purposes of this Act, to have made a decision to reject the application.

85-3 Secretary must give reasons for reviewable decisions

(1) If this Act requires the Secretary to notify a person of the making of a *reviewable decision, the notice must include reasons for the decision.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) Subsection (1) does not affect an obligation, imposed upon the Secretary by any other law, to give reasons for a decision.

85-4 Secretary may reconsider reviewable decisions

(1) The Secretary may reconsider a *reviewable decision if the Secretary is satisfied that there is sufficient reason to reconsider the decision.

(2) However, this section does not apply to a determination under section 44-24 of a care recipient's *ordinary income by:

(a) the Secretary to the Department of Social Security; or

(b) a person to whom the power to make such a determination is sub-delegated under subsection 96-2(7) by the Secretary to the Department of Social Security.

(3) The Secretary may reconsider a decision even if:

(a) an application for reconsideration of the decision has been made under section 85-5; or

(b) if the decision has been confirmed, varied or set aside under section 85-5—an application has been made under section 85-8 for review of the decision.

(4) After reconsidering the decision, the Secretary must:

(a) confirm the decision; or

(b) vary the decision; or

(c) set the decision aside and substitute a new decision.

(5) The Secretary's decision (the ***decision on review***) to confirm, vary or set aside the decision takes effect:

(a) on the day specified in the decision on review; or

(b) if a day is not specified—on the day on which the decision on review was made.

(6) The Secretary must give written notice of the decision on review to the person to whom that decision relates.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires the person to be notified of the person's review rights.

85-5 Reconsideration of reviewable decisions

(1) A person whose interests are affected by a *reviewable decision may request the Secretary to reconsider the decision.

(2) However, this section does not apply to a determination under section 44-24 of a care recipient's *ordinary income by:

(a) the Secretary to the Department of Social Security; or

(b) a person to whom the power to make such a determination is sub-delegated under subsection 96-2(7) by the Secretary to the Department of Social Security.

(3) The person's request must be made by written notice given to the Secretary:

(a) within 28 days, or such longer period as the Secretary allows, after the day on which the person first received notice of the decision; or

(b) if the decision is a decision under section 44-24 to determine a care recipient's *ordinary income—within 90 days, or such longer period as the Secretary allows, after the day on which the person first received notice of the decision.

(4) The notice must set out the reasons for making the request.

(5) After receiving the request, the Secretary must reconsider the decision and:

(a) confirm the decision; or

(b) vary the decision; or

(c) set the decision aside and substitute a new decision.

(6) The Secretary's decision (the ***decision on review***) to confirm, vary or set aside the decision takes effect:

(a) on the day specified in the decision on review; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) if a day is not specified—on the day on which the decision on review was made.

(7) The Secretary is taken, for the purposes of this Part, to have confirmed the decision if the Secretary does not give notice of a decision to the person within 90 days after receiving the person's request.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires the person to be notified of the person's review rights.

(8) If a committee has been established under section 96-3 and a function of the committee is to provide advice to the Secretary in relation to the Secretary's reconsideration of a particular kind of *reviewable decision, the Secretary:

(a) may refer a reviewable decision of that kind to the committee for advice; and

(b) must, in reconsidering the decision, take account of any advice of the committee in relation to the decision.

85-6 Date of effect of certain decisions made under section 1239 of the *Social Security Act 1991*

(1) If a determination of a person's *ordinary income under section 44-24 of this Act is reviewed under section 1239 of the *Social Security Act 1991*, a decision on review to vary or set aside the determination takes effect:

(a) on the day specified in the decision; or

(b) if a day is not specified—on the day on which the decision was made.

(2) Subject to subsections (3) and (4), the day specified under paragraph (1)(a) must not be earlier than the day on which the decision on review was made.

(3) The day specified under paragraph (1)(a) may be earlier than the day on which the decision on review was made if:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the decision has the effect of increasing the amount determined under section 44-24 as the person's *ordinary income; and

(b) the amount determined under section 44-24 as the person's ordinary income was less than what it ought to have been because the person made a false statement or misrepresentation.

(4) The day specified under paragraph (1)(a) may be earlier than the day on which the decision on review was made if:

(a) the decision does not have the effect of increasing the amount determined under section 44-24 as the person's *ordinary income; and

(b) the day specified under paragraph (1)(a) is not more than 3 months before the day on which the decision was made.

(5) In this section, a reference to setting a determination aside is a reference to setting the determination aside and substituting a new determination.

85-7 Date of effect of certain decisions made under section 1243 of the *Social Security Act 1991*

(1) Subject to subsections (2) and (3), if:

(a) an application under section 1240 of the *Social Security Act 1991* has been made for review of a determination of a person's *ordinary income under section 44-24 of this Act; and

(b) a decision is made under section 1243 of the *Social Security Act 1991* to vary or set aside the determination;

the decision to vary or set aside the determination takes effect on the day on which the determination was made.

(2) If the application for review of the determination under section 1240 of the *Social Security Act 1991* was made more than 3 months after notice of the determination was given under

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

subsection 44-24(7) of this Act, the decision to vary or set aside the determination takes effect on the day on which the application for review was made.

(3) If the decision to vary or set aside the determination has the effect of increasing the amount determined under section 44-24 as the person's *ordinary income, the decision takes effect:

(a) on the day specified in the decision; or

(b) if a day is not specified—on the day on which the decision was made.

(4) The day specified under paragraph (3)(a) may be earlier than the day on which the decision was made only if the amount determined under section 44-24 as the person's *ordinary income was less than what it ought to have been because the person made a false statement or misrepresentation.

(5) In this section, a reference to setting a determination aside is a reference to setting the determination aside and substituting a new determination.

85-8 AAT review of reviewable decisions

An application may be made to the Administrative Appeals Tribunal for the review of a *reviewable decision that has been confirmed, varied or set aside under section 85-4 or 85-5.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 6.2—Protection of information

Division 86—Protection of information

86-1 Meaning of *protected information*

In this Part, ***protected information*** is information that:

(a) was acquired under or for the purposes of this Act; and

(b) either:

(i) is *personal information; or

(ii) relates to the affairs of an approved provider; or

(iii) relates to the affairs of an applicant for approval under Part 2.1; or

(iv) relates to the affairs of an applicant for a grant under Chapter 5.

86-2 Use of protected information

(1) A person is guilty of an offence if:

(a) the person makes a record of, discloses or otherwise uses information; and

(b) the information is *protected information; and

(c) the information was acquired by the person in the course of performing duties or exercising powers or functions under this Act.

Penalty: Imprisonment for 2 years.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

(2) This section does not apply to:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) conduct that is carried out in the performance of a function or duty under this Act or the exercise of a power under, or in relation to, this Act; or

(b) the disclosure of information only to the person to whom it relates; or

(c) conduct carried out by an approved provider; or

(d) conduct that is authorised by the person to whom the information relates; or

(e) conduct that is otherwise authorised under this or any other Act.

Note: A defendant bears an evidential burden in relation to the matters in subsection (2) (see subsection 13.3(3) of the *Criminal Code)*.

86-3 Disclosure of protected information for other purposes

The Secretary may disclose *protected information:

(a) if the Secretary certifies, in writing, that it is necessary in the public interest to do so in a particular case—to such people and for such purposes as the Secretary determines; and

(b) to a person who is, in the opinion of the Secretary, expressly or impliedly authorised by the person to whom the information relates to obtain it; and

(c) to the Health Insurance Commission for the purposes of the *Health and Other Services (Compensation) Act 1995* or the *Health and Other Services (Compensation) Care Charges Act 1995*; and

(d) to a State or Territory for the purposes of facilitating the transition from the application of this Act in respect of *aged care services in the State or Territory to regulation by the State or Territory in respect of those aged care services; and

(e) if the Secretary believes, on reasonable grounds, that disclosure is necessary to prevent or lessen a serious risk to the safety, health or well-being of a care recipient—to such people as the Secretary determines, for the purpose of preventing or lessening the risk; and

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(f) if the Secretary believes, on reasonable grounds, that:
  (i) a person's conduct breaches the standards of professional conduct of a profession of which the person is a member; and
  (ii) the person should be reported to a body responsible for standards of conduct in the profession;

to that body, for the purposes of maintaining standards of professional conduct in the profession; and

(g) if a person has temporarily taken over the provision of care through a particular service to care recipients—to the person for the purposes of enabling the person properly to provide that care; and

(h) if the Secretary believes, on reasonable grounds, that disclosure of the information is reasonably necessary for:
  (i) enforcement of the criminal law; or
  (ii) enforcement of a law imposing a pecuniary penalty; or
  (iii) protection of the public revenue;

to an agency whose functions include that enforcement or protection, for the purposes of that enforcement or protection; and

(i) to the Secretary to the Department of Veterans' Affairs, for purposes connected with the provision of treatment under Part V of the *Veterans' Entitlements Act 1986*; and

(j) to a person of a kind specified in the Information Principles, for the purposes specified in the Information Principles in relation to people of that kind.

86-4 Disclosure of protected information by people conducting assessments

A person to whom powers under Part 2.3 have been delegated under subsection 96-2(5), or a person making assessments under section 22-4, may make a record of, disclose or otherwise use *protected information, relating to a person and acquired in the

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

course of exercising those powers, or making those assessments, for any one or more of the following purposes:

(a) provision of *aged care, or other community, health or social services, to the person;

(b) assessing the needs of the person for aged care, or other community, health or social services;

(c) reporting on, and conducting research into, the level of need for, and access to, aged care, or other community, health or social services.

86-5 Limits on use of protected information disclosed by Secretary

A person is guilty of an offence if:

(a) the person makes a record of, discloses or otherwise uses information; and

(b) the information is information disclosed to the person under section 86-3 or 86-4; and

(c) the purpose for which the person makes a record of, discloses or otherwise uses the information is not the purpose for which the information was disclosed.

Penalty: Imprisonment for 2 years.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

86-6 Limits on use of protected information disclosed under the *Social Security Act 1991* or *Veterans' Entitlements Act 1986*

A person is guilty of an offence if:

(a) *protected information has been disclosed under section 1314 of the *Social Security Act 1991* or section 130 of the *Veterans' Entitlements Act 1986*, to the person or another person, for any of the following purposes:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(i) determining whether *residential care subsidy is payable to an approved provider in respect of a care recipient;

(ii) determining the amount of residential care subsidy that is payable to an approved provider in respect of a care recipient;

(iii) determining whether an approved provider has complied, or is complying, with its responsibilities under Chapter 4 of this Act; and

(b) the person makes a record of, discloses or otherwise uses the information for a purpose not referred to in subparagraph (a)(i), (ii) or (iii).

Penalty: Imprisonment for 2 years.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

86-7 Limits on use of protected information by Departments of Social Security and Veterans' Affairs

An *officer of the Department of Social Security or the Department of Veterans' Affairs, the *CEO or an *employee of the *Services Delivery Agency is guilty of an offence if he or she:

(a) acquires *protected information for the purposes of this Act; and

(b) makes a record of, discloses or otherwise uses the information for a purpose that is neither a purpose for which it was acquired nor a purpose in respect of which the person to whom the information relates has given written consent.

Penalty: Imprisonment for 2 years.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

86-8 Disclosure to court

A court, or any other body or person that has power to require the production of documents or the answering of questions, may require a person to disclose *protected information only if one of the following applies:

(a) the disclosure is required for the purposes of this Act;

(b) the information was originally disclosed to the person under section 86-3 and the disclosure is required for the purpose for which it was disclosed under that section;

(c) the person to whom the information relates has consented, in writing, to the disclosure.

86-9 Information about an aged care service

(1) The Secretary may make publicly available the following information about an *aged care service:

(a) the name, address and telephone number of the service;

(b) the number of *places included in the service;

(c) the location of the service and its proximity to community facilities, for example, public transport, shops, libraries and community centres;

(d) the services provided by the service;

(e) the fees and charges connected with the service, including *accommodation bonds;

(f) the facilities and activities available to care recipients receiving care through the service;

(g) the name of the approved provider of the service and the names of directors, or members of the committee of management, of the approved provider;

(h) the amounts of funding received by the service under this Act;

(i) information about the variety and type of service provided by approved providers;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(j) any action taken, or intended to be taken, under this Act to protect the welfare of care recipients at a particular service, and the reasons for that action;

(k) information about the service's status under this Act (for example, the service's accreditation record);

(l) information about the approved provider's performance in relation to responsibilities and standards under this Act;

(m) any other information of a kind specified in the Information Principles for the purposes of this section.

Note: The Information Principles are made by the Minister under section 96-1.

(2) Information disclosed under subsection (1) must not include *personal information about a person (other than the information referred to in paragraph (1)(g)).

(3) The Secretary may make information about the outcome of a complaint relating to an *aged care service available to the complainant.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 6.3—Record keeping

Division 87—Introduction

87-1 What this Part is about

This Part sets out the obligations of approved providers and former approved providers to maintain and retain certain records. A person who does not comply with these obligations may be guilty of an offence and, in the case of an approved provider, may be taken to be not complying with its responsibilities under Part 4.3.

Table of Divisions

87-2 Records Principles

Obligations of approved providers in relation to record keeping is also dealt with in the Records Principles. The provisions of this Part indicate when a particular matter is or may be dealt with in these Principles.

Note: The Records Principles are made by the Minister under section 96-1.

87-3 Failure to meet obligations does not have consequences apart from under this Act

(1) If:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Section 87-3

(a) a person fails to meet an obligation imposed under this Part; and

(b) the failure does not give rise to an offence;

the failure has no consequences under any law other than this Act.

(2) However, if the act or omission that constitutes the failure also constitutes a breach of an obligation under another law, this section does not affect the operation of any law in relation to that breach of obligation.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 88—What records must an approved provider keep?

88-1 Approved provider to keep and retain certain records

(1) An approved provider must:

(a) keep records that enable:

(i) claims for payments of subsidy under Chapter 3 to be properly verified; and

(ii) proper assessments to be made of whether the approved provider has complied, or is complying, with its responsibilities under Chapter 4; and

(b) in relation to each of those records, retain the record for the period ending 3 years after the 30 June of the year in which the record was made.

Note: Approved providers have a responsibility under Part 4.3 to comply with this subsection. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(2) An approved provider who ceases permanently to provide care to a care recipient must retain, for the period ending 3 years after the 30 June of the year in which provision of the care ceased, such records relating to the care recipient as are specified in the Records Principles.

Note: Approved providers have a responsibility under Part 4.3 to comply with this subsection. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(3) A record may be kept and retained in written or electronic form.

(4) An approved provider that:

(a) is a *corporation; and

(b) fails to comply with subsection (1) or (2);

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

is guilty of an offence punishable, on conviction, by a fine not exceeding 30 penalty units.

(5) If:

(a) an approved provider fails to comply with subsection (1) or (2); and

(b) the failure arises in respect of records relating to subsidy under Chapter 3 paid to the approved provider;

the approved provider is guilty of an offence punishable, on conviction, by a fine not exceeding 30 penalty units.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

88-2 Approved providers to keep records specified in Records Principles

(1) An approved provider must keep records of the kind specified in the Records Principles.

Note: Approved providers have a responsibility under Part 4.3 to comply with this subsection. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(2) The following are examples of the kinds of records that may be specified in the Records Principles:

(a) care recipient assessment and classification records;

(b) individual care plans for care recipients;

(c) the medical records, progress notes and other clinical records of care recipients;

(d) the schedules of fees and charges (including retention amounts relating to *accommodation bonds) for previous and current care recipients of the *aged care;

(e) agreements between care recipients and the approved provider;

(f) accounts of care recipients;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(g) records relating to the approved provider meeting prudential requirements for accommodation bonds;

(h) records relating to the payment of accommodation bonds (including periodic payments);

(i) records relating to care recipients' entry, discharge and leave arrangements, including death certificates where appropriate.

(3) A record may be kept in written or electronic form.

(4) This section does not affect an approved provider's obligations under section 88-1.

88-3 False or misleading records

(1) An approved provider must not, in purported compliance with subsection 88-1(1), make a record that is false or misleading in a material particular.

Note: Approved providers have a responsibility under Part 4.3 to comply with this subsection. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(2) If a person:

(a) in purported compliance with subsection 88-1(1), makes a record of any matter or thing; and

(b) the record is false or misleading in a material particular; and

(c) the record relates to the affairs of an approved provider that is a *corporation, or to the payment of a subsidy under Chapter 3;

the person is guilty of an offence punishable, on conviction, by a fine not exceeding 30 penalty units.

Note: Chapter 2 of the *Criminal* Code sets out the general principles of criminal responsibility.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 89—What records must a person who was an approved provider retain?

89-1 Former approved provider to retain records

(1) A person who has ceased to be an approved provider is guilty of an offence if:

(a) the person fails to retain a record referred to in subsection (2) for 3 years commencing on the day that the person ceased to be an approved provider; and

(b) the record relates to care provided by the person; and

(c) either:

(i) the person is a *corporation; or

(ii) the record relates to subsidy under Chapter 3 paid to the person.

Penalty: 30 penalty units.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

(2) The records the person is required to retain are the records that the person was required to retain under section 88-1 immediately before the person ceased to be an approved provider. However, they do not include records that the person is required to transfer to another approved provider under section 16-10.

(3) A record may be retained in written or electronic form.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 6.4—Powers of officers

Division 90—Introduction

90-1 What this Part is about

This Part sets out the powers of *authorised officers under this Act. A person who does not comply with an obligation imposed under this Part may be guilty of an offence and, in the case of an approved provider, may be taken to be not complying with its responsibilities under Part 4.4.

Table of Divisions

90-2 Failure to meet obligations does not have consequences apart from under this Act

(1) If:

(a) a person fails to meet an obligation imposed under this Part; and

(b) the failure does not give rise to an offence;

the failure has no consequences under any law other than this Act.

(2) However, if the act or omission that constitutes that failure also constitutes a breach of an obligation under another law, this section

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

does not affect the operation of any law in relation to that breach of obligation.

90-3 Meaning of *authorised officer*

An ***authorised officer*** is an *officer of the Department appointed by the Secretary, by written instrument, to be an authorised officer for the purposes of this Part.

90-4 Meaning of *monitoring powers*

(1) The following powers are ***monitoring powers***:

(a) any of the following in relation to premises:

(i) to search the premises;

(ii) to take photographs (including a video recording), or make sketches, of the premises or any substance or thing at the premises;

(iii) to inspect, examine and take samples of, any substance or thing on or in the premises;

(iv) to inspect any document or record kept at the premises;

(v) to take extracts from, or make copies of, any document or record at the premises;

(vi) to take onto the premises any equipment or material reasonably necessary for the purpose of exercising a power under paragraph (i), (ii), (iii), (iv) or (v);

(b) in relation to a thing that may afford evidence of the commission of an offence against this Act, the powers in subsection (2);

(c) in relation to documents or records at premises, the powers in subsections (3) and (4).

(2) If an *authorised officer, during a search of premises, believes on reasonable grounds that there is at the premises a thing that may afford evidence of the commission of an offence against this Act,

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

the ***monitoring powers*** include securing the thing pending the obtaining of a warrant to seize it.

(3) The ***monitoring powers*** include operating equipment at the premises to see whether:

(a) the equipment; or

(b) a disk, tape or other storage device that:

(i) is at the premises; and

(ii) can be used with or is associated with the equipment;

contains information that is relevant to assessing, in respect of an approved provider, any of the following things:

(c) whether responsibilities under Chapter 4 have been complied with;

(d) whether claims for payments under Chapter 3 or other payments under this Act have been properly made;

(e) whether appraisals or reappraisals made under Part 2.4 have been properly made;

(f) whether conditions of grants under Chapter 5 have been complied with;

(g) whether records have been kept as required under Part 6.3.

(4) If an *authorised officer, after operating equipment at the premises, finds that the equipment, or a disk, tape or other storage device at the premises, contains information of that kind, the ***monitoring powers*** include:

(a) operating facilities at the premises to put the information in documentary form and copying the documents so produced; or

(b) if the information can be transferred to a disk, tape or other storage device that:

(i) is brought to the premises; or

(ii) is at the premises and the use of which for the purpose has been agreed in writing by the occupier of the premises;

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

operating the equipment or other facilities to copy the information to the storage device and removing the storage device from the premises.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 91—What powers can be exercised with an occupier's consent?

91-1 Power to enter premises with occupier's consent to monitor compliance

(1) An *authorised officer may, to the extent that it is reasonably necessary for any of the purposes set out in subsection (2):

(a) enter:

(i) the premises of an *aged care service at any time of the day or night; or

(ii) any other premises (including residential premises) at any time between 9 am and 5 pm on a *business day; and

(b) exercise *monitoring powers.

(2) An *authorised officer may act as provided for under subsection (1) for any of the following purposes:

(a) assessing whether an approved provider is complying with its responsibilities under Chapter 4;

(b) assessing whether an approved provider's claims for payments under Chapter 3 or other payments under this Act have been properly made;

(c) assessing whether appraisals or reappraisals made under Part 2.4 have been properly made;

(d) assessing whether conditions of a grant under Chapter 5 have been complied with;

(e) assessing whether records have been kept as required under Part 6.3;

(f) assessing any application made under this Act.

(3) However, an *authorised officer must not enter premises under subsection (1) unless the occupier of the premises has consented to

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

the entry. An occupier of premises may withdraw consent at any time. The authorised officer must leave the premises if the occupier asks the authorised officer to do so.

(4) Before obtaining the consent of an occupier, the *authorised officer must inform the occupier that he or she may refuse to give consent, or withdraw that consent at any time. An entry by an authorised officer by virtue of the consent of an occupier is not lawful unless the person voluntarily consented to the entry.

Note: Approved providers have a responsibility under paragraph 63-1(1)(b) to co-operate with a person exercising powers under this Part and to comply with this Part in relation to the person's exercise of those powers. An approved provider who:

(a) refuses to consent to the entry of an *authorised officer; or

(b) withdraws consent for an authorised officer to enter premises;

may not be complying with that responsibility. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(5) An *authorised officer must not enter premises under subsection (1) or do a thing referred to in section 90-4 if:

(a) the occupier of the premises has asked the authorised officer to produce his or her identity card for inspection by the occupier; and

(b) the authorised officer fails to do so.

91-2 Power to ask people to answer questions etc.

(1) An *authorised officer who has entered premises under subsection 91-1(1) may ask a person at the premises:

(a) to answer any questions put by the authorised officer; and

(b) to produce any documents or records requested by the authorised officer.

(2) A person is not obliged to comply with a request under subsection (1).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: Approved providers have a responsibility under paragraph 63-1(1)(b) to co-operate with a person exercising powers under this Part and to comply with this Part in relation to the person's exercise of those powers. An approved provider who does not comply with a request under subsection (1) may not be complying with that responsibility. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(3) The powers of an *authorised officer under this section are to be exercised subject to the requirements of Information Privacy Principles 1, 2 and 3 of the *Privacy Act 1988*.

91-3 Occupier of premises to assist authorised officers

(1) An *authorised officer may ask the occupier of any premises entered under subsection 91-1(1) to provide reasonable assistance to the officer, at any time while the officer is entitled to remain on the premises, for the purpose of the exercise of the officer's powers under that section.

(2) An occupier may refuse to provide assistance as requested under subsection (1).

Note: Approved providers have a responsibility under paragraph 63-1(1)(b) to co-operate with a person exercising powers under this Part and to comply with this Part in relation to the person's exercise of those powers. An approved provider who does not assist an *authorised officer when requested under subsection (1) may not be complying with that responsibility. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 92—What powers can be exercised without an occupier's consent?

92-1 Circumstances in which the powers in this Division can be exercised

The powers in this Division can only be exercised in circumstances relating to:

(a) the affairs of an approved provider that is a *corporation; or

(b) the payment of subsidy under Chapter 3.

92-2 Monitoring warrants

(1) An *authorised officer may apply to a magistrate for a warrant under this section in relation to particular premises.

(2) Subject to subsection (3), the magistrate may issue the warrant if satisfied, by information on oath or affirmation, that it is reasonably necessary that the *authorised officer should have access to the premises for any of the following purposes:

(a) assessing whether an approved provider is complying with its responsibilities under Chapter 4;

(b) assessing whether an approved provider's claims for payments under Chapter 3 and other payments under this Act have been properly made;

(c) assessing whether appraisals or reappraisals under Part 2.4 have been properly made;

(d) assessing whether records have been kept as required under Part 6.3.

(3) The magistrate must not issue the warrant unless the *authorised officer or someone else has given the magistrate, either orally (on oath or affirmation) or by affidavit, any further information the

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

magistrate may require about the grounds on which the issue of the warrant is being sought.

(4) The warrant must:

(a) authorise an *authorised officer named in the warrant, with such assistance and by such force as is necessary and reasonable, from time to time while the warrant remains in force, to enter the premises and exercise *monitoring powers; and

(b) state whether an entry under the warrant is authorised to be made at any time of the day or night or during specified hours of the day or night; and

(c) specify the day (not more than 6 months after the issue of the warrant) on which the warrant ceases to have effect; and

(d) state the purpose for which the warrant is issued.

Note: An *authorised officer who is at premises under this section may require any person present to answer questions under section 92-7.

92-3 Offence-related warrants

(1) An *authorised officer may apply to a magistrate for a warrant under this section in relation to particular premises.

(2) Subject to subsection (3), a magistrate may issue the warrant if satisfied, by information on oath or affirmation, that there are reasonable grounds for suspecting that there is, or may be within the next 72 hours, at the premises a particular thing, including information, that may afford evidence of the commission of an offence against this Act.

(3) A magistrate must not issue the warrant unless the *authorised officer or someone else has given the magistrate, either orally (on oath or affirmation) or by affidavit, any further information the magistrate may require about the grounds on which the issue of the warrant is being sought.

(4) The warrant must:

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) authorise an *authorised officer named in the warrant, with such assistance and by such force as is necessary and reasonable, to do any of the following:

(i) to enter the premises;

(ii) to search the premises for the thing;

(iii) if the thing is found, to take photographs (including video recordings) of the premises or thing, to take samples of the thing, to seize the thing or to undertake more than one of those activities;

(b) if the thing is, or includes, information in a written or electronic form—authorise the authorised officer to exercise the powers set out in subsections (5), (6) and (7) in respect of the thing;

(c) state whether the entry is authorised to be made at any time of the day or night or during specified hours of the day or night;

(d) specify the day (not more than 7 days after the issue of the warrant) on which the warrant ceases to have effect;

(e) state the purpose for which the warrant is issued.

(5) If the thing referred to in subsection (2) is, or includes, information in a written or electronic form, an *authorised officer may operate equipment at premises referred to in the warrant to see whether the information is contained in:

(a) the equipment; or

(b) a disk, tape or other storage device that:

(i) is at the premises; and

(ii) can be used with or is associated with the equipment.

(6) If the *authorised officer, after operating equipment at the premises, finds that the equipment contains the information, or that a disk, tape or other storage device at the premises contains the information, he or she may:

(a) seize the equipment or the disk, tape or other storage device; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) if the information can, by using facilities at the premises, be put in documentary form—operate the facilities to put the information in that form and seize the documents so produced; or

(c) if the information can be transferred to a disk, tape or other storage device:

(i) that is brought to the premises; or

(ii) that is at the premises and the use of which for the purpose has been agreed to in writing by the occupier of the premises;

operate the equipment or other facilities to copy the information to the storage device and remove the storage device from the premises.

(7) An *authorised officer may seize equipment under paragraph (6)(a) only if:

(a) it is not practicable to put the relevant information in documentary form as mentioned in paragraph (6)(b) or to copy the information as mentioned in paragraph (6)(c); or

(b) possession by the occupier of the equipment could constitute an offence.

(8) If, in the course of searching for a particular thing in relation to a particular offence, an *authorised officer finds another thing that the authorised officer believes, on reasonable grounds, to be:

(a) a thing that will afford evidence as to the commission of an offence (although not the thing specified in the warrant); or

(b) a thing that will afford evidence as to the commission of another offence against this Act;

and the authorised officer believes, on reasonable grounds, that it is necessary to seize that thing in order to prevent its concealment, loss or destruction, or its use in committing, continuing or repeating the offence or the other offence, the warrant is to be taken to authorise the authorised officer to seize that thing.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: An *authorised officer who is at premises under this section may require any person present to answer questions under section 92-7.

92-4 Warrants may be granted by telephone etc.

(1) If, because of circumstances of urgency, an *authorised officer thinks it necessary, the authorised officer may apply for a warrant under section 92-3 by telephone, telex, facsimile or other electronic means under this section.

(2) Before making such an application, an *authorised officer must prepare an information of the kind mentioned in subsection 92-3(2) that sets out the grounds on which the issue of the warrant is being sought, but may, if it is necessary to do so, make the application before the information has been sworn.

(3) If a magistrate to whom an application under this section is made is satisfied:

(a) after having considered the terms of the information prepared under subsection (2); and

(b) after having received any further information that the magistrate may require about the grounds on which the issue of the warrant is being sought;

that there are reasonable grounds for issuing the warrant, the magistrate must complete and sign a warrant that is the same as the warrant that the magistrate would issue under section 92-3 if the application had been made under that section.

(4) If a magistrate signs a warrant under subsection (3):

(a) the magistrate must inform the *authorised officer of the terms of the warrant, the day and time when it was signed, and the day on which it ceases to have effect, and record on the warrant the reasons for issuing it; and

(b) the authorised officer must complete a form of warrant in the terms given to the authorised officer by the magistrate and write on it the magistrate's name and the day and time when the warrant was signed.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(5) If an *authorised officer completes a form of warrant, the authorised officer must, not later than the day after:

(a) the day on which the warrant ceases to have effect; or

(b) the day on which the warrant is executed;

whichever happens first, send the magistrate who signed the warrant the form of warrant completed by the authorised officer and the information duly sworn in connection with the warrant.

(6) On receipt of the documents mentioned in subsection (5), the magistrate must attach to them the warrant signed by the magistrate and deal with the documents in the same way that the magistrate would have dealt with the information if the application for the warrant had been made under section 92-3.

(7) The form of warrant completed by an *authorised officer under subsection (4) is, if it is in accordance with the terms of the warrant signed by the magistrate, authority for any entry, search, seizure or other exercise of a power that the warrant so signed has authorised.

(8) If:

(a) in any proceedings, the court must be satisfied that an entry, search, seizure, or other exercise of power, was authorised under this section; and

(b) the warrant signed by a magistrate under this section authorising the entry, search, seizure, or other exercise of power, is not produced in evidence;

the court must assume (unless the contrary is proved) that the entry, search, seizure, or other exercise of power, was not authorised by such a warrant.

92-5 Seizures without offence-related warrant in emergency situations

(1) This section applies when an *authorised officer is at premises under section 91-1 or by virtue of a warrant issued under section 92-2.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) If the *authorised officer suspects, on reasonable grounds, that:

(a) a thing relevant to an offence against this Act is at premises; and

(b) it is necessary to exercise a power under paragraph (d) or (e) in order to prevent the thing from being concealed, lost or destroyed; and

(c) it is necessary to exercise the power without the authority of a warrant under section 92-3 because the circumstances:

(i) relate to the health and safety of a care recipient; and

(ii) are so serious and urgent;

the authorised officer may:

(d) search the premises, and any receptacle at the premises for the thing; and

(e) secure the thing pending the obtaining of a warrant to seize it, if he or she finds it there.

92-6 Discovery of evidence

(1) If:

(a) an *authorised officer who enters under a warrant under section 92-3 finds the thing (***evidence***) which the authorised officer entered the premises to find; and

(b) the officer seizes the evidence;

the authorised officer:

(c) may keep the evidence so seized for 60 days; and

(d) if proceedings are instituted within 60 days after the seizure and the evidence may be used in the proceedings—may keep the evidence so seized until the proceedings (including any appeal to a court in relation to the proceedings) are terminated; and

(e) must allow it to be inspected at any reasonable time by anyone who would be entitled to inspect it if it were not in the authorised officer's possession.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) If, in the course of searching premises entered under a warrant under section 92-3, the *authorised officer:

(a) finds a thing that he or she believes, on reasonable grounds, to be:

(i) a thing (other than the evidence mentioned in subsection (1)) that will afford evidence of the commission of the offence in relation to which the search was undertaken; or

(ii) a thing that will afford evidence of the commission of another offence against this Act; and

(b) the authorised officer believes, on reasonable grounds, that it is necessary to seize the thing to prevent its concealment, loss or destruction;

subsection (l) applies to the thing as if it were the evidence mentioned in that subsection.

(3) An *authorised officer may apply to a magistrate to extend the periods of time referred to in paragraphs (1)(c) and (d). The magistrate may extend the periods of time for so long as the magistrate considers necessary.

92-7 Power to require people to answer questions etc.

(1) If an *authorised officer is at premises that he or she entered under a warrant, the officer may require any person at the premises:

(a) to answer any questions put by the authorised officer; and

(b) to produce any documents requested by the authorised officer.

(2) A person is guilty of an offence if the person fails to comply with a requirement under subsection (1).

Penalty: 30 penalty units.

Note 1: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note 2: Approved providers also have a responsibility under paragraph 63-1(1)(b) to co-operate with a person exercising powers under this Part and to comply with this Part in relation to the person's exercise of those powers. An approved provider who does not comply with a requirement under subsection (1) may not be complying with that responsibility. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(3) A person is excused from complying with a requirement under subsection (1) if the answer to the question or the production of the document might tend to incriminate the person or expose the person to a penalty.

(4) The powers of an *authorised officer under this section are to be exercised subject to the requirements of Information Privacy Principles 1, 2 and 3 of the *Privacy Act 1988*.

92-8 Person on premises to assist authorised officers

(1) An *authorised officer may require any person at premises entered under a warrant to provide reasonable assistance to the officer at any time while the officer is entitled to remain on the premises.

(2) The authorised officer may require the assistance for the purpose of the exercise of the officer's powers under section 92-2 (monitoring warrant) or section 92-3 (offence-related warrant) in relation to the premises.

(3) A person is guilty of an offence if the person fails to comply with a requirement under subsection (1).

Penalty: 30 penalty units.

Note 1: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

Note 2: Approved providers also have a responsibility under paragraph 63-1(1)(b) to co-operate with a person exercising powers under this Part and to comply with this Part in relation to the person's exercise of those powers. An approved provider who does not comply with a requirement under subsection (1) may not be complying with that

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

responsibility. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(4) A person is excused from complying with a requirement made of the person under subsection (1) to assist an *authorised officer if to do so might tend to incriminate the person or expose the person to a penalty.

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 93—What powers are there to examine people and obtain documents?

93-1 Secretary's power to obtain information and documents

(1) The Secretary may, by written notice, require any person whom the Secretary believes on reasonable grounds to be capable of giving information relevant to any of the matters set out in subsection (2), to attend before an *authorised officer specified in the notice, at a time and place specified in the notice:

(a) to answer any questions put by the officer; and

(b) to produce to the officer such documents, or copies of documents, as are referred to in the notice.

Note: Sections 28A and 29 of the *Acts Interpretation Act 1901* (which deal with service of documents) apply to notice given under this section.

(2) The Secretary may act as provided for under subsection (1) in relation to any of the following matters:

(a) assessing whether an approved provider is complying with its responsibilities under Chapter 4;

(b) assessing whether an approved provider's claims for payments under Chapter 3 or other payments under this Act have been properly made;

(c) assessing whether appraisals or reappraisals made under Part 2.4 have been properly made;

(d) assessing whether conditions of a grant under Chapter 5 have been complied with;

(e) assessing whether records have been kept as required under Part 6.3;

(f) assessing any application made under this Act.

(3) A person may refuse to comply with a requirement under subsection (1) that does not relate to:

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(a) the affairs of an approved provider that is a *corporation; or

(b) the payment of subsidy under Chapter 3.

Note: Approved providers have a responsibility under paragraph 63-1(1)(b) to co-operate with a person exercising powers under this Part and to comply with this Part in relation to the person's exercise of those powers. An approved provider who does not comply with a requirement under subsection (1) may not be complying with that responsibility. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(4) A person is guilty of an offence if:

(a) the person refuses or fails to comply with a requirement under subsection (1); and

(b) the requirement relates to:

(i) the affairs of an approved provider that is a *corporation; or

(ii) the payment of subsidy under Chapter 3.

Penalty: 30 penalty units.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

(5) The powers of an *authorised officer under this section are to be exercised subject to the requirements of Information Privacy Principles 1, 2 and 3 of the *Privacy Act 1988*.

(6) A person is entitled to be paid by the Commonwealth reasonable compensation for complying with a request covered by paragraph (1)(b).

93-2 Self-incrimination

A person is excused from complying with a requirement made of the person under section 93-1 if the answer to the question or the production of the document might tend to incriminate the person or expose the person to a penalty.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

93-3 Offences related to statements and documents

(1) A person is guilty of an offence if:

(a) the person makes a statement, or produces a document, to an *authorised officer relating to:

(i) the affairs of an approved provider that is a *corporation; or

(ii) the payment of subsidy under Chapter 3; and

(b) the statement or document is false or misleading in a material particular.

A statement may be either oral or written.

Penalty: 30 penalty units.

Note 1: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

Note 2: Approved providers also have a responsibility under paragraph 63-1(1)(b) to co-operate with a person exercising powers under this Part and to comply with this Part in relation to the person's exercise of those powers. An approved provider who contravenes subsection (1) may not be complying with that responsibility. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(2) Subsection (1) does not apply to a person who produces a document, or a copy of a document, that, to the knowledge of the person, is false or misleading in a material particular if the document or copy is accompanied by a written statement signed by the person or, in the case of a body corporate, by a competent officer of the body corporate:

(a) stating that the document or copy is, to the knowledge of the first-mentioned person, false or misleading in a material particular; and

(b) setting out, or referring to, the material particular in which the document or copy is, to the knowledge of the first-mentioned person, false or misleading.

Note: A defendant bears an evidential burden in relation to the matters in subsection (2) (see subsection 13.3(3) of the *Criminal Code*).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

93-4 Authorised officers may examine on oath or affirmation

(1) An *authorised officer may examine a person on oath or affirmation and may, for that purpose:

(a) require the person either to take an oath or make an affirmation; and

(b) administer an oath or affirmation to the person.

(2) A person may refuse to be sworn or make an affirmation if required to do so for the purpose of answering questions or producing documents that do not relate to:

(a) the affairs of an approved provider that is a *corporation; or

(b) the payment of subsidy under Chapter 3.

Note: Approved providers have a responsibility under paragraph 63-1(1)(b) to co-operate with a person exercising powers under this Part and to comply with this Part in relation to the person's exercise of those powers. An approved provider who does not comply with a requirement under subsection (1) may not be complying with that responsibility. Failure to comply with a responsibility can result in a sanction being imposed under Part 4.4.

(3) A person is guilty of an offence if:

(a) the person refuses or fails to be sworn or make an affirmation when so required; and

(b) the requirement has been made for the purpose of answering questions or producing documents that relate to:

(i) the affairs of an approved provider that is a *corporation; or

(ii) the payment of subsidy under Chapter 3.

Penalty: 30 penalty units.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

(4) The oath or affirmation to be taken or made by the person for the purposes of the examination is an oath or affirmation that the statements that the person will make will be true.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Division 94—What are the obligations relating to identity cards?

94-1 Identity cards for authorised officers

(1) The Secretary must cause an identity card to be issued to each person appointed as an *authorised officer under section 90-3.

(2) The identity card must specify the name and appointment of the person.

(3) A recent photograph of the person must be attached to the card.

94-2 Return of identity cards issued to authorised officers

A person appointed as an *authorised officer under section 90-3 must, upon ceasing to be an authorised officer, return to the Secretary the identity card issued to the person under section 94-1.

Penalty: 1 penalty unit.

Note: Chapter 2 of the *Criminal Code* sets out the general principles of criminal responsibility.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Part 6.5—Recovery of overpayments

Division 95—Recovery of overpayments

95-1 Recoverable amounts

(1) If the Commonwealth pays an amount to a person by way of subsidy under Chapter 3, any part of the amount that is an overpayment is a ***recoverable amount***.

(2) If:

(a) the Commonwealth pays an amount to a person by way of a grant under Chapter 5; and

(b) a condition to which the grant is subject is not met;

the amount of the grant (or so much of the amount as the Secretary determines) is a ***recoverable amount***.

95-2 Recoverable amount is a debt

A *recoverable amount is a debt due to the Commonwealth and may be recovered by the Commonwealth in a court of competent jurisdiction.

95-3 Recovery by deductions from amounts payable to debtor

If an approved provider is liable to pay a *recoverable amount, the amount (or part of it) may be deducted from one or more other amounts payable to the approved provider under this Act.

95-4 Recovery where there is a transfer of places

If:

(a) a person is liable to pay a *recoverable amount because of an overpayment in respect of an *aged care service; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) all allocated *places included in the aged care service have been transferred to another person (the ***transferee***) under Division 16;

the recoverable amount (or part of it) may be deducted from one or more other amounts payable to the transferee under this Act.

95-5 Refund to transferee if Commonwealth makes double recovery

(1) If:

(a) a person (the ***debtor***) is liable to pay a *recoverable amount under this Part; and

(b) the Commonwealth recovers the amount (or part of it) from another person (the ***transferee***) by way of deductions under section 95-4; and

(c) the Commonwealth later recovers the amount (or part of it) from the debtor;

the Commonwealth is liable to make a refund to the transferee.

(2) The refund payable to the transferee is the smaller of the following amounts:

(a) the total amount recovered from the transferee by way of deductions under section 95-4;

(b) the amount recovered from the debtor.

95-6 Write-off and waiver of debt

The Secretary may, on behalf of the Commonwealth, determine to do any of the following:

(a) write off a debt or class of debts arising under this Act;

(b) waive the right of the Commonwealth to recover a debt or class of debts arising under this Act;

(c) allow an amount of a debt that is payable by a person to the Commonwealth under this Act to be paid in instalments.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Chapter 7—Miscellaneous

Division 96—Miscellaneous

96-1 Principles

(1) The Minister may make Principles, specified in the second column of the table, providing for matters:

(a) required or permitted by the corresponding Part or section of this Act specified in the third column of the table to be provided; or

(b) necessary or convenient to be provided in order to carry out or give effect to that Part or section.

Principles Minister may make

Item	Principles	Part or provision
1	Accountability Principles	Part 4.3
2	Accreditation Grant Principles	Part 5.4
3	Advocacy Grant Principles	Part 5.5
4	Allocation Principles	Part 2.2
5	Approval of Care Recipients Principles	Part 2.3
6	Approved Provider Principles	Part 2.1
7	Assessment Grant Principles	Part 5.3
8	Certification Principles	Part 2.6
9	Classification Principles	Part 2.4
10	Committee Principles	section 96-3
11	Community Care Grant Principles	Part 5.2
12	Community Care Subsidy Principles	Part 3.2
13	Community Visitors Grant Principles	Part 5.6
14	Extra Service Principles	Part 2.5

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Principles Minister may make		
Item	**Principles**	**Part or provision**
15	Flexible Care Subsidy Principles	Part 3.3
16	Information Principles	Part 6.2
17	Other Grants Principles	Part 5.7
18	Quality of Care Principles	Part 4.1
19	Records Principles	Part 6.3
20	Residential Care Grant Principles	Part 5.1
21	Residential Care Subsidy Principles	Part 3.1
22	Sanctions Principles	Part 4.4
23	User Rights Principles	Part 4.2

(2) Principles are disallowable instruments for the purposes of section 46A of the *Acts Interpretation Act 1901*.

96-2 Delegations

(1) The Secretary may, in writing, delegate to an *officer of the Department all or any of the powers of the Secretary under this Act, the regulations or any Principles made under section 96-1.

(2) In exercising his or her powers under subsection (1), the Secretary is to have regard to the powers to be exercised by the delegate and the responsibilities of the *officer to whom the power is delegated.

(3) The Secretary may, in writing, delegate to either or both of the following:

(a) the Secretary to the Department of Social Security;

(b) the *Repatriation Commission;

the Secretary's powers relating to making a determination of a care recipient's *ordinary income under section 44-24.

Note: The determination of a care recipient's *ordinary income is relevant to applying the income test under Subdivision 44-E and to working out the *standard resident contribution under Division 58.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(4) The Secretary may, in writing, delegate the Secretary's powers, under section 85-4 or 85-5, relating to reconsidering a determination made under section 44-24 to the *Repatriation Commission.

(5) The Secretary may, in writing, delegate to a person making an assessment for the purposes of section 22-4 all or any of the Secretary's functions under Part 2.3.

(6) The Secretary may, in writing, delegate to a body to which an *accreditation grant is payable any functions of the Secretary that the Secretary considers necessary for the purposes of the grant.

(7) If, under paragraph (3)(a), the Secretary delegates a power mentioned in subsection (3) to the Secretary to the Department of Social Security, the Secretary to the Department of Social Security may, by writing, sub-delegate the power to all or any of the following:

(a) an *officer of that Department; or

(b) the *CEO; or

(c) an *employee of the *Services Delivery Agency.

(8) If, under paragraph (3)(b) or subsection (4), the Secretary delegates a power mentioned in subsection (3) or (4) to the *Repatriation Commission, the *Repatriation Commission may, by writing, sub-delegate the power to any person to whom it may delegate powers under section 213 of the *Veterans' Entitlements Act 1986*.

(9) Sections 34AA, 34AB and 34A of the *Acts Interpretation Act 1901* apply in relation to a sub-delegation in a corresponding way to the way in which they apply to a delegation.

96-3 Committees

(1) The Minister may establish committees for the purposes of this Act.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(2) Without limiting subsection (1), the Minister may establish a committee for the following purposes:

(a) co-ordinating and reviewing:

(i) the resolution of complaints relating to approved providers, *aged care services or the provision of *aged care, being complaints in respect of matters dealt with under this Act or Principles made under section 96-1; or

(ii) the resolution of complaints relating to the administration of this Act or Principles made under section 96-1;

(b) in the circumstances set out in the Committee Principles, making determinations resolving those complaints.

(3) The Committee Principles may provide for the following matters in relation to a committee:

(a) its functions;

(b) its constitution;

(c) its composition;

(d) the remuneration (if any) of its members;

(e) the disclosure of members' interests;

(f) its procedures;

(g) the fees (if any) that may be charged, on behalf of the Commonwealth, for services provided by it;

(h) any other matter relating to its operation.

(4) Fees charged for a service provided by a committee must be reasonably related to the cost of providing the service and must not be such as to amount to taxation.

96-4 Care provided on behalf of an approved provider

A reference in this Act to an approved provider providing care includes a reference to the provision of that care by another person, on the approved provider's behalf, under a contract or arrangement entered into between the approved provider and the other person.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Note: The approved provider will still be subject to the responsibilities under Chapter 4 in respect of care provided by the other person.

96-5 Care recipients etc. lacking capacity to enter agreements

If:

(a) this Act provides for an approved provider and a care recipient, or a person proposing to enter an *aged care service, to enter into an agreement; and

(b) the care recipient or person is, because of any physical or mental incapacity, unable to enter into the agreement;

another person (other than an approved provider) representing the care recipient or person may enter into the agreement on behalf of the care recipient or person.

Note: The agreements provided for in this Act are *accommodation bond agreements, *community care agreements, *extra service agreements and *resident agreements.

96-6 Applications etc. on behalf of care recipients

If this Act provides for a care recipient to make an application or give information, the application may be made or the information given by a person authorised to act on the care recipient's behalf.

96-7 Withdrawal of applications

(1) A person who has made an application to the Secretary under this Act may withdraw the application at any time before the Secretary makes a decision relating to the application.

(2) If:

(a) this Act provides that an application under this Act is taken to be withdrawn if the application does not give further information, within a particular period, as requested by the Secretary; and

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) the Secretary, at the applicant's request, extends the period for giving the further information;

the application is not taken to be withdrawn unless the applicant does not give the further information within the period as extended.

96-8 Giving false or misleading information relating to income

A person is guilty of an offence if:

(a) the person gives to the Secretary information requested by the Secretary for the purpose of determining the person's ordinary income under section 44-24; and

(b) the information is false or misleading in a material particular.

Penalty: 30 penalty units.

Note: Chapter 2 of the Criminal Code sets out the general principles of criminal responsibility.

96-9 Application of the *Criminal Code*

Chapter 2 of the *Criminal Code* applies to all offences against this Act.

96-10 Appropriation

(1) Subject to subsection (2), subsidies payable under Chapter 3 are payable out of the Consolidated Revenue Fund, which is appropriated accordingly.

(2) This section does not apply to any amount payable in respect of treatment (within the meaning of Part V of the *Veterans' Entitlements Act 1986*) that the *Repatriation Commission has arranged under section 84 of that Act.

Note: Under Part V of the *Veterans' Entitlements Act 1986*, the treatments that the *Repatriation Commission can arrange could include the provision of *aged care for which subsidy is payable under Chapter 3 of this Act.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

96-11 Minister may give general policy directions

(1) The Secretary's functions under this Act must be performed, and the Secretary's powers under this Act must be exercised, in accordance with any general directions given to the Secretary by the Minister in writing.

(2) Subsection (1) applies to the performance of the Secretary's functions, or the exercise of the Secretary's powers, by the Secretary or by any person or body to whom functions or powers of the Secretary have been delegated or sub-delegated under this or any other Act.

(3) The Minister must not give such a direction more than 12 months after the commencement of this section. However, a direction may be revoked at any time.

(4) Subsection (1) does not empower the Minister to give directions that would be inconsistent with this Act, the regulations or Principles made under section 96-1.

(5) The Minister must cause a copy of any direction under subsection (1) to be laid before each House of the Parliament within 15 sitting days of that House after that direction was given.

96-12 Determinations by Minister to be laid before each House of the Parliament

The Minister must cause a copy of any determination made by the Minister under Chapter 3 to be laid before each House of the Parliament within 15 sitting days of that House after that determination was made.

96-13 Regulations

The Governor-General may make regulations prescribing matters:

(a) required or permitted by this Act to be prescribed; or

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

(b) necessary or convenient to be prescribed for carrying out or giving effect to this Act.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Schedule 1—Dictionary

Note: Section 1-3 describes how asterisks are used to identify terms that are defined in this Act.

1 Definitions

In this Act, unless the contrary intention appears:

accommodation bond, in relation to a person, means an amount of money paid or payable to an approved provider by the person for the person's *entry to a residential care service or flexible care service through which care is, or is to be, provided by the approved provider.

accommodation bond agreement has the meaning given in section 57-9.

accommodation bond balance, in relation to an *accommodation bond (other than an accommodation bond that is to be paid by periodic payments), is, at a particular time, an amount equal to the difference between:

(a) the amount of the accommodation bond; and

(b) any amounts that have been, or are permitted to be, deducted under section 57-19 as at that time.

accreditation body means a body to which an *accreditation grant is payable.

accreditation day has the meaning given in subsection 42-4(2).

accreditation grant means a grant payable under Part 5.4.

accreditation requirement means a requirement set out in section 42-4.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

adjusted subsidy place means a place included in a residential care service, or a part of a residential care service, that the Minister has determined under paragraph 44-19(1)(b) to be an adjusted subsidy residential care service.

advocacy grant means a grant payable under Part 5.5.

aged care means care of one or more of the following types:

(a) residential care;

(b) community care;

(c) flexible care.

aged care service means an undertaking through which *aged care is provided.

approved provider means a person or body in respect of which an approval under Part 2.1 is in force, and, to the extent provided for in section 8-6, includes any State or Territory, *authority of a State or Territory or *local government authority.

assessment grant means a grant payable under Part 5.3.

assisted resident has the meaning given by section 44-8.

authorised officer has the meaning given in section 90-3.

authority of a State or Territory means a body established for a public purpose by or under a law of a State or Territory.

available for allocation, in relation to a place, means determined by the Minister under section 12-3 to be available for allocation.

basic age pension amount means the annual maximum basic rate under point 1064-B1 of the *Social Security Act 1991* that applies to a person who is not a member of a couple within the meaning of that section.

business day means a day that is not a Saturday, Sunday or a public holiday in the place concerned.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

capital repayment deduction is an amount deducted, in accordance with section 43-6, from an amount of *residential care subsidy otherwise payable under Division 43.

capital works costs is defined in section 70-3.

care means services, or accommodation and services, provided to a person whose physical, mental or social functioning is affected to such a degree that the person cannot maintain himself or herself independently.

CEO means the Chief Executive Officer of the *Services Delivery Agency.

certified, in relation to a residential care service, means certified under Part 2.6.

classification level, in relation to a person, means the classification level to which the person has been classified under Part 2.4.

close relation has the meaning given in section 44-11.

community care has the meaning given by section 45-3.

community care agreement means an agreement referred to in section 61-1.

community care grant means a grant payable under Part 5.2.

community care service means an undertaking through which community care is provided.

community care subsidy means a subsidy payable under Part 3.2.

community visitors grant means a grant payable under Part 5.6.

concessional resident has the meaning given by section 44-7.

corporation means a trading or financial corporation within the meaning of paragraph 51(xx) of the Constitution.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

Clause 1

daily income tested reduction has the meaning given in step 4 of the income tested reduction calculator in section 44-21. However, section 44-22 or 44-23 may affect the meaning of this term in certain cases.

dependent child has the meaning given in section 44-11.

distinct part, in relation to a residential care service, has the meaning given by section 30-3.

employee, in relation to the *Services Delivery Agency, has the same meaning as in the *Commonwealth Services Delivery Agency Act 1997*.

entry, in relation to a person and an *aged care service, means the commencement of the provision of care to the person through that aged care service.

expiry date means:

(a) in relation to a classification under Part 2.4, the expiry date fixed under Division 27; or

(b) in relation to *extra service status for a residential care service, the expiry date fixed under section 33-2.

extended hospital leave, in relation to a care recipient provided with residential care, means leave taken by the care recipient under section 42-2, for a continuous period of 30 days or more, in order to attend a hospital for the purpose of receiving hospital treatment.

extra service agreement means an agreement referred to in paragraph 36-1(1)(b).

extra service place has the meaning given by section 31-1.

extra service status means the extra service status referred to in paragraph 31-1(a).

flexible care has the meaning given by section 49-3.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

flexible care service means an undertaking through which flexible care is provided.

flexible care subsidy means a subsidy payable under Part 3.3.

high level of residential care means a level of residential care corresponding to a *classification level applicable to residential care (other than a classification level applicable only to *respite care) that is not lower than the mid-point of all such classification levels that could apply to residential care.

homeowner has the meaning given in section 44-11.

income support payment means:

(a) an income support payment within the meaning of subsection 23(1) of the *Social Security Act 1991*; or

(b) an *income support supplement; or

(c) a payment of farm household support, or a drought relief payment, under the *Farm Household Support Act 1992*; or

(d) a payment of benefit under Part 2 of the *Student and Youth Assistance Act 1973*.

income support supplement means an income support supplement under Part IIIA of the *Veterans' Entitlements Act 1986*.

leave, in relation to a care recipient provided with residential care, has the meaning given by section 42-2.

local government authority means a body established for the purposes of local government by or under a law of a State or Territory.

lowest applicable classification level means the lowest applicable classification level for the purposes of subsection 25-2(3).

member of a couple has the meaning given in section 44-11.

monitoring powers has the meaning given in section 90-4.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

officer has the same meaning as in the *Public Service Act 1922*.

ordinary income has the meaning given in section 44-24. However, section 44-25 may affect the meaning of this term in certain cases.

ordinary income free area has the meaning given in section 44-26.

partner has the meaning given in section 44-11.

payment period means:

(a) in relation to residential care—a period under section 43-2 in respect of which *residential care subsidy is payable in respect of a residential care service; and

(b) in relation to community care—a period under section 47-2 in respect of which *community care subsidy is payable in respect of a community care service.

pensioner supplement is the supplement referred to in section 44-28.

people with special needs has the meaning given in section 11-3.

personal information means information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

place means a capacity within an *aged care service for provision of residential care, community care or flexible care to an individual.

protected information has the meaning given by section 86-1.

provide, in relation to care, includes the meaning given by section 96-4.

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

provisional allocation means an allocation of *places under Division 14 that has not taken effect under subsection 15-1(1).

provisional allocation period means the period referred to in section 15-7, at the end of which a *provisional allocation lapses.

recoverable amount has the meaning given in section 95-1.

region, in respect of a type of subsidy under Chapter 3, means a region for the purposes of section 12-6.

relinquish, in relation to a *place, means:*

(a) no longer conduct an *aged care service that includes that place; or

(b) no longer include that place in an aged care service that continues to be conducted;

but does not include a transfer of the place under Division 16.

Repatriation Commission means the Repatriation Commission continued in existence by section 179 of the *Veterans' Entitlements Act 1986*.

resident agreement means an agreement referred to in section 59-1.

residential care has the meaning given by section 41-3.

residential care grant means a grant payable under Part 5.1.

residential care service means an undertaking through which residential care is provided.

residential care subsidy means a subsidy payable under Part 3.1.

respite care means residential care 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. However, it does not include residential care provided through a residential care service

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

while the care recipient in question is on *leave under section 42-2 from another residential care service.

reviewable decision has the meaning given in section 85-1.

Secretary means the Secretary to the Department of Health and Family Services.

service pension has the same meaning as in subsection 5Q(1) of the *Veterans' Entitlements Act 1986.*

Services Delivery Agency means the Commonwealth Services Delivery Agency established by the *Commonwealth Services Delivery Agency Act 1997*.

standard pensioner contribution means an amount (rounded down to the nearest cent) equal to 85% of the *basic age pension amount worked out on a per day basis.

standard resident contribution means an amount referred to in section 58-3 or 58-4 (whichever is applicable).

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*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

[*Minister's second reading speech made in—*
House of Representatives on 26 March 1997
Senate on 16 June 1997]

(53/97)

*To find definitions of asterisked terms, see the Dictionary in Schedule 1.

I HEREBY CERTIFY that the above is a fair print of the Aged Care Bill 1997 which originated in the House of Representatives and has been finally passed by the Senate and the House of Representatives.

Clerk of the House of Representatives

IN THE NAME OF HER MAJESTY, I assent to this Act.

Governor-General
1997