EXPLANATORY STATEMENT

Issued by the authority of the Assistant Minister for Social Services

Aged Care Act 1997

Subsidy Principles 2014

The *Aged Care Act 1997* (the Act) provides for the regulation and funding of aged care services. Persons who are approved under the Act to provide aged care services (approved providers) can be eligible to receive subsidy payments in respect of the care they provide to approved care recipients.

Section 96-1 of the Act allows the Minister to make Principles providing for various matters required or permitted by a Part or section of the Act.

Among the Principles made under section 96-1 are the *Subsidy Principles 2014* (the Principles).

The Principles deal with:

- the eligibility requirements for the payment of subsidies and supplements in respect of care recipients in residential care and home care;
- the reductions to subsidy that may be made for care recipients in residential or home care; and
- eligibility for flexible care subsidy and the basis on which flexible care subsidy is paid.

These Principles only describe matters relating to subsidy and supplements for care recipients who are not continuing care recipients. The arrangements for care recipients who are continuing care recipients are described in the *Aged Care (Transitional Provisions) Act 1997* and the *Aged Care (Transitional Provisions) Principles 2014.*

The Principles are a legislative instrument for the purposes of the *Legislative Instruments Act 2003.*

Consultation

In April 2012, the former Government launched a major program of aged care reforms. The reform agenda was developed in close consultation with the aged care sector, including consumers, industry and professional bodies.

As part of the consultation on the proposed changes to the Act, and to delegated legislation, arising from the reforms, the former Government communicated its intention to examine the delegated legislation and, where possible, simplify it.

This intent was communicated in November 2012, with the public release of a paper providing an overview of the proposed legislative changes. A video presentation detailing the proposed reforms was also made available online to assist members of the public to understand these changes.

During late 2012 and in the first half of 2013, briefing sessions were held across Australia to provide information and to explain, in detail, the proposed legislative changes included in the package of Bills introduced into Parliament on 13 March 2013. As part of these consultations, the intention to make related changes to delegated legislation was again discussed. For those interested members of the public unable to attend the briefings, the presentation, supporting handouts, a detailed Question and Answer document and an information video were made available online.

During May 2014, an exposure draft of these Principles was made available for comment on the Department of Social Services' website, along with an Addendum to the explanatory document, *Overview: Proposed changes from 1 July 2014 to the Aged Care Principles made under the Aged Care Act 1997 - April 2014*, entitled *Addendum to the Overview: Draft Subsidy Principles 2014.* Comments on the draft Principles were invited and taken into account in the finalisation of these Principles.

Regulation Impact Statement

The Office of Best Practice Regulation has advised that no RIS is required (OBPR ID 16682).

Commencement

The Principles commence on 1 July 2014.

ATTACHMENT

Details of the Subsidy Principles 2014

Part 1 – Preliminary

Section 1 – Name of principles
This section states that the name of the Principles is the *Subsidy Principles 2014* (the Principles).

Section 2 – Commencement
This section provides that the Principles commence on 1 July 2014.

Section 3 – Authority
This section provides that the authority for making the Principles is section 96-1 of the *Aged Care Act 1997* (the Act).

Section 4 – Definitions
This section defines certain terms used in the Principles.

1997 scheme service is defined in section 64.

2001 scheme service is defined in section 65.

2005 scheme service is defined in section 66.

ACAP code in relation to a health condition specified in the table in Schedule 1, means the Aged Care Assessment Program code specified in the table for that health condition. This is based on the *Aged Care Assessment Program Data Dictionary* as published by the Australian Institute of Health and Welfare.

accepted mental health condition means a mental health condition for which liability has been accepted by the Repatriation Commission or the Military Rehabilitation and Compensation Commission to pay either a pension or compensation in accordance with the relevant Act.

accessible location means a location that has an Accessibility Remoteness Index of Australia (ARIA) value of more than 1.84 but no more than 3.51.

An ***accommodation wing*** of a residential care service includes: a building; a floor or level of a building; and an annex to a building, that is used to provide accommodation for a care recipient being provided with residential care.

An ***accreditation application*** means an application, by the approved provider of a residential care service to the Australian Aged Care Quality Agency for accreditation or re-accreditation of a service.

Act means the *Aged Care Act 1997*.

ARIA value in relation to a location, means the value given in accordance with a methodology for measuring the concept of remoteness. This methodology is set out the document *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)*.

assisted resident is defined in clause 1 of Schedule 1 to the *Aged Care (Transitional Provisions) Act 1997* as a person who meets the conditions described in section 44-8 of the *Aged Care (Transitional Provisions) Act 1997*. The criteria for determining assisted resident status are the same as for concessional resident status except that, at the time of entry to a residential care service, an assisted resident had assets of between 2.5 and 4 times the annual single basic age pension amount if they entered before 1 July 2005, or between 2.25 and 3.61 times the annual single basic age pension amount if they entered on or after 1 July 2005.

Australian accounting standards means the accounting standards as in force under section 334 of the *Corporations Act 2001*.

care day deficit, for a residential care service, means the number of days worked out for a quarter in accordance with section 19.

A ***care recipient's room***, in a residential care service, means a personal room or a part of a room that is intended to be occupied by a care recipient, which includes a bed, the areas in the immediate vicinity of the bed, the bathroom facilities and the contents of the room. For example, this includes the bedroom, en-suite/shared bathrooms and/or toilets; the contents of bedrooms and en-suite/shared bathrooms and/or toilets, such as walls, floors, ceilings, windows, equipment, furniture, fixtures, fittings and coverings.

Classification Principles means the *Classification Principles 2014* as in force under the 96-1 of the Act.

concessional resident is defined in clause 1 of Schedule 1 to the *Aged Care Transitional Provisions) Act 1997* as a person who meets the conditions described in section 44-7 of the *Aged Care (Transitional Provisions) Act 1997*. These conditions include that the person entered a residential care service before 20 March 2008 and, at the time the person entered the residential care service:

- the person was receiving an income support payment;
- the person was not a home owner (or the person's home was occupied by a protected person such as a partner or a dependent child); and
- the value of the person's assets was less than 2.5 times the annual single basic age pension amount if the person entered residential care prior to 1 July 2005, or less than 2.25 times the basic age pension amount if the person entered residential care on or after 1 July 2005.

episode of transition care means a continuous period of the provision of flexible care in the form of transition care to a care recipient by an approved provider.

essential expenses are defined in section 61 (for residential care) and section 96 (for home care). Expenditure on essential expenses is one of the matters taken into account when the Secretary is considering a care recipient's eligibility for a hardship determination.

An ***exceptional circumstances determination application*** is an application to the Secretary of the Department of Social Services by an approved provider of a residential care service for a determination under the Act that the service is taken to have met its accreditation requirements.

further transition care needs, for a care recipient, means the ACAT assessed needs of a care recipient during an episode of transition care.

Health Department means the Department responsible for the administration of the *National Health Act 1953.*

A ***highly accessible location*** means a location that has a value of no more than 1.84 using the ARIA methodology.

A ***homeowner*** is defined in section 48.

innovative care service means the provision of flexible care service in areas where mainstream aged care services may not appropriately meet the needs of a location or target group as defined in section 105.

in-patient hospital episode for a care recipient, means a continuous period of acute or subacute care provided to a care recipient as an in-patient of a hospital.

KICA-Cog means the Kimberley Indigenous Cognitive Assessment tool as it exists on 1 August 2013.

low-intensity therapy, for a care recipient, means therapy that maintains physical and cognitive functioning and facilitates improvement in the care recipient's capacity for activities of daily living.

low-means care recipient is defined in section 5.

major city means one of the major cities of Australia within the meaning of the *Australian Statistical Geography Standard (ASGS): Volume 5—Remoteness Structure*, July 2011, produced by the Australian Bureau of Statistics.

minimum monetary spend amount is defined in section 6.

moderately accessible location means a location that has an ARIA value of more than 3.51 but no more than 5.8.

multi-purpose service is defined in section 104.

A ***non-registered entity*** means an entity that is not a registered entity and has incurred a liability to pay payroll tax to a registered entity in relation to residential care provided to care recipients through a residential care service. An approved provider will be more likely to be a non-registered entity if it is operated by a charitable, religious or government provider.

NPI-NH test means the test called the Neuropsychiatric Inventory - Nursing Home Version as it exists on 1 August 2013.

A ***principal home*** is defined in section 11A of the *Social Security Act 1991*, other than subsections 11A(8) and 11A(9).

Psychogeriatric Assessment Scale means the assessment tool of that name as it exists on 1 August 2013.

Quality Agency means the Australian Aged Care Quality Agency. The Quality Agency is the accreditation body for residential aged care homes and is responsible for the quality review of home care services.

Quality Agency Principles means the Quality Agency Principles in force under the *Australian Aged Care Quality Agency Act 2013*.

quarter means a period of 3 months.

refurbishment cost, for a residential care service, is defined in section 7.

registered entity means an entity that is registered with a revenue office of a State or Territory for the purposes of paying payroll tax in accordance with the laws of that State or Territory. An approved provider will be more likely to be a registered entity if it is operated on a for profit basis.

remote location means a location that has an ARIA value of more than 5.8 but no more than 9.08.

Rowland Universal Dementia Assessment Scale means the assessment tool of the same name, as it exists on 1 August 2013.

Social Security Act means the *Social Security Act 1991*.

subacute care means the provision of medical or related care or services to a care recipient who is not in the acute phase of an illness. Examples of subacute care include geriatric evaluation and management, palliative care, psychogeriatric care and rehabilitation.

supported resident is defined in clause 1 of Schedule 1 to the *Aged Care (Transitional Provisions) Act 1997* and is one that meets the conditions described in section 44-5B of the *Aged Care (Transitional Provisions) Act 1997*. A person is a supported resident if they enter a residential care service as a permanent resident for the first time on or after 20 March 2008 and their assets at the time of entry are valued at or below a certain threshold determined by the Secretary by legislative instrument.

transition care means a form of flexible care that is provided at the conclusion of an in-patient hospital episode. It provides a package of services that includes low intensity therapy and either nursing support and/or personal care, as outlined in section 106.

unrealisable asset, of a care recipient, has the meaning given by subsections 11(12) and (13) of the *Social Security Act 1991.*

very remote location means a location that has an ARIA value of more than 9.08 but no more than 12.

veteran is a person who:
- has rendered eligible war service or is paid a pension under the Veterans' Entitlements Act; or
- is a member of the Forces; or
- is a member of a Peacekeeping Force;
- a member (or former member) within the meaning of the *Military Rehabilitation and Compensation Act 2004*; or
- is an employee within the meaning of the *Safety, Rehabilitation and Compensation Act 1988.*

Veterans' Entitlements Act means the *Veterans' Entitlements Act 1986.*

This section also notes that a number of expressions used in these Principles are defined in Schedule 1 of the Act.

Section 5 – Meaning of *low-means care recipient*
This section states that a care recipient is a low-means care recipient on a day if the care recipient is being provided with residential care and is eligible for an accommodation supplement under section 44-28 of the Act or, upon entry to the service, the care recipient's means tested amount was less than the maximum accommodation supplement amount for the entry day.

The maximum accommodation supplement amount is defined in subsection 44-21(6) of the Act and set by Ministerial determination.

Section 6 – Meaning of *minimum monetary spend amount* in relation to refurbished residential care service
This section outlines the meaning of the minimum monetary spend amount, in relation to a refurbished residential care service, being the amount worked out by multiplying $25,000 by 40 per cent of the lower of:
- the total number of care recipient's rooms before commencement of the refurbishment; and
- the total number of care recipient's rooms after completion of the refurbishment.

Example
The minimum monetary spend amount for a service with 100 care recipient's rooms before the refurbishment and 104 care recipient's rooms after the refurbishment would be: $25,000 × 40 per cent × 100 = $1,000,000.

Section 7 – Meaning of *refurbishment cost* in relation to residential care service
This section provides that the refurbishment cost in relation to a residential care service is the total cost of the refurbishment, or the proposed refurbishment, unless the refurbishment, or a proposed refurbishment, includes fire safety improvements and the cost of such improvements is greater than 25 per cent of the minimum monetary

spend amount. In this case, the refurbishment cost is the amount worked out by using the formula:

A – (B – C)

where:
A is the total cost of the refurbishment.

B is the cost of the fire safety improvements.

C is the amount that is 25 per cent of the minimum monetary spend amount.

Example
If the required minimum monetary spend amount is calculated to be $1,000,000 then only $250,000 of fire safety related expenditure can be counted in the refurbishment cost and at least $750,000 would need to be spent on other significant refurbishment work.

Example
This example demonstrates the calculation of the refurbishment cost, using the above formula, where the cost of fire safety improvements is greater than 25 per cent of the minimum monetary spend amount.

An approved provider spends a total of $1,100,000 on the refurbishment of their 100 care recipient's room service, including $400,000 spent to install fire sprinklers in the service. The calculated minimum monetary spend amount is $1,000,000 (refer to the example under section 6 to work out the 'minimum monetary spend amount').

In this example:
A = $1,100,000 (including the $400,000 spent on fire sprinkler installation).
B = $400,000 (cost of the fire sprinkler installation).
C = $250,000 (25 per cent of calculated minimum monetary spend amount of $1,000,000).

Refurbishment cost - $1,100,000 – ($400,000 – $250,000) = $950,000.

As the refurbishment cost is worked out to be $950,000, which is less than the required minimum monetary spend amount of $1,000,000, the approved provider would need to spend an additional $50,000 on non-fire safety work to meet the minimum monetary spend amount.

Chapter 2 – Residential care subsidy

Part 1 – Who is eligible for residential care subsidy?

Division 1 – Purpose of this Part

Section 8 – Purpose of this Part
This section describes the purpose of Part 1 which is to outline the matters in relation to whether an approved provider is eligible to receive residential care subsidy for the

provision of care, including the requirements for when a care recipient is on leave and provisions for a Secretary's determination on whether a residential care service has met its accreditation requirements.

Division 2 – Leave from residential care services

Section 9 – Care recipient provided with transition care
Section 42-2 of the Act describes the circumstances under which a care recipient, who is absent from a residential care service, is to be taken to be on leave.

In accordance with that subsection, this section specifies the requirements that must be met for a care recipient, for whom a flexible leave subsidy is payable for a day, to be on leave from a residential care service on that day. The requirement is that the type of care for which flexible care subsidy is payable must be transition care.

Notes included in the section remind the reader that:
- a care recipient can be taken to be provided with residential care whilst that person is on leave; and
- transition care is defined in section 106 of these Principles.

Division 3 – Exceptional circumstances determinations

Section 10 – Determination by Secretary
Subsection 42-5(1) of the Act allows the Secretary to make a determination that a residential care service is meeting its accreditation requirements where exceptional circumstances apply.

In accordance with that subsection, this section states that the Secretary may determine that a residential care service is taken to meet its accreditation requirements, if:
- an approved provider provides the Secretary with an application for an exceptional circumstances determination; and
- the Secretary is satisfied of the matters under section 12.

Notes included in the section remind the reader that:
- an approved provider is not eligible for residential care subsidy if it does not meet its accreditation requirements; and
- exceptional circumstances determination application is defined in section 4.

Section 11 – Application for determination
This section specifies the information about a residential care service that the CEO of the Australian Aged Care Quality Agency (the Quality Agency) may be requested to provide the Secretary with, including:
- whether the Quality Agency has received an accreditation application from an approved provider; and
- if so, the status of the application.

This section also provides that if a response from the CEO of the Quality Agency states that a decision on an application has been made not to accredit a residential aged care service or that no decision has been made on the application, then:

- the accreditation application is taken to include an exceptional circumstances determination application; and
- the date the response was received by the Secretary is taken to be the date the exceptional circumstances determination application was received by the Secretary.

This applies whether or not the accreditation application complies with the Quality Agency Principles.

Nothing in this section prevents an approved provider from making an application to the Secretary for an exceptional circumstances determination.

A note refers readers to the definition of accreditation application in section 4.

Section 12 – Matters the Secretary must take into account
This section sets out matters the Secretary must consider when determining whether a residential care service has met its accreditation requirements, including:
- the reasons for the service not meeting the standards required for accreditation;
- the action required for the residential care service to meet those standards; and
- the impact of the residential care service not meeting those standards on the residential care, accommodation and other services provided to care recipients.

In addition, this section also provides that the Secretary may also take into account any other relevant matter.

A note included in this section reminds readers that, in accordance with subsection 42-5(1) of the Act, the Secretary must first be satisfied that exceptional circumstances apply to the service before making a determination.

Part 2 – How is residential care subsidy paid?

Division 1 – Purpose of this Part

Section 13 – Purpose of this Part
Division 43 of the Act sets out how residential care subsidy is paid.

In accordance with that Division, this section describes the purpose of Part 2, which is to specify matters relating to the payment of residential care subsidy to an approved provider by the Commonwealth for the provision of residential care, including:
- the kinds of payments made that are capital payments and the methods for working out the proportions to be deducted that are equal to the capital payments; and
- the conditions to be met for non-compliance deductions to not apply in respect of the service and the circumstances in which non-compliance deductions will not apply even if a condition has not been met.

Division 2 – Capital repayment deductions

Section 14 – Kinds of payments that are capital payments
In accordance with the definition of capital payment in subsection 43-6(5) of the Act, this section outlines the kinds of payments that are considered a capital payment, including:

- financial assistance by way of a grant made under the *Aged or Disabled Persons Care Act 1954*, as in force before it was repealed;
- a grant of a Commonwealth benefit made under the *National Health Act 1953*;
- a grant made under the *Aged or Disabled Persons Hostels Act 1972*, as in force before it was repealed;
- a grant approved on, or after 1 July 1989 made under the Residential Aged Care Upgrading Program; and
- capital funding approved on or after 1 July 1989, made under the Small Homes Capital Funding Initiative.

This section notes that a residential care grant is also a capital payment, as defined in subsection 43-6(5) of the Act.

Section 15 - Working out proportion of amounts to be deducted if distinct part of residential care service has extra service status
Subsection 43-6(3) of the Act lists circumstances where only a proportion of the amounts equal to the capital payments made in respect of the service are to be deducted under an agreement.

In accordance with that subsection, this section provides the formula for calculating the proportion of the amounts equal to the capital payments made in respect of a residential care service, being:

$$P \times \frac{ESP}{AP}$$

where:

AP which is short for allocated places, is the number of residential care places allocated to the service.

ESP which is short for extra service places, is the number of places in a distinct part of a residential care service for which extra service status is granted.

P which is short for proportion, is:

- 100% for each capital payment for which the first capital repayment deduction is to be made within 5 years after approval of the capital payment; or
- 100% reduced by 10% for each complete year over 5 years.

For proportions calculated under this section:

- a place can only be counted as an extra service, or allocated place if the allocation has taken effect under section 15-1 of the Act; and
- a period of at least 6 months and less than 1 year is to be counted as a complete year.

A note is included at the end of this section reminding readers that a provisionally allocated place cannot be counted (because of section 15-1 of the Act).

Division 3 – Non-compliance deductions

Section 16 – When non-compliance deductions may apply – conditions that must be met

Subsection 43-8(1) of the Act provides for circumstances where non-compliance deductions apply. In accordance with that subsection, this section states that if the conditions in relation to the proportion of care that is to be provided to assisted residents, concessional residents, low-means care recipients, recipients of respite care and supported residents have not been met, then non-compliance deductions apply.

The note to this section reminds the reader that assisted resident, concessional resident, low-means care recipient, and supported resident are defined in section 4 and respite care is defined in the dictionary to the Act.

Section 17 – Circumstances in which non-compliance deductions do not apply

This section lists the circumstances in which non-compliance deductions do not apply even where a condition specified in section 16 has not been met.

The circumstances in which non-compliance deductions do not apply for a quarter, in respect of a service are when:

- fewer than 6 care recipients being provided with care through the service in the quarter entered after 30 September 1997; or
- the service has extra service status and fewer than 6 care recipients being provided with care (not in an extra service place) in the quarter entered the service after 30 September 1997; or
- the care day deficit for the quarter is less than 92.

The note to this section indicates that care day deficit is worked out under section 19.

This section also states that if:

- one or more allocated places are transferred from one residential care service to another;
- some or all of the places are occupied by care recipients from the first service; and
- before the transfer, the second service was not subject to a non-compliance deduction;

then the deductions do not apply to the service receiving the transferred places for the number of quarters that is the lesser of 4 and the number of additional places received, divided by 3 rounded up to the nearest whole number.

In addition, this section also states the circumstances in which non-compliance deductions do not apply in respect of a residential care service, for a quarter. These are where:

- at least one of the allocated places is not occupied for the quarter; and
- the care day deficit would have been less than 92 if the unoccupied place or places was occupied by an assisted, concessional, supported resident, or a low-means care recipient.

Section 18 – Working out amounts of non-compliance deductions
This section sets out the method for working out the amount of non-compliance deduction for a quarter, in respect of a residential care service, being:

$$\frac{A \times (B - C)}{D}$$

where:

A is the care day deficit for the quarter in respect of the residential care service.

B is the total of the basic subsidy amounts for each day that residential care is provided through a service, in the quarter for each care recipient.

C is the total of the reductions worked out under sections 44-21 to 44-23 of the Act and by applying the income test under Subdivision 44-E of the *Aged Care (Transitional Provisions) Act 1997* for each day that residential care is provided through the service in the quarter for each care recipient.

D is the total number of days that residential care is provided in the quarter for each care recipient.

This section also states that the non-compliance deduction is taken to be zero if ***C*** is greater than ***B***.

Section 19 – Working out the *care day deficit*
This section presents the care day deficit calculator which is used to work out the care day deficit for a residential care service for a quarter. The care day deficit is worked out as follows:

- Step 1 - Count the number of care recipients being provided with residential care through the residential care service who entered the service after 30 September 1997 and during the quarter, are receiving care on a permanent basis and are not occupying a place that is an extra service place.
- Step 2 - Multiply the number of care recipients counted under step 1 by the number of days in the quarter.
- Step 3 - Count the number of care recipients mentioned in step 1 who are: assisted residents; and concessional residents; and low-means care recipients; and supported residents.
- Step 4 - Multiply the number of care recipients counted under step 3 by the number of days in the quarter.
- Step 5 - Subtract the number worked out under step 4 from the number worked out under step 2.

Part 3 – What is the amount of residential care subsidy?

Division 1 – Purpose of this Part

Section 20 – Purpose of this Part
Division 44 of the Act prescribes the amount of residential care subsidy.

In accordance with that Division, this section describes the purpose of Part 3 which is to set out matters that relate to the amount of residential care subsidy payable to an approved provider in respect of a care recipient who is being provided with residential care through a service, including:

- other matters on which the Minister may base a determination of different amounts of basic subsidy;
- primary supplements that may apply to the care recipient, including the respite, oxygen, enteral feeding, dementia and severe behaviours, or payroll tax supplement;
- matters that relate to the reduction in subsidy that may apply to a care recipient, including the compensation payment or care subsidy reduction; and
- other supplements that may apply to a care recipient, including the accommodation, hardship, viability, veterans' or homeless supplement.

Division 2 – Basic subsidy amount

Section 21 – Determination by Minister of basic subsidy amount for care recipient – other matters

This section provides that the Minister may base a determination of different amounts of basic subsidy on the following:

- whether the service provides a greater proportion of care to recipients of respite care than the proportion required by conditions of the allocated place;
- whether, for a particular day, the number of days where a care recipient has previously been provided with respite care during the financial year, equals or exceeds 63 days or another amount as determined by the Secretary in accordance with section 23;
- if an appraisal of a care recipient's care needs has not been received within the timeframe specified in paragraph 26-1(a) or (b) of the Act, the circumstances of the appraisal not being received within that period; and
- if a reappraisal of a care recipient's care needs was not received within the timeframe specified in section 27-2 of the Act, the circumstances of the reappraisal not being received within that period.

Division 3 – Primary supplements

Subdivision A – Respite supplement

Section 22 – Respite supplement

This section states that the respite supplement for a care recipient is the sum of all respite supplements for a payment period on which an eligible care recipient was provided with residential care through the relevant service.

Section 23 – Eligibility for respite supplement

This section outlines the eligibility criteria for a care recipient to receive a respite supplement. A care recipient is eligible for a respite supplement on a particular day if, on that day:

- the residential care provided to the care recipient through the service was provided as respite care;

- the care recipient was not precluded from receiving respite care in accordance with the care recipient's approval under Part 2.3 of the Act; and
- the care recipient had not previously been provided with respite care, for the financial year, for equal or greater than 63 days or another period as determined by the Secretary.

This section also outlines the criteria by which the Secretary may increase the number of days a care recipient can be provided with respite care by up to 21 days, including because of:

- carer stress;
- severity of the care recipient's condition;
- carer absence; and
- any other relevant matter.

An increase in the days that respite care can be provided to a care recipient can be made more than once in a financial year.

Subdivision B – Oxygen supplement

Section 24 – Oxygen supplement

This section states that the oxygen supplement for a care recipient is the sum of all oxygen supplements for a payment period on which:

- a care recipient was provided with residential care through the relevant service;
- a determination was in force under section 25; and
- the provision of residential care included the provision of oxygen as specified in section 26.

Section 25 – Eligibility for oxygen supplement – determination by Secretary

This section states that a residential care provider may apply to the Secretary for a determination that a care recipient is eligible for an oxygen supplement. On receipt of an application, the Secretary may determine if the care recipient is eligible for the oxygen supplement.

The section also:

- outlines the criteria for the application, including that the application must be in a form approved by the Secretary and include all information and documentation specified in the approved form; and
- states that the Secretary must notify the applicant of the decision in writing within 28 days of making a decision on an application. If the application for a determination is refused, then this decision is a reviewable decision under section 27.

A determination that a care recipient is eligible for the oxygen supplement is not a legislative instrument. This statement is included in section 25 to assist readers, as the instrument is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 26 – Circumstances relating to provision of oxygen
Section 24 requires that in order for a care recipient to be eligible for the oxygen supplement, the service must be providing the oxygen to the care recipient in the circumstances specified in section 26. This section specifies those circumstances as follows:

- the residential care service must hire, temporarily obtain or own the materials and equipment used to provide the oxygen;
- oxygen must not be provided because of a medical emergency or on a short-term or episodic basis;
- the care recipient must have a continued need for the oxygen as certified by a medical practitioner in writing; and
- the oxygen must be provided in the most economical way available, taking into account the medical needs of the care recipient.

Section 27 – Reviewable decision
Part 6.1 of the Act sets out the process for the reconsideration and review of decisions. This section states that a decision to refuse to make a determination in relation to a care recipient's eligibility to receive the oxygen supplement is a reviewable decision under section 85-1 of the Act and that Part 6.1 of the Act applies.

Subdivision C – Enteral feeding supplement

Section 28 – Enteral feeding supplement
This section states that in respect of a payment period, the enteral feeding supplement is the sum of all the enteral feeding supplements for the days during the period on which:

- the care recipient was provided with residential care through the relevant service;
- a determination was in force under section 29; and
- the provision of residential care included the provision of enteral feeding in the circumstances specified in section 30.

Section 29 – Eligibility for enteral feeding supplement – determination by Secretary
This section states that a residential care provider may apply to the Secretary for a determination that a care recipient is eligible for an enteral feeding supplement. On receipt of an application, the Secretary may determine the eligibility of the care recipient to receive the enteral feeding supplement.

The section:

- outlines the criteria for the application, including that the application must be in a form approved by the Secretary and include all information and documentation specified in the approved form; and
- states that after making a decision on the application, the Secretary must notify the applicant of the decision in writing within 28 days of receiving the application. A decision to refuse an application is a reviewable decision under section 31.

A determination that a care recipient is eligible for the enteral feeding supplement is not a legislative instrument. This statement is included in section 29 to assist readers, as the instrument is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 30 – Circumstances relating to provision of enteral feeding
Section 28 requires that in order for a care recipient to be eligible for the enteral feeding supplement, the service must be providing the enteral feeding to the care recipient in the circumstances specified in section 30. This section specifies those circumstances as follows:

- there must be a written notice from a medical practitioner stating that the care recipient requires enteral feeding;
- the care recipient must be provided with a liquid dietary formula administered by a specific feeding method;
- the formula must be certified by a medical practitioner or dietician as nutritionally complete;
- the enteral feeding must not be intermittent or supplementary to oral feeding; and
- the enteral feeding must be provided in the most economical way available, taking into account the care recipient's needs

Section 31 – Reviewable decision
This section states that a decision to refuse to make a determination that a care recipient is eligible for an enteral feeding supplement is a reviewable decision under section 85-1 of the Act and that Part 6.1 of the Act applies.

Subdivision D – Dementia and severe behaviours supplement

Section 32 – Dementia and severe behaviours supplement
This section provides that the dementia and severe behaviours supplement for a care in respect of a payment period ending on or before 31 July 2014 is the sum of all the dementia and severe behaviours supplements for the days during the period on which the care recipient was:

- provided with residential care through the residential care service in question; and
- eligible for that supplement.

Section 33 – Eligibility for dementia and severe behaviours supplement
This section outlines the criteria for a care recipient's eligibility for the dementia and severe behaviours supplement. A care recipient is eligible for a dementia and severe behaviours supplement on a particular day in a payment period ending on or before 31 July 2014 if:

- on that day, the service provided a care recipient with residential care that was not respite care;
- the care recipient has been diagnosed by a medical practitioner with one or more of the specified health conditions (ACAP code between 0500 and 0599). ACAP code is defined in section 4;
- the assessment requirements in section 34 are satisfied in respect of the care recipient on the day; and
- the approved provider has a written copy of the care recipient's medical diagnosis and assessment results (as described in section 34).

This section also states that:

- a care recipient is not eligible for the dementia and severe behaviours supplement for a certain day unless a claim for residential care subsidy, which includes the

dementia and severe behaviours supplement, is made within 56 days after that day; and

- a care recipient who enters after 30 June 2014 is not eligible for the dementia and severe behaviours supplement. Subdivision D recognises that, consistent with the assessment requirements in section 34, an assessment must be conducted more than 7 days after the care recipient commenced being provided with care. A care recipient who enters care on 30 June 2014 could be assessed on 7 July 2014 and the supplement would become payable until 31 July 2014. The supplement would not be payable on 7 July 2014 for a care recipient who enters after 30 June 2014 because the assessment could not have been done in accordance with the assessment requirements (and the supplement would not therefore be payable on 7 July 2014 or throughout July 2014).

Section 34 – Assessment requirements

This section outlines the requirements for assessment of a care recipient. In summary:

- the care recipient must have been assessed using the NPI-NH test before the relevant day; and
- results must include:
  - a frequency score of 4 and a severity score of 3 for at least two behavioural domains. The behavioural domains are: delusions; hallucinations; agitation/aggression; depression/dysphoria; anxiety; and disinhibition;
  - a score of 4 or above for occupational disruptiveness for at least 2 behavioural domains; and
  - a total score of 50 or above for the 12 behavioural domains mentioned in the NPI-NH test. The NPI-NH test is defined in section 4.

The assessment must have been conducted, in respect of the care recipient and the relevant day:

- by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner;
- if the supplement was not payable for the care recipient for the day before the relevant day, within 3 months of the relevant day;
- if the dementia and severe behaviours supplement was payable for the care recipient for the day before the relevant day, and the relevant day was within 12 months of the care recipient's eligibility start day, within 3 months before the care recipient's eligibility start day;
- if the dementia and severe behaviours supplement was payable for the care recipient for the day before the relevant day, and the relevant day was within 12 months of an anniversary of the care recipient's eligibility start day, within 3 months before that anniversary; and
- more than 7 days after the care recipient commenced being provided with residential care through the residential care service (not including a day on which the care recipient was on pre-entry leave).

A care recipient's eligibility start day is:

- the first day for which residential care subsidy that includes the dementia and severe behaviours supplement becomes payable for the care recipient; or
- if residential care subsidy that includes the dementia and severe behaviours supplement was payable for the care recipient but has ceased to be payable for the

care recipient, the first day for which residential care subsidy that includes the dementia and severe behaviours supplement becomes payable again for the care recipient.

The results of the assessment must have been given to the Secretary, but not during the period of 28 days (not including any day on which the care recipient was on pre-entry leave) starting on the day on which an approved provider began providing residential care to the care recipient.

A note informs readers that, in accordance with section 112, this Subdivision expires on 1 November 2014.

Subdivision E – Payroll tax supplement

Section 35 – Payroll tax supplement
This section states that the payroll tax supplement for a care recipient is the total of all payroll tax supplements for the days where:

- the care recipient was receiving residential care from the service;
- the care recipient's classification was not at the lowest level; and
- the service met eligibility requirements for the payroll tax supplement under section 36.

This section reminds readers that the lowest applicable classification level is defined in the Dictionary to the Act and is also discussed in the *Classification Principles 2014*.

Section 36 – Eligibility for payroll tax supplement
This section outlines requirements that a service must meet to be eligible for a payroll tax supplement, including:

- if the provider is a registered entity, they must have incurred a payroll tax liability to the relevant State of Territory revenue office; and
- if the provider is not a registered entity:
  - the provider must have been given, from a registered entity, an itemised invoice for services, including salary, wages and payroll tax;
  - the provider must have incurred a liability to pay payroll tax to the registered entity; and
  - the provider must have met requirements under subsection 36(2), being that the approved provider must, at the end of each payment period, notify the Secretary in writing of changes to their liability for payroll tax for the prior payment period and the extent to which their liability for payroll tax has been affected by any variation.

Notes in this section remind readers that:

- the terms 'registered entity' and 'non-registered entity' are defined in section 4; and
- in accordance with section 112, this Subdivision expires on 1 April 2015.

Division 4 – Reductions in subsidy

Subdivision A – Compensation payment reduction

Section 37 – Determination by Secretary if judgement or settlement does not, or does not adequately, take into account future costs of residential care

Subsection 44-20(5) of the Act provides that if a care recipient is entitled to compensation under a judgment or settlement and it does not take into account the future costs of providing residential care to the care recipient, the Secretary may, in accordance with these Principles, determine that the judgment or settlement is to be treated as having taken into account the cost of providing that residential care and the part of the compensation that is to be treated as relating to the future costs of providing residential care (for the purposes of working out the care subsidy reduction for the care recipient).

Similarly subsection 44-20(6) provides that if a care recipient is entitled to compensation under a settlement that takes into account the future costs of providing residential care to the recipient, and the Secretary is satisfied that the settlement does not adequately take into account the future costs of providing residential care, the Secretary may, in accordance with these Principles, determine the part of the compensation that is to be treated as relating to the future costs of providing residential care.

For the purposes of these subsections this section provides that in making either of the determinations described above the Secretary must consider:

- the amount of the judgment or settlement;
- for a judgment - the components stated in the judgment and the amount stated for each component (such as loss of income or costs of future care);
- the proportion of liability apportioned to the care recipient; and
- the amounts spent on residential care at the time of the judgment or settlement.

Other matters the Secretary may take into account include:

- the amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;
- the amounts spent on care (other than residential care) at the time of the judgment or settlement;
- the likely cost of residential care for the care recipient;
- other costs of care for which the care recipient is likely to be liable;
- the amount of the accommodation bond, accommodation payment or accommodation contribution paid or payable by the care recipient; and
- other reasonable amounts (not related to care) that the care recipient has spent at the time of the judgment or settlement or is likely to be liable for.

The purpose of these considerations is to ensure that all relevant matters are considered and that care recipients are not disadvantaged.

Section 38 – Determination by Secretary if compensation information not given on request

This section provides that in determining compensation payment reductions for a care recipient if information or a document requested about a judgment, settlement or reimbursement arrangement is not produced or given, the Secretary must take into account the amounts spent on residential care at the time of the judgment, settlement or reimbursement arrangement.

The Secretary may also take into account any other matters the Secretary considers relevant, including:

- the amount of the judgment, settlement or reimbursement arrangement;
- for a judgment - the components stated in the judgment and the amount stated for each component;
- the proportion of liability apportioned to the care recipient;
- the amounts that are likely to be paid to or withheld by other government agencies because of the judgment, settlement or reimbursement arrangement;
- the amounts spent on care (other than residential care) at the time of the judgment, settlement or reimbursement arrangement;
- the likely cost of residential care for the care recipient;
- other costs of care for which the care recipient is likely to be liable;
- the amount of the accommodation bond, accommodation payment or accommodation contribution paid or payable by the care recipient;
- other amounts, not related to care, that the care recipient had spent at the time of the judgment, settlement or reimbursement arrangement or is likely to be liable for.

Subdivision B – Care subsidy reduction – general

Section 39 – Classes of people for whom care subsidy reduction is taken to be zero

Paragraph 44-23(1)(c) of the Act provides that these Principles can prescribe a class of care recipient for whom the care subsidy reduction is set to zero. This means that a care recipient within this class will not be charged a means tested care fee but can still be asked to pay the standard resident contribution and may also be liable to pay some or all of their accommodation costs.

This section prescribes those classes of care recipient in residential care for whom a care subsidy reduction is taken to be zero.

The prescribed classes are:

- care recipients who exit the service and do not enter another or who die prior to the approved provider being informed of the care recipient's care subsidy reduction;
- care recipients who are not told of their care subsidy reduction within six months of entering the service. If a care recipient falls within this class, they will only fit within this class from the day they enter the service until they are told of their care subsidy reduction. That is, once the care recipient is advised of the amount of his or her care subsidy reduction, the care recipient will no longer have his or her care subsidy reduction set to zero;
- care recipients with one or more dependent children;

- care recipients who fit the description of former prisoners of war as outlined in paragraph 85(4)(b) of the Veterans' Entitlement Act; and
- care recipients whose care subsidy reduction calculates to less than $1 per day.

Section 40 – Matters to which Secretary must have regard in deciding whether to determine if care subsidy reduction is to be taken to be zero

This section outlines the matters the Secretary must consider in deciding whether to set a care recipient's care subsidy reduction to zero under subsection 44-23(4) of the Act. The Secretary must have regard to:

- the care recipient's total assessable income worked out under section 44-24 of the Act and section 41 of these Principles and assets valued under section 44-26A of the Act and section 47 of these Principles;
- the care recipient's financial arrangements;
- the care recipient's entitlement to income support under the Social Security Act, Veterans' Entitlement Act or from any other source;
- whether the care recipient has sought to gain information regarding his or her entitlement to income support;
- whether the care recipient has access to support under section 1129 of the Social Security Act, the pension loans scheme or from any other source;
- whether the care recipient does not have access to any of their income;
- if there is a charge on the care recipient's income where the payment of resident fees cannot take priority;
- whether any of the care recipient's assets are unrealisable as defined in section 4 of these Principles; and
- whether the care recipient is temporarily in Australia.

The Secretary may also consider any other matters that are relevant.

To enable the Secretary to have regard to the care recipient's entitlement to income support or other benefits the Secretary may require the care recipient to contact the relevant Department about his or her entitlement to an income support payment or seek advice about the care recipient's financial arrangements, from Centrelink's Financial Information Service.

Subdivision C - Care subsidy reduction - amounts excluded from total assessable income

Section 41 - Working out care recipient's means tested amount - amounts excluded from care recipient's total assessable income

Section 41 prescribes the income amounts that are to be excluded from determinations of a care recipient's assessable income where the care recipient is specified in sections 42 to 46 of these Principles. The income amounts are:

- disability allowances and impairment compensation payments mentioned in section 42;
- gifts mentioned in section 43;
- receipts for rent where the care recipient is paying his or her accommodation costs as either a daily accommodation contribution or daily accommodation payment (as mentioned in section 44);
- GST compensation mentioned in section 45; and

- clean energy payments mentioned in section 46.

Section 42 – Excluded amounts – disability pensions and permanent impairment compensation payments
This section provides that the amount of disability pension paid to a person who has qualifying service under section 7A of the Veterans' Entitlements Act (or is the partner of such a person) should be an excluded amount when determining the care recipient's total assessable income. The amount will only be an excluded amount if it is also exempt under section 5H of the Veterans Entitlements Act.

For a person who is or has been a member as defined under the *Military, Rehabilitation and Compensation Act 2004* (or their partner) excluded amounts are:
- any compensation for permanent impairment paid to the person under Part 2 of Chapter 4 of the *Military, Rehabilitation and Compensation Act 2004;* and
- any amount of Special Rate Disability Pension paid to the person under Part 6 of Chapter 4 of the *Military, Rehabilitation and Compensation Act 2004*.

Section 43 – Excluded amounts - gifts
This section states that:
- for a person who disposed of ordinary income on or prior to 20 August 1996, the amount of ordinary income disposed of is an excluded amount for the purposes of calculating the care recipient's total assessable income. The section also notes those sections of the Social Security Act and the Veterans' Entitlement Act that deals with disposal of ordinary income; and
- for a person who disposed of assets on or prior to 20 August 1996, the amount of ordinary income the person is taken to have received is an excluded amount from the care recipient's total assessable income. This subsection notes the sections of the Social Security Act and the Veterans' Entitlement Act that deal with deemed income on financial assets.

Section 44 – Excluded amounts – rent receipts
Section 44 provides that where a care recipient is meeting his or her accommodation costs by daily accommodation contribution or daily accommodation payment, the rental income from the care recipient's former principal home will be an excluded amount when determining his or her total assessable income. This rule applies provided that at least part of the accommodation costs are being met by daily accommodation contribution or daily accommodation payment.

The first note to this section explains that paragraph 8(8)(znaa) of the Social Security Act and paragraph 5H(8)(nf) of the Veterans Entitlement Act describe how income is defined for those Acts where a person is liable to pay a daily accommodation contribution or daily accommodation payment.

The second note to this section explains that subsection 5L(6A) of the Veterans' Entitlements Act explains how assets are defined for the purposes of that Act where a person is liable to pay a daily accommodation contribution or daily accommodation payment.

Section 45 – Excluded amounts – GST compensation
This section applies to:

- a person who receives a pension under Part II or IV of the Veterans' Entitlement Act at a rate determined through that Act by reference to the following provisions of that Act:
  - section 22, for a person on a disability pension at the general rate;
  - sections 22 and 27, for a person on a disability pension at the general rate plus an increased rate for war-related injury;
  - sections 23 and 27, for a person on a disability pension at the intermediate rate or such a person who also has an increased rate for war-related injury;
  - section 24, for a person on a disability pension at the special rate;
  - subsection 30(1), for a person receiving a war widow or widower pension;
- a person who receives a payment under Part 6 of Chapter 4 or Part 2 of Chapter 5 of the *Military Rehabilitation and Compensation Act 2004* at a rate determined under the following provisions of that Act:
  - sections 198 and 204, for a person on a Special Rate Disability Pension;
  - subsection 234(5) for a person receiving weekly compensation for the death of a partner.

This section provides that an amount equal to four per cent of the amount paid to a person under the provisions of the Veterans' Entitlement Act listed above or the *Military Rehabilitation and Compensation Act 2004* listed above is an excluded amount when determining the care recipient's total assessable income.

Notes to this section explain that:

- pensions (other than service pensions) payable to veterans' and their dependants are dealt with in Part II of the Veterans' Entitlement Act;
- pensions that are payable to members of the Defence Force or a Peacekeeping Force and their dependants is dealt with in Part IV of the Veterans' Entitlement Act;
- a choice to receive a Special Rate Disability Pension instead of compensation is afforded to former members who are entitled to compensation for their incapacity to work in accordance with Part 6 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004*; and
- wholly dependent partners of deceased members are entitled to compensation which can be taken as a lump sum or as a weekly amount, under Part 2 of Chapter 5 of the *Military Rehabilitation and Compensation Act 2004*.

Section 46 – Excluded amounts – clean energy payments
This section specifies that each of the following amounts (paid to a care recipient in accordance with the Social Security Act or the Veterans' Entitlements Act) are excluded amounts:

- the clean energy advance;
- the clean energy supplement; and
- the quarterly clean energy supplement.

Subdivision D – Care subsidy reduction – value of assets

Section 47 – Working out care recipient's means tested amount – value of assets
Section 47 provides, how in addition to section 44-26A of the Act, the value of someone's assets is to be determined for the purposes of the working out the means tested amount.

The value of a person's assets is to be worked out in accordance with Division 1 of part 3.12 of the Social Security Act. However, this amount is to be reduced by any compensation payments received by the person under:

- the *Compensation (Japanese Internment) Act 2001*;
- the *Veterans' Entitlements (Compensation – Japanese Internment) Regulations 2001*;
- Part 2 of the *Veterans' Entitlements (Clarke Review) Act 2004*; or
- Schedule 5 to the Social *Security and Veterans' Affairs Legislation Amendment (One-Off Payments and Other 2007 Budget Measures) Act 2007*.

The section also identifies provisions of the Social Security Act that do not apply when working out the value of a person's assets under the Act.

Value of home

Subsection 44-26A(7) of the Act provides that in working out the value of the assets of someone who is or was a homeowner, the value of the home above the maximum home value is to be disregarded. The maximum home value is a defined term set by Ministerial determination. The determination effectively caps the value of the home that is included as an asset.

This section also provides that the value of the home should first be worked out under section 47 of the Principles before disregarding the value of the home above the maximum home value.

Example

Josie is entering care on 7 July 2014. She has a home that will be unoccupied when she enters care. The estimated market value of the home is $600,000. Josie has an outstanding mortgage over the home valued at $55,000.

To work out the value of the home to be included in the value of Josie's assets first subtract the outstanding mortgage from the estimated market value to calculate the net value ($600,000 - $55,000 = $545,000). The net value of Josie's home is $545,000.

Assuming that the maximum home value is $154,179.20, the amount of the net value of the home above this amount should be disregarded. Therefore the value of Josie's home to be included when valuing her assets is $154,179.20.

Section 48 – Meaning of *homeowner*
This section specifies for the purposes of the definition of homeowner that:

- a person who is not a member of a couple is a homeowner if the person has a right or an interest in the principal home and the right or interest gives the person

reasonable security of tenure in the home. Principal home is defined in section 4; and

- a person who is a member of a couple is a homeowner if the person, or their partner, has a right or interest in either the person, the partner's, or a combination of both, principal home and the right or interest gives the person or their partner reasonable security of interest in the home.

For the purposes of this section the premises that can be defined as a person's principal home, includes premises that constitute, or is taken to constitute, a retirement village as in accordance with the meaning under subsections 12(3) and 12(4) of the Social Security Act.

Division 5 – Other supplements

Subdivision A – Accommodation supplement

Section 49 – Purpose of this Subdivision
This section states that Subdivision A specifies other matters that relate to the determination of the amount of accommodation supplement payable for a care recipient for a day.

Section 50 – Matters on which determination of accommodation supplement amount may be based
This section states that the Minister may determine the amount of accommodation supplement payable for a care recipient for a day, or the method for working out the amount, based on either or both of the following:

- whether the Secretary has made a determination under subsection 52(1) or 53(1) of these Principles (that the service has been significantly refurbished); and
- whether more than 40 per cent of care recipients being provided with residential care (other than as respite care) through the service are assisted residents, concessional residents, low-means care recipients or supported residents.

The effect of this section is to allow the Minister to determine different rates of accommodation supplement based on these factors. A note to the section reminds the reader that there are other factors that can also influence the rate of accommodation supplement and that there are described in section 44-28 of the Act (such as the care recipient's income and assets).

Section 51 – Application for determination
This section provides that:

- an approved provider of a refurbished residential care service may apply to the Secretary for a determination that their residential care service is significantly refurbished;
- an approved provider with a proposal for refurbishment of their residential care service may apply to the Secretary for a determination that their residential care service will be significantly refurbished;
- an application must be in writing, in a form approved by the Secretary and accompanied by the required supporting information and documentation as specified in the application form; and

- there must be a separate application for each residential aged care service for which a determination of significant refurbishment is sought. If an approved provider has more than one residential care service, a separate application must be submitted for each service.

Section 52 – Determination in relation to residential care service that has been significantly refurbished

After receiving an application from an approved provider of a refurbished service, the Secretary may determine, in writing, that the approved provider's residential care service is significantly refurbished.

Notes included in the section provide that:

- for the purposes of this section, in certain circumstances the Secretary must not make a determination (as noted in this section and in section 54);
- for the purposes of clarity, a determination made under this section is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*; and
- if an application for a determination is refused, the applicant may seek to have the decision reviewed under section 85-1 of the Act.

The section also sets out the criteria that must be met for the Secretary to determine that a refurbished residential care service is significantly refurbished. In summary, the Secretary must not make a determination unless the Secretary is satisfied that:

- the refurbishment was completed on or after 20 April 2012;
- the improvements that have been made have resulted in the service being significantly different in form, quality and functionality;
- a significant proportion of the areas of the service that have been refurbished are areas that are accessible to, and for the use of, care recipients for the provision of residential care;
- the refurbishment provides significant benefits to assisted, concessional, and supported residents and low-means care recipients;
- the relevant costs of the refurbishment will be capitalised for the purposes of the Australian accounting standards because the refurbishment consisted of structural improvements or because those costs can be depreciated because they relate to fixtures, fittings or anything else that can be removed intact;
- the refurbishment:
  - means that at least 40 per cent of the care recipients being provided with care through the service have a room that has been significantly refurbished. Example 1 (below) demonstrates this; or
  - provides a significant benefit to at least 40 per cent of care recipients. This is intended to allow consideration of refurbishments that, for example, involve refurbished care recipient's rooms and common area refurbishments. Changes to common areas benefit care recipients as they provide access to improved facilities and amenities. Example 2 (below) demonstrates this; or
  - consisted of an extension to the service involving an increase of at least 25 per cent of the number of care recipient's rooms. The cost to build an extension, such as a new accommodation wing, is typically higher than for refurbishments that do not include extensions. To recognise those higher costs, this criterion requires the significant refurbishment to have increased the

number of care recipient's rooms by at least 25 per cent. Example 3 (below) demonstrates this;
- the proportion of the total number of care recipient's rooms that are available after the refurbishment for assisted residents, concessional residents, low-means care recipients or supported residents is equivalent to, or higher than, the proportion of the total number of care recipient's rooms that were available before the refurbishment for these groups of care recipients;
- that the refurbishment cost is at least the minimum monetary spend amount, as defined in section 6.

Subsection 52(3) provides that, in deciding whether to be satisfied that the refurbishment was completed on or after 20 April 2012, the Secretary must take into account:
- if the refurbishment consisted solely of the building of a new accommodation wing, the date when the occupancy certificate (or equivalent) was issued for the new wing. Accommodation wing is defined in section 4;
- if the refurbishment did not include the building of a new accommodation wing, the date when all work involved in the refurbishment was completed;
- if the refurbishment consisted of the building of a new accommodation wing and the refurbishment of existing parts of the service, the later of the date when the occupancy certificate (or equivalent) was issued for the new wing and the date when all work involved in the refurbishment was completed; and
- any other matter the Secretary considers to be relevant.

Example 1

A residential service accommodates 100 residents in 40 × two-bed rooms (80 care recipients' rooms) and 20 × single-bed rooms (20 care recipients' rooms).

A refurbishment to the service is completed and improvements to care recipients' rooms were made in the following combination:
- 20 × two-bed rooms (40 per cent of care recipients have a refurbished room); or
- 10 × two-bed rooms and 20 × single-bed rooms (40 per cent of care recipients have a refurbished room).

Either of the above combinations would satisfy the requirement that at least 40 per cent of the care recipients have a significantly refurbished room.

Example 2

A residential service accommodating 100 residents elects to refurbish:
- 10 × two-bed rooms (benefits 20 per cent of care recipients);
- 10 × single-bed rooms (benefits 10 per cent of care recipients); and
- common living areas accessible to all care recipients (benefits 100 per cent of residents).

In this example, the Secretary may consider, depending on the scope and significance of the changes to common areas, that the requirements have been met, even though less than 40 per cent of care recipients benefited from a direct care recipient's room

refurbishment. Alternatively, the facility could decide to refurbish an additional 10 care recipients' rooms which would allow them to more simply prove they have met the criteria, as at least 40 per cent of the care recipients would have a significantly refurbished care recipient's room.

Example 3

A residential service with 100 care recipients' rooms (accommodating 100 residents) adds an extension in the form of a new accommodation wing with 15 × two-bed rooms, noting that this is the equivalent of 30 care recipients' rooms. The additional percentage of care recipients' rooms (30 per cent) satisfies the minimum requirement of 25 per cent additional care recipients' rooms.

Where a provider has undertaken an extension (but does not meet the requirement that there be an extension involving an increase of at least 25 per cent of care recipients' rooms), a provider may still meet the requirement that the refurbishment has resulted in at least 40 per cent of care recipients having rooms that have been significantly refurbished if, in combination with the additional care recipients' rooms in the new wing, the approved provider also made additional improvements to existing care recipients' rooms in the residential care service.

For example, a residential service with 100 care recipients' rooms may add a new accommodation wing comprising 10 × two-bed rooms (20 care recipient's rooms), noting that this number (20 per cent) is insufficient to meet the requirement that the number of care recipient's rooms increase by at least 25 per cent.

However, in addition to the extension the service also undertakes refurbishments to its existing care recipients' rooms as follows: 10 × two-bed rooms (20 care recipients' rooms) and 10 × single-bed rooms (10 care recipients' rooms).

The total number of care recipients' rooms involved in the refurbishment is 50 (20 care recipients' rooms in the extension plus 30 care recipients' rooms within the existing service buildings). As this is the equivalent of 50 per cent of the initial number of care recipients' rooms, the refurbishment will meet and surpass the requirement that at least 40 per cent of the care recipients have a significantly refurbished care recipient's room.

Example 4

A residential care service is expanded from 50 care recipients' rooms (with 25 rooms, that is 50 per cent, available to supported, concessional or assisted residents) to 80 care recipients' rooms. Following the expansion, at least 50 per cent (40 care recipients' rooms) of the 80 care recipients' rooms would have to be available to supported, concessional or assisted residents.

Alternatively, if the refurbishment resulted in a reduction in care recipient's room numbers to 40, then after the refurbishment, at least 50 per cent (20 care recipients' rooms) of the 40 care recipients' rooms would have to be available to supported, concessional or assisted residents.

Section 53 – Determination in relation to residential care service that is proposed to be significantly refurbished

Subsection 53(1) provides that if the Secretary receives an application from an approved provider with a proposal for a refurbishment of their residential care service, the Secretary may determine that the approved provider's residential care service is a significantly refurbished service, subject to the condition that the determination does not take effect unless:

- upon completion of the proposed refurbishment, the approved provider gives the Secretary, using an approved form, written information substantiating the completed significant refurbishment. The written information supplied by the approved provider must demonstrate fulfilment of the criteria described under subsection 53(3); and
- the Secretary notifies the approved provider that he or she is satisfied that the criteria referred to in paragraphs 53(3)(a) – (h) have been met based on the information provided by the approved provider.

Notes included at the end of subsection 53(1) provide that:

- a determination must not be made if the Secretary is not satisfied of the matters in subsection 53(2) (described below) or if the refurbishment consists only of routine repairs, maintenance of premises, replacement of furniture or fire safety improvements (see section 58);
- a determination made under subsection 53(1) is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003* This statement is included to assist readers, as the instrument is not a legislative instrument within the meaning of that section; and
- if an application for a determination is refused, the applicant may seek to have the decision reviewed under section 85-1 of the Act.

Subsection 53(2) provides that the Secretary must not make a determination under subsection (1) unless the Secretary is satisfied that:

- the proposed refurbishment includes improvements that will provide a significant difference in form, quality or functionality following the refurbishment;
- a significant proportion of the areas of the service that are proposed to be refurbished are areas that are accessible to, and for the use of, care recipients;
- the proposed refurbishment will provide significant benefits to assisted, concessional, and supported residents and low-means care recipients;
- the relevant costs of the proposed refurbishment will be capitalised for the purposes of the Australian accounting standards because the proposed refurbishment will consist of structural improvements or because those costs will be able to be depreciated because they will relate to fixtures, fittings or anything else that can be removed intact;
- that as a result of the proposed refurbishment:
  - at least 40 per cent of the care recipients who will be provided with care through the service will have a room that has been significantly refurbished; or
  - there will be significant benefit to at least 40 per cent of care recipients; or
  - there will be an extension to the service involving an increase of at least 25 per cent of the number of care recipient's rooms. The cost to build an extension, such as a new accommodation wing, is typically higher than for refurbishments that do not include extensions. To recognise those higher costs,

this criterion requires the significant refurbishment to have increased the number of care recipient's rooms by at least 25 per cent;

- the proportion of the total number of care recipient's rooms that will be available after the proposed refurbishment for assisted residents, concessional residents, low-means care recipients or supported residents will be equivalent to, or higher than, the proportion of the total number of care recipient's rooms that were available before the proposed refurbishment for these groups of care recipients; and
- the refurbishment cost will be at least the minimum monetary spend amount, as defined in section 6.

Subsection 53(3) sets out the information that must be provided to the Secretary by an approved provider of a refurbished residential care service, including information showing that:

- the proposed refurbishment has been completed;
- the improvements that have been made have resulted in the service being significantly different in form, quality and functionality;
- a significant proportion of the refurbished areas are areas that are accessible to, and for the use of, care recipients for the provision of residential care;
- the refurbishment provides significant benefit to assisted, concessional and supported residents and low-means care recipients;
- the relevant refurbishment costs will be capitalised for the purposes of the Australian accounting standards because the refurbishment consisted of structural improvements or because those costs can be depreciated because they relate to fixtures, fittings or anything else that can be removed intact;
- the refurbishment:
  - has resulted in at least 40 per cent of the care recipients having significantly refurbished rooms; or
  - provides significant benefits to at least 40 per cent of care recipients; or
  - consisted of an extension that involving an increase of at least 25 per cent of the number of care recipient's rooms;
- the proportion of the total number of care recipient's rooms that are available after the refurbishment for assisted residents, concessional residents, low-means care recipients or supported residents is equivalent to, or higher than, the proportion of the total number of care recipient's rooms that were available before the refurbishment for these groups of care recipients; and
- the refurbishment cost is at least the minimum monetary spend amount, as defined in section 6.

This section also provides that:

- where the Secretary requires additional information to decide whether to be satisfied that the criteria have been met, the approved provider may be notified to provide the information within 28 days;
- the Secretary must make a decision as to whether he or she is satisfied that the criteria have been met and notify the approved provider of such a decision in writing within 28 days after receiving the required information from the approved provider. If the Secretary has requested additional information, the period of time starting from the date of request through to and including the date of receipt by the Secretary of that additional information is not counted towards the 28 day period;

- if the Secretary decides that he or she is not satisfied that the criteria have been met, the applicant may seek to have the decision reviewed in accordance with section 85-1 of the Act; and
- if the Secretary is satisfied that the criteria have been met, the notice from the Secretary to the approved provider must specify the date on which the determination becomes effective. The date of effect is provided by subsection 57(2).

Section 54 – Circumstances in which Secretary must not make determination
This section states that the Secretary will not determine that a refurbished residential care service is (or a proposed refurbishment of a residential service will be) significantly refurbished if the refurbishment consists only of routine repairs, maintenance activity, replacement of furniture, or fire safety improvements.

Section 55 – Requests for further information etc.
This section provides that:
- if the Secretary requires additional information prior to making a determination of an application, the applicant may be asked to provide the information. For example, if it is not clear from the information provided with the application whether or not a necessary condition has been met, the Secretary may seek clarification before making a decision. The applicant may be asked to provide the information within 28 days; and
- if the information sought is not provided within the period specified in the notice, the application for a determination is taken to be withdrawn. The notice must include a statement setting out this effect.

Section 56 – Notification of Secretary's decision
This section:
- requires the Secretary to notify the applicant of his or her decision, in writing, on whether to make the determination under subsection 52(1) or 53(1);
- provides that if a determination is made in relation to an application for a completed refurbishment, the date on which the determination is effective must be stated on the notice. This date will be 1 July 2014 (if the application for the determination was received before this date) or if the application was received after this date, the date the application was received;
- provides that if a determination is made in relation to a proposed refurbishment, the notice must include a statement setting out the conditions as outlined in subsection 53(1) (including the information referred to in subsection 53(3)); and
- provides that in all cases the written notice must be provided within 60 days after the Secretary has received the application, unless a request to the applicant has been made for further information. If the Secretary has requested additional information, the period of time starting from the date of request through to and including the date of receipt by the Secretary of that additional information is not counted towards the 60 day period.

Section 57 – Day of effect of determination
This section provides that a determination that a residential care service is significantly refurbished will take effect:
- for applications received on or before 31 July 2014 (where the refurbishment was completed before 1 July 2014) - on 1 July 2014; and

- in any other case - on the date the application was received.

A determination in relation to a residential care service that is proposed to be significantly refurbished, takes effect on the date the Secretary receives the written information substantiating the completed significant refurbishment.

Section 58 – Determinations are not legislative instruments
This provision is included to assist readers, as the Secretary's determinations relating to significant refurbishment are not legislative instruments within the meaning of section 5 of the *Legislative Instruments Act 2003.*

Section 59 – Reviewable decisions
This section provides that the following decisions are reviewable decisions for the purposes of section 85-1 of the Act:

- a decision under subsections 52(1) (for a service that has been refurbished) or subsection 53(1) (for a service that is proposed to be refurbished) to refuse to make a determination in relation to the residential care service; and
- a decision under paragraph 53(5)(a) that the Secretary is not satisfied that the criteria described in paragraphs 53(1)(b) have been met in relation to a refurbished service.

Part 6.1 of the Act applies to these reviewable decisions.

Subdivision B – Hardship supplement

Section 60 – Eligibility for hardship supplement – determination by Secretary
Subsection 44-31(2) of the Act provides that the Secretary must have regard to matters set out in these Principles when deciding whether to determine that a care recipient is eligible for a hardship supplement in respect of their standard resident contribution and/or the means tested care fee.

There are three circumstances in which the Secretary must not make a financial hardship determination in relation to a care recipient:

- If the care recipient has not had their means assessed the Secretary must not make a financial hardship determination.

- The value of the care recipient's assets, as assessed under the Act and these Principle must be less than or equal to 1.5 times the basic age pension amount (as defined in Schedule 1 to the Act), the pension supplement amount and the clean energy supplement. If the assets exceed this amount, the Secretary must not make a financial hardship determination. When considering the value of the care recipient's assets, unrealisable assets will not be considered. An unrealisable asset is defined in the Social Security Act. It includes an asset the person cannot sell or realise, or cannot be reasonably expected to sell or realise. It also includes an asset the person cannot use as a security for borrowing or be reasonably expected to use as a security for borrowing.

- The Secretary must not make a determination if the care recipient has gifted more than $10,000 in the previous 12 months or more than $30,000 in the previous five years.

In deciding whether to make a financial hardship determination, the Secretary may have regard to:

- the care recipient's total assessable income worked out under the Act and these Principles and the amount of income available to the care recipient after expenditure on essential expenses. In particular the Secretary will consider whether the care recipient has less than 15 per cent of their income remaining after paying essential expenses. The list of essential expenses is included at section 61;
- the care recipient's financial arrangements;
- the care recipient's entitlement to income support;
- whether the care recipient has sought to determine his or her entitlement to a pension, benefit or other income support payment;
- whether the care recipient has access to financial assistance under section 1129 or Division 4 of Part 3.12 of the Social Security Act or from any other source;
- whether the care recipient is unable to access any of their income;
- whether there is a charge over the care recipient's income over which the payment of fees cannot practically take precedence;
- whether the care recipient is in Australia on a permanent basis; and
- any other matters the Secretary considers relevant.

Section 61 – Meaning of *essential expenses* for a recipient of residential care

This section lists the items that would be considered an essential expense. It is not an exhaustive list. Essential expenses include:

- resident fees;
- rent or mortgage payments for the principal home where a partner or dependent child remains in the care recipient's principal home;
- private health cover;
- ambulance cover;
- medical expenses including expenses incurred under a health professional's direction;
- transport costs to attend medical appointments;
- dental care;
- one pair of prescription glasses per year or contact lenses;
- artificial limbs, eyes or hearing aids for amounts that are the not already covered by other government schemes or programs;
- wheelchair and mobility aids; and
- a funeral plan which is being paid on a periodic basis.

The section also lists three types of expenditure that will not be considered essential expenses by the Secretary when deciding to make a financial hardship determination. These expenditures are:

- extra service fees for a place in a residential care service that has extra service status;
- amounts paid for additional care and services; and
- amounts spent by someone else authorised to act on the person's behalf other than for the benefit of the person.

Section 62 – Circumstances in which Secretary may revoke financial hardship determination
This section provides that a hardship determination may be revoked by the Secretary if:

- the care recipient's circumstances have changed. An example of how a person's circumstances may change is if the person's unrealisable assets become realisable; and
- the Secretary is satisfied that the care recipient would not be subject to financial hardship if the care recipient was to pay a daily amount of resident fees that is more than the amount specified in the determination.

Subdivision C – Viability supplement

Section 63 – Viability supplement
This section states that in respect of a payment period, the viability supplement for a care recipient is the sum of all the viability supplements for the days during the period on which:

- the care recipient was provided with residential care through the service in question; and
- the residential care service was either a 1997, 2001 or 2005 scheme service; and
- the residential care service or a distinct part of the service does not have extra service status.

Section 64 – Meaning of *1997 scheme service*
A residential care service will be considered a 1997 scheme service for the number of days the service meets the requirements set out in this section.

The section describes a scoring system that calculates whether a residential care service has met the requirements to be considered a 1997 scheme service.

Section 65 – Meaning of *2001 scheme service*
A residential care service will be considered a 2001 scheme service for the number of days the service meets the requirements set out in this section.

The section describes a scoring system that can be used in different circumstances to calculate whether a residential care service has met the requirements to be considered a 2001 scheme service.

Section 66 – Meaning of *2005 scheme service*
A residential care service will be considered a 2005 scheme service for the number of days the service meets the requirements set out in this section.

The section includes a scoring system that can be used in different circumstances to calculate whether a residential care service has met the requirements to be considered a 2005 scheme service.

Subdivision D – Veterans' supplement

Section 67 – Veterans' supplement
This section states that in respect of a payment period, the veterans' supplement is the sum of all veterans' supplements for the days during the period on which residential care was provided to an eligible care recipient through the service in question.

Section 68 – Eligibility for veterans' supplement
This section outlines the eligibility requirements for a care recipient to receive the veterans' supplement for a particular day, including if:

- the care recipient is a veteran with an accepted mental health condition on that day. An accepted mental health condition is a mental health condition for which liability has been accepted by the Repatriation Commission or the Military Rehabilitation and Compensation Commission to pay either a pension or compensation in accordance with the relevant Act; and
- before or on that day, the care recipient has authorised either, or both, the Secretary of the Department of Veterans' Affairs or the Secretary of the Department of Social Services to disclose to the approved provider that the care recipient is a veteran with an accepted mental health condition.

Subdivision E – Homeless supplement

Section 69 – Homeless supplement
This section states that for a payment period, the homeless supplement for a care recipient is the sum of all homeless supplements paid for the days during the period on which residential care was provided to the care recipient through the service in question and the service met the eligibility requirements under section 70 of these Principles.

Section 70 – Eligibility for homeless supplement
This section outlines the eligibility requirements for a residential care service to receive a homeless supplement for a particular day. A service meets the requirements for eligibility on a particular day if:

- at least 50% of care recipients provided with residential care (other than respite care) through the service have been appraised using appraisal tool A in subclause 2(1) of Schedule 2 as demonstrating complex behavioural needs and social disadvantage associated with their background as a homeless person; and
- either the allocation of places was made subject to conditions relating to caring for people with a history of being homeless or the approved provider or its key personnel have experience or the capacity to provide specialist services, for such people.

Chapter 3 – Home care subsidy

Part 1 – Who is eligible for home care subsidy?

Division 1 – Purpose of this Part

Section 71 – Purpose of this Part

This Part specifies requirements relating to the suspension, on a temporary basis, of the provision of home care to a care recipient in accordance with a home care agreement.

Division 2 – Suspension of home care

Section 72 – Suspension of home care
This section specifies the requirements that relate to the temporary suspension of the provision of home care to a care recipient in accordance with a home care agreement.

The section recognises that a care recipient may request that the provision of home care be suspended. In such circumstances:
- the home care agreement remains in force throughout the suspension period;
- home care is taken to have been provided on each day of the suspension period; and
- the suspension period includes the commencement day but does not include the day the provision of home care recommences.

Part 2 – What is the amount of home care subsidy?

Division 1 – Purpose of this Part

Section 73 – Purpose of this Part
The purpose of this Part is to detail the circumstances and conditions under which home care subsidy amounts will be payable to an approved provider of a home care service. The home care subsidy amount includes primary supplements (the oxygen supplement, the enteral feeding supplement, the dementia and cognition supplement, and the veterans' supplement) and other supplements (the hardship supplement and the viability supplement).

The Part also describes reductions to subsidy that may apply to the care recipient (the compensation payment reduction and the care subsidy reduction).

Division 2 – Primary supplements

Subdivision A – Oxygen supplement

Section 74 – Oxygen supplement
This section states that in respect of a payment period, the oxygen supplement is the sum of all the oxygen supplements for the days during the period on which:
- there was in force a home care agreement between the care recipient and home care service in question; and
- a determination under section 75 was in force; and
- the circumstances in section 76 are met.

Section 75 – Eligibility for oxygen supplement – determination by Secretary
This section states that a home care provider may apply to the Secretary for a determination that a care recipient is eligible for an oxygen supplement. On receipt of an application, the Secretary may determine if the care recipient is eligible for the oxygen supplement.

The section also:

- outlines the criteria for the application, including that the application must be in a form approved by the Secretary and include all information and documentation specified in the approved form; and
- states that the Secretary must notify the applicant of the decision in writing within 28 days of making a decision on an application. If the application for a determination is refused, then this decision is a reviewable decision under section 77.

A determination that a care recipient is eligible for the oxygen supplement is not a legislative instrument. This statement is included to assist readers, as the instrument is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 76 – Circumstances relating to provision of oxygen

Section 74 requires that in order for a care recipient to be eligible for the oxygen supplement, the service must be providing the oxygen to the care recipient in the circumstances specified in section 76. This section specifies those circumstances as follows:

- the home care service must hire, temporarily obtain or own the materials and equipment used to provide the oxygen;
- oxygen must not be provided because of a medical emergency or on a short-term or episodic basis;
- the care recipient must have a continued need for the oxygen as certified by a medical practitioner in writing; and
- the oxygen must be provided in the most economical way available, taking into account the medical needs of the care recipient.

Section 77 – Reviewable decision

Part 6.1 of the Act sets out the process for the reconsideration and review of decisions. This section states that a decision to refuse to make a determination in relation to a care recipient's eligibility to receive the oxygen supplement is a reviewable decision under section 85-1 of the Act and that Part 6.1 of the Act applies.

Subdivision B – Enteral feeding supplement

Section 78 – Enteral feeding supplement

This section states that in respect of a payment period, the enteral feeding supplement is the sum of all the enteral feeding supplements for the days during the period on which:

- there was in force a home care agreement between the care recipient and home care service in question; and
- a determination under section 79 was in force; and
- the circumstances in section 80 are met.

Section 79 – Eligibility for enteral feeding supplement – determination by Secretary

This section states that a home care provider may apply to the Secretary for a determination that a care recipient is eligible for an enteral feeding supplement. On

receipt of an application, the Secretary may determine the eligibility of the care recipient to receive the enteral feeding supplement.

The section:

- outlines the criteria for the application, including that the application must be in a form approved by the Secretary and include all information and documentation specified in the approved form; and
- states that after making a decision on the application, the Secretary must notify the applicant of the decision in writing within 28 days of receiving the application. A decision to refuse an application is a reviewable decision under section 81.

A determination that a care recipient is eligible for the enteral feeding supplement is not a legislative instrument. This statement is included in section 79 to assist readers, as the instrument is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 80 – Circumstances relating to provision of enteral feeding

Section 80 requires that in order for a care recipient to be eligible for the enteral feeding supplement, the service must be providing the enteral feeding to the care recipient in the circumstances specified in this section as follows:

- there must be a written notice from a medical practitioner stating that the care recipient requires enteral feeding;
- the care recipient must be provided with a liquid dietary formula administered by a specific feeding method;
- the formula must be certified by a medical practitioner or dietician as nutritionally complete;
- the enteral feeding must not be intermittent or supplementary to oral feeding; and
- the enteral feeding must be provided in the most economical way available, taking into account the care recipient's needs.

Section 81 – Reviewable decision

This section provides that a decision to refuse to make a determination that a care recipient is eligible for an enteral feeding supplement, is a reviewable decision in accordance with section 85-1 of the Act. Part 6.1 of the Act applies to such a reviewable decision as if a reference in that part included a reference to these Principles.

Subdivision C – Dementia and cognition supplement

Section 82 – Dementia and cognition supplement

Section 82 states that the dementia and cognition supplement is only be payable to an approved provider, in respect of a care recipient, for the days in a payment period in which:

- there was in force a home care agreement between the care recipient and home care service in question; and
- the care recipient was eligible for the dementia and cognition supplement.

Section 83 – Eligibility for dementia and cognition supplement

This section sets out the eligibility criteria for the dementia and cognition supplement in home care. The dementia and cognition supplement is not payable for a care recipient for whom the veterans' supplement is being paid.

To be eligible for the dementia and cognition supplement there must be a home care agreement in force between the approved provider and the care recipient. In addition, one of the following criteria must be met:

- an assessment has been conducted in accordance with the *Psychogeriatric Assessment Scale (PAS)* and undertaken by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner, resulting in a score of 10 or more; or
- the care recipient is from a culturally or linguistically diverse background and an assessment has been undertaken in accordance with the *Rowland Universal Dementia Assessment Scale (RUDAS*), by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner, resulting in a score of 22 or less; or
- the care recipient is an Aboriginal person, or a Torres Strait Islander, living in a rural or remote area and an assessment has been undertaken in accordance with the *Kimberley Indigenous Cognitive Assessment (KICA-Cog)* by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner or by a health practitioner trained in its use, resulting in a score of 33 or less.

The approved provider must also keep a record of the assessment mentioned above.

In addition to a care recipient who is assessed as eligible in the way described above, a care recipient who, immediately before 1 August 2013, was receiving care, or was approved to receive care, in the form of extended aged care at home – dementia, is eligible for the dementia and cognition supplement in home care.

Subdivision D – Veterans' supplement

Section 84 – Veterans' supplement

This section provides that the veterans' supplement is payable to an approved provider, in respect of a care recipient, for the days in a payment period in which:

- there was in force a home care agreement between the care recipient and home care service in question; and
- the care recipient was eligible for the veterans' supplement.

Section 85 – Eligibility for veterans' supplement

Section 85 sets out the eligibility criteria for the veterans' supplement in home care. The requirements for the veterans' supplement include:

- that the care recipient was a veteran (within the meaning set out in section 4) and had an accepted mental health condition (in accordance with the meaning set out in section 4); and
- that the care recipient has authorised the disclosure to the approved provider that the care recipient is a veteran with an accepted mental health condition.

Division 3 – Reductions in subsidy

Subdivision A – Compensation payment reduction

Section 86 – Determination by Secretary if judgment or settlement does not, or does not adequately, take into account future costs of home care

Subsection 48-5(5) of the Act provides that if a care recipient is entitled to compensation under a judgment or settlement and it does not take into account the future costs of providing home care to the care recipient, the Secretary may, in accordance with these Principles, determine that the judgment or settlement is to be treated as having taken into account the cost of providing that home care and the part of the compensation that is to be treated as relating to the future costs of providing home care (for the purposes of working out the care subsidy reduction for the care recipient).

Similarly subsection 48-5(6) provides that if a care recipient is entitled to compensation under a settlement that takes into account the future costs of providing home care to the recipient, and the Secretary is satisfied that the settlement does not adequately take into account the future costs of providing home care, the Secretary may, in accordance with these Principles, determine the part of the compensation that is to be treated as relating to the future costs of providing home care.

For the purposes of these subsections this section provides that in making either of the determinations described above the Secretary must consider:
- the amount of the judgment or settlement;
- for a judgment - the components stated in the judgment and the amount stated for each component (such as loss of income or costs of future care);
- the proportion of liability apportioned to the care recipient; and
- the amounts spent on home care at the time of the judgment or settlement.

Other matters the Secretary may take into account include:
- the amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;
- the amounts spent on care (other than home care) at the time of the judgment or settlement;
- the likely cost of home care for the care recipient;
- other costs of care for which the care recipient is likely to be liable; and
- other reasonable amounts (not related to care) that the care recipient has spent at the time of the judgment or settlement or is likely to be liable for.

The purpose of these considerations is to ensure that all relevant matters are considered and that care recipients are not disadvantaged.

Section 87 – Determination by Secretary if compensation information not given on request

This section provides that in determining compensation payment reductions for a care recipient if information or a document requested about a judgment, settlement or reimbursement arrangement is not produced or given, the Secretary must take into account the amounts spent on home care at the time of the judgment, settlement or reimbursement arrangement.

The Secretary may also take into account any other matters the Secretary considers relevant, including:
- the amount of the judgment, settlement or reimbursement arrangement;

- for a judgment - the components stated in the judgment and the amount stated for each component;
- the proportion of liability apportioned to the care recipient;
- the amounts that are likely to be paid to or withheld by other government agencies because of the judgment, settlement or reimbursement arrangement;
- the amounts spent on care (other than home care) at the time of the judgment, settlement or reimbursement arrangement;
- the likely cost of home care for the care recipient;
- other costs of care for which the care recipient is likely to be liable; and
- other amounts, not related to care, that the care recipient has spent at the time of the judgment, settlement or reimbursement arrangement or is likely to be liable for.

Subdivision B – Care subsidy reduction – general

Section 88 – Classes of people for whom care subsidy reduction is taken to be zero

Paragraph 48-8(1)(b) of the Act provides that these Principles can prescribe a class of care recipient for whom the care subsidy reduction is set to zero. This means that a care recipient within this class cannot be charged an income tested care fee.

This section prescribes those classes of care recipient in home care for whom a care subsidy reduction is taken to be zero. The prescribed classes are:

- care recipients who stop being provided with home care without commencing care with another service or who die, prior to the approved provider being informed of the care recipient's care subsidy reduction;
- care recipients who are not told of their care subsidy reduction within six months of receiving home care. If a care recipient falls within this class, they will only fit within this class from the day they commenced receiving care until they are told of their care subsidy reduction. That is, once the care recipient is advised of the amount of his or her care subsidy reduction, the care recipient will no longer have his or her care subsidy reduction set to zero;
- care recipients with one or more dependent children;
- care recipients who fit the description of former prisoners of war as outlined in paragraph 85(4)(b) of the Veterans' Entitlement Act; and
- care recipients whose care subsidy reduction calculates to less than $1 per day.

Section 89 – Matters to which Secretary must have regard in deciding whether to determine if care subsidy reduction is to be taken to be zero

This section supplements subsection 48-8(4) of the Act, and details the factors that the Secretary must consider when determining that the compensation payment reduction in respect of a care recipient, is taken to be zero.

The Secretary must have regard to:

- the care recipient's total assessable income (worked out under section 44-24 of the Act and section 90 of these Principles) and assets valued under section 44-26A of the Act and section 47 of these Principles;
- the care recipient's financial arrangements;
- the care recipient's entitlement to income support under the Social Security Act, Veterans' Entitlement Act or from any other source;

- whether the care recipient has sought to gain information regarding his or her entitlement to income support;
- whether the care recipient has access to support under section 1129 of the Social Security Act, the pension loans scheme or from any other source;
- whether the care recipient does not have access to any of their income;
- if there is a charge on the care recipient's income where the payment of home care fees cannot take priority;
- whether any of the care recipient's assets are unrealisable as defined in section 4 of these Principles; and
- whether the care recipient is temporarily in Australia.

The Secretary may also consider any other matters that are relevant.
In order to be able to consider the care recipient's entitlement to income support and whether the care recipient has sought to obtain information about his or her entitlement to income support, the Secretary may require the care recipient to contact the relevant Department about his or her entitlement to an income support payment or advise the care recipient to seek advice about the care recipient's financial arrangements, from Centrelink's Financial Information Service.

Subdivision C – Care subsidy reduction – amounts excluded from total assessable income

Section 90 – Working out care recipient's means tested amount – amount excluded from care recipient's total assessable income
This section supplements section 48-7 of the Act by providing further information about how to determine a care recipient's total assessable income under section 44-24 of the Act.

The section provides that the following income amounts are to be excluded from determinations of a care recipient's assessable income where the care recipient is specified in sections 91 and 94 of these Principles. The income amounts are:
- disability pensions and permanent impairment payments mentioned in section 91;
- gifts mentioned in section 92;
- GST compensation mentioned in section 93; and
- clean energy payments mentioned in section 94.

Section 91 – Excluded amounts – disability pensions and permanent impairment compensation payments
This section provides that the amount of disability pension paid to a person who has qualifying service under section 7A of the Veterans' Entitlements Act (or is the partner of such a person) should be an excluded amount when determining the care recipient's total assessable income. The amount will only be an excluded amount if it is also exempt under section 5H of the Veterans Entitlements Act.

For a person who is, or has been, a member as defined under the *Military, Rehabilitation and Compensation Act 2004* (or their partner) excluded amounts are:
- any compensation for permanent impairment paid to the person under Part 2 of Chapter 4 of the *Military, Rehabilitation and Compensation Act 2004;* and

- any amount of Special Rate Disability Pension paid to the person under Part 6 of Chapter 4 of the *Military, Rehabilitation and Compensation Act 2004*.

Section 92 – Excluded amounts – gifts

This section provides that:

- for a person who disposed of ordinary income on or prior to 20 August 1996, the amount of ordinary income disposed of is an excluded amount for the purposes of calculating the care recipient's total assessable income. The section also notes those sections of the Social Security Act and the Veterans' Entitlement Act that deals with disposal of ordinary income; and
- for a person who disposed of assets on or prior to 20 August 1996, the amount of ordinary income the person is taken to have received is an excluded amount from the care recipient's total assessable income. This subsection notes the sections of the Social Security Act and the Veterans' Entitlement Act that deal with deemed income on financial assets.

Section 93 – Excluded amounts – GST compensation

This section applies to:

- a person who receives a pension under Part II or IV of the Veterans' Entitlement Act at a rate determined through that Act by reference to the following provisions of that Act:
  - section 22, for a person on a disability pension at the general rate;
  - sections 22 and 27, for a person on a disability pension at the general rate including an increased rate for war-related injury;
  - sections 23 and 27, for a person on a disability pension at the intermediate rate or such a person who also has an increased rate for war-related injury;
  - section 24, for a person on a disability pension at the special rate;
  - subsection 30(1), for a person receiving a war widow or widower pension;
- a person who receives a payment under Part 6 of Chapter 4 or Part 2 of Chapter 5 of the *Military Rehabilitation and Compensation Act 2004* at a rate determined under the following provisions of that Act:
  - sections 198 and 204, for a person on a Special Rate Disability Pension; and
  - subsection 234(5) for a person receiving weekly compensation for the death of a partner.

This section provides that an amount equal to four per cent of the amount paid to a person under the provisions of the Veterans' Entitlement Act listed above or the *Military Rehabilitation and Compensation Act 2004* listed above is an excluded amount when determining the care recipient's total assessable income.

Notes to this section explain that:

- pensions (other than service pensions) payable to veterans' and their dependants are dealt with in Part II of the Veterans' Entitlement Act;
- pensions that are payable to members of the Defence Force or a Peacekeeping Force and their dependants is dealt with in Part IV of the Veterans' Entitlement Act;
- a choice to receive a Special Rate Disability Pension instead of compensation is afforded to former members who are entitled to compensation for their incapacity to work in accordance with Part 6 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004*; and

- wholly dependent partners of deceased members are entitled to compensation which can be taken as a lump sum or as a weekly amount, under Part 2 of Chapter 5 of the *Military Rehabilitation and Compensation Act 2004*.

Section 94 – Excluded amounts – clean energy payments
This section specifies that each of the following amounts (paid to a care recipient in accordance with the Social Security Act or the Veterans' Entitlements Act) are excluded amounts:
- the clean energy advance;
- the clean energy supplement; and
- the quarterly clean energy supplement.

Division 4 – Other supplements

Subdivision A – Hardship supplement

Section 95 – Eligibility for hardship supplement – determination by Secretary
Subsection 48-11(2) of the Act provides that the Secretary must have regard to matters set out in these Principles when deciding whether to determine that a care recipient is eligible for a hardship supplement in respect of their home care fees. Home care fees refer to the basic daily care fee and/or the income tested care fee.

There are three circumstances in which the Secretary must not make a financial hardship determination in relation to a person:

- If the care recipient has not had their means assessed the Secretary must not make a financial hardship determination.

- The value of the care recipient's assets, as assessed under the Act and these Principles, must be less than or equal to 1.5 times the basic age pension amount (as defined in Schedule 1 to the Act), the pension supplement amount and the clean energy supplement. If the assets exceed this amount, the Secretary must not make a financial hardship determination. When considering the value of the care recipient's assets, unrealisable assets will not be considered. An unrealisable asset is defined in the Social Security Act. It includes an asset the person cannot sell or realise, or cannot be reasonably expected to sell or realise. It also includes an asset the person cannot use as a security for borrowing or be reasonably expected to use as a security for borrowing.

- The Secretary must not make a determination if the care recipient has gifted more than $10,000 in the previous 12 months or more than $30,000 in the previous five years.

In deciding whether to make a financial hardship determination, the Secretary may have regard to:
- the care recipient's total assessable income worked out under the Act and these Principles and the amount of income available to the care recipient after expenditure on essential expenses. In particular the Secretary will consider whether the care recipient has less than 15 per cent of their income remaining after paying essential expenses. The list of essential expenses is included at section 96;

- the care recipient's financial arrangements;
- the care recipient's entitlement to income support;
- whether the care recipient has sought to determine his or her entitlement to a pension, benefit or other income support payment;
- whether the care recipient has access to financial assistance under section 1129 or Division 4 of Part 3.12 of the Social Security Act or from any other source;
- whether the care recipient is unable to access any of their income;
- whether there is a charge over the care recipient's income over which the payment of fees cannot practically take precedence;
- whether the care recipient is in Australia on a permanent basis; and
- any other matters the Secretary considers relevant.

Section 96 – Meaning of *essential expenses* for a recipient of home care
This section lists the items that would be considered an essential expense. It is not an exhaustive list. Essential expenses include:

- home care fees;
- food costs;
- costs relating to the home including:
  - rent or mortgage repayments;
  - home maintenance;
  - home insurance;
  - rates;
  - water, sewage, gas and electricity costs; and
  - telephone and internet costs;
- medical expenses including expenses incurred under a health professional's direction;
- dental care;
- one pair of prescription glasses per year or contact lenses;
- artificial limbs, eyes or hearing aids for amounts that are the not already covered by other government schemes or programs;
- wheelchair and mobility aids;
- ambulance cover;
- transport related costs including public transport costs, vehicle registration, vehicle repairs and vehicle insurance;
- private health insurance; and
- a funeral plan which is being paid on a periodic basis.

One type of expenditure that will not be considered essential expenses by the Secretary when deciding to make a financial hardship determination is amounts spent by someone else authorised to act on the person's behalf other than for the benefit of the person.

Section 97 – Circumstances in which Secretary may revoke financial hardship determination
This section provides that a hardship determination may be revoked by the Secretary if:

- the care recipient's circumstances have changed. An example of how a person's circumstances may change is if the person's unrealisable assets become realisable; and

- the Secretary is satisfied that the care recipient would not be subject to financial hardship if the care recipient was to pay a daily amount of home care fees that is more than the amount specified in the determination.

Subdivision B – Viability supplement

Section 98 – Viability supplement
Section 98 states that the viability supplement is payable to an approved provider, in respect of a care recipient, for the days in a payment period in which:
- there was in force a home care agreement between the care recipient and home care service in question; and
- the service meets the eligibility requirements for the viability supplement, as described in section 99.

Section 99 – Eligibility for viability supplement
This section sets out the eligibility criteria for the viability supplement. The viability supplement is an additional daily amount payable to an approved provider that provides home care to a care recipient in a rural or remote location, provided that location has an Accessibility/Remoteness Index of Australia (ARIA) value of 3.52 or more. The additional daily amount increases as the ARIA value (the measure of accessibility and remoteness of the geographical location at which the care recipient resides) increases.

Under the ARIA, each suburb and town in Australia is allocated an ARIA value based on its accessibility and remoteness. ARIA values for all Australian locations are contained in the document titled *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)*, Occasional Papers: New Series Number 14, published by the Department of Health in October 2001.

Chapter 4 – Flexible care subsidy

Part 1 – Who is eligible for flexible care subsidy?

Division 1 – Purpose of this Part

Section 100 – Purpose of this Part
The purpose of this Part is to supplement Division 50 of the Act by providing further details about:
- the classes of people who do not need approval under Part 2.3 of the Act in respect of flexible care;
- the circumstances in which an approved provider is taken to provide flexible care to a care recipient; and
- the kinds of care for which flexible care subsidy may be payable.

Division 2 – Eligibility for flexible care subsidy

Section 101 – Classes of people who do not need approval in respect of flexible care
This section details the classes of care recipients that do not need approval, in order for the approved provider to provide funded flexible care to the care recipient. These

people are those who receive care through a multi-purpose service and those who receive care through an innovative care service.

Section 102 – Circumstances in which flexible care is taken to be provided
This section provides that an approved provider is taken to provide flexible care during a day if the provider holds, in respect of that day, an allocated place that is in force under Part 2.2 of the Act (other than a provisional allocation) for the provision of care through a multi-purpose service.

Division 3 – Kinds of care for which flexible care subsidy may be payable

Section 103 – Kinds of care
This section provides that flexible care subsidy is payable for:
- flexible care provided through a multi-purpose service or an innovative care service; or
- flexible care provided as transition care.

Section 104 – Multi-purpose services
This section defines a multi-purpose service. A multi-purpose service is a flexible care service where residential care is and at least one of the following services is also provided:
- a health service;
- a home and community care service;
- a dental service;
- a transport service;
- a home care service;
- a service for which a Medicare benefit is payable under the *Health Insurance Act 1973*;
- a service that provides a pharmaceutical benefit under the *National Health Act 1953*;
- a service that the Minister nominates, in an agreement with the responsible Minister of the State or Territory in which the service is located, as an appropriate service.

If the requirements in this section are not met, the approved provider would not be eligible to receive a flexible care subsidy in respect to the service in question.

Section 105 – Innovative care services
This section defines an innovative care. An innovative care service is a flexible care service through which any of the following is provided:
- care that, by its nature, provides alternative care options, including care for older persons with complex conditions or who require coordination and integration of care;
- care provided in circumstances that require the delivery of alternative care options, including care: provided in an emergency; as part of an initiative to address access by older persons to, or the viability of, aged care services, where the care needs of a care recipient are not being adequately met by available residential or home care services; or as part of a joint initiative between the Commonwealth and a State or Territory to promote alternative care options;

- care provided in a location that, by its nature, requires the delivery of alternative care options, including care provided in an area that is not a major city;
- care provided to a group of people who are in need of alternative care options, including care provided to older persons who require coordination and integration of care or have complex, chronic conditions or need short term aged care following hospitalisation;
- care provided for a limited period to facilitate alternative care options, including care provided by a pilot service or to care recipients in places that have been allocated for a limited time in an emergency; and
- other kinds of care that, to the satisfaction of the Secretary are provided in a residential or community setting and provide alternative care options.

If the requirements in this section are not met, the approved provider would not be eligible to receive a flexible care subsidy in respect of the innovative care service in question.

Section 106 – Transition care
This section provides that transition care is a form of flexible care that:
- is provided to a care recipient at the conclusion of an in-patient hospital episode and as a package of services that includes at least low intensity therapy and nursing support or personal care; and
- can be characterised as goal-oriented, time-limited, therapy-focussed, targeted towards older people and necessary to complete the care recipient's restorative process, optimise the care recipient's functional capacity and assist the care recipient, and his or her family or carer (if any), to make long-term arrangements for his or her care.

If the requirements in this section are not met, the approved provider would not be eligible to receive a flexible care subsidy in respect to the transition care in question.

Part 2 – Basis on which flexible care subsidy is paid

Section 107 – Purpose of this Part
The purpose of this Part is to supplement Division 51 of the Act by providing further details about the periods in which flexible care subsidy may be paid and other matters relating to the payment of flexible care subsidy.

Section 108 – Flexible care provided through multi-purpose service
This section specifies the circumstances in which flexible care subsidy would be payable to an approved provider in respect of care provided through a multi-purpose service.

Flexible care subsidy is payable to the approved provider of the service for each payment period during which the approved provider is eligible. An approved provider is eligible for flexible care subsidy in respect of a day if:
- during that day, there is in force an agreement between the Secretary and the approved provider for the provision of flexible care through a multi-purpose service; and
- the approved provider has complied with the agreement.

Section 109 – Decision by Secretary to enter multi-purpose service agreement
This section:

- specifies the circumstances in which the approved provider may enter into an agreement with the Secretary to provide flexible care services through a multi-purpose service;
- lists the matters that the approved provider must demonstrate to the satisfaction of the Secretary, before an agreement can be entered into; and
- lists other matters that the Secretary must be satisfied of, before an agreement can be entered into.

In summary the Secretary must not enter into an agreement with an approved provider for the provision of flexible care through a multi-purpose service unless the approved provider has demonstrated to the Secretary:

- that the approved provider will, in relation to the service improve access to care, increase coordination, flexibility and innovation in the delivery of care in the area, provide cost-effective care and provide culturally appropriate care;
- that the service is or will be, in an area that is not a major city and is able to sustain a viable multi-purpose service; and
- that the service has, or is likely to have, the broad support of the community within the area in which the service is, or will be, located;
- that the Commonwealth, State and Territory agencies that administer existing aged care or health programs in the area agree to take part in the service; and
- that the Commonwealth and the State or Territory in which the service is located agree that the area needs a multi-purpose service.

The Secretary must also be satisfied:

- that the service satisfies, or will satisfy, the requirements in section 104;
- that there is a demonstrated need for a multi-purpose service in the area in which the service is, or will be, located;
- that a multi-purpose service would be viable in the area in which the service is, or will be, located;
- that there has been broad-based consultation about the multi-purpose service, including consultation with existing service providers and agencies;
- that the service is broadly supported by the community within the area in which the service is, or will be, located; and
- that an evaluation strategy has been established for the service that includes consideration of the service as a whole, the outcomes that the provider intends to provide and the impact of the service on other aged care services in the area.

Section 110 – Flexible care provided through innovative care service
This section specifies the circumstances in which a flexible care subsidy is payable to an approved provider in respect of flexible care provided through an innovative care service.

Flexible care subsidy in respect of an innovative care service is payable to the approved provider in accordance with the conditions, if any, set by the Secretary under section 14-5 of the Act in relation to the allocation of places to the provider.

However, flexible care subsidy in respect of flexible care that is provided through an innovative care service in accordance with a joint initiative of the Commonwealth and

a State or Territory is payable to the approved provider only if the State or Territory also provides funding, at a level agreed with the Commonwealth, for the service and the State or Territory funding is directed to meeting the needs of care recipients that are the responsibility of the State or Territory.

Section 111 – Flexible care provided as transition care

This section specifies the circumstances in which flexible care subsidy is payable to an approved provider in respect of flexible care provided by the approved provider through transition care.

Flexible care subsidy for transition care is payable to the approved provider for each payment period during which the approved provider is eligible under this section (where the payment period is the period specified in the agreement with the Secretary).

An approved provider is eligible for flexible care subsidy in respect of a day if, during that day there is in force an agreement between the Secretary and the provider for the provision of transition care and a State or Territory provides funding for the service, at a level agreed with the Commonwealth.

An agreement between the Secretary and the approved provider for the provision of transition care may provide for the following:

- the period of the agreement;
- that flexible care subsidy is to be paid monthly, and in advance;
- how claims for flexible care subsidy are to be made;
- care recipients' entitlements and obligations, including procedures for formal agreements between the approved provider and the care recipient;
- reports and information to be given to the Secretary by the approved provider for the purposes of evaluating the care and accounting for income received (including the sources of the income) and expenditure;
- an appropriate quality assurance framework in respect of the provision of transition care;
- outcome standards against which the provision of transition care services is to be evaluated;
- the circumstances in which the agreement can be varied or terminated;
- conditions for the effective provision of care, including conditions that must be met by the provider to be eligible for the payment of flexible care subsidy;
- the maximum amount of fees the provider may charge a care recipient;
- conditions relating to the charging of fees for the provision of transition care by the approved provider; and
- indemnity and insurance requirements that the provider is required to satisfy.

This section also provides that the maximum number of days for which flexible care subsidy is payable in respect of an episode of transition care is 84 days or such greater number of days, to a maximum of 126 days, as is necessary to ensure that the further transition care needs of the care recipient, as assessed by an Aged Care Assessment Team, or a member of such a team, are met.

Chapter 5 – Miscellaneous

Section 112 – Expiry of certain provisions
This section provides that:

- provisions relating to the dementia and severe behaviours supplement in relation to residential care expire on 1 November 2014 as if they had been repealed by another legislative instrument; and
- provisions relating to the payroll tax supplement in relation to residential care expire on 1 April 2015 as if they had been repealed by another legislative instrument.

Leaving the provisions on the face of the legislation for 3 months post cessation of the supplements ensures transparency. This provision then enables the redundant provisions to be removed from the Principles without the need for further repeal.

Schedule 1 – ACAP codes

This Schedule specifies the ACAP codes for certain health conditions. This is based on the *Aged Care Assessment Program Data Dictionary* as published by the Australian Institute of Health and Welfare.

Schedule 2 – Appraisal procedures for targeting care for homeless people or people from Aboriginal and Torres Strait Islander communities

This section sets out the appraisal procedures that must be followed for targeting care for homeless people of people from Aboriginal and Torres Strait Islander communities.

If these procedures are not followed, it may prevent an approved provider from meeting the requirements set out in subsections 66 and 70 in relation to the viability supplement in residential care.

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Subsidy Principles 2014

The *Subsidy Principles 2014* (the Principles) are compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Legislative Instrument

The Principles specify matters in relation to the eligibility of an approved provider of a residential care service for residential care subsidy, including:

- the eligibility requirements for various supplements that may be payable in addition to the basic subsidy amount;
- the circumstances under which subsidy continues to be payable when a care recipient is on leave from a residential care service; and
- provisions relating to the making of a determination by the Secretary that a residential care service is taken, in exceptional circumstances, to meet its accreditation requirement.

The Principles also set out matters in relation to the amount of home care subsidy and various supplements that may be payable to an approved provider of a home care service and the kinds of care for which flexible care subsidy may be payable.

Human Rights Implications

The Principles are compatible with the right to an adequate standard of living and the right to the enjoyment of the highest attainable standard of physical and mental health as contained in article 11(1) and article 12(1) of the International Covenant on Economic, Social and Cultural Rights, and article 25 and article 28 of the Convention on the Rights of Persons with Disabilities. The Principles provide for the payment of subsidy to approved providers for the provision of care and services to people with a condition of frailty or disability who require assistance to achieve and maintain the highest attainable standard of physical and mental health. The Principles also provide for additional payments in the form of supplements to ensure that people with special needs, including people who live in rural or remote areas, people who are financially or socially disadvantaged, people from Aboriginal and Torres Strait Islander communities and people who are homeless or at risk of becoming homeless, are provided with the aged care services they need.

Conclusion

This legislative instrument is compatible with human rights as it promotes the human right to an adequate standard of living and the highest attainable standard of physical and mental health.

Senator the Hon Mitch Fifield
Assistant Minister for Social Services