Subsidy Principles 2014

I, Mitch Fifield, Assistant Minister for Social Services, make the following principles.

Dated 26 June 2014

Mitch Fifield
Assistant Minister for Social Services

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Contents

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Chapter 1—Preliminary

1 Name of principles

These principles are the *Subsidy Principles 2014*.

2 Commencement

These principles commence on 1 July 2014.

3 Authority

These principles are made under section 96-1 of the *Aged Care Act 1997*.

4 Definitions

In these principles:

1997 scheme service: see section 64.

2001 scheme service: see section 65.

2005 scheme service: see 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.

accepted mental health condition means a mental health condition for which:

(a) the Repatriation Commission has accepted liability to pay a pension under the Veterans' Entitlements Act; or

(b) the Military Rehabilitation and Compensation Commission has accepted liability to pay compensation under the *Military Rehabilitation and Compensation Act 2004* or the *Safety, Rehabilitation and Compensation Act 1988*.

accessible location means a location that has an ARIA value of more than 1.84 but no more than 3.51.

accommodation wing, of a residential care service, includes any of the following:

(a) a building;

(b) a floor or level of a building;

(c) an annex to a building;

that is used to provide accommodation for a care recipient being provided with residential care through the service.

accreditation application means an application to the CEO of the Quality Agency, under subsection 2.2(2) of the Quality Agency Principles, by the

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approved provider of a residential care service for accreditation or re-accreditation of the service.

Act means the *Aged Care Act 1997*.

ARIA value, in relation to a location, means the value given to that location in accordance with the methodology set out in the document titled *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)*, Revised Edition, Occasional Papers: New Series Number 14, published by the Health Department in October 2001, as the document existed on 1 August 2013.

Note: In 2014, the *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)* was accessible at http://www.health.gov.au.

assisted resident has the meaning given by clause 1 of Schedule 1 to the *Aged Care (Transitional Provisions) Act 1997*.

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

Note: In 2014, the Australian accounting standards were accessible at http://www.aasb.gov.au.

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

care recipient's room, in a residential care service:

(a) means a room, or a part of a room, in the service that:
  (i) is intended to be occupied as personal space by an individual care recipient; and
  (ii) contains a bed to be used by the care recipient; and
(b) includes:
  (i) the areas that are in the immediate vicinity of the bed in the room or the part of the room; and
  (ii) the contents of the room or the part of the room; and
  (iii) an ensuite, or a shared bathroom and toilet, that is for the use of a care recipient being provided with accommodation in the room or the part of the room.

Classification Principles means the Classification Principles in force under section 96-1 of the Act.

concessional resident has the meaning given by clause 1 of Schedule 1 to the *Aged Care (Transitional Provisions) Act 1997*.

episode of transition care, in relation to a care recipient and an approved provider, means a continuous period during which the care recipient is provided with flexible care in the form of transition care by the approved provider.

essential expenses:

(a) for a recipient of residential care: see section 61; and
(b) for a recipient of home care: see section 96.

exceptional circumstances determination application means an application to the Secretary by an approved provider of a residential care service for a

determination under subsection 42-5(1) of the Act that the service is taken, for the purposes of Division 42 of the Act, to meet its accreditation requirement.

further transition care needs, in relation to a care recipient, means the care needs of the care recipient, as assessed during an episode of transition care by an Aged Care Assessment Team or a member of such a team.

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

highly accessible location means a location that has an ARIA value of no more than 1.84.

homeowner: see section 48.

innovative care service: see section 105.

in-patient hospital episode, in relation to a care recipient, means a continuous period during which the care recipient:

(a) is an in-patient of a hospital; and

(b) is provided with acute care or subacute care, or both.

KICA-Cog means the assessment tool called the Kimberley Indigenous Cognitive Assessment, as that tool exists on 1 August 2013.

low intensity therapy, in relation to a care recipient, means therapy that:

(a) maintains the care recipient's physical and cognitive functioning; and

(b) facilitates an improvement in the care recipient's capacity in relation to activities of daily living.

Note: Examples of low intensity therapy include the following:

(a) occupational therapy;

(b) physiotherapy;

(c) social work.

low-means care recipient: see 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, in relation to a refurbished residential care service: see 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: see section 104.

non-registered entity means an entity that:

(a) is not a registered entity; and

(b) 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.

Example: 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 the test exists on 1 August 2013.

principal home has the meaning given by section 11A of the Social Security Act other than subsections 11A(8) and (9) (which deal with the effect of absences from the principal home).

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

Quality Agency means the Australian Aged Care Quality Agency established by the *Australian Aged Care Quality Agency Act 2013*.

Quality Agency Principles means the Quality Agency Principles in force under section 53 of the *Australian Aged Care Quality Agency Act 2013*.

quarter means a period of 3 months.

refurbishment cost, in relation to a residential care service, has the meaning given by section 7.

registered entity means an entity that is registered with a revenue office (however described) of a State or Territory for the purposes of paying payroll tax in accordance with the laws of that State or Territory.

Example: 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 that name, as that tool exists on 1 August 2013.

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

subacute care means medical or related care or services provided to a care recipient who is not in the acute phase of an illness.

Note: Examples of subacute care include the following:
(a) geriatric evaluation and management;
(b) palliative care;
(c) psychogeriatric care;
(d) rehabilitation.

supported resident has the meaning given by clause 1 of Schedule 1 to the *Aged Care (Transitional Provisions) Act 1997*.

transition care: see section 106.

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

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

veteran means a person:

(a) who is taken to have rendered eligible war service under section 7 of the Veterans' Entitlements Act; or

(b) in respect of whom a pension is payable under subsection 13(6) of that Act; or

(c) who is:

(i) a member of the Forces within the meaning of subsection 68(1) of that Act; or

(ii) a member of a Peacekeeping Force within the meaning of that subsection; or

(d) who is:

(i) a member within the meaning of the *Military Rehabilitation and Compensation Act 2004*; or

(ii) a former member within the meaning of that Act; or

(e) who is an employee within the meaning of the *Safety, Rehabilitation and Compensation Act 1988*.

Note: The Acts mentioned in paragraphs (d) and (e) provide that, in some cases:

(a) a member of the Forces, or a member of a Peacekeeping Force, includes a person who is no longer serving; and

(b) an employee includes a person who has ceased to be an employee.

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

Note: A number of expressions used in these principles are defined in the Act, including the following:

(a) payment period;

(b) respite care.

5 Meaning of *low-means care recipient*

A care recipient is a ***low-means care recipient*** on a day if:

(a) the care recipient is being provided with residential care through a residential care service on that day; and

(b) either:

(i) the care recipient is eligible for accommodation supplement under section 44-28 of the Act for that day; or

(ii) on the day (the ***entry day***) on which the care recipient entered the residential care service, the care recipient's means tested amount was less than the maximum accommodation supplement amount for the entry day.

Note: ***Maximum accommodation supplement amount*** has the meaning given by subsection 44-21(6) of the Act.

6 Meaning of *minimum monetary spend amount* in relation to refurbished residential care service

The ***minimum monetary spend amount*** in relation to a refurbished residential care service is the amount worked out by multiplying $25 000 by 40% of the lower of:

(a) the total number of care recipient's rooms in the service before the commencement of the refurbishment; and

(b) the total number of care recipient's rooms in the service after the completion of the refurbishment.

7 Meaning of *refurbishment cost* in relation to residential care service

(1) The ***refurbishment cost*** in relation to a residential care service is the total cost of the refurbishment, or the proposed refurbishment, of the service unless subsection (2) applies in relation to the refurbishment.

(2) If:

(a) the refurbishment, or the proposed refurbishment, includes fire safety improvements; and

(b) the cost of those improvements is more than 25% of the minimum monetary spend amount in relation to the service;

then the ***refurbishment cost*** in relation to the service is the amount worked out using the following formula:

$$A - \left(B - C \right)$$

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% of the minimum monetary spend amount in relation to the service.

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Chapter 2—Residential care subsidy

Part 1—Who is eligible for residential care subsidy?

Division 1—Purpose of this Part

8 Purpose of this Part

For Division 42 of the Act, this Part specifies matters in relation to whether an approved provider of a residential care service is eligible for residential care subsidy for providing residential care to care recipients, including the following:

(a) the requirements for when a care recipient is on leave from a residential care service (Division 2);

(b) provisions relating to the making of a determination by the Secretary that a residential care service is taken to meet its accreditation requirement (Division 3).

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Division 2—Leave from residential care services

9 Care recipient provided with transition care

(1) For paragraph 42-2(3A)(b) of the Act, this section specifies requirements that must be met for a care recipient (in respect of whom flexible leave subsidy is payable for a day) to be on leave under section 42-2 of the Act from a residential care service on that day.

Note: A care recipient can be taken to be provided with residential care while he or she is on leave from that care (see section 42-2 of the Act).

(2) The kind of care provided to the care recipient, for which the flexible care subsidy is payable, must be transition care.

Note: ***Transition care*** is defined in section 106.

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Division 3—Exceptional circumstances determinations

10 Determination by Secretary

For subsection 42-5(1) of the Act, the Secretary may determine that a residential care service is taken, for the purposes of Division 42 of the Act, to meet its accreditation requirement, in accordance with this section, if:

(a) the Secretary receives an exceptional circumstances determination application from the approved provider of the service; and

(b) the Secretary is satisfied of the matters under section 12.

Note 1: An approved provider is not eligible for residential care subsidy in respect of a day if the residential care service through which residential care is provided does not meet its accreditation requirement (see sections 42-1 and 42-4 of the Act).

Note 2: ***Exceptional circumstances determination application*** is defined in section 4.

11 Application for determination

(1) The Secretary may give a written request to the CEO of the Quality Agency for the following information about a residential care service:

(a) whether an accreditation application by the approved provider of the service has been received by the Quality Agency;

(b) if so, information about the status of the accreditation application.

Note: ***Accreditation application*** is defined in section 4.

(2) If the response states that the approved provider has made an accreditation application in relation to the residential care service, and that a decision has been made not to accredit the service, or that no decision has been made on the application:

(a) the accreditation application is taken to include an exceptional circumstances determination application in relation to the service; and

(b) the date on which the response was received by the Secretary is taken to be the date on which the exceptional circumstances determination application was received by the Secretary.

(3) Subsection (2) applies whether or not the accreditation application complies with subsection 2.3(1) of the Quality Agency Principles.

(4) Nothing in this section prevents an approved provider of a residential care service from making an exceptional circumstances determination application to the Secretary in relation to the service.

12 Matters the Secretary must take into account

(1) In deciding whether to make a determination that a residential care service is taken to meet its accreditation requirement, the Secretary must take into account the following matters:

(a) the reasons for the residential care service not meeting the standards required for accreditation;

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(b) the action that the approved provider must take for the residential care service to meet those standards;

(c) the impact of the residential care service not meeting those standards on the residential care, accommodation and other services provided to care recipients through the service.

Note: Before making a determination, the Secretary must first be satisfied that exceptional circumstances apply to the service (see subsection 42-5(1) of the Act).

(2) The Secretary may also take into account any other relevant matter.

Part 2—How is residential care subsidy paid?

Division 1—Purpose of this Part

13 Purpose of this Part

For Division 43 of the Act, this Part specifies matters in relation to the payment of residential care subsidy by the Commonwealth to an approved provider for providing residential care to care recipients, including the following:

(a) the kinds of payments made in respect of the service that are capital payments and working out the proportion of the amounts equal to the capital payments that are to be deducted (Division 2);

(b) the conditions that must be met for non-compliance deductions to not apply in respect of the residential care service and the circumstances in which a non-compliance deduction will not apply even if a condition has not been met (Division 3).

Division 2—Capital repayment deductions

14 Kinds of payments that are capital payments

For paragraph (b) of the definition of ***capital payment*** in subsection 43-6(5) of the Act, each of the following kinds of payment is a capital payment:

(a) financial assistance by way of a grant under Part II, or Division 3 of Part III, of the *Aged or Disabled Persons Care Act 1954*, as in force before it was repealed;

(b) a grant of a Commonwealth benefit under Part VAB or VAC of the *National Health Act 1953*;

(c) a grant under the *Aged or Disabled Persons Hostels Act 1972*, as in force before it was repealed;

(d) a grant approved on or after 1 July 1989 under the Commonwealth program known as the Residential Aged Care Upgrading Program;

(e) capital funding approved on or after 1 July 1989 under the Commonwealth program known as the Small Homes Capital Funding Initiative.

Note: A residential care grant is also a capital payment (see paragraph (a) of the definition of ***capital payment*** in subsection 43-6(5) of the Act).

15 Working out proportion of amounts to be deducted if distinct part of residential care service has extra service status

(1) For subsection 43-6(3) of the Act, this section sets out how the proportion of the amounts equal to the capital payments made in respect of a residential care service (for which extra service status is granted only in respect of a distinct part of the service) is to be worked out.

(2) The proportion is:

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

where:

AP (short for allocated places) is the number of places allocated by the Secretary to the approved provider under Part 2.2 of the Act, in respect of residential care subsidy, that are included in the residential care service.

ESP (short for extra service places) is the number of places included in the distinct part of the residential care service, for which extra service status is granted, that are extra service places.

P (short for proportion) is:

(a) for each capital payment for which the first capital repayment deduction is to be made within 5 years after approval of the capital payment—100%; or

(b) for each capital payment for which the first capital repayment deduction is to be made more than 5 years after approval of the capital payment—100% reduced by 10% for each complete year over 5 years.

(3) For subsection (2):

(a) a place can only be counted as an extra service place or an allocated place if the allocation of the place has taken effect under section 15-1 of the Act; and

(b) a period of at least 6 months and less than 1 year is to be counted as a complete year.

Note: The allocation of a place that is a provisional allocation cannot be counted (see section 15-1 of the Act).

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Division 3—Non-compliance deductions

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

For subsection 43-8(1) of the Act, conditions (to which the allocation of places included in a residential care service are subject under section 14-5 or 14-6 of the Act) relating to the proportion of care to be provided to the following:

(a) assisted residents;
(b) concessional residents;
(c) low-means care recipients;
(d) recipients of respite care;
(e) supported residents;

are specified as conditions in respect of which non-compliance deductions apply if the conditions have not been met.

Note: ***Assisted resident***, ***concessional resident***, ***low-means care recipient*** and ***supported resident*** are defined in section 4. ***Respite care*** is defined in the Dictionary to the Act.

17 Circumstances in which non-compliance deductions do not apply

(1) For subsection 43-8(2) of the Act, this section specifies the circumstances in which non-compliance deductions do not apply in respect of a residential care service even if a condition specified in section 16 has not been met.

(2) Non-compliance deductions do not apply in respect of the residential care service for a quarter if:

(a) fewer than 6 care recipients being provided with residential care through the service in the quarter entered the service after 30 September 1997; or
(b) for a service that has extra service status—fewer than 6 care recipients being provided with residential care through the service in the quarter (each receiving care on a permanent basis and not occupying extra service places) entered the service after 30 September 1997; or
(c) the care day deficit for the service for the quarter is less than 92.

Note: The care day deficit is worked out under section 19.

(3) If:

(a) one or more allocated places (the ***additional places***) are transferred to the residential care service (the ***receiving service***) from another residential care service (the ***other service***); and
(b) some or all of the additional places are occupied by care recipients from the other service; and
(c) the receiving service was not subject to a non-compliance deduction for the quarter before the transfer of the allocated places;

then non-compliance deductions do not apply in respect of the receiving service for the number of quarters that is the lesser of:

(d) 4; and
(e) the number of additional places divided by 3 (rounded up to the nearest whole number).

(4) Non-compliance deductions do not apply in respect of the residential care service for a quarter if:

(a) one or more allocated places are not occupied for the quarter; and

(b) the care day deficit for the service would have been less than 92 if the allocated place or places had been occupied by:

(i) an assisted resident; or

(ii) a concessional resident; or

(iii) a low-means care recipient; or

(iv) a supported resident.

18 Working out amounts of non-compliance deductions

(1) For subsection 43-8(4) of the Act, this section sets out how to work out the amount of a non-compliance deduction in respect of a residential care service for a quarter.

(2) The non-compliance deduction, for a residential care service for a quarter, is:

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

where:

A is the care day deficit for the residential care service for the quarter.

B is the total of the basic subsidy amounts, worked out under Subdivision 44-B of the Act and Subdivision 44-B of the *Aged Care (Transitional Provisions) Act 1997*, for each day of residential care provided through the residential care service in the quarter for each care recipient.

C is the total of the reductions, worked out in accordance with 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 of residential care provided through the residential care service in the quarter for each care recipient.

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

(3) However, if ***C*** is greater than ***B***, the non-compliance deduction is zero.

19 Working out the *care day deficit*

The ***care day deficit*** for a residential care service for a quarter is worked out as follows:

Care day deficit calculator

Step 1. Count the number of care recipients being provided with residential care through the residential care service who:

(a) entered the service after 30 September 1997; and

(b) 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:

(a) assisted residents; and

(b) concessional residents; and

(c) low-means care recipients; and

(d) 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.

The result is the ***care day deficit*** for the residential care service for the quarter.

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

Division 1—Purpose of this Part

20 Purpose of this Part

For Division 44 of the Act, this Part sets out matters in relation to the amount of residential care subsidy payable to an approved provider of a residential care service in respect of a care recipient who is being provided with residential care through the service, including the following:

(a) other matters on which the Minister may base a determination of different amounts (including nil amounts) of the basic subsidy amount for the care recipient (Division 2);

(b) the following primary supplements that may apply to the care recipient (Division 3):
  (i) the respite supplement;
  (ii) the oxygen supplement;
  (iii) the enteral feeding supplement;
  (iv) the dementia and severe behaviours supplement;
  (v) the payroll tax supplement;

(c) matters relating to the following reductions in subsidy that may apply to the care recipient (Division 4):
  (i) the compensation payment reduction;
  (ii) the care subsidy reduction;

(d) other matters relating to the following other supplements that may apply to the care recipient (Division 5):
  (i) the accommodation supplement;
  (ii) the hardship supplement;

(e) the following other supplements that may apply to the care recipient (Division 5):
  (i) the viability supplement;
  (ii) the veterans' supplement;
  (iii) the homeless supplement.

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Division 2—Basic subsidy amount

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

For paragraph 44-3(3)(e) of the Act, other matters on which the Minister may base a determination of different amounts (including nil amounts) of the basic subsidy amount for a care recipient who is being provided with residential care through a residential care service are the following:

(a) whether the service provides a greater proportion of care to recipients of respite care than the proportion required to be provided by conditions (if any) imposed on the allocation of places to the approved provider of the service;

(b) whether, on a particular day, the number of days on which the care recipient had previously been provided with residential care as respite care during the financial year in which the day occurs equals or exceeds the maximum number of days specified in paragraph 23(1)(c);

(c) if an appraisal of the care recipient's care needs is received after the end of the period mentioned in paragraph 26-1(a) or (b) of the Act (whichever is applicable)—the circumstances of the appraisal not being received within that period;

(d) if a reappraisal of the care recipient's care needs is received after the end of the reappraisal period mentioned 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

22 Respite supplement

The respite supplement for a care recipient in respect of a payment period is the sum of all the respite supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) the care recipient was eligible for a respite supplement.

23 Eligibility for respite supplement

(1) A care recipient is eligible for a respite supplement on a particular day if, on that day:

(a) the residential care provided through the residential care service was provided as respite care; and

(b) the care recipient's approval under Part 2.3 of the Act as a care recipient was not limited so as to preclude the provision of respite care; and

(c) the number of days on which the care recipient had previously been provided with residential care as respite care during the financial year in which the day occurred is less than:

(i) 63; or

(ii) if the Secretary has increased the number of days under subsection (2)—the number of days as so increased (or as most recently increased).

(2) The Secretary may increase the number of days on which a care recipient can be provided with residential care as respite care during a financial year by up to 21 if the Secretary considers that an increase in the number of days is necessary because of any of the following:

(a) carer stress;

(b) severity of the care recipient's condition;

(c) absence of the care recipient's carer;

(d) any other relevant matter.

(3) An increase under subsection (2) may be made more than once in a financial year.

Subdivision B—Oxygen supplement

24 Oxygen supplement

The oxygen supplement for a care recipient in respect of a payment period is the sum of all the oxygen supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) a determination was in force under subsection 25(3) in relation to the care recipient; and
(c) the residential care provided through the residential care service included providing oxygen to the care recipient in circumstances specified in section 26.

25 Eligibility for oxygen supplement—determination by Secretary

(1) An approved provider that is providing, or is to provide, residential care to a care recipient may apply to the Secretary for a determination under subsection (3) that the care recipient is eligible for an oxygen supplement.

(2) The application must:
(a) be in a form approved by the Secretary; and
(b) include the information, and be accompanied by any documents, specified by the approved form.

(3) If the Secretary receives an application from an approved provider in respect of a care recipient under subsection (1), the Secretary may determine that the care recipient is eligible for an oxygen supplement.

Note: A decision to refuse to make a determination is a reviewable decision under section 27.

(4) A determination made under subsection (3) is not a legislative instrument.

(5) The Secretary must notify the applicant, in writing, of the Secretary's decision on whether to make the determination. The notice must be given within 28 days after the Secretary receives the application.

26 Circumstances relating to provision of oxygen

For paragraph 24(c), the circumstances for the provision of oxygen are as follows:
(a) the materials and equipment used by the residential care service to provide the oxygen must be hired, temporarily obtained or owned by the residential care service;
(b) the oxygen must not be provided:
(i) because of a medical emergency; or
(ii) on a short-term or episodic basis;
(c) a medical practitioner must have certified, in writing, that the care recipient has a continual need for the provision of oxygen;
(d) the oxygen must be provided in the most economical way available, taking into account the medical needs of the care recipient.

27 Reviewable decision

(1) A decision under subsection 25(3) to refuse to make a determination that a care recipient is eligible for an oxygen supplement is a reviewable decision under section 85-1 of the Act.

(2) Part 6.1 of the Act applies to a reviewable decision mentioned in subsection (1) as if a reference in that Part to this Act included a reference to these principles.

Subdivision C—Enteral feeding supplement

28 Enteral feeding supplement

The enteral feeding supplement for a care recipient in respect of a payment period is the sum of all the enteral feeding supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) a determination was in force under subsection 29(3) in relation to the care recipient; and

(c) the residential care provided through the residential care service included providing enteral feeding to the care recipient in circumstances specified in section 30.

29 Eligibility for enteral feeding supplement—determination by Secretary

(1) An approved provider that is providing, or is to provide, residential care to a care recipient may apply to the Secretary for a determination under subsection (3) that the care recipient is eligible for an enteral feeding supplement.

(2) The application must:

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

(b) include the information, and be accompanied by any documents, specified by the approved form.

(3) If the Secretary receives an application from an approved provider in respect of a care recipient under subsection (1), the Secretary may determine that the care recipient is eligible for an enteral feeding supplement.

Note: A decision to refuse to make a determination is a reviewable decision under section 31.

(4) A determination made under subsection (3) is not a legislative instrument.

(5) The Secretary must notify the applicant, in writing, of the Secretary's decision on whether to make the determination. The notice must be given within 28 days after the Secretary receives the application.

30 Circumstances relating to provision of enteral feeding

For paragraph 28(c), the circumstances for the provision of enteral feeding are as follows:

(a) a medical practitioner must have certified, in writing, that the care recipient has a medical need for enteral feeding;

(b) the care recipient must have been given a liquid dietary formula (not including food supplements or any supplementary feeding connected with the administration of the dietary formula) administered by a nasogastric, gastrostomy or jejeunostomy feeding method;

(c) a medical practitioner or dietician must have certified, in writing, that the dietary formula is a nutritionally complete formula;

(d) the enteral feeding must not be intermittent or supplementary enteral feeding given in addition to oral feeding;

(e) the enteral feeding must be provided in the most economical way available, taking into account the medical needs of the care recipient.

31 Reviewable decision

(1) A decision under subsection 29(3) 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.

(2) Part 6.1 of the Act applies to a reviewable decision mentioned in subsection (1) as if a reference in that Part to this Act included a reference to these principles.

Subdivision D—Dementia and severe behaviours supplement

32 Dementia and severe behaviours supplement

The dementia and severe behaviours supplement for a care recipient 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:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) the care recipient was eligible for a dementia and severe behaviours supplement.

33 Eligibility for dementia and severe behaviours supplement

(1) 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:

(a) on that day, the residential care provided through the residential care service to the care recipient was not respite care; and

(b) the care recipient has been medically diagnosed by a registered medical practitioner with one or more of the health conditions assigned an ACAP code between 0500 and 0599; and

(c) each of the assessment requirements in section 34 are satisfied in respect of the care recipient and the day; and

(d) the approved provider of the residential care service has received a written copy of:

(i) the medical diagnosis mentioned in paragraph (b); and

(ii) the results of the assessment mentioned in paragraph 34(1)(a).

Note: ***ACAP code*** is defined in section 4.

(2) However, the care recipient is not eligible for a dementia and severe behaviours supplement on a particular day if a claim, under paragraph 43-4(1)(a) of the Act, for residential care subsidy that includes the dementia and severe behaviours supplement for that day is not made within 56 days after that day.

(3) Also, the care recipient is not eligible for a dementia and severe behaviours supplement on any day in July 2014 unless a dementia and severe behaviours supplement under this Subdivision was payable in respect of the care recipient on 7 July 2014.

34 Assessment requirements

(1) The assessment requirements in respect of a care recipient and a day (the ***relevant day***) are the following:

(a) the care recipient must have been assessed, before the relevant day, in accordance with the NPI-NH test;

(b) the results of the assessment must include:

(i) for at least 2 behavioural domains mentioned in subsection (2)—both a score of 4 for frequency and a score of 3 for severity; and

(ii) also, for at least 2 behavioural domains mentioned in subsection (2)—a score of 4 or higher for occupational disruptiveness; and

(iii) for the 12 behavioural domains mentioned in the NPI-NH test—a score of at least 50 for the sum of the total scores for each domain.

Note: ***NPI-NH test*** is defined in section 4.

(2) For subparagraphs (1)(b)(i) and (ii), the ***behavioural domains*** are the following:

(a) delusions;

(b) hallucinations;

(c) agitation/aggression;

(d) depression/dysphoria;

(e) anxiety;

(f) disinhibition.

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

(a) by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner; and

(b) if the dementia and severe behaviours supplement was not payable for the care recipient for the day before the relevant day—within 3 months before the relevant day; and

(c) 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; and

(d) 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

(e) 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).

(4) For subsection (3), the ***eligibility start day*** for the care recipient is:

(a) the first day for which residential care subsidy that includes the dementia and severe behaviours supplement becomes payable for the care recipient; or

(b) 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.

(5) 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.

Note: This Subdivision expires on 1 November 2014 (see section 112).

Subdivision E—Payroll tax supplement

35 Payroll tax supplement

The payroll tax supplement for a care recipient in respect of a payment period ending on or before 31 December 2014 is the sum of all the payroll tax supplements for the days during the period on which:

(a) the care recipient was provided with residential care (including care provided as respite care) through the residential care service in question; and

(b) for a care recipient provided with care, other than as respite care—the care recipient's classification level is not the lowest applicable classification level; and

(c) the residential care service met the requirements for eligibility for payroll tax supplement under section 36.

Note: ***Lowest applicable classification level*** is defined in the Dictionary to the Act (see also the Classification Principles).

36 Eligibility for payroll tax supplement

(1) A residential care service meets the requirements for eligibility for a payroll tax supplement on a day in a payment period ending on or before 31 December 2014 if the approved provider has satisfied the Secretary that:

(a) if the approved provider is a registered entity—the approved provider incurred a payroll tax liability in respect of the payment period that is payable to a State or Territory revenue office (however described) with which it is registered for the purposes of paying payroll tax; and

(b) if the approved provider is a non-registered entity:

(i) the approved provider received, from a registered entity, an invoice including a cost breakdown showing, for the services provided, a salary and wages component and a payroll tax component; and

(ii) the approved provider has incurred a liability to pay the amount of the payroll tax component to the registered entity; and

(iii) in relation to the payment period, the approved provider has complied with the requirements in subsection (2).

Note: ***Registered entity*** and ***non-registered entity*** are defined in section 4.

Condition for eligibility—non-registered entities

(2) For subparagraph (1)(b)(iii), the approved provider must, at the end of each payment period, notify the Secretary in writing of:

(a) any variation, in relation to the previous payment period, in its liability for payroll tax; and

(b) for any variation—to what extent its liability for payroll tax is affected by the variation.

Note: This Subdivision expires on 1 April 2015 (see section 112).

Division 4—Reductions in subsidy

Subdivision A—Compensation payment reduction

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

(1) For subsections 44-20(5) and (6) of the Act, in making a determination in respect of a judgment or settlement entitling a care recipient to compensation, the Secretary must take into account the following matters:

(a) the amount of the judgment or settlement;

(b) for a judgment—the components stated in the judgment and the amount stated for each component;

(c) the proportion of liability apportioned to the care recipient;

(d) the amounts spent on residential care at the time of the judgment or settlement.

Note: For paragraph (1)(b), examples of the components of a judgment include the following:
(a) loss of income;
(b) costs of future care.

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

(a) the amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;

(b) the amounts spent on care (other than residential care) at the time of the judgment or settlement;

(c) the likely cost of residential care for the care recipient;

(d) other costs of care for which the care recipient is likely to be liable;

(e) the amount of the accommodation bond, accommodation payment or accommodation contribution paid or payable by the care recipient;

(f) other reasonable amounts (not related to care) that the care recipient:

(i) had spent at the time of the judgment or settlement; or

(ii) is likely to be liable for.

38 Determination by Secretary if compensation information not given on request

(1) For subsection 44-20A(5) of the Act, 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.

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

(a) the amount of the judgment, settlement or reimbursement arrangement;

(b) for a judgment—the components stated in the judgment and the amount stated for each component;

(c) the proportion of liability apportioned to the care recipient;

(d) the amounts that are likely to be paid to or withheld by other government agencies because of the judgment, settlement or reimbursement arrangement;
(e) the amounts spent on care (other than residential care) at the time of the judgment, settlement or reimbursement arrangement;
(f) the likely cost of residential care for the care recipient;
(g) other costs of care for which the care recipient is likely to be liable;
(h) the amount of the accommodation bond, accommodation payment or accommodation contribution paid or payable by the care recipient;
(i) other amounts, not related to care, that the care recipient:
(i) had spent at the time of the judgment, settlement or reimbursement arrangement; or
(ii) is likely to be liable for.

Subdivision B—Care subsidy reduction—general

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

(1) For paragraph 44-23(1)(c) of the Act, the classes of persons for whom a care subsidy reduction is taken to be zero are the following:
(a) care recipients who leave a residential care service (without entering another residential care service), or who die, before the approved provider of the service has been informed of the care recipient's care subsidy reduction (if any);
(b) care recipients who are not, within 6 months of entry to the residential care service, informed of the care recipient's care subsidy reduction (if any);
(c) care recipients who have one or more dependent children;
(d) care recipients who are described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war);
(e) care recipients for whom the care subsidy reduction is worked out as less than $1.

(2) If a care recipient is included in the class of persons mentioned in paragraph (1)(b), the care recipient is included in that class from the day the care recipient enters the residential care service until the day the care recipient is informed of the care recipient's care subsidy reduction.

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

(1) For subsection 44-23(4) of the Act, in deciding whether to determine that the care subsidy reduction in respect of a care recipient is to be taken to be zero, the Secretary must have regard to the following matters:
(a) the care recipient's total assessable income (worked out in accordance with section 44-24 of the Act and section 41 of these principles) and assets (worked out in accordance with section 44-26A of the Act and section 47 of these principles);
(b) the care recipient's financial arrangements;
(c) the care recipient's entitlement to income support:

(i) under the Social Security Act; or
(ii) under the Veterans' Entitlements Act; or
(iii) from any other source;

(d) whether the care recipient has taken steps to obtain information about his or her entitlement to pension, benefit or other income support payments;

(e) whether the care recipient has access to financial assistance:
(i) under section 1129 of the Social Security Act (relating to access to financial hardship rules for pensions); or
(ii) under the pension loans scheme under Division 4 of Part 3.12 of the Social Security Act; or
(iii) from any other source;

(f) whether any income of the care recipient is income that the care recipient does not reasonably have access to;

(g) whether there is a charge on the care recipient's income over which the payment of resident fees cannot practically take precedence;

(h) whether any assets of the care recipient are unrealisable assets;

(i) whether the care recipient is in Australia on a temporary basis.

Note: ***Unrealisable asset*** is defined in section 4.

(2) The Secretary may have regard to any other matters the Secretary considers relevant.

(3) To enable the Secretary to have regard to the matters mentioned in paragraph (1)(c) or (d), the Secretary may:
(a) require the care recipient to seek information from the relevant Department about his or her entitlement to a benefit, income support payment or other assistance, and give the Secretary copies of written replies from the Department; or
(b) advise the care recipient to seek advice about his or her financial arrangements from the Financial Information Service established by Centrelink.

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

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

For subsection 44-24(5) of the Act, the amounts (in this Subdivision called ***excluded amounts***) that are to be taken, in relation to the kinds of care recipients specified in sections 42 to 46, to be excluded from determinations by the Secretary under subsection 44-24(1) or paragraph 44-24(2)(b), (3)(b) or (4)(b) of the Act are the following:

(a) disability pensions and permanent impairment compensation payments mentioned in section 42;
(b) gifts mentioned in section 43;
(c) rent receipts mentioned in section 44;
(d) GST compensation mentioned in section 45;

(e) clean energy payments mentioned in section 46.

42 Excluded amounts—disability pensions and permanent impairment compensation payments

(1) For a person who has qualifying service under section 7A of the Veterans' Entitlements Act, or the partner of such a person, the amount (if any) of disability pension (within the meaning of subsection 5Q(1) of the Veterans' Entitlements Act) paid to the person that is exempt under section 5H of that Act is an excluded amount.

(2) For a person who is a member or former member (within the meaning of the *Military Rehabilitation and Compensation Act 2004*) or the partner of such a person, each of the following is an excluded amount:

(a) any amount of compensation for permanent impairment paid to the person under Part 2 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004*;

(b) 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*.

43 Excluded amounts—gifts

(1) For a person who, on or before 20 August 1996, disposed of ordinary income, the amount of ordinary income disposed of on or before 20 August 1996 that is included in the person's ordinary income under:

(a) sections 1106, 1107, 1108 and 1109 of the Social Security Act; or

(b) sections 48, 48A, 48B and 48C of the Veterans' Entitlements Act;

is an excluded amount.

Note: Sections 1106, 1107, 1108 and 1109 of the Social Security Act, and sections 48, 48A, 48B and 48C of the Veterans' Entitlements Act, deal with disposal of ordinary income.

(2) For a person who, on or before 20 August 1996, disposed of assets, the amount of ordinary income the person is taken to receive because assets disposed of on or before 20 August 1996 are assessed as financial assets under:

(a) section 1076, 1077 or 1078 of the Social Security Act; or

(b) sections 46D and 46E of the Veterans' Entitlements Act;

is an excluded amount.

Note: Section 1076, 1077 or 1078 of the Social Security Act, and sections 46D and 46E of the Veterans' Entitlements Act, deal with deemed income from financial assets.

44 Excluded amounts—rent receipts

For a care recipient for whom a daily accommodation contribution or a daily accommodation payment is payable, the amount of any income received by the care recipient, or the care recipient's partner, from rental of the care recipient's principal home to another person is an excluded amount.

Note 1: Paragraph 8(8)(znaa) of the Social Security Act and paragraph 5H(8)(nf) of the Veterans' Entitlements Act describe how, for the purposes of each Act, ***income*** is defined for a person who is accruing a liability to pay a daily accommodation payment or a daily accommodation contribution.

Note 2: Subsection 5L(6A) of the Veterans' Entitlements Act describes how, for the purposes of that Act, ***assets*** are defined for a person who is accruing a liability to pay a daily accommodation payment or a daily accommodation contribution.

45 Excluded amounts—GST compensation

(1) This section applies in relation to:

(a) a person receiving a pension under Part II or IV of the Veterans' Entitlements Act at a rate determined under or by reference to the following provisions of that Act:

(i) for a person receiving a disability pension payable at the general rate—section 22;

(ii) for a person receiving a disability pension payable at the general rate including an increased rate for a war-caused injury or disease—sections 22 and 27;

(iii) for a person receiving a disability pension payable at the intermediate rate—section 23;

(iv) for a person receiving a disability pension payable at the intermediate rate including an increased rate for a war-caused injury or disease—sections 23 and 27;

(v) for a person receiving a disability pension payable at the special rate—section 24;

(vi) for a person receiving a war widow or widower pension—subsection 30(1); and

(b) a person receiving a pension under Part 6 of Chapter 4, or a weekly amount of compensation under Part 2 of Chapter 5, of the *Military Rehabilitation and Compensation Act 2004* at a rate determined under or by reference to the following provisions of that Act:

(i) for a person receiving a Special Rate Disability Pension—sections 198 and 204;

(ii) for a person receiving a weekly amount of compensation for the death of the person's partner—subsection 234(5).

(2) The amount that is equal to 4% of the amount of pension, or the weekly amount of compensation, payable to a person under a provision referred to in subsection (1), as applicable from time to time, is an excluded amount.

Note 1: Part II of the Veterans' Entitlements Act deals with pensions, other than service pensions, payable to veterans and their dependants.

Note 2: Part IV of the Veterans' Entitlements Act deals with pensions payable to members of the Defence Forces or a Peacekeeping Force and their dependants.

Note 3: Part 6 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004* gives former members who are entitled to compensation for incapacity for work a choice to receive a Special Rate Disability Pension instead of compensation.

Note 4: Part 2 of Chapter 5 of the *Military Rehabilitation and Compensation Act 2004* gives wholly dependent partners of deceased members an entitlement to compensation in respect of the death of the members. The compensation may be taken as a lump sum or as a weekly amount.

46 Excluded amounts—clean energy payments

For a care recipient who is being provided with residential care through a residential care service, each of the following is an excluded amount:

(a) any amount of clean energy advance, clean energy supplement or quarterly clean energy supplement paid to the care recipient under the Social Security Act;

(b) any amount of clean energy advance, clean energy supplement or quarterly clean energy supplement paid to the care recipient under the Veterans' Entitlements Act.

Subdivision D—Care subsidy reduction—value of assets

47 Working out care recipient's means tested amount—value of assets

(1) For subsection 44-26A(1) of the Act, the value of a person's assets is the value worked out in accordance with Division 1 of Part 3.12 of the Social Security Act, reduced by any compensation payments received by the person under:

(a) the *Compensation (Japanese Internment) Act 2001*; or

(b) the *Veterans' Entitlements (Compensation—Japanese Internment) Regulations 2001*; or

(c) Part 2 of the *Veterans' Entitlements (Clarke Review) Act 2004*; or

(d) Schedule 5 to the *Social Security and Veterans' Affairs Legislation Amendment (One-off Payments and Other 2007 Budget Measures) Act 2007*.

(2) However, the following provisions of Division 1 of Part 3.12 of the Social Security Act do not apply for the purposes of working out the person's assets:

(a) paragraphs 1118(1)(a), (b) and (g), subparagraphs 1118(1)(ga)(ii) and (gb)(ii), paragraphs 1118(1)(u) and (v) and subsection 1118(4) (Certain assets to be disregarded in calculating the value of a person's assets);

(b) section 1118AB (Value of person's assets reduced: certain transactions to do with aged care accommodation bonds);

(c) section 1118AC (Value of person's assets reduced: refunds to charge exempt residents).

Value of home

(3) For subsection 44-26A(7) of the Act, the value of a home is the value worked out after applying this section.

48 Meaning of *homeowner*

(1) For the definition of ***homeowner*** in subsection 44-26B(1) of the Act:

(a) a person who is not a member of a couple is a ***homeowner*** if:

(i) the person has a right or interest in the person's principal home; and

(ii) the person's right or interest in the person's principal home gives the person reasonable security of tenure in the home; and

(b) a person who is a member of a couple is a ***homeowner*** if:

(i) the person, or the person's partner, has a right or interest in one residence that is the person's principal home, or the partner's principal home, or the principal home of both of them; and

(ii) the person's right or interest, or the partner's right or interest, in the home gives the person, or the person's partner, reasonable security of tenure in the home.

Note: ***Principal home*** is defined in section 4.

(2) For subsection (1), the person's principal home can be premises that:

(a) constitute a retirement village (within the meaning of subsection 12(3) of the Social Security Act); or

(b) are taken to constitute a retirement village (within the meaning of subsection 12(4) of the Social Security Act).

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Division 5—Other supplements

Subdivision A—Accommodation supplement

49 Purpose of this Subdivision

For paragraph 44-28(5)(d) of the Act, this Subdivision specifies other matters relating to the determination of the amount of accommodation supplement payable for a care recipient for a day.

50 Matters on which determination of accommodation supplement amount may be based

The Minister may determine the amount of accommodation supplement, or a method for working out the amount of accommodation supplement, payable for a day for a care recipient who is being provided with residential care (other than as respite care), based on either or both of the following:

(a) whether a determination under subsection 52(1) or 53(1) is in force in relation to the service;

(b) whether more than 40% 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.

Note: See section 44-28 of the Act for other matters that may affect whether accommodation supplement is payable, and the amount of accommodation supplement that may be payable, in respect of a payment period for the care recipient.

51 Application for determination

(1) An approved provider of a residential care service that has been significantly refurbished may apply to the Secretary for a determination under subsection 52(1) in relation to the service.

(2) An approved provider of a residential care service that is proposed to be significantly refurbished may apply to the Secretary for a determination under subsection 53(1) in relation to the service.

(3) An application must:

(a) be in writing; and

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

(c) include the information, and be accompanied by any documents, specified by the approved form.

(4) An application must not relate to more than one residential care service.

Note: An approved provider of more than one residential care service would need to make a separate application in relation to each residential care service.

Section 52

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

(1) If the Secretary receives an application under subsection 51(1) from an approved provider of a residential care service, the Secretary may determine, in writing, that the service is a significantly refurbished residential care service.

Note 1: The Secretary must not make a determination under this subsection in certain circumstances (see subsection (2) and section 54).

Note 2: A determination under this subsection is not a legislative instrument (see section 58).

Note 3: A decision to refuse to make a determination under this subsection is a reviewable decision under section 85-1 of the Act (see section 59 of these principles).

(2) The Secretary must not make a determination under subsection (1) unless the Secretary is satisfied of the following:

(a) the refurbishment was completed on or after 20 April 2012;

(b) the alterations, updates, upgrades or other improvements that have been made to the service have resulted in the service being significantly different in form, quality or functionality after the refurbishment;

(c) 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 who are being provided with residential care through the service;

(d) the refurbishment provides significant benefits to assisted residents, concessional residents, low-means care recipients or supported residents who are being provided with residential care through the service;

(e) the relevant costs of the refurbishment will be capitalised for the purposes of the Australian accounting standards because:

(i) the refurbishment consisted of structural improvements; or

(ii) those costs can be depreciated because they relate to fixtures, fittings or anything that can be removed intact;

(f) the refurbishment:

(i) has resulted in at least 40% of the care recipients being provided with residential care through the service having a care recipient's room that has been significantly refurbished; or

(ii) provides a significant benefit to at least 40% of the care recipients being provided with residential care through the service; or

(iii) consisted of an extension to the service involving an increase of at least 25% of the number of care recipient's rooms in the service;

(g) the proportion of the total number of care recipient's rooms in the service 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 in the service that were available before the refurbishment for assisted residents, concessional residents, low-means care recipients or supported residents;

(h) the refurbishment cost in relation to the service is at least the minimum monetary spend amount in relation to the service.

Note 1: Paragraph (2)(a) is affected by subsection (3).

Note 2: ***Care recipient's room*** is defined in section 4.

Note 3: The ***refurbishment cost*** in relation to a residential care service is defined in section 7. The ***minimum monetary spend amount*** in relation to a residential care service is defined in section 6.

(3) In deciding whether to be satisfied that the refurbishment was completed on or after 20 April 2012, the Secretary must take into account the following:

(a) 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;

(b) if the refurbishment did not include the building of a new accommodation wing—the date when all work involved in the refurbishment was completed;

(c) if the refurbishment consisted of the building of a new accommodation wing and the refurbishment of existing parts of the service—the later of:

(i) the date when the occupancy certificate (or equivalent) was issued for the new wing; and

(ii) the date when all work involved in the refurbishment was completed;

(d) any other matter the Secretary considers to be relevant.

Note: ***Accommodation wing*** is defined in section 4.

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

(1) If the Secretary receives an application under subsection 51(2) from an approved provider of a residential care service, the Secretary may determine, in writing, that the service is a significantly refurbished residential care service, subject to the condition that the determination does not take effect unless:

(a) after the refurbishment is completed, the approved provider gives the Secretary, in a form approved by the Secretary, the information about the refurbished service referred to in subsection (3); and

(b) the Secretary notifies the approved provider under paragraph (5)(b) that he or she is satisfied, having regard to the information given by the approved provider, that the requirements referred to in paragraphs (3)(a) to (h) are met in relation to the refurbished service.

Note 1: The Secretary must not make a determination under this subsection in certain circumstances (see subsection (2) and section 54).

Note 2: A determination under this subsection is not a legislative instrument (see section 58).

Note 3: A decision to refuse to make a determination under this subsection is a reviewable decision under section 85-1 of the Act (see section 59 of these principles).

(2) The Secretary must not make a determination under subsection (1) unless the Secretary is satisfied of the following:

(a) the proposed refurbishment includes alterations, updates, upgrades or other improvements to the service that will result in the service being significantly different in form, quality or functionality after the refurbishment;

(b) 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 who will be provided with residential care through the service;

(c) the proposed refurbishment will provide significant benefits to assisted residents, concessional residents, low-means care recipients or supported residents who will be provided with residential care through the service;

(d) the relevant costs of the proposed refurbishment will be capitalised for the purposes of the Australian accounting standards because:

(i) the proposed refurbishment will consist of structural improvements; or

(ii) those costs will be able to be depreciated because they will relate to fixtures, fittings or anything that can be removed intact;

(e) the proposed refurbishment:

(i) will result in at least 40% of the care recipients who will be provided with residential care through the service having a care recipient's room that has been significantly refurbished; or

(ii) will provide a significant benefit to at least 40% of the care recipients who will be provided with residential care through the service; or

(iii) will consist of an extension to the service involving an increase of at least 25% of the number of care recipient's rooms in the service;

(f) the proportion of the total number of care recipient's rooms in the service 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 in the service that were available before the proposed refurbishment for assisted residents, concessional residents, low-means care recipients or supported residents;

(g) the refurbishment cost in relation to the service will be at least the minimum monetary spend amount in relation to the service.

Note 1: ***Care recipient's room*** is defined in section 4.

Note 2: The ***refurbishment cost*** in relation to a residential care service is defined in section 7. The ***minimum monetary spend amount*** in relation to a residential care service is defined in section 6.

(3) For paragraph (1)(a), the information about the refurbished service that the approved provider must give the Secretary is information showing the following:

(a) the proposed refurbishment has been completed;

(b) the alterations, updates, upgrades or other improvements that have been made to the service have resulted in the service being significantly different in form, quality or functionality after the refurbishment;

(c) 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 who are being provided with residential care through the service;

(d) the refurbishment provides significant benefits to assisted residents, concessional residents, low-means care recipients or supported residents who are being provided with residential care through the service;

(e) the relevant costs of the refurbishment will be capitalised for the purposes of the Australian accounting standards because:

(i) the refurbishment consisted of structural improvements; or

(ii) those costs can be depreciated because they relate to fixtures, fittings or anything that can be removed intact;

(f) the refurbishment:

(i) has resulted in at least 40% of the care recipients being provided with residential care through the service having a care recipient's room that has been significantly refurbished; or

(ii) provides a significant benefit to at least 40% of the care recipients being provided with residential care through the service; or

(iii) consisted of an extension to the service involving an increase of at least 25% of the number of care recipient's rooms in the service;

(g) the proportion of the total number of care recipient's rooms in the service 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 in the service that were available before the refurbishment for assisted residents, concessional residents, low-means care recipients or supported residents;

(h) the refurbishment cost in relation to the service is at least the minimum monetary spend amount in relation to the service.

Note: The ***refurbishment cost*** in relation to a residential care service is defined in section 7. The ***minimum monetary spend amount*** in relation to a residential care service is defined in section 6.

(4) If the Secretary needs further information to decide whether to be satisfied as referred to in paragraph (1)(b) in relation to the refurbished service, the Secretary may give the approved provider a notice requesting the approved provider to give the further information within 28 days after receiving the notice.

(5) The Secretary must, within 28 days after receiving information from the approved provider in relation to the refurbished service:

(a) decide whether, having regard to the information, the Secretary is satisfied as referred to in paragraph (1)(b) in relation to the refurbished service; and

(b) notify the approved provider, in writing, of the Secretary's decision.

Note: A decision under paragraph (5)(a) that the Secretary is not satisfied as referred to in paragraph (1)(b) in relation to the refurbished service is a reviewable decision under section 85-1 of the Act (see section 59 of these principles).

(6) If the Secretary requested further information under subsection (4), the 28 day period referred to in subsection (5) does not include the period beginning on the day the request was made and ending on the day the information was received.

(7) If the Secretary is satisfied as referred to in paragraph (1)(b) in relation to the refurbished service, the notice given under paragraph (5)(b) must specify the date on which the determination under subsection (1) is to take effect, as provided by subsection 57(2).

54 Circumstances in which Secretary must not make determination

The Secretary must not make a determination under subsection 52(1) or 53(1) in relation to a residential care service if the refurbishment of the service consisted, or the proposed refurbishment of the service will consist, only of:

(a) routine repairs; or

(b) maintenance of premises (such as painting, plumbing, electrical work or gardening); or

(c) replacement of furniture; or
(d) fire safety improvements.

55 Requests for further information etc.

(1) If the Secretary needs further information to determine an application made under subsection 51(1) or (2), the Secretary may give the applicant a notice requesting the applicant to give the further information within 28 days after receiving the notice.

(2) The application is taken to be withdrawn if:
(a) further information is requested under subsection (1); and
(b) the information is not given within the period referred to in that subsection.

(3) The notice given under subsection (1) must include a statement setting out the effect of subsection (2).

56 Notification of Secretary's decision

(1) The Secretary must notify, in writing, the applicant for a determination under subsection 52(1) or 53(1) of the Secretary's decision on whether to make the determination.

(2) If:
(a) the decision relates to an application made under subsection 51(1) in relation to a residential care service that has been significantly refurbished; and
(b) the decision is to make the determination;
the notice must state the day on which the determination takes effect, as provided by subsection 57(1).

(3) If:
(a) the decision relates to an application made under subsection 51(2) in relation to a residential care service that is proposed to be significantly refurbished; and
(b) the decision is to make the determination;
the notice must include a statement setting out the condition referred to in subsection 53(1) (including the information referred to in subsection 53(3)).

(4) The notice must be given to the applicant within 60 days after the Secretary receives the application.

(5) If the Secretary requested further information under subsection 55(1) to determine the application, the 60 day period referred to in subsection (4) of this section does not include the period beginning on the day the request was made and ending on the day the information was received.

57 Day of effect of determination

(1) A determination under subsection 52(1) in relation to a residential care service that has been significantly refurbished takes effect:

(a) if the refurbishment was completed before 1 July 2014 and the application for the determination was received on or before 31 July 2014—on 1 July 2014; or

(b) in any other case—on the day the application was received.

(2) A determination under subsection 53(1) in relation to a residential care service that is proposed to be significantly refurbished takes effect on the day the Secretary receives the information about the refurbished service referred to in subsection 53(3).

58 Determinations are not legislative instruments

A determination under subsection 52(1) or 53(1) is not a legislative instrument.

59 Reviewable decisions

(1) Each of the following is a reviewable decision under section 85-1 of the Act:

(a) a decision under subsection 52(1) or 53(1) to refuse to make a determination in relation to a residential care service;

(b) a decision under paragraph 53(5)(a) that the Secretary is not satisfied as referred to in paragraph 53(1)(b) in relation to a refurbished service.

(2) Part 6.1 of the Act applies to a reviewable decision referred to in subsection (1) as if a reference in that Part to this Act included a reference to these principles.

Subdivision B—Hardship supplement

60 Eligibility for hardship supplement—determination by Secretary

(1) For subsection 44-31(2) of the Act, this section sets out the matters the Secretary must have regard to in deciding whether to determine that a care recipient is eligible for a hardship supplement.

(2) The Secretary must not determine that a care recipient is eligible for a hardship supplement if:

(a) the care recipient's means have not been assessed in accordance with the Act; or

(b) the value of the care recipient's assets (worked out under section 44-26A of the Act and section 47 of these principles) is more than 1.5 times the sum of the annual amount of the following (worked out under the Social Security Act):

(i) the basic age pension amount;

(ii) the pension supplement amount;

(iii) the clean energy supplement amount; or

(c) the care recipient has gifted:

(i) more than $10 000 in the previous 12 months; or

(ii) more than $30 000 in the previous 5 years.

Note: ***Basic age pension amount*** is defined in clause 1 of Schedule 1 to the Act.

(3) For paragraph (2)(b), in determining the value of the care recipient's assets for this section, unrealisable assets are not to be included.

Note: ***Unrealisable asset*** is defined in section 4.

(4) In deciding whether to determine that a care recipient is eligible for a hardship supplement, the Secretary may have regard to the following matters:

(a) the care recipient's total assessable income (worked out under section 44-24 of the Act and section 41 of these principles);

(b) whether the amount of income available to the care recipient after expenditure on essential expenses is less than 15% of the basic age pension amount;

(c) the financial arrangements of the care recipient;

(d) the care recipient's entitlement to income support:

(i) under the Social Security Act; or

(ii) under the Veterans' Entitlements Act; or

(iii) from any other source;

(e) whether the care recipient has taken steps to obtain information about his or her entitlement to pension, benefit or other income support payments;

(f) whether the care recipient has access to financial assistance:

(i) under section 1129 of the Social Security Act (relating to access to financial hardship rules for pensions); or

(ii) under the pension loans scheme under Division 4 of Part 3.12 of the Social Security Act; or

(iii) from any other source;

(g) whether any income of the care recipient is income that he or she does not reasonably have access to;

(h) whether there is a charge on the care recipient's income over which the payment of resident fees cannot practically take precedence;

(i) whether the care recipient is in Australia on a temporary basis;

(j) any other matters the Secretary considers relevant.

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

(1) ***Essential expenses***, for a recipient of residential care, include expenditure on any of the following:

(a) resident fees;

(b) if the partner or a dependent child of the care recipient lives in the care recipient's principal home—rent or mortgage for the principal home;

(c) private health insurance;

(d) ambulance cover;

(e) medical expenses, including expenses incurred under a health professional's direction;

(f) transport costs to attend medical appointments;

(g) dental care;

(h) prescription glasses (one pair per year) or contact lenses;

(i) artificial limbs, eyes or hearing aids for amounts that are not already covered by other government schemes or programs;

(j) wheelchair and mobility aids;

(k) if the care recipient is paying a funeral plan on a periodic basis—the funeral plan.

(2) However, ***essential expenses***, for a recipient of residential care, do not include expenditure on any of the following:

(a) extra service fees for a place in a residential care service that has extra service status;

(b) amounts paid for additional care and services agreed as mentioned in paragraph 56-1(e) of the Act;

(c) amounts spent by a person, authorised to act on the care recipient's behalf, other than for the benefit of the care recipient.

62 Circumstances in which Secretary may revoke financial hardship determination

For subsection 44-32(1) of the Act, the Secretary may revoke a determination that a care recipient is eligible for a hardship supplement if:

(a) the circumstances of the care recipient have changed; and

(b) the Secretary is satisfied that paying a daily amount of resident fees that is more than the amount specified in the determination would not cause the person financial hardship.

Example: For paragraph (a), a person's circumstances may change if assets of the person that were unrealisable assets are no longer assets of that kind.

Subdivision C—Viability supplement

63 Viability supplement

For paragraph 44-27(1)(c) of the Act, the viability supplement for a care recipient in respect of a payment period is the sum of all the viability supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) the residential care service was:

(i) a 1997 scheme service; or

(ii) a 2001 scheme service; or

(iii) a 2005 scheme service; and

(c) the residential care service, or a distinct part of the residential care service, does not have extra service status.

64 Meaning of *1997 scheme service*

(1) A residential care service is a ***1997 scheme service*** on a day if the service:

(a) meets the requirements of subsection (2); and

(b) does not meet the requirements of subsection 66(6).

(2) A residential care service meets the requirements of this subsection if:

(a) the service was in operation on 31 December 2004, and, on that date, the point score of the service would have been at least 60 points, under the scoring system set out in the table in this subsection; and

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(b) on 1 January 2005, the point score of the service was either:

(i) less than 50 points, under the scoring system set out in the table in subsection 66(2); or

(ii) if the amount of viability supplement payable in accordance with a determination made under subsection 44-27(3) of the Act, for a day in respect of a care recipient to whom care provided through the service as a 2005 scheme service was less than the amount of viability supplement payable in respect of the care recipient for the day if the service was taken to be a 1997 scheme service—at least 50 points, under the scoring system set out in the table in subsection 66(2).

1997 scheme services—scoring

Item	Criterion	Points
1	Location:	
	(a) remote zone;	40
	(b) other rural area;	30
	(c) small rural centre;	20
	(d) large rural centre.	10
2	Beds:	
	(a) less than 30;	20
	(b) less than 16.	30
3	Service not co-located with another service and unable to co-locate.	20
4	Supported, concessional or assisted residents:	
	(a) over 70%;	20
	(b) 50% to 70%.	10
5	Caters largely for care recipients who are people with special needs (other than people with special needs only because they live in a rural or remote area or are financially or socially disadvantaged).	10

(3) For paragraph (2)(a), for an item of the table in subsection (2) that has paragraphs, points may be scored under only one paragraph in the item.

(4) For item 1 of the table in subsection (2), a location of a particular kind is a statistical local area of that kind defined in the "Rural, Remote and Metropolitan Area Classification", 1991 Census Edition, published by the Australian Government Publishing Service, as in force on November 1994.

(5) For item 3 of the table in subsection (2), a residential care service is taken to be unable to co-locate with another aged care service if:

(a) the service is not on the same site as, or an adjoining site to, another residential care service or a multi-purpose service; or

(b) the service is on the same site as, or an adjoining site to, another residential care service or multi-purpose service but the total of the places allocated for the provision of residential care and flexible care equivalent to residential care on the same or adjoining site is less than 45; or

(c) the service is more than 25 kilometres from the nearest residential care service; or

(d) for a residential care service in a remote zone—the service is not more than 25 kilometres from the nearest residential care service, but the total number of places in both services is less than 30; or

(e) for a residential care service not in a remote zone—the service is not more than 25 kilometres from the nearest residential care service, but the total number of places in both services is less than 16.

Note: ***Multi-purpose service*** is defined in section 4.

65 Meaning of *2001 scheme service*

(1) A residential care service is a ***2001 scheme service*** on a day if, on that day, the service:

(a) meets the requirements of subsection (2) or (3); and

(b) does not meet the requirements of subsection 66(7).

(2) A residential care service meets the requirements of this subsection if:

(a) the service was in operation on 31 December 2004, and, on that date, the point score of the service would have been at least 40 points, under the scoring system set out in the table in this subsection; and

(b) on 1 January 2005, the point score of the service was either:

(i) less than 50 points, under the scoring system set out in the table in subsection 66(2); or

(ii) if the amount of viability supplement payable in accordance with the determination made under subsection 44-27(3) of the Act for a day in respect of a care recipient to whom care provided through the service as a 2005 scheme service was less than the amount of viability supplement payable in respect of the care recipient for the day if the service was taken to be a 2001 scheme service—at least 50 points, under the scoring system set out in the table in subsection 66(2).

2001 scheme services—scoring

Item	Criterion	Points
1	Location:	
	(a) very remote location;	60
	(b) remote location;	50
	(c) moderately accessible location;	40
	(d) accessible location;	30
	(e) highly accessible location.	0
2	Places:	
	(a) less than 20;	30
	(b) more than 19 but less than 30;	20
	(c) more than 29 but less than 45.	10
3	More than 50% of care recipients are people with special needs (other than people who are people with special needs only because they live in rural or remote areas or they are financially or socially disadvantaged).	10

Note: ***Accessible location***, ***highly accessible location***, ***moderately accessible location***, ***remote location*** and ***very remote location*** are defined in section 4.

(3) A residential care service meets the requirements of this subsection if:
  (a) the service commenced operating on or after 1 January 2005 and before 1 July 2005; and
  (b) on the day that the service commenced operating, the point score of the service was at least 40 points, under the scoring system set out in the table in subsection (2); and
  (c) also, on the day that the service commenced operating, the point score of the service was either:
    (i) less than 50 points, under the scoring system set out in the table in subsection 66(2); or
    (ii) if the amount of viability supplement payable in accordance with a determination made under subsection 44-27(3) of the Act, for that day in respect of a care recipient to whom care was provided through the service as a 2005 scheme service was less than the amount of viability supplement payable in respect of the care recipient for that day if the service was taken to be a 2001 scheme service—at least 50 points, under the scoring system set out in the table in subsection 66(2).

66 Meaning of *2005 scheme service*

(1) A residential care service is a ***2005 scheme service*** on a day if, on that day, the service meets the requirements of subsection (2), (6) or (7).

(2) A residential care service meets the requirements of this subsection if, on or after 1 January 2005, the service:
  (a) is not a 1997 scheme service or a 2001 scheme service; and
  (b) scores at least 50 points, worked out as follows:

2005 scheme service points calculator

Step 1. Work out the number of points (if any) applicable to the service in respect of its location under subsection (3).

Step 2. Add an additional 15 points if the service is in a very remote location, a remote location or a moderately accessible location, and more than 50% of care recipients of the service (other than care recipients receiving respite care) are classified at a classification level that does not include any of the following:

  (a) a domain category of medium or high in at least 2 domains;

  (b) a domain category of high in the ADL domain;

  (c) a domain category of high in the CHC domain;

  (d) a domain category of high in the behaviour domain and a domain category other than nil in either the ADL domain or the CHC domain.

Step 3.	Add the number of points (if any) applicable to the service in respect of targeting care for homeless people, people from Aboriginal and Torres Strait Islander communities, or both, under subsection (4).
Step 4.	If the total of steps 1, 2 and 3 is more than 65, reduce the total to 65 points.
Step 5.	Add the number of points (if any) applicable to the service in respect of its number of places under subsection (5).
Step 6.	Add an additional 5 points if more than 50% of care recipients are people with special needs (other than people who are people with special needs only because they live in rural or remote areas or are financially or socially disadvantaged).

The result is the points score for the 2005 scheme service.

Note 1: For the classification of care recipients mentioned in step 2, see the Classification Principles.

Note 2: ***Moderately accessible location***, ***remote location*** and ***very remote location*** are defined in section 4.

(3) For step 1 of the points calculator in subsection (2), the number of points applicable to the service in respect of its location is calculated using the scoring system in the following table:

2005 scheme services—locations

Item	Location	Points
1	Very remote location	65
2	Remote location	55
3	Moderately accessible location	40
4	Accessible location	30
5	Highly accessible location	0

Note: ***Accessible location***, ***highly accessible location***, ***moderately accessible location***, ***remote location*** and ***very remote location*** are defined in section 4.

(4) For step 3 of the points calculator in subsection (2), the service scores 60 points if more than 50% of care recipients of the service (other than care recipients receiving respite care) have been appraised using either appraisal tool A or appraisal tool B in Schedule 2 as demonstrating complex behavioural needs and social disadvantage associated with their background as a homeless person or their background as a person from an Aboriginal or Torres Strait Islander community, or both, and:

(a) the places allocated in respect of the residential care service are subject to a condition of allocation under section 14-5 of the Act relating to the care of people with a background as homeless persons or persons from an Aboriginal or Torres Strait Islander community; or

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(b) the approved provider of the residential care service or its key personnel have demonstrated experience in providing, or the capacity to provide, specialist services for such persons, including:

(i) programs and interventions to manage complex behavioural needs; or

(ii) programs to promote social engagement and participation; or

(iii) any other relevant services that the Secretary considers appropriate.

(5) For step 5 of the points calculator in subsection (2), the number of points applicable to the service in respect of its number of places is calculated using the scoring system in the following table:

2005 scheme service—places

Item	Places	Points
1	Less than 20	30
2	More than 19 but less than 25	25
3	More than 24 but less than 30	20
4	More than 29 but less than 35	15
5	More than 34 but less than 40	10
6	More than 39 but less than 45	5

(6) A residential care service meets the requirements of this subsection if the service was a 1997 scheme service and, on at least 1 day on or after 1 January 2005:

(a) the service scores at least 50 points, under the scoring system set out in the points calculator in subsection (2); and

(b) the amount of viability supplement payable in accordance with a determination made under subsection 44-27(3) of the Act, for a day in respect of a care recipient to whom care is provided through the service as a 2005 scheme service is the same as or greater than the amount of viability supplement payable in respect of the care recipient for the day if the service was taken to be a 1997 scheme service.

(7) A residential care service meets the requirements of this subsection if the service was a 2001 scheme service and, on at least 1 day on or after 1 January 2005:

(a) the service scores at least 50 points, under the scoring system set out in the points calculator in subsection (2); and

(b) the amount of viability supplement payable in accordance with a determination made under subsection 44-27(3) of the Act, for a day in respect of a care recipient to whom care is provided through the service as a 2005 scheme service is the same as or greater than the amount of viability supplement payable in respect of the care recipient for the day if the service was taken to be a 2001 scheme service.

Subdivision D—Veterans' supplement

67 Veterans' supplement

For paragraph 44-27(1)(c) of the Act, the veterans' supplement for a care recipient in respect of a payment period is the sum of all the veterans' supplements for the days during the period on which:

(a) the care recipient was provided with residential care (other than respite care) through the residential care service in question; and

(b) the care recipient was eligible for a veterans' supplement.

68 Eligibility for veterans' supplement

A care recipient is eligible for a veterans' supplement on a particular day if:

(a) on that day, the care recipient is a veteran with an accepted mental health condition; and

(b) the care recipient has before, on or after that day, authorised either, or both, of the following to disclose to the approved provider that the care recipient is a veteran with an accepted mental health condition:

(i) the Secretary of the Department administered by the Minister administering the Veterans' Entitlements Act;

(ii) the Secretary of the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

Note: ***Accepted mental health condition*** and ***veteran*** are defined in section 4.

Subdivision E—Homeless supplement

69 Homeless supplement

For paragraph 44-27(1)(c) of the Act, the homeless supplement for a care recipient in respect of a payment period is the sum of all the homeless supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and

(b) the service met the requirements for eligibility under section 70.

70 Eligibility for homeless supplement

A residential care service meets the requirements for eligibility for a homeless supplement on a particular day if:

(a) 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

(b) either:

(i) the allocation of places to the approved provider in respect of the service was made (under section 14-5 of the Act) subject to conditions relating to care of people with a background as homeless persons; or

(ii) the approved provider or its key personnel have demonstrated experience in providing, or the capacity to provide, specialist services for such persons, including programs and interventions to manage complex behavioural needs, or programs to promote social engagement and participation.

Chapter 3—Home care subsidy

Part 1—Who is eligible for home care subsidy?

Division 1—Purpose of this Part

71 Purpose of this Part

For Division 46 of the Act, 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.

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Division 2—Suspension of home care

72 Suspension of home care

(1) For subsection 46-2(3) of the Act, this section 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.

(2) The home care agreement, as in force on the date specified in the request by the care recipient to suspend the provision of home care (the ***commencement day***), is taken to remain in force during the period for which the provision of home care is suspended (the ***suspension period***).

(3) The care recipient is taken to have been provided with home care, as required by the home care agreement, on each day of the suspension period.

(4) The suspension period:
  (a) includes the commencement day; but
  (b) does not include the day on which the provision of home care to the care recipient recommences.

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

Division 1—Purpose of this Part

73 Purpose of this Part

For Division 48 of the Act, this Part sets out matters in relation to the amount of home care subsidy payable to an approved provider of a home care service in respect of a care recipient who is being provided with home care through the service, including the following:

(a) the following primary supplements that may apply to the care recipient (Division 2):
  (i) the oxygen supplement;
  (ii) the enteral feeding supplement;
  (iii) the dementia and cognition supplement;
  (iv) the veterans' supplement;
(b) matters relating to the following reductions in subsidy that may apply to the care recipient (Division 3):
  (i) the compensation payment reduction;
  (ii) the care subsidy reduction;
(c) other matters relating to the hardship supplement (Division 4);
(d) the viability supplement (Division 4).

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Division 2—Primary supplements

Subdivision A—Oxygen supplement

74 Oxygen supplement

The oxygen supplement for a care recipient in respect of a payment period is the sum of all the oxygen supplements for the days during the period on which:

(a) there was in force a home care agreement under which the care recipient was to be provided with home care through the home care service in question (whether or not home care was provided); and

(b) a determination was in force under subsection 75(3) in relation to the care recipient; and

(c) the home care provided through the home care service included providing oxygen to the care recipient in circumstances specified in section 76.

75 Eligibility for oxygen supplement—determination by Secretary

(1) An approved provider that is providing, or is to provide, home care to a care recipient may apply to the Secretary for a determination under subsection (3) that the care recipient is eligible for an oxygen supplement.

(2) The application must:

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

(b) include the information, and be accompanied by any documents, specified by the approved form.

(3) If the Secretary receives an application from an approved provider in respect of the care recipient under subsection (1), the Secretary may determine that the care recipient is eligible for an oxygen supplement.

Note: A decision to refuse to make a determination is a reviewable decision under section 77.

(4) A determination made under subsection (3) is not a legislative instrument.

(5) The Secretary must notify the applicant, in writing, of the Secretary's decision on whether to make the determination. The notice must be given within 28 days after the decision is made.

76 Circumstances relating to provision of oxygen

For paragraph 74(c), the circumstances for the provision of oxygen are as follows:

(a) the materials and equipment used by the home care service to provide the oxygen must be hired, temporarily obtained or owned by the home care service;

(b) the oxygen must not be provided:

(i) because of a medical emergency; or

(ii) on a short-term or episodic basis;

(c) a medical practitioner must have certified, in writing, that the care recipient has a continual need for the provision of oxygen;
(d) the oxygen must be provided in the most economical way available, taking into account the medical needs of the care recipient.

77 Reviewable decision

(1) A decision under subsection 75(3) to refuse to make a determination that a care recipient is eligible for an oxygen supplement is a reviewable decision under section 85-1 of the Act.

(2) Part 6.1 of the Act applies to a reviewable decision mentioned in subsection (1) as if a reference in that Part to this Act included a reference to these principles.

Subdivision B—Enteral feeding supplement

78 Enteral feeding supplement

The enteral feeding supplement for a care recipient in respect of a payment period is the sum of all the enteral feeding supplements for the days during the period on which:
(a) there was in force a home care agreement under which the care recipient was to be provided with home care through the home care service in question (whether or not home care was provided); and
(b) a determination was in force under subsection 79(3) in relation to the care recipient; and
(c) the home care provided through the home care service included providing enteral feeding to the care recipient in circumstances specified in section 80.

79 Eligibility for enteral feeding supplement—determination by Secretary

(1) An approved provider that is providing, or is to provide, home care to a care recipient may apply to the Secretary for a determination under subsection (3) that the care recipient is eligible for an enteral feeding supplement.

(2) The application must:
(a) be in a form approved by the Secretary; and
(b) include the information, and be accompanied by any documents, specified by the approved form.

(3) If the Secretary receives an application from an approved provider in respect of the care recipient under subsection (1), the Secretary may determine that the care recipient is eligible for an enteral feeding supplement.

Note: A decision to refuse to make a determination is a reviewable decision under section 81.

(4) A determination made under subsection (3) is not a legislative instrument.

(5) The Secretary must notify the applicant, in writing, of the Secretary's decision on whether to make the determination. The notice must be given within 28 days after the decision is made.

80 Circumstances relating to provision of enteral feeding

For paragraph 78(c), the circumstances for the provision of enteral feeding are as follows:

(a) a medical practitioner must have certified, in writing, that the care recipient has a medical need for enteral feeding;

(b) the care recipient must have been given a liquid dietary formula (not including food supplements or any supplementary feeding connected with the administration of the dietary formula) administered by a nasogastric, gastrostomy or jejeunostomy feeding method;

(c) a medical practitioner or dietician must have certified, in writing, that the dietary formula is a nutritionally complete formula;

(d) the enteral feeding must not be intermittent or supplementary enteral feeding given in addition to oral feeding;

(e) the enteral feeding must be provided in the most economical way available, taking into account the medical needs of the care recipient.

81 Reviewable decision

(1) A decision under subsection 79(3) 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.

(2) Part 6.1 of the Act applies to a reviewable decision mentioned in subsection (1) as if a reference in that Part to this Act included a reference to these principles.

Subdivision C—Dementia and cognition supplement

82 Dementia and cognition supplement

The dementia and cognition supplement for a care recipient in respect of a payment period is the sum of all dementia and cognition supplements for the days during the period on which:

(a) there was in force a home care agreement under which the care recipient was to be provided with home care through the home care service in question (whether or not home care was provided); and

(b) the care recipient was eligible for a dementia and cognition supplement.

83 Eligibility for dementia and cognition supplement

(1) A care recipient is eligible for a dementia and cognition supplement on a particular day if, on that day:

(a) subsection (2), (3), (4) or (5) applied to the care recipient; and

(b) if subsection (2), (3) or (4) applied to the care recipient—the approved provider had a record of the assessment mentioned in the relevant subsection; and

(c) the care recipient was not eligible for a veterans' supplement under section 85.

(2) This subsection applies to a care recipient on a day if:

(a) the care recipient has been assessed in accordance with the Psychogeriatric Assessment Scales; and
(b) the assessment was conducted by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner; and
(c) the assessment resulted in a score of 10 or more.

Note: ***Psychogeriatric Assessment Scales*** is defined in section 4.

(3) This subsection applies to a care recipient on a day if:
(a) the care recipient is from a culturally or linguistically diverse background; and
(b) the care recipient has been assessed in accordance with the Rowland Universal Dementia Assessment Scale; and
(c) the assessment was conducted by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner; and
(d) the assessment resulted in a score of 22 or less.

Note: ***Rowland Universal Dementia Assessment Scale*** is defined in section 4.

(4) This subsection applies to a care recipient on a day if:
(a) the care recipient is an Aboriginal person, or a Torres Strait Islander, who lives in a rural or remote area; and
(b) the care recipient has been assessed in accordance with the KICA-Cog; and
(c) the assessment was conducted by:
(i) a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner; or
(ii) another health practitioner trained in assessing a person in accordance with the KICA-Cog; and
(d) the assessment resulted in a score of 33 or less.

Note: ***KICA-Cog*** is defined in section 4.

(5) This subsection applies to a care recipient on a day if, immediately before 1 August 2013, the care recipient was receiving care, or was approved to receive care, in respect of a place allocated for the provision of flexible care in the form called extended aged care at home—dementia.

Subdivision D—Veterans' supplement

84 Veterans' supplement

The veterans' supplement for a care recipient in respect of a payment period is the sum of all the veterans' supplements for the days during the period on which:
(a) there was in force a home care agreement under which the care recipient was to be provided with home care through the home care service in question (whether or not home care was provided); and
(b) the care recipient was eligible for a veterans' supplement.

85 Eligibility for veterans' supplement

A care recipient is eligible for a veterans' supplement on a particular day if:

(a) on that day, the care recipient is a veteran with an accepted mental health condition; and

(b) the care recipient has before, on or after that day, authorised either, or both, of the following to disclose to the approved provider that the care recipient is a veteran with an accepted mental health condition:

(i) the Secretary of the Department administered by the Minister administering the Veterans' Entitlements Act;

(ii) the Secretary of the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

Note: ***Accepted mental health condition*** and ***veteran*** are defined in section 4.

Division 3—Reductions in subsidy

Subdivision A—Compensation payment reduction

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

(1) For subsections 48-5(5) and (6) of the Act, in making a determination in respect of a judgment or settlement entitling a care recipient to compensation, the Secretary must take into account the following matters:

(a) the amount of the judgment or settlement;

(b) for a judgment—the components stated in the judgment and the amount stated for each component;

(c) the proportion of liability apportioned to the care recipient;

(d) the amounts spent on home care at the time of the judgment or settlement.

Note: For paragraph (1)(b), examples of the components of a judgment include the following:

(a) loss of income;

(b) costs of future care.

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

(a) the amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;

(b) the amounts spent on care (other than home care) at the time of the judgment or settlement;

(c) the likely cost of home care for the care recipient;

(d) other costs of care for which the care recipient is likely to be liable;

(e) other reasonable amounts, not related to care, that the care recipient:

(i) has spent at the time of the judgment or settlement; or

(ii) is likely to be liable for.

87 Determination by Secretary if compensation information not given on request

(1) For subsection 48-6(5) of the Act, 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.

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

(a) the amount of the judgment, settlement or reimbursement arrangement;

(b) for a judgment—the components stated in the judgment and the amount stated for each component;

(c) the proportion of liability apportioned to the care recipient;

(d) the amounts that are likely to be paid to or withheld by other government agencies because of the judgment, settlement or reimbursement arrangement;

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(e) the amounts spent on care (other than home care) at the time of the judgment, settlement or reimbursement arrangement;
(f) the likely cost of home care for the care recipient;
(g) other costs of care for which the care recipient is likely to be liable;
(h) other amounts, not related to care, that the care recipient:
(i) had spent at the time of the judgment, settlement or reimbursement arrangement; or
(ii) is likely to be liable for.

Subdivision B—Care subsidy reduction—general

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

(1) For paragraph 48-8(1)(b) of the Act, the classes of persons for whom a care subsidy reduction, in respect of a care recipient being provided with home care through a home care service, is taken to be zero are the following:
(a) care recipients who stop being provided with home care (without being provided with other home care), or who die, before the approved provider is informed of the person's care subsidy reduction (if any);
(b) care recipients who are not, within 6 months of receiving home care, informed of the care recipient's care subsidy reduction (if any);
(c) care recipients who have one or more dependent children;
(d) care recipients who are described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war);
(e) care recipients for whom the care subsidy reduction is worked out at less than $1.

(2) If the care recipient is included in the class of persons mentioned in paragraph (1)(b), the care recipient is included in that class from the day the care recipient starts being provided with home care through the home care service until the day the care recipient is informed of the care recipient's care subsidy reduction.

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

(1) For subsection 48-8(4) of the Act, in deciding whether to determine that the care subsidy reduction in respect of a care recipient is to be taken to be zero, the Secretary must have regard to the following matters:
(a) the care recipient's total assessable income (worked out in accordance with section 44-24 of the Act and section 90 of these principles) and assets (worked out under section 44-26A of the Act and section 47 of these principles);
(b) the care recipient's financial arrangements;
(c) the care recipient's entitlement to income support:
(i) under the Social Security Act; or
(ii) under the Veterans' Entitlements Act; or
(iii) from any other source;

(d) whether the care recipient has taken steps to obtain information about his or her entitlement to pension, benefit or other income support payments;
(e) whether the care recipient has access to financial assistance:
(i) under section 1129 of the Social Security Act (relating to access to financial hardship rules for pensions); or
(ii) under the pension loans scheme under Division 4 of Part 3.12 of the Social Security Act; or
(iii) from any other source;
(f) whether any income of the care recipient is income that the care recipient does not reasonably have access to;
(g) whether there is a charge on the care recipient's income over which the payment of home care fees cannot practically take precedence;
(h) whether any assets of the care recipient are unrealisable assets;
(i) whether the care recipient is in Australia on a temporary basis.

Note: ***Unrealisable asset*** is defined in section 4.

(2) The Secretary may have regard to any other matters the Secretary considers relevant.

(3) To enable the Secretary to have regard to the matters mentioned in paragraph (1)(c) or (d), the Secretary may:
(a) require the care recipient to seek information from a Department about his or her entitlement to a benefit, income support payment or other assistance, and give the Secretary copies of written replies from the Department; or
(b) advise the care recipient to seek advice about his or her financial arrangements with the Financial Information Service established by Centrelink.

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

90 Working out care recipient's care subsidy reduction—amounts excluded from care recipient's total assessable income

(1) This section applies for the purpose of working out, under step 1 of the care subsidy reduction calculator in subsection 48-7(2) of the Act, a care recipient's ***total assessable income*** on a yearly basis using section 44-24 of the Act.

(2) For subsection 44-24(5) of the Act, the amounts (in this Subdivision called ***excluded amounts***) that are to be taken, in relation to the kinds of care recipients specified in sections 91 to 94, to be excluded from determinations by the Secretary under subsection 44-24(1) or paragraph 44-24(2)(b), (3)(b) or (4)(b) of the Act are the following:
(a) disability pensions and permanent impairment compensation payments mentioned in section 91;
(b) gifts mentioned in section 92;
(c) GST compensation mentioned in section 93;
(d) clean energy payments mentioned in section 94.

91 Excluded amounts—disability pensions and permanent impairment compensation payments

(1) For a person who has qualifying service under section 7A of the Veterans' Entitlements Act, or the partner of such a person, the amount (if any) of disability pension (within the meaning of subsection 5Q(1) of the Veterans' Entitlements Act) paid to the person that is exempt under section 5H of that Act is an excluded amount.

(2) For a person who is a member or former member (within the meaning of the *Military Rehabilitation and Compensation Act 2004*) or the partner of such a person, each of the following is an excluded amount:

(a) any amount of compensation for permanent impairment paid to the person under Part 2 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004*;

(b) 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*.

92 Excluded amounts—gifts

(1) For a person who, on or before 20 August 1996, disposed of ordinary income, the amount of ordinary income disposed of on or before 20 August 1996 that is included in the person's ordinary income under:

(a) sections 1106, 1107, 1108 and 1109 of the Social Security Act; or

(b) sections 48, 48A, 48B and 48C of the Veterans' Entitlements Act;

is an excluded amount.

Note: Sections 1106, 1107, 1108 and 1109 of the Social Security Act, and sections 48, 48A, 48B and 48C of the Veterans' Entitlements Act, deal with disposal of ordinary income.

(2) For a person who, on or before 20 August 1996, disposed of assets, the amount of ordinary income the person is taken to receive because assets disposed of on or before 20 August 1996 are assessed as financial assets under:

(a) section 1076, 1077 or 1078 of the Social Security Act; or

(b) sections 46D and 46E of the Veterans' Entitlements Act;

is an excluded amount.

Note: Section 1076, 1077 or 1078 of the Social Security Act, and sections 46D and 46E of the Veterans' Entitlements Act, deal with deemed income from financial assets.

93 Excluded amounts—GST compensation

(1) This section applies in relation to:

(a) a person receiving a pension under Part II or IV of the Veterans' Entitlements Act at a rate determined under or by reference to the following provisions of that Act:

(i) for a person receiving a disability pension payable at the general rate—section 22;

(ii) for a person receiving a disability pension payable at the general rate including an increased rate for a war-caused injury or disease—sections 22 and 27;

(iii) for a person receiving a disability pension payable at the intermediate rate—section 23;

(iv) for a person receiving a disability pension payable at the intermediate rate including an increased rate for a war-caused injury or disease—sections 23 and 27;

(v) for a person receiving a disability pension payable at the special rate—section 24;

(vi) for a person receiving a war widow or widower pension—subsection 30(1); and

(b) a person receiving a pension under Part 6 of Chapter 4, or a weekly amount of compensation under Part 2 of Chapter 5, of the *Military Rehabilitation and Compensation Act 2004* at a rate determined under or by reference to the following provisions of that Act:

(i) for a person receiving a Special Rate Disability Pension—sections 198 and 204;

(ii) for a person receiving a weekly amount of compensation for the death of the person's partner—subsection 234(5).

(2) The amount that is equal to 4% of the amount of pension, or the weekly amount of compensation, payable to a person under a provision referred to in subsection (1), as applicable from time to time, is an excluded amount.

Note 1: Part II of the Veterans' Entitlements Act deals with pensions, other than service pensions, payable to veterans and their dependants.

Note 2: Part IV of the Veterans' Entitlements Act deals with pensions payable to members of the Defence Forces or a Peacekeeping Force and their dependants.

Note 3: Part 6 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004* gives former members who are entitled to compensation for incapacity for work a choice to receive a Special Rate Disability Pension instead of compensation.

Note 4: Part 2 of Chapter 5 of the *Military Rehabilitation and Compensation Act 2004* gives wholly dependent partners of deceased members an entitlement to compensation in respect of the death of the members. The compensation may be taken as a lump sum or as a weekly amount.

94 Excluded amounts—clean energy payments

For a care recipient who is being provided with home care through a home care service, each of the following is an excluded amount:

(a) any amount of clean energy advance, clean energy supplement or quarterly clean energy supplement paid to the care recipient under the Social Security Act;

(b) any amount of clean energy advance, clean energy supplement or quarterly clean energy supplement paid to the care recipient under the Veterans' Entitlements Act.

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Division 4—Other supplements

Subdivision A—Hardship supplement

95 Eligibility for hardship supplement—determination by Secretary

(1) For subsection 48-11(2) of the Act, this section sets out the matters the Secretary must have regard to in deciding whether to determine that a care recipient is eligible for a hardship supplement.

(2) The Secretary must not determine that a care recipient is eligible for a hardship supplement if:

(a) the care recipient's means have not been assessed in accordance with the Act; or

(b) the value of the care recipient's assets (worked out under section 44-26A of the Act and section 47 of these principles) is more than 1.5 times the sum of the annual amount of the following (worked out under the Social Security Act):

(i) the basic age pension amount;

(ii) the pension supplement amount;

(iii) the clean energy supplement amount; or

(c) the care recipient has gifted:

(i) more than $10 000 in the previous 12 months; or

(ii) more than $30 000 in the previous 5 years.

Note: ***Basic age pension amount*** is defined in clause 1 of Schedule 1 to the Act.

(3) For paragraph (2)(b), in determining the value of the care recipient's assets for this section, unrealisable assets are not to be included.

Note: ***Unrealisable asset*** is defined in section 4.

(4) In deciding whether to determine that a care recipient is eligible for a hardship supplement, the Secretary must have regard to the following matters:

(a) the care recipient's total assessable income (worked out under section 44-24 of the Act and section 90 of these principles);

(b) whether the amount of income available to the care recipient after expenditure on essential expenses is less than 15% of the basic age pension amount;

(c) the financial arrangements of the care recipient;

(d) the care recipient's entitlement to income support:

(i) under the Social Security Act; or

(ii) under the Veterans' Entitlements Act; or

(iii) from any other source;

(e) whether the care recipient has taken steps to obtain information about the care recipient's entitlement to pension, benefit or other income support payments;

(f) whether the care recipient has access to financial assistance:

(i) under section 1129 of the Social Security Act (relating to access to financial hardship rules for pensions); or
(ii) under the pension loans scheme under Division 4 of Part 3.12 of the Social Security Act; or
(iii) from any other source;

(g) whether any income of the care recipient is income that the care recipient does not reasonably have access to;
(h) whether there is a charge on the care recipient's income over which the payment of home care fees cannot practically take precedence;
(i) whether the care recipient is in Australia on a temporary basis;
(j) any other matters that the Secretary considers relevant.

96 Meaning of *essential expenses* for a recipient of home care

(1) ***Essential expenses***, for a recipient of home care, include expenditure on any of the following:
(a) home care fees;
(b) food costs;
(c) costs relating to the home, including:
(i) rent or mortgage repayments; and
(ii) home maintenance, including repair and replacement costs; and
(iii) home insurance; and
(iv) rates; and
(v) water, sewage, gas and electricity costs; and
(vi) telephone and internet costs;
(d) medical expenses, including expenses incurred under a health professional's direction;
(e) dental care;
(f) prescription glasses (one pair per year) or contact lenses;
(g) artificial limbs, eyes or hearing aids for amounts that are not already covered by other government schemes or programs;
(h) wheelchair and mobility aids;
(i) ambulance cover;
(j) transport related costs, including public transport costs, vehicle registration, vehicle repairs and vehicle insurance;
(k) private health insurance;
(l) if the care recipient is paying a funeral plan on a periodic basis—the funeral plan.

(2) However, ***essential expenses***, for a recipient of home care, do not include amounts spent by a person, authorised to act on the care recipient's behalf, other than for the benefit of the care recipient.

97 Circumstances in which Secretary may revoke financial hardship determination

For subsection 48-12(1) of the Act, the Secretary may revoke a determination that a care recipient is eligible for a hardship supplement if:

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(a) the circumstances of the care recipient have changed; and
(b) the Secretary is satisfied that paying a daily amount of home care fees that is more than the amount specified in the determination would not cause the person financial hardship.

Example: For paragraph (a), a person's circumstances may change if assets of the person that were unrealisable assets are no longer assets of that kind.

Subdivision B—Viability supplement

98 The viability supplement

The viability supplement for a care recipient in respect of a payment period is the sum of all the viability supplements for the days during the period on which:

(a) there was in force a home care agreement under which the care recipient was to be provided with home care through the home care service in question (whether or not home care was provided); and
(b) the service meets the eligibility requirements under section 99.

99 Eligibility for viability supplement

A home care service meets the eligibility requirements for a viability supplement on a particular day if, on that day, home care is provided through the home care service to the care recipient in a location that has an ARIA value of 3.52 or greater.

Note: ***ARIA value*** is defined in section 4.

Chapter 4—Flexible care subsidy

Part 1—Who is eligible for flexible care subsidy?

Division 1—Purpose of this Part

100 Purpose of this Part

For Division 50 of the Act, this Part specifies:

(a) the classes of people who do not need approval under Part 2.3 of the Act in respect of flexible care (Division 2); and

(b) the circumstances in which an approved provider is taken to provide flexible care to a care recipient (Division 2); and

(c) the kinds of care for which flexible care subsidy may be payable (Division 3).

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Division 2—Eligibility for flexible care subsidy

101 Classes of people who do not need approval in respect of flexible care

For subparagraph 50-1(1)(b)(ii) of the Act, the classes of people who do not need approval under Part 2.3 of the Act in respect of flexible care are the following:

(a) people who receive flexible care through a multi-purpose service;

(b) people who receive flexible care through an innovative care service.

Note: Subsidy cannot be paid to an approved provider for providing flexible care in respect of a person unless the person is approved under Part 2.3 of the Act as a recipient of that kind of flexible care, or the person is included in a class of people specified in this section (see subsection 20-1(3) of the Act).

102 Circumstances in which flexible care is taken to be provided

For subparagraph 50-1(1)(b)(iii) of the Act, 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.

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

103 Kinds of care

For section 50-2 of the Act, the kinds of care for which flexible care subsidy may be payable are the following:

(a) flexible care provided through a multi-purpose service;

(b) flexible care provided through an innovative care service;

(c) flexible care provided as transition care.

104 Multi-purpose services

A ***multi-purpose service*** is a flexible care service in relation to which the following requirements are satisfied:

(a) residential care is provided through the service;

(b) at least one of the following services is also provided through the service:

(i) a health service;

(ii) a home and community care service;

(iii) a dental service;

(iv) a transport service;

(v) a home care service;

(vi) a service for which a Medicare benefit is payable under the *Health Insurance Act 1973*;

(vii) a service that provides a pharmaceutical benefit under the *National Health Act 1953*;

(viii) 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.

105 Innovative care services

(1) An ***innovative care service*** is a flexible care service through which any of the following is provided:

(a) care that, by its nature, provides alternative care options, including care for older persons:

(i) with complex conditions; or

(ii) who require coordination and integration of care;

(b) care provided in circumstances that require the delivery of alternative care options, including care provided:

(i) in an emergency such as a natural disaster involving fire or flood; or

(ii) as part of an initiative to address access by older persons to, or the viability of, aged care services; or

(iii) where the care needs of a care recipient are not being adequately met by available residential care services or home care services; or

(iv) as part of a joint initiative between the Commonwealth and a State or Territory to promote alternative care options for older persons;

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(c) 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;

(d) care provided to a group of people who are in need of alternative care options, including care provided to older persons who:
  (i) require coordination and integration of care; or
  (ii) have complex, chronic conditions; or
  (iii) need short term aged care following hospitalisation;

(e) care provided for a limited period to facilitate alternative care options, including care provided:
  (i) by a pilot service or project; or
  (ii) to care recipients in places that have been allocated for a limited time in an emergency;

(f) other kinds of care that, to the satisfaction of the Secretary:
  (i) are provided in a residential or community setting; and
  (ii) provide alternative care options.

(2) For subsection (1), ***alternative care options*** are options for providing flexible care to older persons that meet the needs of care recipients in alternative ways to the care provided through residential care services and home care services.

106 Transition care

Transition care is a form of flexible care that:

(a) is provided to a care recipient:
  (i) at the conclusion of an in-patient hospital episode; and
  (ii) in the form of a package of services that includes at least low intensity therapy and nursing support or personal care; and

(b) can be characterised as:
  (i) goal-oriented; and
  (ii) time-limited; and
  (iii) therapy-focussed; and
  (iv) targeted towards older people; and
  (v) 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.

Note: ***In-patient hospital episode*** and ***low intensity therapy*** are defined in section 4.

Part 2—Basis on which flexible care subsidy is paid

107 Purpose of this Part

For Division 51 of the Act, this Part deals with the basis on which flexible care subsidy may be paid, including:

(a) the periods in which flexible care subsidy is payable; and

(b) other matters relating to the payment of flexible care subsidy.

108 Flexible care provided through multi-purpose service

(1) Flexible care subsidy in respect of flexible care provided through a multi-purpose service is payable to the approved provider of the service for each payment period during which the approved provider is eligible under this section.

Note: The amount of flexible care subsidy that is payable in respect of a day is the amount determined by the Minister in writing under paragraph 52-1(1)(a) of the Act.

(2) The payment period is the period specified in the agreement mentioned in paragraph (3)(a).

(3) An approved provider is eligible for flexible care subsidy in respect of a day if:

(a) 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

(b) the approved provider has complied with the agreement.

109 Decision by Secretary to enter multi-purpose service agreement

(1) The Secretary must not enter into an agreement with an approved provider for the provision of flexible care through a multi-purpose service unless:

(a) the approved provider has demonstrated to the Secretary the matters mentioned in subsection (2); and

(b) the Secretary is satisfied of the matters mentioned in subsection (3).

(2) For paragraph (1)(a), the matters in relation to the multi-purpose service that the approved provider must demonstrate to the Secretary are as follows:

(a) that the approved provider will, in relation to the service:

(i) improve access to care; and

(ii) increase coordination, flexibility and innovation in the delivery of care in the area; and

(iii) provide care that is cost-effective; and

(iv) provide care that is culturally appropriate;

(b) that the service:

(i) is, or will be, in an area that is not a major city; and

(ii) is, or will be, in an area that is able to sustain a viable multi-purpose service; and

(iii) has, or is likely to have, the broad support of the community within the area in which the service is, or will be, located;

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(c) 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;

(d) that the Commonwealth and the State or Territory in which the service is located agree that the area needs a multi-purpose service.

(3) For paragraph (1)(b), the matters of which the Secretary must be satisfied are as follows:

(a) that the service satisfies, or will satisfy, the requirements in paragraphs 104(a) and (b);

(b) that there is a demonstrated need for a multi-purpose service in the area in which the service is, or will be, located;

(c) that a multi-purpose service would be viable in the area in which the service is, or will be, located;

(d) that there has been broad-based consultation about the multi-purpose service, including consultation with existing service providers and agencies;

(e) that the service is broadly supported by the community within the area in which the service is, or will be, located;

(f) that an evaluation strategy has been established for the service that includes:

(i) consideration of the service as a whole; and

(ii) the outcomes that the approved provider intends to provide in respect of the provision of aged care services in the area; and

(iii) the impact of the service on other aged care services in the area.

110 Flexible care provided through innovative care service

(1) Flexible care subsidy in respect of flexible care provided by an approved provider through 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.

(2) 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:

(a) the State or Territory also provides funding, at a level agreed with the Commonwealth, for the service; and

(b) the State or Territory funding is directed to meeting the needs of care recipients that are the responsibility of the State or Territory.

Note: The amount of flexible care subsidy that is payable in respect of a day is the amount determined by the Minister in writing under paragraph 52-1(1)(a) of the Act.

111 Flexible care provided as transition care

(1) Flexible care subsidy in respect of flexible care provided by an approved provider as transition care is payable to the approved provider for each payment period during which the approved provider is eligible under this section.

(2) The payment period is the period specified in the agreement mentioned in paragraph (3)(a).

(3) An approved provider is eligible for flexible care subsidy in respect of a day if, during that day:
  (a) there is in force an agreement between the Secretary and the approved provider for the provision of transition care; and
  (b) a State or Territory provides funding for the service, directed at meeting the needs of care recipients being provided with transition care, at a level agreed with the Commonwealth.

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

Note: The amount of flexible care subsidy that is payable in respect of a day is the amount determined by the Minister in writing under paragraph 52-1(1)(a) of the Act.

(5) The maximum number of days for which flexible care subsidy is payable in respect of an episode of transition care is:
  (a) 84 days; or
  (b) 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.

Note: ***Episode of transition care*** and ***further transition care needs*** are defined in section 4.

Federal Register of Legislative Instruments F2014L00862

Chapter 5—Miscellaneous

112 Expiry of certain provisions

Dementia and severe behaviours supplement

(1) The following provisions of these principles expire on 1 November 2014 as if they had been repealed by another legislative instrument:
  (a) subparagraph 20(b)(iv);
  (b) Subdivision D of Division 3 of Part 3 of Chapter 2.

Payroll tax supplement

(2) The following provisions of these principles expire on 1 April 2015 as if they had been repealed by another legislative instrument:
  (a) subparagraph 20(b)(v);
  (b) Subdivision E of Division 3 of Part 3 of Chapter 2.

Schedule 1—ACAP codes

Note: See the definition of ***ACAP code*** in section 4.

1 ACAP codes

The following table specifies the ACAP codes for certain health conditions.

ACAP Codes	
ACAP Code	**Health condition**
0500	**Dementia in Alzheimer's disease**
0501	Dementia in Alzheimer's disease with early onset (less than 65 years)
0502	Dementia in Alzheimer's disease with late onset (65 or more years)
0503	Dementia in Alzheimer's disease, atypical or mixed type
0504	Dementia in Alzheimer's disease, unspecified
0510	**Vascular dementia**
0511	Vascular dementia of acute onset
0512	Multi-infarct dementia
0513	Subcortical vascular dementia
0514	Mixed cortical and subcortical vascular dementia
0515	Other vascular dementia
0516	Vascular dementia—unspecified
0520	**Dementia in other diseases classified elsewhere**
0521	Dementia in Pick's disease
0522	Dementia in Creutzfeldt-Jakob disease
0523	Dementia in Huntington's disease
0524	Dementia in Parkinson's disease
0525	Dementia in human immunodeficiency virus (HIV) disease
0526	Dementia in other specified diseases classified elsewhere
0530	**Other dementia**
0531	Alcoholic dementia
0532	Unspecified dementia (includes presenile and senile dementia)
0540	**Delirium**
0541	Delirium not superimposed on dementia
0542	Delirium superimposed on dementia
0543	Other delirium
0544	Delirium—unspecified
0550	**Psychoses and depression/mood affective disorders**
0551	Schizophrenia
0552	Depression/mood affective disorders
0553	Other psychoses (includes paranoid states)
0560	**Neurotic, stress related and somatoform disorders**
0561	Phobic and anxiety disorders (includes agoraphobia, panic disorder)

Clause 1

ACAP Codes	
ACAP Code	**Health condition**
0562	Nervous tension/stress
0563	Obsessive-compulsive disorder
0564	Other neurotic, stress related and somatoform disorders
0570	**Intellectual and developmental disorders**
0571	Mental retardation/intellectual disability
0572	Other development disorders (includes autism, Rett syndrome, Asperger's syndrome, developmental learning disorders, specific development disorders of speech and language, specific developmental disorder of motor function (for example, dyspraxia))
0580	**Other mental and behavioural disorders**
0581	Mental and behavioural disorders due to alcohol and other psychoactive substance use (includes alcoholism, Korsakov's psychosis (alcoholic))
0582	Adult personality and behavioural disorders
0583	Speech impediment (for example, stuttering or stammering)
0599	Other mental and behavioural disorders not elsewhere classified or not otherwise specified (includes harmful use of non-dependent substances such as laxatives, analgesics and antidepressants, eating disorders such as anorexia nervosa and bulimia nervosa, and mental disorders not otherwise specified)

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

Note: See subsection 66(4) and paragraph 70(a).

1 Appraisal procedures

(1) An appraisal of whether a person demonstrates complex behavioural needs and social disadvantage associated with their background as a homeless person or a person from an Aboriginal or Torres Strait Islander community must be undertaken using appraisal tool A in clause 2 of this Schedule or appraisal tool B in clause 3 of this Schedule (as the case requires).

(2) If a person is both a homeless person and a person from an Aboriginal or Torres Strait Islander community then both appraisal tool A and appraisal tool B must be completed.

(3) Notification of the outcome of the appraisal must be received by the Secretary within the period commencing 28 days after the day on which the approved provider began providing care to the care recipient (the ***care recipient's entry day***) and ending 2 months after the care recipient's entry day.

(4) However, if the care recipient dies or leaves the residential care service through which the approved provider provides care before the end of 28 days after the care recipient's entry day, notification of the outcome of the appraisal may be given to the Secretary before the end of 28 days after the care recipient's entry day.

(5) If notification of the outcome of the appraisal is received by the Secretary before the end of the period specified in subclause (3), any points that may be added under subsection 66(4) (for the purposes of step 3 of the 2005 scheme service points calculator in subsection 66(2)) as a result of the outcome of the appraisal take effect on the care recipient's entry day.

(6) If notification of the outcome of the appraisal is received by the Secretary after the end of the period specified in subclause (3), any points that may be added under subsection 66(4) (for the purposes of step 3 of the 2005 scheme service points calculator in subsection 66(2)) as a result of the outcome of the appraisal take effect on the day the notification of the outcome of the appraisal is received by the Secretary.

2 Appraisal tool A—homelessness—additional special needs

(1) The care recipient must:

(a) demonstrate one or both of the following:

(i) complex behavioural needs;

(ii) complex social support needs; and

(b) meet each of the 4 criteria set out in the table in this clause.

Clause 2

(2) For the purposes of the checklists in the table in this clause, the diagnosis can be made by any health professional acting within their approved scope of practice.

Table—Appraisal tool A—homelessness

Item	Criteria	Tick if Yes
1	**Homelessness background**	
	The person has a history of homelessness or is at severe risk of homelessness, including that the person, immediately prior to entering care at the current or a previous residential aged care home:	
	(a) was living in a public place or temporary shelter; short-term crisis, emergency or transitional accommodation; boarding house, rooming house or private hotel; or supported community accommodation; or	☐
	(b) had no recent housing address; or	☐
	(c) had a long history of unsuccessful tenancies or unstable housing arrangements.	☐
2	**Financial status**	
	The person is eligible for:	
	(a) the maximum basic rate of social security pension or benefit as defined in the Social Security Act; or	☐
	(b) service pension or disability pension as defined in the Veterans' Entitlements Act.	☐
3	**Relevant behavioural diagnosis**	
	The person has mental and behavioural diagnosis associated with one of the following disorders:	
	(a) dementia in Alzheimer's disease including early onset dementia, late onset dementia, atypical or mixed type or unspecified dementia (ACAP code 0500);	☐
	(b) vascular dementia including acute onset dementia, multi-infarct dementia, subcortical vascular dementia, mixed cortical and subcortical vascular dementia, other vascular or unspecified dementia (ACAP code 0510);	☐
	(c) dementia in other diseases classified elsewhere including Pick's Disease, Creutzfeldt-Jakob disease, Huntington's disease, Parkinson's disease, human immunodeficiency virus (HIV) (ACAP code 0520);	☐
	(d) other dementia including alcoholic dementia or unspecified dementia (such as presenile and senile dementia) (ACAP code 0530);	☐
	(e) delirium including delirium not superimposed on dementia, delirium superimposed on dementia, other delirium or unspecified delirium (ACAP code 0540);	☐
	(f) psychoses and depression/mood affective disorders including schizophrenia or other psychoses (such as paranoid states) (ACAP code 0550);	☐
	(g) neurotic, stress-related and somatoform disorders including phobic and anxiety disorders (such as agoraphobia and panic disorder), nervous tension/stress or obsessive-compulsive disorder (ACAP code 0560);	☐
	(h) intellectual and developmental disorders including mental retardation, intellectual disability or other developmental disorders (such as autism, Rett syndrome, Asperger's syndrome, developmental learning disorders, specific developmental disorders of speech and language, specific	☐

Table—Appraisal tool A—homelessness

Item	Criteria	Tick if Yes
	development disorder of motor function such as dyspraxia) (ACAP code 0570);	
	(i) other mental and behavioural disorders including mental and behavioural disorders due to alcohol and other psychoactive substance use (such as alcoholism, Korsakov's psychosis (alcoholic), adult personality and behavioural disorders, speech impediment (stuttering or stammering)) or other mental and behavioural disorders not otherwise specified or not elsewhere classified (such as harmful use of non-dependant substances (for example, laxatives, analgesics or antidepressants), eating disorders (for example, anorexia nervosa or bulimia nervosa) or mental disorders not otherwise specified) (ACAP code 0580).	☐
4	**Challenging behaviours and need for intensive social support**	
	(a) The person displays challenging behaviours which require ongoing management and prevention including one or both of the following:	
	(i) episodic catastrophic behaviours such as severe physical and verbal abuse, violent mood swings, aggression;	☐
	(ii) the person is considered at high risk of leaving without warning with ongoing staff intervention required to prevent this from occurring;	☐
	(b) The person requires intensive social support or intensive assistance with continuing to perform activities of daily living including initiation of and assistance with:	
	(i) personal care and hygiene matters (for example, shows aversion to showering and washing hands, has problems with toileting and dressing, requires assistance or guidance with meals); or	☐
	(ii) social and recreational activities, with significant one-on-one staff intervention necessary to enable the person to participate in community activities.	☐

3 Appraisal tool B—Aboriginal and Torres Strait Islanders—additional special needs

(1) The care recipient must:

(a) demonstrate one or both of the following:

(i) complex behavioural needs;

(ii) complex social support needs; and

(b) meet each of the 4 criteria set out in the following table.

(2) For the purposes of the checklists in the table in this clause, the diagnosis can be made by any health professional acting within their approved scope of practice.

Table—Appraisal tool B—Aboriginal and Torres Strait Islanders

Item	Criteria	Tick if Yes
1	**Indigenous status** The person is of Aboriginal or Torres Strait Islander origin.	☐
2	**Financial status** The person is eligible for:	

Clause 3

Table—Appraisal tool B—Aboriginal and Torres Strait Islanders

Item	Criteria	Tick if Yes
	(a) the maximum basic rate of social security pension or benefit as defined in the Social Security Act; or	☐
	(b) service pension or disability pension as defined in the Veterans' Entitlements Act.	☐
3	**Relevant behavioural diagnosis** The person has mental and behavioural diagnosis associated with one of the following disorders:	
	(a) dementia in Alzheimer's disease including early onset dementia, late onset dementia, atypical or mixed type or unspecified dementia (ACAP code 0500);	☐
	(b) vascular dementia including acute onset dementia, multi-infarct dementia, subcortical vascular dementia, mixed cortical and subcortical vascular dementia, other vascular or unspecified dementia (ACAP code 0510);	☐
	(c) dementia in other diseases classified elsewhere including Pick's Disease, Creutzfeldt-Jakob disease, Huntington's disease, Parkinson's disease, human immunodeficiency virus (HIV) (ACAP code 0520);	☐
	(d) other dementia including alcoholic dementia or unspecified dementia (such as presenile and senile dementia) (ACAP code 0530);	☐
	(e) delirium including delirium not superimposed on dementia, delirium superimposed on dementia, other delirium or unspecified delirium (ACAP code 0540);	☐
	(f) psychoses and depression/mood affective disorders including schizophrenia or other psychoses (such as paranoid states) (ACAP code 0550);	☐
	(g) neurotic, stress-related and somatoform disorders including phobic and anxiety disorders (such as agoraphobia and panic disorder), nervous tension/stress or obsessive-compulsive disorder (ACAP code 0560);	☐
	(h) intellectual and developmental disorders including mental retardation, intellectual disability or other developmental disorders (such as autism, Rett syndrome, Asperger's syndrome, developmental learning disorders, specific developmental disorders of speech and language, specific development disorder of motor function such as dyspraxia) (ACAP code 0570);	☐
	(i) other mental and behavioural disorders including mental and behavioural disorders due to alcohol and other psychoactive substance use (such as alcoholism, Korsakov's psychosis (alcoholic), adult personality and behavioural disorders, speech impediment (stuttering or stammering)) or other mental and behavioural disorders not otherwise specified or not elsewhere classified (such as harmful use of non-dependant substances (for example, laxatives, analgesics, antidepressants), eating disorders (for example, anorexia nervosa or bulimia nervosa) or mental disorders not otherwise specified) (ACAP code 0580).	☐
4	**Challenging behaviours and need for intensive social support**	
	(a) The person displays challenging behaviours which require ongoing management and prevention, including one or both of the following:	
	(i) episodic catastrophic behaviours such as severe physical and verbal abuse, violent mood swings, aggression;	☐

Clause 3

Table—Appraisal tool B—Aboriginal and Torres Strait Islanders

Item	Criteria	Tick if Yes
	(ii) the person is considered at high risk of leaving without warning with ongoing staff intervention required to prevent this from occurring.	☐
	(b) The person requires intensive social support or intensive assistance with continuing to perform activities of daily living including initiation of and assistance with:	
	(i) personal care and hygiene matters (for example, shows aversion to showering and washing hands, has problems with toileting and dressing, requires assistance or guidance with meals); or	☐
	(ii) social and recreational activities, with significant one-on-one staff intervention necessary to enable the person to participate in community activities.	☐