

27 February 2025

To the Department of Health and Aged Care

New Aged Care Act Rules consultation – Release 2b – Funding for other aged care programs

Ageing Australia welcomes the opportunity to provide feedback on the rules relating to funding for other aged care programs included in release 2b.

Ageing Australia is the national peak body for aged care, representing providers of retirement living, seniors housing, residential care, home care and community services. We advocate for our members, providing expert advice, resources and tailored services to ensure they deliver exceptional care to older Australians.

Ageing Australia's recommendations and key messages are provided below. Specific comments on the release 2b rules are contained in **Appendix 1**.

Recommendations

- R1. Clarify language used in the rules to ensure they are easy to understand and there is no room for misunderstanding.**
- R2. That rules 2b incur a further round of consultation as part of, or following, rules 2c.**
- R3. Modify the higher everyday living fee requirements to be the least prescriptive needed to meet the Aged Care Taskforce recommendation as published, until the impact on providers and individuals can be thoroughly explored - before any additional requirements are introduced. This includes:**
 - a. Clarification as to whether the higher everyday living fee requirements are intended to apply only to items in the service list (which are described as everyday living), or extend to all service list items, or extend to any goods or services provided by a registered provider to an individual for a fee whether on the service list or not.**
 - b. The draft rules should be amended to allow registered providers to provide higher services to low means or partially low means individuals for a fee.**
 - c. Existing contracts in place as at 30 June 2025 for extra services or additional services should be allowed to continue as per the contract, unless the registered provider and the individual agree otherwise. Extra service fees and additional service fees should also be allowed to increase from 1 July 2025.**
- R4. Adopt the changes outlined in Appendix 1.**

Overall

We believe that some of the current language is unclear, making it difficult for providers to be certain of meaning. As a result, there may be significant unintended consequences and unintentional non-compliance.

We also have a number of concerns and questions in relation to the proposed requirements for higher everyday living fees in relation to residential aged care (see below and Appendix 1).

In addition, we recommend that the rules be clarified to make it clear that home care providers can offer additional services to clients for a fee. Legal advice indicates that, as currently written, additional services cannot be offered by home care providers.

We also note there are many sections of the rules for the new Aged Care Act (including Chapter 4 – Fees, payments and subsidies), that are yet to be drafted. A lack of clarity is adding to the pressures providers already face when preparing for the commencement of the new Aged Care Act on 1 July 2025. The criticality of this Chapter to the future sustainability of the aged care system warrants further consultation on rules 2b to avoid unintended consequences.

Higher everyday living fees

The proposed requirements, as currently drafted, limit the ability of residential care providers and individuals to freely enter into an agreement, are overly prescriptive and extend beyond the published discussion of the Aged Care Taskforce of the need to improve consumer protection.

Further policy development, in close consultation with the sector, is needed to ensure an appropriate balance between consumer protection and ability for providers to innovate and support increasing demand and diverse choices for residential aged care. There is also a need to ensure manageable transition time (beyond 12 months), given the relationship with new builds or refurbishment and business models currently or imminently underway – which often take years to plan and deliver.

Feedback from members indicates that registered providers will be discouraged from offering higher everyday living services, leading to reduced choices to individuals to enhance their residential care experience.

The impact on providers currently offering, or intending to offer, additional services or extra services needs to be thoroughly explored before these requirements are introduced. Providers have developed and implemented business models providing these services and as such, are integral to almost every aspect of their operations, from building design to furnishings to services. Some additional services cannot be 'switched off', including the provision of gyms, pools, and more. Providers need to have a reasonable level of certainty that they will receive a return on these investments.

We are concerned that the requirements will have a negative impact on what would otherwise be reasonable business decisions, reducing service offerings in the sector, and limiting options for individuals to receive additional services they want and are prepared to pay for. We are also concerned that the proposed requirements will lead to increased administration costs and therefore increased fees for individuals.

In relation to higher everyday living fees, we also recommend the following:

- a. Clarification as to whether the higher everyday living fee requirements are intended to apply only to items in the service list (which are described as everyday living), or extend to all service list items, or extend to any goods or services provided by a registered provider to an individual for a fee whether on the service list or not.

- i. Our view is that the higher everyday living fee requirements should, at least, not extend to items not on the service list which a registered provider may offer to residents, as this would seem to be outside the scope of the *Aged Care Act 2024* and there are other consumer protections available in Australia.
- b. The draft rules should be amended to allow registered providers to provide higher services to low means or partially low means individuals for a fee. Low means or partially low means individuals should not be denied the opportunity to receive additional services noting that often family members pay for these services.
- c. Existing contracts in place, as at 30 June 2025 for extra services or additional services, should be allowed to continue as per the contract, unless the registered provider and the individual agree otherwise. Extra service fees and additional service fees should also be allowed to increase from 1 July 2025, which is consistent with normal business contractual arrangements and other proposed grandfathering arrangements.

For further feedback on the release 2b rules, please see **Appendix 1**.

Thank you again for the opportunity to provide feedback on rules relating to funding for other aged care programs included in release 2b. Please contact Anne Liddell, Head of Policy, at anne.liddell@ageingaustralia.asn.au if you have any questions or would like to discuss this submission.

Yours sincerely,

Roald Versteeg
General Manager Policy & Advocacy

Attachments Appendix 1: Feedback on consultation draft rules – release 2b

CONSULTATION DRAFT

Appendix 1: Feedback on consultation draft rules – release 2b



CONSULTATION DRAFT

Aged Care Rules 2025

I, Anika Wells, Minister for Aged Care, make the following rules.

Dated 2025

Anika Wells [DRAFT ONLY—NOT FOR SIGNATURE]
Minister for Aged Care

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Introduction Chapter 1
Preliminary Part 1

Section 1

Chapter 1—Introduction

Part 1—Preliminary

1 Name

This instrument is the *Aged Care Rules 2025*.

2 Commencement

- (1) Each provision of this instrument specified in column 1 of the table commences, or is taken to have commenced, in accordance with column 2 of the table. Any other statement in column 2 has effect according to its terms.

Commencement information		
Column 1	Column 2	Column 3
Provisions	Commencement	Date/Details
1. The whole of this instrument	At the same time as the <i>Aged Care Act 2024</i> commences.	

Note: This table relates only to the provisions of this instrument as originally made. It will not be amended to deal with any later amendments of this instrument.

- (2) Any information in column 3 of the table is not part of this instrument. Information may be inserted in this column, or information in it may be edited, in any published version of this instrument.

3 Authority

This instrument is made under the *Aged Care Act 2024*.

4 Simplified outline of this instrument

[To be drafted.]

[Amounts in this draft are approximate and subject to change before 1 July 2025.]

CONSULTATION DRAFT

Chapter 1 Introduction

Part 2 Definitions

Section 5

Part 2—Definitions

5 Definitions

Note: The following expressions used in this instrument are defined in the Act:

- (a) care and services plan;
- (b) enrolled nurse;
- (c) health service;
- (d) means testing category;
- (e) Multi-Purpose Service Program;
- (f) National Law;
- (g) nursing;
- (h) nursing assistant;
- (i) registered nurse;
- (j) service agreement;
- (k) specialist aged care program;
- (l) subsidy basis;
- (m) Transition Care Program;
- (n) transition time.

In this instrument:

2017 MM category means a category for an area provided for by the Modified Monash Model, as the model existed on 1 January 2017.

2019 MM category means a category for an area provided for by the Modified Monash Model, as the model existed on 1 October 2022.

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 MRC Act or the *Safety, Rehabilitation and Compensation Act 1988*.

accommodation wing, of an approved residential care home, 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 an individual to whom funded aged care services are being delivered in the home.

Act means the *Aged Care Act 2024*.

additional service fee: see section 285-20.

age pension means age pension under Part 2.2 of the Social Security Act.

ARIA value, for 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)*, Occasional Papers: New

CONSULTATION DRAFT

Introduction **Chapter 1**
Definitions **Part 2**

Section 5

Series Number 14, published by the Department in October 2001, as the document existed on 1 July 2013.

Note: The *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)* could in 2025 be viewed on the Department's website (<https://www.health.gov.au>).

AT-HM List means the Assistive Technology and Home Modifications List published by the Department, as existing on [date of commencement of this instrument].

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

building status amount for an individual for a day: see subsection 230-15(1).

Category A residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category A service within the meaning of section 88 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category B residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category B service within the meaning of section 89 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category C residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category C service within the meaning of section 90 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category D residential care home means an approved residential care home that is not a Category A residential care home, Category B residential care home or Category C residential care home.

CHSP contribution: see subsection 286-15(1).

compensation has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

compensation payer has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

day of eligible residential funded aged care services: see subsection 239-15(4).

diverse individual, means an individual who is:

- (a) an Aboriginal or Torres Strait Islander person, including an Aboriginal or Torres Strait Islander person from the stolen generations; or
- (b) a veteran or war widow; or
- (c) from a culturally, ethnically and linguistically diverse background; or
- (d) experiencing homelessness or at risk of experiencing homelessness; or
- (e) a parent or child who is or was separated by forced adoption or removal; or

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- (f) an adult survivor of institutional child sexual abuse; or
- (g) a care-leaver, including a Forgotten Australian or former child migrant placed in out of home care; or
- (h) lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or is gender diverse or bodily diverse; or
- (i) an individual with disability or mental ill-health; or
- (j) neurodivergent; or
- (k) deaf, deafblind, vision impaired or hard of hearing.

extra service fee: see section 285-15.

first asset threshold means \$206,039.

first income threshold means \$83,324.

fourth asset threshold means \$502,981.

fourth income threshold means \$131,279.

group A residential care home, for a payment period: see subsection 239-15(2).

group B residential care home, for a payment period: see subsection 239-15(3).

has specialised Aboriginal or Torres Strait Islander status: an approved residential care home **has specialised Aboriginal or Torres Strait Islander status** on a day if a determination that the home has specialised Aboriginal or Torres Strait Islander status under subsection 243(3) of the Act is in effect on the day.

has specialised homeless status: an approved residential care home **has specialised homeless status** on a day if a determination that the home has specialised homeless status under subsection 243(3) of the Act is in effect on the day.

home or community place, for an approved residential care home of a registered provider in or from which the provider delivers funded aged care services through the service group home support, assistive technology or home modifications under the MPSP, means a place allocated to the registered provider for delivering those services in or from that home.

income tested fee, for an individual in the pre-2014 residential contribution class for a day, means the daily means tested amount for the individual.

Note: For an individual in the pre-2014 residential contribution class, the calculation of the daily means tested amount involves the individual's income but not their assets (see section 319-15).

individual's room, in an approved residential care home:

- (a) means a room, or a part of a room, in the home that:
 - (i) is intended to be occupied as personal space by an individual to whom funded aged care services are delivered in the home; and
 - (ii) contains a bed to be used by the individual; and
- (b) includes:

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- (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 the individual.

judgment has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

low-means individual: an individual to whom a registered provider is delivering funded aged care services for a classification type for the service group residential care is a **low-means individual** if, on the start day for the individual for the classification type, the individual's means tested amount was less than the maximum accommodation supplement amount for that day.

low means resident: see section 230-13.

major city means one of the major cities of Australia within the meaning of the *Australian Statistical Geography Standard (ASGS) Edition 3*, as existing from time to time, published by the Australian Bureau of Statistics.

Note: The *Australian Statistical Geography Standard (ASGS) Edition 3* could in 2025 be viewed on the Australian Bureau of Statistics website (<https://www.abs.gov.au>).

means tested care fee, for an individual in the post-2014 home contribution class or the post-2014 residential contribution class for a day, means the daily means tested amount for the individual (see section 319-20).

means testing class: each of the following is a **means testing class**:

- (a) full-pensioner;
- (b) part pensioner;
- (c) seniors health card holder;
- (d) self-funded retiree.

minimum monetary spend amount, for an approved residential care home that has been, or is proposed to be, significantly refurbished, means the amount worked out by multiplying \$25,000 by 40% of the lower of:

- (a) the total number of individual's rooms in the home before the commencement of the refurbishment; and
- (b) the total number of individual's rooms in the home after the completion of the refurbishment.

Modified Monash Model means the model known as the Modified Monash Model developed by the Department for categorising metropolitan, regional, rural and remote locations according to both geographical remoteness and population size, based on population data published by the Australian Bureau of Statistics, as the model exists from time to time.

Note: The Modified Monash Model could in 2025 be viewed on the Department's website (<https://www.health.gov.au>).

MRC Act means the *Military Rehabilitation and Compensation Act 2004*.

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national efficient price: the **national efficient price** for residential care activity is \$280.01.

newly built home: see section 230-20.

NWUA (short for National Weighted Activity Unit) means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set.

occupied bed, for an approved residential care home on a day, means an operational bed for the home that is occupied by an individual to whom funded aged care services are delivered on the day.

offline bed, for an approved residential care home, means a bed covered by the approval of the home that is covered by a notice under section 167 of the Act given in accordance with section [to be drafted] of this instrument.

operational bed, for an approved residential care home, means a bed covered by the approval of the home that is not an offline bed for the home.

Pension Rate Calculator A means the Rate Calculator at the end of section 1064 of the Social Security Act.

post-2014 home contribution class: an individual is in the **post-2014 home contribution class** if:

- (a) on 12 September 2024, the individual was approved as a recipient of home care (within the meaning of the old Act); and
- (b) the individual has not elected, in the approved form, to cease being a member of the class or of the post-2014 residential contribution class.

post-2014 residential accommodation class: an individual is in the **post-2014 residential accommodation class** if:

- (a) at the transition time, the individual is in the post-2014 residential contribution class; and
- (b) since the transition time, the individual has not:
 - (i) both:
 - (A) elected, in the approved form, to cease being a member of the post-2014 residential contribution class; and
 - (B) ceased accessing funded aged care services in an approved residential care home and started accessing funded aged care services in another approved residential care home; or
 - (ii) ceased accessing funded aged care services in an approved residential care home for a continuous period of more than 28 days.

post-2014 residential contribution class: an individual is in the **post-2014 residential contribution class** if:

- (a) the individual entered residential care (other than as a recipient of respite care) (within the meaning of the old Act) before the transition time; and
- (b) immediately before the transition time, the individual was not a continuing residential care recipient (within the meaning of the old Act); and

Commented [A1]: Is this correct? This clause and the following definition for post-2014 residential contribution class appears to be at odds and exclude those people who are residents prior to transition and remain in the home post transition and whose fee and means tested care fee arrangements should be grandfathered (refer section 277 of this instrument)

Commented [A2]: How will this work with leave such as hospital leave and emergency leave?

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- (c) if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home—the sum of the following periods is not more than 28 days:
 - (i) the period (if any) immediately before the transition time during which the individual had ceased to be provided with residential care by a residential care service (other than because the person was on leave (within the meaning of the old Act));
 - (ii) the period beginning at the transition time during which the individual does not access funded aged care services in an approved residential care home; and
- (d) the individual has not elected, in the approved form, to cease being a member of the class or of the post-2014 home contribution class.

pre-2014 accommodation class: an individual is in the ***pre-2014 accommodation class*** if:

- (a) immediately before the transition time, any of the following were in effect for the individual:
 - (i) a formal agreement (within the meaning of the old Act);
 - (ii) an accommodation bond agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*);
 - (iii) an accommodation charge agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*); and
- (b) if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home—the sum of the following periods is not more than 28 days:
 - (i) the period (if any) immediately before the transition time during which the individual had ceased to be provided with residential care by a residential care service (other than because the person was on leave (within the meaning of the old Act));
 - (ii) the period beginning at the transition time during which the individual does not access funded aged care services in an approved residential care home; and
- (c) since the transition time, the individual has not:
 - (i) elected, in the approved form, to cease being a member of the pre-2014 residential contribution class; and
 - (ii) ceased accessing funded aged care services in an approved residential care home and started accessing funded aged care services in another approved residential care home.

pre-2014 residential contribution class: an individual is in the ***pre-2014 residential contribution class*** if:

- (a) immediately before the transition time, the individual was a continuing residential care recipient (within the meaning of the old Act); and
- (b) if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home—the sum of the following periods is not more than 28 days:
 - (i) the period (if any) immediately before the transition time during which the individual had ceased to be provided with residential care

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by a residential care service (other than because the person was on leave (within the meaning of the old Act));

- (ii) the period beginning at the transition time during which the individual does not access funded aged care services in an approved residential care home; and

- (c) the individual has not elected, in the approved form, to cease being a member of the class.

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).

Note: An individual's principal home may be in a retirement village (see section 12 of the Social Security Act).

qualifying residential care home, for a payment period: see subsection 239-15(1).

refurbishment cost, for an approved residential care home that has been, or is proposed to be, significantly refurbished, means:

- (a) unless paragraph (b) applies—the total cost of the refurbishment or proposed refurbishment of the home; or
- (b) if the refurbishment or proposed refurbishment includes fire safety improvements, and the cost of the fire safety improvements is more than 25% of the minimum monetary spend amount for the home—the total cost of the refurbishment or proposed refurbishment, reduced by the amount by which the cost of the fire safety improvements exceeds 25% of the minimum monetary spend amount for the home.

reimbursement arrangement has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

residential care place, for an approved residential care home of a registered provider in which the provider delivers funded aged care services through the service group residential care under the MPSP, means a place allocated to the registered provider for delivering those services in that home.

RRMA Classification means the *Rural, Remote and Metropolitan Area Classification*, 1991 Census Edition, published by the Australian Government Publishing Service, as in force in November 1994.

second asset threshold means \$238,000.

second income threshold means \$95,400.

seniors health card has the same meaning as in the Social Security Act.

settlement has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

significantly refurbished home means an approved residential care home in relation to which a determination under subsection 230-30(1) or 230-35(1) is in effect.

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

specialist Aboriginal or Torres Strait Islander programs means specialist programs for Aboriginal or Torres Strait Islander persons and includes, but is not limited to, the following:

- (a) programs to deliver care and services that are culturally safe for, and tailored to meet the particular needs of, the Aboriginal or Torres Strait Islander persons to whom funded aged care services are being delivered in the approved residential care home in question;
- (b) programs to promote social and cultural engagement and participation of Aboriginal or Torres Strait Islander persons;
- (c) any other relevant programs that the System Governor considers appropriate.

specialist aged care program fee: see subsection 286-10(1).

specialist homeless programs means specialist programs for persons with a background as a homeless person and includes, but is not limited to, the following:

- (a) programs and interventions to manage complex behavioural needs of persons with that background;
- (b) programs to promote social engagement and participation of persons with that background;
- (c) any other relevant programs that the System Governor considers appropriate.

supported individual: an individual is a ***supported individual*** if, immediately before the transition time, the individual was a supported resident within the meaning of the *Aged Care (Transitional Provisions) Act 1997*.

third asset threshold means \$299,480.

third income threshold means \$103,583.

transitional classification level: each of the following is a ***transitional classification level***:

- (a) HCP class 1;
- (b) HCP class 2;
- (c) HCP class 3;
- (d) HCP class 4.

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

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:

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- (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 MRC Act; 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*.

7-11 Cost

For the purposes of the definition of **cost** in section 7 of the Act, the cost for the delivery by a registered provider of a funded aged care service for which the subsidy basis is cost means the amount charged by the provider for the delivery of the service.

7-17 Entry day

- (1) This section is made for the purposes of the definition of **entry day** in section 7 of the Act.

Classification type ongoing

- (2) The first day an individual accesses a funded aged care service for the classification type ongoing through a service group is the entry day for the individual for that classification type for that service group.

Classification type short-term for the service groups home support, assistive technology and home modifications

- (3) The first day an individual accesses a funded aged care service for a classification level for the classification type short-term for the service group home support, assistive technology or home modifications is the entry day for the individual for the period of effect for that classification level.

Classification type short-term for the service group residential care

- (4) The first day an individual accesses a funded aged care service for the classification type short-term for the service group residential care is the entry day for the individual for that classification type for that service group.

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Classification type hospital transition

- (5) The first day an individual accesses a funded aged care service for a classification level for the classification type hospital transition for a service group is the entry day for the individual for the period of effect for that classification level.

7-18 Final efficient price

- (1) This section is made for the purposes of the definition of **final efficient price** in section 7 of the Act.

Services for which subsidy basis is efficient price

- (2) The final efficient price for the delivery of a funded aged care service for which the subsidy basis is efficient price to an individual on a day is the sum of:
- (a) the base efficient price for an hour of the service on the day; and
 - (b) the loading amount for each loading type that applies to the service on the day.

Services for which subsidy basis is unit price

- (3) The final efficient price for the delivery of a funded aged care service for which the subsidy basis is unit price to an individual on a day is the sum of:
- (a) the base unit price for a unit of the service on the day; and
 - (b) the loading amount for each loading type that applies to the service on the day.

7-19 Homeowner

For the purposes of the definition of **homeowner** in section 7 of the Act:

- (a) an individual who is not a member of a couple is a **homeowner** if:
 - (i) the individual has a right or interest in the individual's principal home; and
 - (ii) the individual's right or interest in the individual's principal home gives the individual reasonable security of tenure in the home; and
- (b) an individual who is a member of a couple is a **homeowner** if:
 - (i) the individual, or the individual's partner, has a right or interest in one residence that is the individual's principal home, or the partner's principal home, or the principal home of both of them; and
 - (ii) the individual's right or interest, or the individual's right or interest, in the home gives the individual, or the individual's partner, reasonable security of tenure in the home.

Commented [A3]: Should this be 'partner's'?

7-20 Lifetime cap

For the purposes of the definition of **lifetime cap** in section 7 of the Act, the amount is:

- (a) unless paragraph (b) applies ~~\$130,000~~; or

Commented [A4]: Is this amount indexed, and, if yes, on what basis?

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- (b) for an individual in the post-2014 home contribution class or the post-2014 residential contribution class \$82,018.15.

7-21 Price charged

For the purposes of the definition of ***price charged*** in section 7 of the Act, the price charged for the delivery by a registered provider of a funded aged care service for which the subsidy basis is efficient price or unit price means the amount charged by the provider for an hour or unit of the service (whichever is applicable).

Commented [A5]: Is this amount indexed, and, if yes, on what basis?

Commented [A6]: Please make clear that there is no restriction on home care providers being able to provide additional services for a fee to a client.

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**Chapter 7—Funding of aged care services—
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190-5 Simplified outline of this Chapter

[to be drafted]

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Part 2—Subsidy for home support

Division 1—Person-centred subsidy

Subdivision A—Eligibility

191-5 Excluded classification levels

For the purposes of subparagraph 191(2)(d)(ii) of the Act, the following classification levels are prescribed:

- (a) CHSP class 1;
- (b) CHSP class 2;
- (c) CHSP class 3;
- (d) CHSP class 4.

Subdivision B—Available ongoing home support account balance

193-5 Quarterly rollover credit

For the purposes of subsection 193(5) of the Act, the amount for a quarter is the higher of the following amounts:

- (a) \$1,000;
- (b) the amount that is 10% of the sum of the following for the day on which the amount is credited, multiplied by the number of days in the quarter:
 - (i) the base individual amount for the individual for the classification type for the service group;
 - (ii) the sum of any primary person-centred supplements for the classification type for the service group that apply to the individual;
 - (iii) for an individual covered by subsection 203(3) of the Act—the base provider amount for a registered provider in relation to the individual.

193-10 Order of debits

For the purposes of subsection 193(8) of the Act, the order is the order in which the claims are made.

193-15 Circumstances for no credits

For the purposes of subsection 193(10) of the Act, each of the following are circumstances in which a credit to an individual's notional ongoing home support account, which would otherwise be required under subsection 193(4) or (5) of the Act, is not to be made:

- (a) more than 393 days have passed since an ongoing funded aged care service was delivered to the individual through the service group home support;
- (b) more than 60 days have passed since the day a registered provider provided a start notification to the System Governor and the Commissioner about starting the delivery of funded aged care services to the individual through the service group residential care.

Commented [A7]: It needs to be made clear how these provisions work where providers are still holding client commonwealth funds from before the 'approved payment arrangements' reform.

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193-20 Circumstances for ceasing of account

For the purposes of subsection 193(11) of the Act, the circumstances in which an individual’s notional ongoing home support account ceases are that:

- (a) more than 60 days have passed since the individual died; and
- (b) any longer period determined by the System Governor under paragraph 251(3)(c) of the Act for a claim for person-centred subsidy that is payable to a registered provider under section 250 of the Act for the delivery of a funded aged care service to the individual has ended.

Subdivision C—Base individual amounts

194-5 Classification type ongoing

- (1) For the purposes of section 194 of the Act, this section sets out the base individual amounts for individuals for the classification type ongoing for the service group home support.

Non-transitional classification levels

- (2) The following table sets out the base individual amounts for individuals who have classification levels that are not transitional classification levels.

Commented [A8]: This should say that these are daily amounts.

Base individual amounts for non-transitional classification levels			
Item	Column 1 For an individual that has the classification level ...	Column 2 if the individual is a full budget individual, the amount is ... (\$)	Column 3 if the individual is an interim budget individual, the amount is... (\$)
1	SAH level 1	27.13	16.24
2	SAH level 2	39.46	23.67
3	SAH level 3	54.24	32.54
4	SAH level 4	73.97	44.38
5	SAH level 5	98.63	59.17
6	SAH level 6	118.36	71.02
7	SAH level 7	143.01	85.81
8	SAH level 8	192.33	115.4

Transitional classification levels

- (3) The following table sets out the base individual amounts for individuals who have transitional classification levels.

Base individual amounts for transitional classification levels		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ... (\$)
1	HCP class 1	26.35

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Base individual amounts for transitional classification levels		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ... (\$)
2	HCP class 2	46.34
3	HCP class 3	100.86
4	HCP class 4	152.91

194-10 Classification type short-term

- (1) For the purposes of section 194 of the Act, this section sets out the base individual amounts for individuals for the classification type short-term for the service group home support.

Non-transitional classification levels

- (2) The following table sets out the base individual amounts for individuals who have classification levels that are not transitional classification levels.

Base individual amounts for non-transitional classification levels		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ... (\$)
1	SAH restorative care pathway	71.43
2	SAH end-of-life	297.62

Transitional classification levels

- (3) The following table sets out the base individual amounts for individuals who have transitional classification levels.

Base individual amounts for transitional classification levels		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ... (\$)
1	STRC class	253.82

Subdivision D—Available short-term home support account balance

195-5 Order of debits

For the purposes of subsection 195(5) of the Act, the order is the order in which the claims are made.

195-10 Circumstances for ceasing of account

For the purposes of subsection 195(7) of the Act, the circumstances in which an individual's notional short-term home support account ceases are that:

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- (a) the individual’s classification level for the classification type short-term for the service group home support was SAH end-of-life; and
- (b) 60 days have passed since the end of the maximum period of effect for that classification level; and
- (c) any longer period determined by the System Governor under paragraph 251(3)(c) of the Act for a claim for person-centred subsidy that is payable to a registered provider under section 250 of the Act for the delivery of a funded aged care service to the individual has ended.

Commented [A9]: Ensure rules cover the situation where the individual continues to need services after 60 days.

Subdivision E—Primary person-centred supplements

196-5 Purpose of this Subdivision

- For the purposes of section 196 of the Act, this Subdivision prescribes:
- (a) primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group home support; and
 - (b) the circumstances in which the supplements will apply to individuals for a day; and
 - (c) the amounts of the supplements.

196-10 Primary person-centred supplements

The following table sets out the primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group home support.

Primary person-centred supplements		
Item	Column 1 For an individual for a day for the following classification type for the service group home support ...	Column 2 the supplements are the following:
1	Ongoing	(a) oxygen supplement; (b) enteral feeding supplement; (c) veterans’ supplement; (d) dementia and cognition supplement; (e) top-up supplement.
2	Short-term	(a) oxygen supplement; (b) enteral feeding supplement; (c) veterans’ supplement.

196-12 Primary person-centred supplements for classification type short-term—circumstances for applicability (general)

The primary person-centred supplements for the classification type short-term will apply to an individual for a day only if, on the day, the individual does not

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have an access approval in effect for the classification type ongoing for the service group home support.

196-15 Oxygen supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) Oxygen supplement will apply to an individual for a day if:
 - (a) on the day, the individual's classification level for a classification type for the service group home support is other than STRC class; and
 - (b) on the day, the care and services plan for the individual covers the delivery of a funded aged care service in the service type nursing care to the individual; and
 - (c) under the plan, the service includes providing oxygen to the individual:
 - (i) other than because of an emergency; and
 - (ii) other than on a short-term or episodic basis; and
 - (iii) using materials and equipment hired, temporarily obtained or owned by the provider; and
 - (d) a medical practitioner or a nurse practitioner has certified, in writing, that the individual has a continual need for the provision of oxygen.

Amount

- (2) The amount of oxygen supplement for a day is \$14.24.

196-20 Enteral feeding supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) Enteral feeding supplement will apply to an individual for a day if:
 - (a) on the day, the individual's classification level for a classification type for the service group home support is other than STRC class; and
 - (b) on the day, the care and services plan for the individual covers the delivery of the funded aged care service nutrition supports to the individual; and
 - (c) under the plan, the service includes supplying enteral supplementary dietary products to the individual, other than for intermittent or supplementary enteral feeding given in addition to oral feeding; and
 - (d) a medical practitioner has certified, in writing, that the individual has a medical need for enteral feeding.

Amount

- (2) The amount of enteral feeding supplement for a day is:
 - (a) for bolus feeding—\$22.57; and
 - (b) for non-bolus feeding—\$25.34.

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196-25 Veterans' supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) Veterans' supplement will apply to an individual for a day if:
 - (a) on the day, the individual's classification level for a classification type for the service group home support is other than STRC class; and
 - (b) the individual is a veteran with an accepted mental health condition; and
 - (c) the individual has, before, on or after that day, authorised either or both of the following to disclose to a registered provider that the individual 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*.

Amount—classification type ongoing

- (2) The amount of veterans' supplement for a day for an individual with a classification level for the classification type ongoing for the service group home support is the amount that is 11.5% of the sum of:
 - (a) the base individual amount for the individual's classification level for the day; and
 - (b) for an individual covered by subsection 203(3) of the Act—the base provider amount for a registered provider in relation to the individual; rounded up to the nearest cent.

Amount—classification type short-term

- (3) The amount of veterans' supplement for a day for an individual with a classification level for the classification type short-term for the service group home support is the amount that is 11.5% of the base individual amount for the individual's classification level for the classification type short-term for the service group home support for the day.

196-30 Dementia and cognition supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) Dementia and cognition supplement will apply to an individual for a day if:
 - (a) on the day, the individual has a transitional classification; and
 - (b) immediately before the transition time, the individual was eligible for a dementia and cognition supplement under section 83 of the *Subsidy Principles 2014*.

Amount

- (2) The amount of dementia and cognition supplement for a day for an individual is the amount that is 11.5% of the sum of:

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- (a) the base individual amount for the individual's classification level for the classification type ongoing for the service group home support for the day; and
- (b) for an individual covered by subsection 203(3) of the Act—the base provider amount for a registered provider in relation to the individual; rounded up to the nearest cent.

196-35 Top-up supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) Top-up supplement will apply to an individual for a day if:
 - (a) on the day, the individual has a transitional classification; and
 - (b) immediately before the transition time, top-up supplement applied to the individual under section 67M of the *Aged Care (Transitional Provisions) Principles 2014*.

Amount

- (2) The amount of top-up supplement for a day is \$3.36.

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Subsidy for home support **Part 2**
Provider-based subsidy **Division 2**

Section 201-5

Division 2—Provider-based subsidy

Subdivision A—Eligibility

201-5 Eligible funded aged care services

For the purposes of paragraph 201(b) of the Act, the funded aged care service home support care management is prescribed.

Subdivision B—Available service delivery branch account balance

203-5 Day by which registered provider must give start notification

For the purposes of paragraph 203(3)(a) of the Act, the day in the previous quarter is the last day in the previous quarter.

203-10 Amount to be credited

For the purposes of subsection 203(4) of the Act, the amount to be credited to the account in relation to an individual for a day is the sum of the following for the day, multiplied by the number of days in the quarter:

- (a) the base provider amount for the registered provider in relation to the individual;
- (b) any provider-based supplements that apply to the service delivery branch of the registered provider in relation to the individual.

203-15 Day for periodic rollover re-set and amount to be credited

- (1) This section is made for the purposes of subsection 203(6) of the Act.
- (2) The day is 1 July in each year.
- (3) For an account that was established between 1 January and 30 June in a year, the amount is:
 - (a) for 1 July in that year—the amount that was in the account immediately before the account was debited to zero; and
 - (b) for 1 July in a later year—the amount under subsection (4).
- (4) For any other account, the amount is the lesser of the following:
 - (a) the amount that was in the account immediately before the account was debited to zero;
 - (b) the amount most recently credited to the account under subsection 203(5) of the Act.

203-20 Order of debits

For the purposes of subsection 203(7) of the Act, the order is the order in which the claims are made.

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Part 2 Subsidy for home support

Division 2 Provider-based subsidy

Section 203-25

203-25 Circumstances for ceasing of account

For the purposes of subsection 203(9) of the Act, the circumstance in which a notional service delivery account for a registered provider in relation to a service delivery branch of the provider ceases is that the registered provider has reported to the System Governor, under subsection 166(1) of the Act, that the service delivery branch has closed.

Subdivision C—Base provider amount

204-5 Classification type ongoing

- (1) For the purposes of section 204 of the Act, this section sets out the base provider amount for a registered provider in relation to an individual covered by subsection 203(3) of the Act for individuals for the classification type ongoing for the service group home support.

Non-transitional classification levels

- (2) The following table sets out the base provider amounts in relation to individuals who have classification levels that are not transitional classification levels,

Commented [A10]: This should say these are daily amounts

Base provider amounts for non-transitional classification levels			
Item	Column 1 For an individual that has the classification level ...	Column 2 if the individual is a full budget individual, the amount is ... (\$)	Column 3 if the individual is an interim budget individual, the amount is... (\$)
1	SAH level 1	3.01	1.81
2	SAH level 2	4.38	2.63
3	SAH level 3	6.03	3.62
4	SAH level 4	8.22	4.93
5	SAH level 5	10.96	6.57
6	SAH level 6	13.15	7.89
7	SAH level 7	15.89	9.53
8	SAH level 8	21.37	12.82

Commented [A11]: We think this table is for care management but this is not clear.

Transitional classification levels

- (3) The following table sets out the base provider amounts in relation to individuals who have transitional classification levels.

Base provider amounts for transitional classification levels		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ... (\$)
1	HCP class 1	2.93
2	HCP class 2	5.15

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Base provider amounts for transitional classification levels		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ... (\$)
3	HCP class 3	11.21
4	HCP class 4	16.99

Subdivision D—Provider-based supplements

205-5 Care management supplement

For the purposes of subsection 205(1) of the Act, the supplement care management supplement is prescribed.

205-10 Care management supplement—applicability

For the purposes of paragraph 205(2)(a) of the Act, the circumstances in which care management supplement will apply to a service delivery branch of a registered provider in relation to an individual on a day are that:

- (a) the individual is an Aboriginal or Torres Strait Islander person; or
- (b) the individual is homeless or at risk of homelessness; or
- (c) the individual is a care leaver, that is, an individual who has spent time in institutional care or out of home care (such as orphanages and foster care), and includes an individual who is a Forgotten Australian, a former child migrant or an Aboriginal or Torres Strait Islander person from the stolen generations; or
- (d) the individual is referred to the provider by the care finder program funded by the Department; or
- (e) veterans' supplement applies to the individual under section 196-25 of this instrument.

205-15 Care management supplement—amount

For the purposes of paragraph 205(2)(b) of the Act, the amount of care management supplement in relation to an individual is [to be drafted].

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Part 3 Subsidy for assistive technology

Division 1 Eligibility

Section 209-5

Part 3—Subsidy for assistive technology

Division 1—Eligibility

209-5 Excluded classification levels

For the purposes of subparagraph 209(2)(d)(ii) of the Act, the classification level AT CHSP is prescribed.

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Subsidy for assistive technology **Part 3**
Available assistive technology account balance **Division 2**

Section 211-5

Division 2—Available assistive technology account balance

211-5 Account period for classification type ongoing

For the purposes of subsection 211(1) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type ongoing for the service group assistive technology, the account period for the account is the period beginning on the entry day and ending at the earlier of the following:

- (a) the end of the day the individual dies;
- (b) the end of the maximum period of effect for the classification level.

211-10 Account period for classification type short-term

- (1) For the purposes of subsection 211(1) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, the account period for the account is:
 - (a) the period of 12 months beginning on the entry day for the individual; or
 - (b) if subsection (2) applies to the individual:
 - (i) the period of 24 months beginning on the entry day for the individual; or
 - (ii) if the System Governor determines a longer period for the individual under subsection (6)—that longer period.
- (2) This subsection applies to an individual if a medical practitioner has certified, in writing, that the individual has been diagnosed with any of the following conditions:
 - (a) cerebral palsy;
 - (b) epilepsy;
 - (c) Huntington's disease;
 - (d) motor neurone disease;
 - (e) multiple sclerosis;
 - (f) Parkinson's disease;
 - (g) polio;
 - (h) spinal cord injury;
 - (i) spinal muscular atrophy;
 - (j) stroke;
 - (k) other acquired brain injury;
 - (l) muscular dystrophy or muscular atrophy.
- (3) A registered provider may apply to the System Governor for a determination of a longer period for an individual under subsection (6).
- (4) An application under subsection (3) must be made:
 - (a) in the approved form; and
 - (b) before the end of 24 months beginning on the entry day for the individual.

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Division 2 Available assistive technology account balance

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- (5) The System Governor must consider an application under subsection (3) and decide whether to determine a longer period under subsection (6).
- (6) The System Governor may determine a period of more than 24 months but not more than 48 months beginning on the entry day for the individual if the System Governor is satisfied it is necessary to do so to ensure that the individual's care needs are met.
- (7) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.
- (8) A notice under subsection (7) must include:
 - (a) the reasons for the decision; and
 - (b) how the registered provider may apply for reconsideration of the decision.

211-15 Day and amount for credit to account for classification type ongoing

For the purposes of subsection 211(4) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type ongoing for the service group assistive technology:

- (a) the day is each anniversary of the day the account is established; and
- (b) the amount is the tier amount for the individual.

211-20 Day and amount for credit to account for classification type short-term for classification level AT High

- (1) For the purposes of subsection 211(4A) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, and the individual has the classification level AT High:
 - (a) the day is the day a determination of an amount under subsection (5) is made for the individual; and
 - (b) the amount is the amount determined for the individual.
- (2) A registered provider may apply to the System Governor for a determination of an amount for an individual under subsection (5).
- (3) An application under subsection (2) must be made:
 - (a) in the approved form; and
 - (b) before the end of 12 months beginning on the entry day for the individual.
- (4) The System Governor must consider an application under subsection (2) and decide whether to determine an amount under subsection (5).
- (5) The System Governor may determine an amount for the individual if:
 - (a) the registered provider has provided written evidence of:
 - (i) the individual's need for an item; and
 - (ii) the cost of the item; and

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Available assistive technology account balance **Division 2**

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- (b) the cost of the item exceeds the sum of the amounts credited to the individual's account under subsections 211(3) and (5) of the Act; and
 - (c) the amount is the amount by which the cost of the item exceeds the sum mentioned in paragraph (b).
- (6) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.
- (7) A notice under subsection (6) must include:
- (a) the reasons for the decision; and
 - (b) how the registered provider may apply for reconsideration of the decision.

211-25 Order of debits

For the purposes of subsection 211(6) of the Act, the order is the order in which the claims are made.

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Chapter 7 Funding of aged care services—Commonwealth contributions

Part 3 Subsidy for assistive technology

Division 3 Tier amounts

Section 212-5

Division 3—Tier amounts

212-5 Classification type ongoing

For the purposes of section 212 of the Act, the following table sets out the tier amount for an individual for an account period for the classification type ongoing for the service group assistive technology.

Tier amounts for the classification type ongoing		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ... (\$)
1	Assistance dogs	2,000

212-10 Classification type short-term

For the purposes of section 212 of the Act, the following table sets out the tier amount for an individual for an account period for the classification type short-term for the service group assistive technology.

Tier amounts for the classification type short-term		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ... (\$)
1	AT Transitional	0
2	AT Low	500
3	AT Medium	2,000
4	AT High	15,000

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Subsidy for assistive technology **Part 3**

Primary person-centred supplements **Division 4**

Section 213-5

Division 4—Primary person-centred supplements

213-5 Rural and remote supplement

For the purposes of section 213 of the Act, for an individual for a day for a classification type for the service group assistive technology:

- (a) the supplement rural and remote supplement is prescribed; and
- (b) the circumstances in which rural and remote supplement will apply to the individual are that the individual resides at a location in the 2019 MM category known as MM 6 or the 2019 MM category known as MM 7; and
- (c) the amount of rural and remote supplement is the amount that is 50% of the tier amount for the individual for the account period for the classification type for the service group assistive technology, rounded to the nearest cent.

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Chapter 7 Funding of aged care services—Commonwealth contributions

Part 4 Subsidy for home modifications

Division 1 Eligibility

Section 218-5

Part 4—Subsidy for home modifications

Division 1—Eligibility

218-5 Excluded classification levels

For the purposes of subparagraph 218(2)(d)(ii) of the Act, the classification level HM CHSP is prescribed.

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Funding of aged care services—Commonwealth contributions **Chapter 7**

Subsidy for home modifications **Part 4**

Available home modifications account balance **Division 2**

Section 220-5

Division 2—Available home modifications account balance

220-5 Account period for classification type short-term

- (1) For the purposes of subsection 220(1) of the Act, if an individual's notional home modifications account is established because an entry day for the individual occurs for the classification type short-term for the service group home modifications, the account period for the account is:
 - (a) the period of 12 months beginning on the entry day for the individual; or
 - (b) if the individual has the classification level HM High for that service type, and the System Governor determines a longer period for the individual under subsection (5)—that longer period.
- (2) A registered provider may apply to the System Governor for a determination of a longer period for an individual under subsection (5).
- (3) An application under subsection (2) must be made:
 - (a) in the approved form; and
 - (b) at least 60 days before the end of 12 months beginning on the entry day for the individual.
- (4) The System Governor must consider an application under subsection (2) and decide whether to determine a longer period under subsection (5).
- (5) The System Governor may determine a period of more than 12 months but not more than 24 months beginning on the entry day for the individual if the System Governor is satisfied that a service in the service group home modifications to be delivered by the registered provider to the individual has been scheduled for delivery, and is in progress, but will not be delivered before the end of 12 months beginning on the entry day for the individual.
- (6) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.
- (7) A notice under subsection (6) must include:
 - (a) the reasons for the decision; and
 - (b) how the registered provider may apply for reconsideration of the decision.

220-10 Order of debits

For the purposes of subsection 220(5) of the Act, the order is the order in which the claims are made.

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Chapter 7 Funding of aged care services—Commonwealth contributions

Part 4 Subsidy for home modifications

Division 3 Tier amounts

Section 221-5

Division 3—Tier amounts

221-5 Classification type short-term

- (1) For the purposes of section 221 of the Act, the following table sets out the tier amount for an individual for an account period for the classification type short-term for the service group home modifications.

Tier amounts for the classification type short-term		
Item	Column 1 For an individual that has the classification level ...	Column 2 the amount is ...
1	HM Transitional	\$0
2	HM Low	\$1,000
3	HM Medium	\$2,000
4	HM High	the amount under subsection (2)

- (2) For the purposes of column 2 of item 3 of the table, the amount for an individual with the classification level HM High is:
- (a) if it is the first occasion that a notional home modifications account is established for the individual with that classification level—\$15,000; and
 - (b) if it is not the first occasion that a notional home modifications account is established for the individual with that classification level—\$15,000 reduced by the total of any amounts debited to the individual's previous notional home modifications accounts when the individual had that classification level.

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Subsidy for home modifications **Part 4**

Primary person-centred supplements **Division 4**

Section 222-5

Division 4—Primary person-centred supplements

222-5 Rural and remote supplement

For the purposes of section 222 of the Act, for an individual for a day for a classification type for the service group home modifications:

- (a) the supplement rural and remote supplement is prescribed; and
- (b) the circumstances in which rural and remote supplement will apply to the individual are that the individual resides at a location in the 2019 MM category known as MM 6 or the 2019 MM category known as MM 7; and
- (c) the amount of rural and remote supplement is the amount that is 50% of the tier amount for the individual for the account period for the classification type for the service group home modifications, rounded to the nearest cent.

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Chapter 7 Funding of aged care services—Commonwealth contributions

Part 5 Fee reduction supplement for home support, assistive technology and home modifications

Section 197-5

Part 5—Fee reduction supplement for home support, assistive technology and home modifications

197-5 Fee reduction supplement—circumstances for applicability (financial hardship) and amount

Circumstances for applicability

- (1) For the purposes of paragraphs 197(2)(a), 214(2)(a) and 223(2)(a) of the Act, the circumstances in which fee reduction supplement will apply to an individual are that:
 - (a) either:
 - (i) the System Governor has not determined the individual contribution rate for the individual for each means testing category; or
 - (ii) the individual does not have means not disclosed status; and
 - (b) the System Governor is satisfied that subsection (2) applies to the individual.
- (2) This subsection applies to an individual if:
 - (a) the value of the individual's assets, worked out in accordance with Division 1 of Part 3.12 of the Social Security Act and reduced by the amounts mentioned in subsection (3), is not more than 1.5 times the sum of the annual amount of the following:
 - (i) the maximum basic rate under point 1064-B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple;
 - (ii) the pension supplement amount under point 1064-BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple;
 - (iii) the energy supplement amount under point 1064-C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple; and
 - (b) the individual has not gifted more than \$10,000 in the current financial year or in any of the previous 4 financial years; and
 - (c) the individual has not gifted more than \$30,000 in the period comprising the current financial year and the previous 4 financial years.
- (3) For the purposes of paragraph (2)(a), the amounts are the following:
 - (a) the value of the individual's principal home;
 - (b) the value of any unrealisable assets.

Amount

- (4) For the purposes of paragraphs 197(2)(b), 214(2)(b) and 223(2)(b) of the Act, the amount of the fee reduction supplement is [calculation to be drafted (to involve matters similar to the matters mentioned in subsection 95(4) of the *Subsidy Principles 2014*)].

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Funding of aged care services—Commonwealth contributions **Chapter 7**
Unspent Commonwealth portions and home care accounts **Part 6**

Section 226A-5

Part 6—Unspent Commonwealth portions and home care accounts

226A-5 Unspent Commonwealth portion—order of debits

For the purposes of subsection 226A(4) of the Act, the order is the order in which the claims are made.

226A-10 Day for reduction of portion and credit of account—provider elects to return available balance

For the purposes of subsections 226A(6) and 226E(4) of the Act, the day at the start of which:

- (a) the unspent Commonwealth portion for an individual is reduced under subsection 226A(6) of the Act; and
- (b) the individual's home care account is credited under subsection 226E(4) of the Act;

because the registered provider that holds the portion has elected to return the available balance of the portion to the Commonwealth under section 226B of the Act is:

- (c) if the provider made the election in the quarter in which the Act commenced—the day the Act commenced; or
- (d) if the provider made the election in a subsequent quarter—the first day of the quarter following the quarter in which the election was made.

226A-15 Day for reduction of portion and credit of account—individual transfers between provider service delivery branches

For the purposes of subsections 226A(7) and 226E(5) of the Act, the day at the start of which:

- (a) the unspent Commonwealth portion for an individual is reduced under subsection 226A(7) of the Act; and
- (b) the individual's home care account is credited under subsection 226E(5) of the Act;

because the registered provider that holds the portion returns the available balance of the portion to the Commonwealth under section 226C of the Act is the day the provider next makes a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

226A-20 Day for reduction of portion and credit of account—provider ceases to deliver services

For the purposes of subsections 226A(8) and 226E(6) of the Act, the day at the start of which:

- (a) the unspent Commonwealth portion for an individual is reduced under subsection 226A(8) of the Act; and

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Part 6 Unspent Commonwealth portions and home care accounts

Section 226E-5

(b) the individual's home care account is credited under subsection 226E(6) of the Act;

because the registered provider that holds the portion returns the available balance of the portion to the Commonwealth under section 226D of the Act is the last day, in the period mentioned in subsection 251(3) of the Act, on which the registered provider makes a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

226E-5 Home care account—order of debits

For the purposes of subsection 226E(7) of the Act, the order is the order in which the claims are made.

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Section 229-5

Part 7—Subsidy for residential care

Division 1—Person-centred subsidy

Subdivision A—Base rates

229-5 Base rates—classification type ongoing

- (1) For the purposes of subsection 229(1) of the Act, this section sets out the base rate for an individual for the classification type ongoing for the service group residential care for a day.

General—classification level Class 0

- (2) If subsection (4) does not apply to the individual, and the classification level for the individual is Class 0, the base rate is the amount worked out by multiplying the national efficient price by:
- (a) if the funded aged care services delivered to the individual are in the form of palliative care—the NWAU specified for the classification level Class 1 in the table in subsection (3); or
 - (b) otherwise—the NWAU specified for the classification level Class 8 in the table in subsection (3).

General—classification levels Class 1 to Class 13

- (3) If subsection (4) does not apply to the individual, and the classification level for the individual is specified in the following table, the base rate is the amount worked out by multiplying the national efficient price by the NWAU specified for the classification level.

Base rates for the classification type ongoing		
Item	Column 1 If the classification level for the individual is ...	Column 2 the NWAU is ...
1	Class 1	0.80
2	Class 2	0.19
3	Class 3	0.37
4	Class 4	0.25
5	Class 5	0.44
6	Class 6	0.40
7	Class 7	0.55
8	Class 8	0.64
9	Class 9	0.52
10	Class 10	0.70
11	Class 11	0.66
12	Class 12	0.66
13	Class 13	0.80

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Part 7 Subsidy for residential care

Division 1 Person-centred subsidy

Section 229-10

Individual on extended hospital leave and day on or after 29th day of leave

- (4) If the individual is on extended hospital leave on the day, and the day is on or after the 29th day of the individual's leave, the base rate is nil.

229-10 Base rates—classification type short-term

For the purposes of subsection 229(1) of the Act, the base rate for an individual for the classification type short-term for the service group residential care for a day is the amount worked out by multiplying the national efficient price by the NWAU specified for the classification level for the individual in the following table.

Item	Column 1 If the classification level of the individual is ...	Column 2 the NWAU is ...
1	Respite Class 0	0.479
2	Respite Class 1	0.365
3	Respite Class 2	0.479
4	Respite Class 3	0.691

Note: For the maximum period of effect for a classification level for the classification type short-term for the service group residential care, see section [to be drafted] of this instrument.

Subdivision B—Primary person-centred supplements

230-3 Purpose of this Subdivision

For the purposes of section 230 of the Act, this Subdivision prescribes:

- (a) other primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care; and
- (b) the circumstances in which the accommodation supplement, oxygen supplement and enteral feeding supplement will apply to individuals for a day; and
- (c) the amounts of the supplements.

Note: The accommodation supplement and the hotelling supplement are primary person-centred supplements for the classification types ongoing and short-term for the service group residential care (see paragraph 230(1)(a) of the Act).

230-4 Other primary person-centred supplements

The following table sets out other primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care.

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Section 230-5

Other primary person-centred supplements		
Item	Column 1 For an individual for a day for the following classification type for the service group residential care ...	Column 2 the supplements are the following:
1	Ongoing	(a) oxygen supplement; (b) enteral feeding supplement.
2	Short-term	(a) oxygen supplement; (b) enteral feeding supplement.

230-5 Hotelling supplement—amount

For the purposes of subsection 230(2) of the Act, the amount of hotelling supplement is \$12.55.

230-10 Accommodation supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) For the purposes of paragraph 230(2)(a) of the Act, the circumstances in which accommodation supplement will apply to an individual for a day are that the funded aged care services delivered to the individual on the day are ongoing funded aged care services.

Amount—general

- (2) Subject to subsections (3) and (4), the amount of accommodation supplement for the individual for the day is:
 - (a) if, for the payment period in which the day occurs, the low means resident percentage for the approved residential care home in which funded aged care services are delivered to the individual is 40% or more—the building status amount for the individual for the day; or
 - (b) otherwise—the amount worked out by reducing the building status amount for the individual for the day by 25%.

Nil amount for individuals with daily means tested amount of at least the amount under subsection (2)

- (3) If the daily means tested amount for the individual for the day is equal to, or more than, the amount of the accommodation supplement that would, apart from this subsection, apply under subsection (2) for the individual for the day, then the amount of the accommodation supplement for the individual for the day is nil.

Reduced amount for individuals with daily means tested amount greater than zero but less than the amount under subsection (2)

- (4) If the daily means tested amount for the individual for the day (the **first amount**) is greater than zero but less than the amount of the accommodation supplement

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(the **second amount**) that would, apart from this subsection, apply under subsection (2) for the individual for the day, then the amount of the accommodation supplement for the individual for the day is the amount equal to the difference between:

- (a) the first amount; and
- (b) the second amount.

230-11 Oxygen supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which oxygen supplement will apply to an individual for a day are that:
 - (a) on the day, the care and services plan for the individual covers the delivery of the funded aged care service nursing to the individual; and
 - (b) under the plan, the service includes providing oxygen to the individual:
 - (i) other than because of an emergency; and
 - (ii) other than on a short-term or episodic basis; and
 - (iii) using materials and equipment hired, temporarily obtained or owned by the provider; and
 - (c) a medical practitioner or a nurse practitioner has certified, in writing, that the individual has a continual need for the provision of oxygen.

Amount

- (2) The amount of oxygen supplement is \$14.11.

230-12 Enteral feeding supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which enteral feeding supplement will apply to an individual for a day are that:
 - (a) on the day, the care and services plan for the individual covers the delivery of the funded aged care service meals and refreshments to the individual; and
 - (b) under the plan, the service includes supplying enteral supplementary dietary products to the individual, other than for intermittent or supplementary enteral feeding given in addition to oral feeding; and
 - (c) a medical practitioner has certified, in writing, that the individual has a medical need for enteral feeding.

Amount

- (2) The amount of enteral feeding supplement is:
 - (a) for bolus feeding—\$22.36; and
 - (b) for non-bolus feeding—\$25.11.

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Subdivision C—Accommodation supplement concepts

230-13 Meaning of *low means resident percentage* for an approved residential care home for a payment period

The *low means resident percentage* for an approved residential care home for a payment period is worked out using the following formula:

$$\frac{\text{Low means resident counted days}}{\text{Total counted days}} \times 100$$

where:

counted day: a day is a **counted day** in respect of an individual in an approved residential care home if an ongoing funded aged care service is delivered to the individual through the service group residential care in the home on the day.

low means resident means:

- (a) an individual to whom the concessional resident supplement applies (see section 231-75); or
- (b) a supported individual; or
- (c) a low-means individual.

low means resident counted days means the total number of counted days delivered in respect of low means residents in the home in the payment period.

total counted days means the total number of counted days in respect of individuals in the home in the payment period.

230-15 Meaning of *building status amount* for an individual for a day

- (1) The **building status amount** for an individual to whom funded aged care services are delivered in an approved residential care home for a day is:
 - (a) if on the day, each building in which funded aged care services are delivered to individuals in the home meets the privacy and space requirements that apply to the building under this section:
 - (i) if the home is a newly built home or a significantly refurbished home—\$69.49; or
 - (ii) if the home is not a newly built home or a significantly refurbished home—\$45.31; or
 - (b) if, on the day, each building in which funded aged care services are delivered to individuals in the home does not meet the privacy and space requirements that apply to the building under this section—\$38.07.

Privacy and space requirements—post-end-July 1999 buildings

- (2) This subsection applies to a building, or part of a building, for which plans were submitted after July 1999 to a body (including a local government body) responsible for building or development approval in the area where the building

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is located or proposed, for approval to construct or alter the building, or part of the building.

- (3) For a building to which subsection (2) applies, the privacy and space requirements are that the building must have:
- (a) subject to subsection (4):
 - (i) an average of no more than 1.5 individuals per room; and
 - (ii) no room that may accommodate more than 2 individuals; and
 - (b) no more than 3 individuals per toilet; and
 - (c) no more than 4 individuals per shower or bath; and
 - (d) toilets, showers and baths distributed across the building to ensure equitable and ready access for all individuals.

Example: If a building has more than one wing, toilets and bathing facilities must not be restricted to one wing, or at a point in a wing where it would be difficult for residents to access them.

- (4) Paragraph (3)(a) does not apply to a room or rooms usually occupied by particular individuals if the approved provider, when requested by the System Governor, is able to demonstrate that it is not, having regard to the culture of those individuals, appropriate for those paragraphs to apply.

Pre-end-July 1999 buildings

- (5) For a building to which subsection (2) does not apply, the privacy and space requirements are that the building must have:
- (a) subject to subsection (6)—an average of no more than 4 individuals per room; and
 - (b) no more than 6 individuals per toilet; and
 - (c) no more than 7 individuals per shower or bath; and
 - (d) toilets, showers and baths distributed across the building to ensure equitable and ready access for all individuals.

Example: If a building has more than one wing, toilets and bathing facilities must not be restricted to one wing, or at a point in a wing where it would be difficult for individuals to access them.

- (6) Paragraph (5)(a) does not apply to a room or rooms usually occupied by particular individuals if the registered provider of the home, when requested by the System Governor, is able to demonstrate that it is not, having regard to the culture of those individuals, appropriate for that paragraph to apply.

Working out numbers of individuals per toilet and shower

- (7) For the purposes of working out the number of individuals per toilet for paragraph (3)(b) or (5)(b), and per shower or bath for paragraph (3)(c) or (5)(c):
- (a) toilets, showers and baths off common areas are to be included; and
 - (b) toilets, showers and baths primarily for the use of staff are to be excluded.

230-20 Meaning of *newly built home*

- (1) An approved residential care home is a **newly built home** if:

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- (a) each building in which funded aged care services are delivered to individuals in the home was completed on or after 20 April 2012; or
 - (b) each building in which funded aged care services are delivered to individuals in the home was converted, on or after 20 April 2012, from one or more buildings that, before that date, were used for a purpose other than delivering funded aged care services care to individuals in an approved residential care home.
- (2) An approved residential care home is also a **newly built home** if:
- (a) more than one building is used to deliver funded aged care services to individuals in the home; and
 - (b) one or more of those buildings was:
 - (i) completed on or after 20 April 2012; or
 - (ii) converted, on or after 20 April 2012, from one or more buildings that, before that date, were used for a purpose other than delivering funded aged care services to individuals in an approved residential care home; and
 - (c) none of those buildings had been used, before 20 April 2012, to deliver funded aged care services to individuals in an approved residential care home.

230-25 Application for determination—approved residential care homes that have been, or are proposed to be, significantly refurbished

- (1) If an approved residential care home of a registered provider has been significantly refurbished, the provider may apply, in the approved form, to the System Governor for a determination under subsection 230-30(1) in relation to the home.
- (2) If it is proposed that an approved residential care home of a registered provider be significantly refurbished, the provider may apply, in the approved form, to the System Governor for a determination under subsection 230-35(1) in relation to the home.
- (3) An application must not relate to more than one approved residential care home.

230-30 Determination for approved residential care homes that have been significantly refurbished

- (1) If the System Governor receives an application under subsection 230-25(1) in relation to an approved residential care home, the System Governor may determine, in writing, that the home is a significantly refurbished home.
 - Note 1: The System Governor must not make a determination under this subsection in certain circumstances (see subsection (2) and section 230-40).
 - Note 2: A decision to refuse to make a determination under this subsection is a reviewable decision under section 557 of the Act (see section [to be drafted] of this instrument).
- (2) The System Governor must not make a determination under subsection (1) unless the System Governor is satisfied of the following:
 - (a) the refurbishment was completed on or after 20 April 2012;

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- (b) the alterations, updates, upgrades or other improvements that have been made to the home have resulted in the home being significantly different in form, quality or functionality after the refurbishment;
- (c) a significant proportion of the areas of the home that have been refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services are being delivered in the home;
- (d) the refurbishment provides significant benefits to low means residents to whom funded aged care services are being delivered in the home;
- (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 individuals to whom funded aged care services are being delivered in the home having an individual's room that has been significantly refurbished; or
 - (ii) provides a significant benefit to at least 40% of the individuals to whom funded aged care services are being delivered in the home; or
 - (iii) consisted of an extension to the home involving an increase of at least 25% of the number of individual's rooms in the home;
- (g) the proportion of the total number of individual's rooms in the home that are available after the refurbishment for low means residents is equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the refurbishment for low means residents;
- (h) the refurbishment cost in relation to the home is at least the minimum monetary spend amount in relation to the home.

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

- (3) In deciding whether to be satisfied that the refurbishment was completed on or after 20 April 2012, the System Governor 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 home—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 System Governor considers to be relevant.

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230-35 Determination for approved residential care homes that are proposed to be significantly refurbished

- (1) If the System Governor receives an application under subsection 230-25(2) in relation to an approved residential care home, the System Governor may determine, in writing, that the home is a significantly refurbished home, subject to the condition that the determination does not take effect unless:
- (a) after the refurbishment is completed, the registered provider of the home gives the System Governor, in the approved form, the information about the refurbished home referred to in subsection (3); and
 - (b) the System Governor notifies the registered provider under paragraph (5)(b) that the System Governor is satisfied, having regard to the information given by the registered provider, that the requirements referred to in paragraphs (3)(a) to (h) are met in relation to the refurbished home.

Note 1: The System Governor must not make a determination under this subsection in certain circumstances (see subsection (2) and section 230-40).

Note 2: A decision to refuse to make a determination under this subsection is a reviewable decision under section 557 of the Act (see section [to be drafted] of this instrument).

- (2) The System Governor must not make a determination under subsection (1) unless the System Governor is satisfied of the following:
- (a) the proposed refurbishment includes alterations, updates, upgrades or other improvements to the home that will result in the home being significantly different in form, quality or functionality after the refurbishment;
 - (b) a significant proportion of the areas of the home that are proposed to be refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services will be delivered in the home;
 - (c) the proposed refurbishment will provide significant benefits to low means residents to whom funded aged care services will be delivered in the home;
 - (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 individuals to whom funded aged care services will be delivered in the home having an individual's room that has been significantly refurbished; or
 - (ii) will provide a significant benefit to at least 40% of the individuals to whom funded aged care services will be delivered in the home; or
 - (iii) will consist of an extension to the home involving an increase of at least 25% of the number of individual's rooms in the home;
 - (f) the proportion of the total number of individual's rooms in the home that will be available after the proposed refurbishment for low means residents will be equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the proposed refurbishment for low means residents;

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- (g) the refurbishment cost in relation to the home will be at least the minimum monetary spend amount in relation to the home.
- (3) For the purposes of paragraph (1)(a), the information about the refurbished home that the registered provider must give the System Governor 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 home have resulted in the home being significantly different in form, quality or functionality after the refurbishment;
 - (c) a significant proportion of the areas of the home that have been refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services are being delivered in the home;
 - (d) the refurbishment provides significant benefits to low means residents to whom funded aged care services are being delivered in the home;
 - (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 individuals to whom funded aged care services are being delivered in the home having an individual's room that has been significantly refurbished; or
 - (ii) provides a significant benefit to at least 40% of the individuals to whom funded aged care services are being delivered in the home; or
 - (iii) consisted of an extension to the home involving an increase of at least 25% of the number of individual's rooms in the home;
 - (g) the proportion of the total number of individual's rooms in the home that are available after the refurbishment for low means residents is equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the refurbishment for low means residents;
 - (h) the refurbishment cost in relation to the home is at least the minimum monetary spend amount in relation to the home.
- (4) If the System Governor needs further information to decide whether to be satisfied as referred to in paragraph (1)(b) in relation to the refurbished home, the System Governor may give the registered provider a notice requesting the registered provider to give the further information within 28 days after receiving the notice.
- (5) The System Governor must, within 28 days after receiving information from the registered provider in relation to the refurbished home:
 - (a) decide whether, having regard to the information, the System Governor is satisfied as referred to in paragraph (1)(b) in relation to the refurbished home; and
 - (b) notify the registered provider, in writing, of the System Governor's decision.

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Note: A decision under paragraph (5)(a) that the System Governor is not satisfied as referred to in paragraph (1)(b) in relation to the refurbished home is a reviewable decision under section 557 of the Act (see section [to be drafted] of this instrument).

- (6) If the System Governor 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 System Governor is satisfied as referred to in paragraph (1)(b) in relation to the refurbished home, the notice given under paragraph (5)(b) must specify the date on which the determination under subsection (1) is to take effect under subsection 230-50(2).

230-40 Circumstances in which System Governor must not make determinations

The System Governor must not make a determination under subsection 230-30(1) or 230-35(1) in relation to an approved residential care home if the refurbishment of the home consisted, or the proposed refurbishment of the home 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.

230-45 Notification of System Governor's decision

- (1) The System Governor must notify, in writing, the applicant for a determination under subsection 230-30(1) or 230-35(1) of the System Governor's decision on whether to make the determination.
- (2) If:
 - (a) the decision relates to an application in relation to an approved residential care home 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 under subsection 230-50(1).
- (3) If:
 - (a) the decision relates to an application in relation to an approved residential care home 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 230-35(1) (including the information referred to in subsection 230-35(3)).
- (4) The notice must be given to the applicant within 60 days after the System Governor receives the application.

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230-50 Day of effect of determination

- (1) A determination under subsection 230-30(1) in relation to an approved residential care home that has been significantly refurbished takes effect on the day the application was received.
- (2) A determination under subsection 230-35(1) in relation to an approved residential care home that is proposed to be significantly refurbished takes effect on the day the System Governor receives the information about the refurbished home referred to in subsection 230-35(3).

Subdivision D—Secondary person-centred supplements

231-5 Purpose of this Subdivision

For the purposes of section 231 of the Act, this Subdivision prescribes:

- (a) other secondary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care; and
- (b) the circumstances in which secondary person-centred supplements will apply to individuals for a day; and
- (c) the amounts of the supplements; and
- (d) that the fee reduction supplement reduces certain fees, payments and contributions, and the method for those reductions.

Note: The fee reduction supplement is a secondary person-centred supplement for the classification types ongoing and short-term for the service group residential care (see paragraph 231(1)(a) of the Act).

231-10 Other secondary person-centred supplements

The following table sets out other secondary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care.

Other secondary person-centred supplements		
Item	Column 1 For an individual for a day for the following classification type for the service group residential care ...	Column 2 the supplements are the following:
1	Ongoing	(a) initial entry adjustment supplement; (b) veterans' supplement; (c) outbreak management support supplement; (d) transitional accommodation supplement; (e) 2012 basic daily fee supplement; (f) accommodation charge top up supplement;

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Other secondary person-centred supplements		
Item	Column 1 For an individual for a day for the following classification type for the service group residential care ...	Column 2 the supplements are the following:
		(g) concessional resident supplement; (h) pensioner supplement; (i) ex-hostel supplement.
2	Short-term	(a) respite supplement; (b) veterans' supplement; (c) outbreak management support supplement.

231-15 Fee reduction supplement—circumstances for applicability (financial hardship) and amount—general

Circumstances for applicability

- (1) Circumstances in which the fee reduction supplement will apply to an individual for a day are that:
 - (a) either:
 - (i) the System Governor has not determined the individual's daily means tested amount; or
 - (ii) the individual does not have means not disclosed status; and
 - (b) the System Governor is satisfied that subsection (2) applies to the individual.
- (2) This subsection applies to an individual if:
 - (a) the value of the individual's assets, worked out in accordance with Division 1 of Part 3.12 of the Social Security Act and reduced by the amounts mentioned in subsection (3), is not more than 1.5 times the sum of the annual amount of the following:
 - (i) the maximum basic rate under point 1064-B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple;
 - (ii) the pension supplement amount under point 1064-BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple;
 - (iii) the energy supplement amount under point 1064-C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple; and
 - (b) the individual has not gifted more than \$10,000 in the current financial year or in any of the previous 4 financial years; and
 - (c) the individual has not gifted more than \$30,000 in the period comprising the current financial year and the previous 4 financial years.
- (3) For the purposes of paragraph (2)(a), the amounts are the following:

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- (a) the amounts mentioned in section 330-10 of this instrument;
- (b) the value of any unrealisable assets.

Amount

- (4) The amount of the fee reduction supplement for an individual to whom the supplement applies under subsection (1) is [calculation to be drafted (to involve matters similar to the matters mentioned in subsection 61(4) of the *Subsidy Principles 2014*)].

231-20 Fee reduction supplement—circumstances for applicability (financial hardship) and amount—individuals with determinations under the Aged Care (Transitional Provisions) Act 1997

Circumstances for applicability

- (1) Circumstances in which the fee reduction supplement will apply to an individual for a day are that, immediately before the transition time, a determination under section 44-31 of the *Aged Care (Transitional Provisions) Act 1997* was in force in relation to the individual.

Amount

- (2) The amount of the fee reduction supplement for an individual to whom the supplement applies under subsection (1) is the amount equal to the difference between:
 - (a) the maximum daily amount of the resident contribution payable by the individual; and
 - (b) the amount specified in the determination.

231-25 Fee reduction supplement—reduction of fees, payments and contributions

General

- (1) For an individual not covered by subsection (2) or (3), the fee reduction supplement for the individual reduces (but not below zero) the following for the individual, in the following order:
 - (a) basic daily fee;
 - (b) hotelling contribution;
 - (c) non-clinical care contribution;
 - (d) accommodation payment or accommodation contribution (as applicable).

Individuals in the pre-2014 residential contribution class

- (2) For an individual in the pre-2014 residential contribution class, the fee reduction supplement for the individual reduces (but not below zero) the following for the individual, in the following order:
 - (a) basic daily fee;
 - (b) income tested fee;

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- (c) accommodation bond or accommodation charge (as applicable).

Individuals in the post-2014 residential contribution class

- (3) For an individual in the post-2014 residential contribution class, the fee reduction supplement for the individual reduces (but not below zero) the following for the individual, in the following order:
 - (a) basic daily fee;
 - (b) means tested care fee;
 - (c) accommodation payment or accommodation contribution (as applicable).

231-30 Respite supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which respite supplement will apply to an individual for a day are that, on the day:
 - (a) the funded aged care services delivered to the individual are short-term funded aged care services; and
 - (b) a classification level for the classification type short-term for the service group residential care is in effect for the individual.

Amount

- (2) The amount of respite supplement is the building status amount for the individual for the day.

231-35 Initial entry adjustment supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which initial entry adjustment supplement will apply to an individual for a day are that it is the individual's start day for the classification type ongoing for the service group residential care.

Amount

- (2) The amount of initial entry adjustment supplement is the amount of the national efficient price multiplied by 5.28.

231-50 Veterans' supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which veterans' supplement will apply to an individual for a day are that:
 - (a) the individual is a veteran with an accepted mental health condition; and

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(b) the individual has, before, on or after that day, authorised either or both of the following to disclose to a registered provider that the individual 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*.

Amount

- (2) The amount of veterans' supplement is \$7.99.

231-55 Outbreak management support supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which outbreak management support supplement will apply to an individual for a day are that the day is before 1 October 2025.

Amount

- (2) The amount of the outbreak management support supplement for a day for an individual is \$1.65.

231-60 Transitional accommodation supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which transitional accommodation supplement will apply to an individual for a day are that:
- (a) the individual is in the pre-2014 residential contribution class; and
 - (b) immediately before the transition time, the individual was eligible for transitional accommodation supplement under section 37 of the *Aged Care (Transitional Provisions) Principles 2014*.

Amount

- (2) The amount of the transitional accommodation supplement for a day for an individual is the amount that is the difference between:
- (a) the amount specified in the following table for the day on which the individual entered residential care (within the meaning of the old Act); and
 - (b) the amount of accommodation supplement for the individual for the day.

Entry day and amount		
Item	Column 1 Entry day	Column 2 Amount (\$)
1	After 19 March 2008 and before 20 September 2010	10.36

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Entry day and amount		
Item	Column 1 Entry day	Column 2 Amount (\$)
2	After 19 September 2010 and before 20 March 2011	6.91
3	After 19 March 2011 and before 20 September 2011	3.45

- (3) However, the amount of transitional accommodation supplement for a day for the individual is nil if the amount worked out under subsection (2) is a negative amount.

231-65 2012 basic daily fee supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which 2012 basic daily fee supplement will apply to an individual for a day are that:
- (a) the individual is in the pre-2014 residential contribution class; and
 - (b) immediately before the transition time, the individual was eligible for 2012 basic daily fee supplement under section 39 of the *Aged Care (Transitional Provisions) Principles 2014*.

Amount

- (2) The amount of the 2012 basic daily fee supplement for a day for an individual is the amount worked out by rounding down to the nearest cent the amount equal to 1% of the basic age pension amount (worked out on a per day basis).

231-70 Accommodation charge top-up supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which accommodation charge top-up supplement will apply to an individual for a day are that:
- (a) the individual is in the pre-2014 residential contribution class; and
 - (b) immediately before the transition time, the individual was eligible for accommodation charge top-up supplement under section 35 of the *Aged Care (Transitional Provisions) Principles 2014*.

Amount

- (2) The amount of the accommodation charge top-up supplement for a day for an individual is the amount that is the difference between:
- (a) the maximum daily amount at which an accommodation charge would accrue under section 57A-6 of the *Aged Care (Transitional Provisions) Act 1997* for the entry of the individual to the residential care service (within the meaning of that Act) in question if the individual were not receiving an

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- income support payment (within the meaning of that Act) on the day of entry; and
- (b) the maximum daily amount at which an accommodation charge would accrue under subsection 118(2) of the *Aged Care (Transitional Provisions) Principles 2014* for the entry of the individual to the service if the individual were a post-reform 2008 resident (within the meaning of the *Aged Care (Transitional Provisions) Act 1997* who was receiving an income support payment (within the meaning of that Act) on that day.
- (3) However, the amount of accommodation charge top-up supplement for a day for the individual is nil if the amount worked out under subsection (2) is a negative amount.

231-75 Concessional resident supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which concessional resident supplement will apply to an individual for a day are that:
- (a) the individual is in the pre-2014 residential contribution class; and
- (b) immediately before the transition time:
- (i) the individual was eligible for concessional resident supplement under section 44-6 of the *Aged Care (Transitional Provisions) Act 1997*; and
- (ii) the amount of the concessional resident supplement for the day for the individual under section 91B of the *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* was not nil.

Amount

- (2) The amount of the concessional resident supplement for a day for an individual is:
- (a) if, for the payment period in which the day occurs, the low means resident percentage for the approved residential care home in which funded aged care services are delivered to the individual is 40% or more—the building status amount for the individual for the day; or
- (b) otherwise—the amount worked out by reducing the building status amount for the individual for the day by 25%.

231-80 Pensioner supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which pensioner supplement will apply to an individual for a day are that:
- (a) the individual is in the pre-2014 residential contribution class; and
- (b) immediately before the transition time, the individual was eligible for concessional resident supplement under section 44-28 of the *Aged Care (Transitional Provisions) Act 1997*.

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Amount

- (2) The amount of the pensioner supplement for a day for an individual is \$10.36.

231-85 Ex-hostel supplement—circumstances for applicability and amount

Circumstances for applicability

- (1) The circumstances in which the ex-hostel supplement will apply to an individual for a day are that:
- (a) the individual is in the pre-2014 residential contribution class; and
 - (b) on 30 September 1997, the individual occupied a place in a hostel approved under the *Aged or Disabled Persons Care Act 1954*, as in force at that date; and
 - (c) as at immediately before the transition time, the individual had not entered an aged care service (within the meaning of the old Act) that was approved, before 1 October 1997, as a nursing home under the *National Health Act 1953*.

Amount

- (2) The amount of the ex-hostel supplement for a day for an individual is \$0.80.

Subdivision E—Person-centred subsidy reduction for ongoing residential care

Note: For the compensation payment reduction for person-centred subsidy, see Part 8.

235-5 Amount of person-centred subsidy reduction—classes of individuals

For the purposes of subsection 235(6) of the Act, the classes are the following:

- (a) the pre-2014 residential contribution class;
- (b) the post-2014 residential contribution class.

235-10 Amount of person-centred subsidy reduction—individuals in pre-2014 residential contribution class

For the purposes of subsection 235(6) of the Act, the person-centred subsidy reduction for a day for an individual in the pre-2014 residential contribution class is worked out as follows:

[Calculator to be drafted to give the same result as for residential care subsidy under Division 44 of the *Aged Care (Transitional Provisions) Act 1997*.]

235-15 Amount of person-centred subsidy reduction—individuals in post-2014 residential contribution class

For the purposes of subsection 235(6) of the Act, the person-centred subsidy reduction for a day for an individual in the post-2014 residential contribution class is worked out as follows:

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[Calculator to be drafted to give the same result as for residential care subsidy under Division 44 of the old Act.]

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Subdivision A—Base provider amount

238-5 Base provider amount

- (1) For the purposes of section 238 of the Act, the base provider amount for the classification types ongoing and short-term for the service group residential care for an individual for a day is the amount worked out using the following table.

Requirements and amount		
Item	Column 1 For a registered provider delivering funded aged care services in an approved residential care home that meets the following requirements ...	Column 2 the amount is ...
1	The approved residential care home: (a) has specialised Aboriginal or Torres Strait Islander status; and (b) is located in the 2019 MM category known as MM 7	The amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 1.80
2	The approved residential care home: (a) has specialised Aboriginal or Torres Strait Islander status; and (b) is located in the 2019 MM category known as MM 6	The amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.78
3	All of the following apply: (a) the approved residential care home does not have specialised status; (b) the approved residential care home is located in the 2019 MM category known as MM 6 or the 2019 MM category known as MM 7; (c) the number of operational places in respect of the approved residential care home is less than 30	The amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.68
4	All of the following apply: (a) the approved residential care home does not have specialised status; (b) the approved residential care home is located in the 2019 MM category known as MM 6 or the 2019 MM category known as MM 7; (c) the number of operational places in respect of the approved residential care home is 30 or more	The sum of the following amounts: (a) the amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.68 and that the number of operational beds were 29; (b) the amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.52 and that the number of operational beds were reduced by 29
5	The approved residential care home: (a) does not have specialised status; and	The amount worked out by multiplying the national efficient price by the NWAU of 0.57

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Requirements and amount		
Item	Column 1 For a registered provider delivering funded aged care services in an approved residential care home that meets the following requirements ...	Column 2 the amount is ...
	(b) is located in the 2019 MM category known as MM 4 or the 2019 MM category known as MM 5	
6	The approved residential care home has specialised homeless status	The amount worked out by multiplying the national efficient price by the NWAU of 0.92
7	The approved residential care home: (a) does not have specialised status; and (b) is located in the 2019 MM category known as MM 2 or the 2019 MM category known as MM 3	The amount worked out by multiplying the national efficient price by the NWAU of 0.55
8	The approved residential care home: (a) does not have specialised status; and (b) is located in the 2019 MM category known as MM 1	The amount worked out by multiplying the national efficient price by the NWAU of 0.50

(2) For the purposes of items 1 to 4 of the table in subsection (1), the formula is:

$$\text{National efficient price} \times \text{NWAU} \times \left(\frac{\text{Operational beds}}{\text{Occupied beds}} \right)$$

Subdivision B—Provider-based supplements

239-5 Registered nurse supplement

For the purposes of subsection 239(1) of the Act, the supplement registered nurse supplement is prescribed for the classification types ongoing and short-term for the service group residential care.

239-10 Registered nurse supplement—applicability

For the purposes of paragraph 239(2)(a) of the Act, the circumstances in which registered nurse supplement will apply in relation to an individual for a day are that funded aged care services are delivered to the individual in a qualifying residential care home for the payment period in which the day occurs.

239-15 Meaning of *qualifying residential care home*

- (1) An approved residential care home is a ***qualifying residential care home*** for a payment period if it is a group A residential care home for the payment period or a group B residential care home for the payment period.

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- (2) An approved residential care home is a **group A residential care home** for a payment period if all of the following criteria are met:
- (a) an exemption from subsection 175(1) of the Act in relation to the approved residential care home is not in force at any time during the period;
 - (b) a report in relation to the approved residential care home and the period has been submitted in accordance with section [to be drafted] of this instrument;
 - (c) the total number of days of eligible residential funded aged care services delivered in respect of individuals at the approved residential care home during the period, divided by the number of days in the period, is no more than 50;
 - (d) the total number of hours, on days during the period on which funded aged care services were delivered at the home, that a registered nurse was not on site and on duty at the home is no more than the number of such days in the period multiplied by 3.
- (3) An approved residential care home is a **group B residential care home** for a payment period if all of the following criteria are met:
- (a) an exemption from section 175 of the Act in relation to the approved residential care home is not in force at any time during the period;
 - (b) a report in relation to the approved residential care home and the period has been submitted in accordance with section [to be drafted] of this instrument;
 - (c) the total number of days of eligible residential funded aged care services delivered in respect of individuals at the approved residential care home during the period, divided by the number of days in the period, is no more than 30;
 - (d) the total number of hours, on days during the period on which funded aged care services were delivered at the home, that a registered nurse was not on site and on duty at the home is:
 - (i) more than the number of such days in the period multiplied by 3; and
 - (ii) no more than the number of such days in the period multiplied by 12.
- (4) A **day of eligible residential funded aged care services** is delivered in respect of an individual if a registered provider is eligible for provider-based subsidy for an ongoing or short-term funded aged care service delivered by the registered provider to the individual in an approved residential care home on the day.

239-20 Registered nurse supplement—amount

- (1) For the purposes of paragraph 239(2)(b) of the Act, the amount of registered nurse supplement for an individual for a day during a payment period is:

$$\frac{\text{Residential care home supplement amount}}{\text{Total residential care home days}}$$

where:

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residential care home supplement amount is the residential care home supplement amount for the payment period, determined under subsections (2) to (9), for the approved residential care home in which funded aged care services are delivered to the individual.

total residential care home days is the total number of days of eligible residential funded aged care services delivered in respect of individuals during the payment period in that approved residential care home.

Residential care home supplement amount—group A residential care homes in 2019 MM category MM 1

- (2) The residential care home supplement amount for a payment period, for a group A residential care home for the period located in the 2019 MM category known as MM 1, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group A residential care homes in 2019 MM category MM 1		
Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
1	Less than or equal to 20	27,055
2	More than 20 but less than or equal to 25	24,124
3	More than 25 but less than or equal to 30	13,167
4	More than 30 but less than or equal to 35	10,687
5	More than 35 but less than or equal to 40	8,207
6	More than 40 but less than or equal to 45	5,727
7	More than 45 but less than or equal to 50	3,247

Residential care home supplement amount—group A residential care homes in 2019 MM categories MM 2 and MM 3

- (3) The residential care home supplement amount for a payment period, for a group A residential care home for the period located in the 2019 MM category known as MM 2 or the 2019 MM category known as MM 3, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group A residential care homes in 2019 MM categories MM 2 and MM 3		
Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
1	Less than or equal to 20	29,715
2	More than 20 but less than or equal to 25	26,496
3	More than 25 but less than or equal to 30	14,461
4	More than 30 but less than or equal to 35	11,738

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Residential care home supplement amount—group A residential care homes in 2019 MM categories MM 2 and MM 3

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
5	More than 35 but less than or equal to 40	9,014
6	More than 40 but less than or equal to 45	6,290
7	More than 45 but less than or equal to 50	3,566

Residential care home supplement amount—group A residential care homes in 2019 MM categories MM 4 and MM 5

- (4) The residential care home supplement amount for a payment period, for a group A residential care home for the period located in the 2019 MM category known as MM 4 or the 2019 MM category known as MM 5, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group A residential care homes in 2019 MM categories MM 4 and MM 5

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
1	Less than or equal to 5	70,883
2	More than 5 but less than or equal to 10	60,143
3	More than 10 but less than or equal to 15	49,403
4	More than 15 but less than or equal to 20	38,663
5	More than 20 but less than or equal to 25	27,162
6	More than 25 but less than or equal to 30	14,825
7	More than 30 but less than or equal to 35	12,032
8	More than 35 but less than or equal to 40	9,240
9	More than 40 but less than or equal to 45	6,448
10	More than 45 but less than or equal to 50	3,655

Residential care home supplement amount—group A residential care homes in 2019 MM categories MM 6 and MM 7

- (5) The residential care home supplement amount for a payment period, for a group A residential care home for the period located in the 2019 MM category known as MM 6 or the 2019 MM category known as MM 7, is the amount set out in the following table for the average daily care count for the home for the period.

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Residential care home supplement amount—group A residential care homes in 2019 MM categories MM 6 and MM 7

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
1	Less than or equal to 5	84,057
2	More than 5 but less than or equal to 10	71,321
3	More than 10 but less than or equal to 15	58,585
4	More than 15 but less than or equal to 20	45,849
5	More than 20 but less than or equal to 25	32,210
6	More than 25 but less than or equal to 30	17,580
7	More than 30 but less than or equal to 35	14,269
8	More than 35 but less than or equal to 40	10,958
9	More than 40 but less than or equal to 45	7,646
10	More than 45 but less than or equal to 50	4,335

Residential care home supplement amount—group B residential care homes in 2019 MM category MM 1

- (6) The residential care home supplement amount for a payment period, for a group B residential care home for the period located in the 2019 MM category known as MM 1, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group B residential care homes in 2019 MM category MM 1

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
1	Less than or equal to 20	13,528
2	More than 20 but less than or equal to 25	12,062
3	More than 25 but less than or equal to 30	6,584

Residential care home supplement amount—group B residential care homes in 2019 MM categories MM 2 and MM 3

- (7) The residential care home supplement amount for a payment period, for a group B residential care home for the period located in the 2019 MM category known as MM 2 or the 2019 MM category known as MM 3, is the amount set out in the following table for the average daily care count for the home for the period.

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Residential care home supplement amount—group B residential care homes in 2019 MM categories MM 2 and MM 3

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
1	Less than or equal to 20	14,858
2	More than 20 but less than or equal to 25	13,248
3	More than 25 but less than or equal to 30	7,231

Residential care home supplement amount—group B residential care homes in 2019 MM categories 4 and 5

- (8) The residential care home supplement amount for a payment period, for a group B residential care home for the period located in the 2019 MM category known as MM 4 or the 2019 MM category known as MM 5, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group B residential care homes in 2019 MM categories MM 4 and MM 5

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
1	Less than or equal to 5	35,442
2	More than 5 but less than or equal to 10	30,072
3	More than 10 but less than or equal to 15	24,702
4	More than 15 but less than or equal to 20	19,332
5	More than 20 but less than or equal to 25	13,581
6	More than 25 but less than or equal to 30	7,413

Residential care home supplement amount—group B residential care homes in 2019 MM categories MM 6 and MM 7

- (9) The residential care home supplement amount for a payment period, for a group B residential care home for the period located in the 2019 MM category known as MM 6 or the 2019 MM category known as MM 7, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group B residential care homes in 2019 MM categories MM 6 and MM 7

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
1	Less than or equal to 5	42,029
2	More than 5 but less than or equal to 10	35,661
3	More than 10 but less than or equal to 15	29,293
4	More than 15 but less than or equal to 20	22,925

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Residential care home supplement amount—group B residential care homes in 2019 MM categories MM 6 and MM 7		
Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount (\$)
5	More than 20 but less than or equal to 25	16,105
6	More than 25 but less than or equal to 30	8,790

Average daily care count

- (10) For the purposes of subsections (2) to (9), the average daily care count for a qualifying residential care home for a payment period is the total number of days of eligible residential funded aged care services delivered in respect of individuals at the residential care home during the period, divided by the number of days in the period.

Subdivision C—Reduction amounts for provider-based subsidy for ongoing residential care

Note: For the compensation payment reduction for provider-based subsidy, see Part 8.

242-5 Provider-based reduction amount—standard base provider amount

For the purposes of subsection 242(2) of the Act, the standard base provider amount for a day for an individual is the amount that would be the base provider amount under section 238-5 of this instrument for the individual for the day if the registered provider were delivering funded aged care services in the classification type ongoing through the service group residential care in an approved residential care home that meets the requirements in column 1 of item 8 in the table in that subsection.

Subdivision D—Approved residential care homes with specialised status

243-5 Kinds of specialised status

For the purposes of paragraph 243(5)(a) of the Act, the following are kinds of specialised status:

- (a) specialised Aboriginal or Torres Strait Islander status;
- (b) specialised homeless status.

243-10 Specialised Aboriginal or Torres Strait Islander status—criteria

For the purposes of paragraph 243(5)(b) of the Act, the criteria that the System Governor must consider when deciding whether to determine an approved residential care home has specialised Aboriginal or Torres Strait Islander status are the following:

- (a) whether, on the day before the application under subsection 243(1) of the Act in relation to the home was made:
 - (i) the home was located in the 2019 MM category known as MM 6 or the 2019 MM category known as MM 7; and

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- (ii) at least 50% of the individuals to whom funded aged care services were delivered in the home, other than individuals to whom funded aged care services were delivered under a specialist aged care program, were Aboriginal or Torres Strait Islander persons;
- (b) whether the registered provider that delivers funded aged care services in the home, or a responsible person of the provider, has demonstrated experience in providing, or the capacity to provide, specialist Aboriginal or Torres Strait Islander programs;
- (c) whether:
 - (i) the provider is delivering specialist Aboriginal or Torres Strait Islander programs in the home; or
 - (ii) the provider has given a written undertaking that the provider will begin delivering specialist Aboriginal or Torres Strait Islander programs in the home within 3 months after the application is made.

243-15 Specialised homeless status—criteria

For the purposes of paragraph 243(5)(b) of the Act, the criteria that the System Governor must consider when deciding whether to determine an approved residential care home has specialised homeless status are the following:

- (a) whether, on the day before the application under subsection 243(1) of the Act in relation to the home was made, at least 50% of the individuals to whom funded aged care services were delivered in the home, other than individuals to whom funded aged care services were delivered under a specialist aged care program, demonstrated complex behavioural needs and social disadvantage associated with their background as a homeless person;
- (b) whether the registered provider that delivers funded aged care services in the home, or a responsible person of the provider, has demonstrated experience in providing, or the capacity to provide, specialist homeless programs;
- (c) whether:
 - (i) the provider is delivering specialist homeless programs in the home; or
 - (ii) the provider has given a written undertaking that the provider will begin delivering specialist homeless programs in the home within 3 months after the application is made.

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Part 8 Reduction amounts—compensation payment reduction for home support, assistive technology, home modifications and residential care

Section 246A-5

Part 8—Reduction amounts—compensation payment reduction for home support, assistive technology, home modifications and residential care

246A-5 Circumstances in which compensation information known

- (1) For the purposes of subsections 199(1), 216(1), 225(1), 233(1) and 241(1) of the Act, circumstances in which:
- (a) a compensation payment reduction for person-centred subsidy; and
 - (b) a compensation payment reduction for provider-based subsidy;
- apply to an individual for a day are that:
- (c) the individual is entitled to compensation under a judgment, settlement or reimbursement arrangement (whether the judgment, settlement or reimbursement arrangement occurred before or after the transition time); and
 - (d) the compensation takes into account the future costs of delivering funded aged care services (however described) to the individual on that day; and
 - (e) the application of compensation payment reductions to the individual for preceding days has not resulted in reductions in subsidy that, in total, exceed or equal the part of the compensation that relates, or is to be treated under subsection (2) or (3) as relating, to future costs of delivering funded aged care services (however described) to the individual.

Determinations relating to future costs of delivering funded aged care services

- (2) If an individual is entitled to compensation under a judgment or settlement that does not take into account the future costs of delivering funded aged care services (however described) to the individual, the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual:
- (a) that, for the purposes of this section, the judgment or settlement is to be treated as having taken into account those future costs; and
 - (b) the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.
- (3) If:
- (a) an individual is entitled to compensation under a settlement; and
 - (b) the settlement takes into account the future costs of delivering funded aged care services (however described) to the individual; and
 - (c) the System Governor is satisfied that the settlement does not adequately take into account those future costs;
- the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual, the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.
- (4) In making a determination under subsection (2) or (3):

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- (a) the System Governor must take into account the following matters:
 - (i) the amount of the judgment or settlement;
 - (ii) for a judgment—the components stated in the judgment and the amount stated for each component;
 - (iii) the proportion of liability apportioned to the individual;
 - (iv) the amounts spent on delivering funded aged care services (however described) to the individual at the time of the judgment or settlement; and
- (b) the System Governor may take into account any other matters the System Governor considers relevant, including the following:
 - (i) the amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;
 - (ii) the amounts spent on care (other than funded aged care services (however described)) at the time of the judgment or settlement;
 - (iii) the likely future costs of delivering funded aged care services to the individual;
 - (iv) other costs of care for which the individual is likely to be liable;
 - (v) other reasonable amounts, not related to care, that the individual has spent at the time of the judgment or settlement, or is likely to be liable for.

Note: For subparagraph (4)(a)(ii), examples of the components of a judgment include the following:

- (a) loss of income;
- (b) costs of future care.

246A-10 Amount for circumstances in which compensation information known

- (1) This section is made for the purposes of subsections 199(2), 216(2), 225(2), 233(2) and 241(2) of the Act.

Non-lump sum compensation with stated proportion of liability

- (2) Subsections (3) and (4) apply if:
 - (a) the individual is entitled to compensation under a judgment or settlement; and
 - (b) the compensation is not paid in a lump sum; and
 - (c) the judgment or settlement states the individual's proportion of liability.
- (3) The amount of the compensation payment reduction for person-centred subsidy for the individual for the day is that proportion of the sum of the following:
 - (a) the amount of the base rate for the individual for the day;
 - (b) if oxygen supplement applies to the individual for the day—the amount of that supplement for the day;
 - (c) if enteral feeding supplement applies to the individual for the day—the amount of that supplement for the individual for the day.

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- (4) The amount of the compensation payment reduction for provider-based subsidy for the individual for the day is that proportion of the standard base provider amount for the day for the individual.

Lump sum compensation with stated amount or proportion for aged care costs

- (5) Subsections (6) and (7) apply if:
- (a) the individual is entitled to compensation under a judgment or settlement; and
 - (b) the compensation is paid in a lump sum; and
 - (c) the judgment or settlement states the amount or proportion of the lump sum that relates to future costs of delivering funded aged care services (however described) to the individual.
- (6) The amount of the compensation payment reduction for person-centred subsidy for the individual for the day is the lesser of the following:
- (a) the amount, or the amount of the proportion, mentioned in paragraph (5)(c), reduced (but not below zero) by the total of the amounts of compensation payment reduction for person-centred subsidy for the individual and compensation payment reduction for provider-based subsidy for the individual for preceding days;
 - (b) the sum of the following:
 - (i) the amount of the base rate for the individual for the day;
 - (ii) if oxygen supplement applies to the individual for the day—the amount of that supplement for the day;
 - (iii) if enteral feeding supplement applies to the individual for the day—the amount of that supplement for the individual for the day.
- (7) The amount of the compensation payment reduction for provider-based subsidy for the individual for the day is the lesser of the following:
- (a) the amount, or the amount of the proportion, mentioned in paragraph (5)(c), reduced (but not below zero) by the total of the amounts of compensation payment reduction for person-centred subsidy for the individual and compensation payment reduction for provider-based subsidy for the individual for preceding days;
 - (b) the standard base provider amount for the day for the individual.

246A-15 Circumstances in which compensation information not known

For the purposes of subsections 199(1), 216(1), 225(1), 233(1) and 241(1) of the Act, circumstances in which:

- (a) a compensation payment reduction for person-centred subsidy; and
 - (b) a compensation payment reduction for provider-based subsidy;
- apply to an individual for a day are that section 234 of the Act applies in relation to section 199, 216, 225, 233 or 241 of the Act (as applicable).

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Section 246A-20

246A-20 Requirements for determining compensation payment reductions for circumstances in which compensation information not known

For the purposes of subsection 234(5) of the Act, in making a determination under subsection 234(4) of the Act in relation to section 199, 216, 225, 233 or 241 of the Act:

- (a) the System Governor must take into account the matter mentioned in subparagraph 246A-5(4)(a)(iv) of this instrument; and
- (b) the System Governor may take into account any other matters the System Governor considers relevant, including the following (to the extent that the matters are known to the System Governor):
 - (i) the matters mentioned in subparagraphs 246A-5(4)(a)(i) to (iii) of this instrument;
 - (ii) the matters mentioned in paragraph 246A-5(4)(b) of this instrument.

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Part 9 Subsidy for certain specialist aged care programs

Division 1 Agreements for delivery of funded aged care services under specialist aged care programs

Section 247-5

Part 9—Subsidy for certain specialist aged care programs

Division 1—Agreements for delivery of funded aged care services under specialist aged care programs

247-5 Circumstances that must apply for System Governor to enter into agreements—Multi-Purpose Service Program

For the purposes of subsection 247(3) of the Act, the circumstances that must apply for the System Governor to enter into an agreement with an entity under subsection 247(1)(a) of the Act (for the MPSP) are the following:

- (a) the System Governor is satisfied that:
 - (i) the entity, once registered as a registered provider, will deliver funded aged care services in an approved residential care home; and
 - (ii) the entity will also deliver a health service in the same location as the home; and
 - (iii) the home is not in a major city; and
 - (iv) there has been adequate consultation about the delivery of funded aged care services by the entity as a registered provider; and
- (b) taking into account the outcomes of the consultation and the views of the State and Territory in which the home is located, the System Governor is satisfied that:
 - (i) there is a demonstrated need for the delivery of funded aged care services under the MPSP to improve access to those services for individuals in the area surrounding the home;
 - (ii) it will be viable to have an arrangement for the integrated delivery of funded aged care services and health services in that area.

247-15 Requirements for agreements for delivery of funded aged care services—Transition Care Program

- (1) For the purposes of paragraph 247(4)(c) of the Act, the requirements that an agreement under paragraph 247(1)(b) of the Act (for the Transition Care Program) must meet are that:
 - (a) the agreement must state the following:
 - (i) the period of the agreement;
 - (ii) the circumstances in which the agreement can be varied or terminated;
 - (iii) any conditions the System Governor considers necessary for the effective delivery of funded aged care services under the Program, that are not conditions of registration (see Part 4 of Chapter 3 of the Act) or conditions of the allocation of a place for the Program (see section 95 of the Act);
 - (iv) any indemnity or insurance requirements that an entity is required to satisfy to be allocated a place for the Program under section 95 of the Act; and
 - (b) the agreement will take effect only if, and takes effect on the day that, the arrangement covered by the agreement meets the following requirements:

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-
- (i) the arrangement is for the delivery of funded aged care services to an individual after the conclusion of a hospital episode, and is targeted towards older people;
 - (ii) the funded aged care services delivered to an individual under the arrangement always include the service transition care therapy services;
 - (iii) the delivery of services to an individual under the arrangement is time-limited; and
 - (c) the agreement will cease to have effect if the arrangement covered by the agreement ceases to meet the requirements referred to in paragraph (b).

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Part 9 Subsidy for certain specialist aged care programs

Division 2 Amount of subsidy—Multi-Purpose Service Program

Section 249-5

Division 2—Amount of subsidy—Multi-Purpose Service Program

249-5 Purpose of Division

For the purposes of subsection 249(1) of the Act, this Division prescribes the amount of subsidy a registered provider is eligible for under section 248 of the Act on a day in relation to funded aged care services delivered through a service group under the MPSP in or from an approved residential care home of the provider.

249-10 Amount of subsidy

The amount of subsidy a registered provider is eligible for under section 248 of the Act on a day in relation to funded aged care services delivered through a service group under the MPSP in or from an approved residential care home of the provider is the amount worked out in accordance with the following formula:

$$\begin{aligned} & \text{ACWSA} + \text{BDFSFA} + \text{DCSA} + \text{DVEA} + \text{HCAA} \\ & + \text{HCPA} + \text{OMSA} + \text{RCPA} + \text{RSEA} + \text{VEA} \end{aligned}$$

where:

ACWSA is the amount worked out by multiplying:

- (a) the aged care wage supplement amount that applies under section 249-25 for the day for a place for the home; and
- (b) the sum of the number of home or community places for the home, and the number of residential care places for the home, that are in effect on the day.

BDFSFA is the amount worked out by multiplying the number of residential care places for the home that are in effect on the day by \$10.00.

DCSA is the amount worked out by multiplying:

- (a) the direct care supplement amount that applies under section 249-30 for the day for a residential care place for the home; and
- (b) the number of residential care places for the home that are in effect on the day.

DVEA is the amount worked out by multiplying the number of home or community places for the home that are in effect on the day by \$1.36.

Note: DVEA is short for dementia and cognition supplement and veterans' supplement equivalent amount.

HCAA is the amount worked out by multiplying:

- (a) the home or community additional amount that applies under section 249-35 for the day for a home or community place for the home; and
- (b) the number of home or community places for the home that are in effect on the day.

HCPA is the amount worked out by multiplying the number of home or community places for the home that are in effect on the day by \$47.12.

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Note: HCPA is short for home or community place amount.

OMSA is the amount worked out by multiplying the number of residential care places for the home that are in effect on the day by \$1.65.

Note: OMSA is short for outbreak management support supplement amount.

RCPA is the amount worked out by multiplying:

- (a) the residential care place amount that applies under section 249-40 for the day for a residential care place for the home; and
- (b) the number of residential care places for the home that are in effect on the day.

RSEA is the respite supplement equivalent amount for the home for the day under section 249-45.

VEA is the amount worked out by multiplying the number of residential care places for the home that are in effect on the day by \$0.08.

Note: VEA is short for veterans' supplement equivalent amount.

249-25 Aged care wage supplement amount

The aged care wage supplement amount for a day for a home or community place, or a residential care place, for an approved residential care home of a registered provider is the amount specified in the following table for the provider.

Aged care wage supplement amount		
Item	Column 1 Registered provider	Column 2 Amount (\$)
1	Churches of Christ Care in Queensland	24.28
2	Huon Eldercare Limited	28.62
3	Norfolk Island Health and Residential Aged Care Services	13.49
4	Any other person	0.00

249-30 Direct care supplement amount

- (1) The direct care supplement amount for a day for a residential care place for an approved residential care home is:
 - (a) if the home is in a State or Territory covered by subsection (2), and is located in a 2017 MM category mentioned in an item of the following table—the amount (if any) specified in the item of the table for the 2017 MM category for the home's location; or
 - (b) if paragraph (a) does not apply—nil.

Direct care supplement amount		
Item	Column 1 2017 MM category for the home's location	Column 2 Amount (\$)
1	2017 MM category known as MM 2	0.00

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Direct care supplement amount		
Item	Column 1 2017 MM category for the home's location	Column 2 Amount (\$)
2	2017 MM category known as MM 3	0.00
3	2017 MM category known as MM 4	16.00
4	2017 MM category known as MM 5	16.00
5	2017 MM category known as MM 6	17.37
6	2017 MM category known as MM 7	17.89

- (2) This subsection covers a State or Territory that is participating in a trial that aims to ensure that set amounts of direct care are provided to individuals accessing funded aged care services through the residential care service group under the MPSP.
- (3) The System Governor must, by notice published on the Department's website, specify each State or Territory covered by subsection (2).

249-35 Home or community additional amount

- (1) The home or community additional amount for a day (the **relevant day**) for a home or community place for an approved residential care home is:
- (a) for a home or community place to which subsection (2) does not apply—the 2017 MM category additional amount for a day for a home or community place for the home; and
 - (b) for a home or community place to which subsection (2) applies—the ARIA value additional amount for a day for a home or community place for the home.
- (2) This subsection applies to a home or community place for an approved residential care home on a day if:
- (a) the home is a Category A residential care home, a Category B residential care home or a Category C residential care home; and
 - (b) on the day, the ARIA value additional amount for a day for a home or community place for the home is greater than the 2017 MM category additional amount for a day for a home or community place for the home.

ARIA value additional amount

- (3) The ARIA value additional amount, for a day for a home or community place for an approved residential care home is the amount specified in the following table for the ARIA value for the home's location.

ARIA value additional amount		
Item	Column 1 ARIA value for the home's location	Column 2 Amount (\$)
1	0 to 3.51 inclusive	0.00
2	3.52 to 4.66 inclusive	6.16
3	4.67 to 5.80 inclusive	7.38

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ARIA value additional amount

Item	Column 1 ARIA value for the home's location	Column 2 Amount (\$)
4	5.81 to 7.44 inclusive	10.32
5	7.45 to 9.08 inclusive	12.38
6	9.09 to 10.54 inclusive	17.34
7	10.55 to 12 inclusive	20.83

2017 MM category additional amount

- (4) The 2017 MM category additional amount, for a day for a home or community place for an approved residential care home, means the amount specified in the following table for the 2017 MM category in which the home is located.

MM category additional amount

Item	Column 1 2017 MM category for the home's location	Column 2 Amount (\$)
1	2017 MM category known as MM 2	0.00
2	2017 MM category known as MM 3	0.00
3	2017 MM category known as MM 4	1.19
4	2017 MM category known as MM 5	2.62
5	2017 MM category known as MM 6	17.34
6	2017 MM category known as MM 7	20.83

249-40 Residential care place amount

The residential care place amount for a day for a residential care place for an approved residential care home of an approved provider is the sum of the following:

- \$148.43;
- the viability supplement equivalent amount for the home for the day under this Division;
- the amount specified in the following table for the region that the home is in.

Amounts for regions

Item	Column 1 Region	Column 2 Amount (\$)
New South Wales		
1	Central Coast	13.42
2	Central West	11.52
3	Far North Coast	12.23
4	Hunter	13.55
5	Illawarra	12.52

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Amounts for regions		
Item	Column 1 Region	Column 2 Amount (\$)
6	Inner West	13.99
7	Mid North Coast	12.82
8	Nepean	12.48
9	New England	8.26
10	Northern Sydney	8.06
11	Orana Far West	15.07
12	Riverina Murray	13.41
13	South East Sydney	13.04
14	Southern Highlands	14.12
15	South West Sydney	15.78
16	Western Sydney	12.60
Victoria		
17	Barwon South Western	8.22
18	Eastern Metro	7.43
19	Gippsland	7.80
20	Grampians	13.76
21	Hume	7.98
22	Loddon-Mallee	12.70
23	Northern Metro	12.60
24	Southern Metro	8.20
25	Western Metro	8.14
Queensland		
26	Brisbane North	12.27
27	Brisbane South	13.13
28	Cabool	13.19
29	Central West	11.52
30	Darling Downs	14.16
31	Far North	12.29
32	Fitzroy	7.20
33	Logan River Valley	14.35
34	Mackay	12.30
35	Northern	11.96
36	North West	18.00
37	South Coast	13.55
38	South West	12.30
39	Sunshine Coast	8.30
40	West Moreton	13.78
41	Wide Bay	12.57

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Amounts for regions		
Item	Column 1 Region	Column 2 Amount (\$)
Western Australia		
42	Goldfields	7.20
43	Great Southern	8.17
44	Kimberley	17.61
45	Metropolitan East	13.19
46	Metropolitan North	13.38
47	Metropolitan South East	13.48
48	Metropolitan South West	14.75
49	Mid West	16.06
50	Pilbara	17.30
51	South West	12.30
52	Wheatbelt	12.64
South Australia		
53	Eyre Peninsula	16.33
54	Hills, Mallee and Southern	14.30
55	Metropolitan East	13.19
56	Metropolitan North	13.38
57	Metropolitan South	13.48
58	Metropolitan West	14.75
59	Mid North	13.43
60	Riverland	14.91
61	South East	13.24
62	Whyalla, Flinders and Far North	13.61
63	Yorke Lower North and Barossa	14.00
Tasmania		
64	Northern	11.96
65	North Western	13.00
66	Southern	13.59
Australian Capital Territory		
67	Australian Capital Territory	13.90
Northern Territory		
68	Alice Springs	19.75
69	Barkly	22.63
70	Darwin	17.00
71	East Arnhem	22.63
72	Katherine	12.29

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Division 2 Amount of subsidy—Multi-Purpose Service Program

Section 249-45

249-45 Respite supplement equivalent amount

The respite supplement equivalent amount for an approved residential care home for a day is the amount specified in the following table for the number of residential care places for the home that are in effect on the day.

Respite supplement equivalent amount		
Item	Column 1 Number of residential care places that are in effect	Column 2 Amount (\$)
1	Less than 11	57.80
2	More than 10 but less than 21	92.48
3	More than 20 but less than 31	104.01
4	More than 30 but less than 41	115.55
5	More than 40	127.15

249-50 Viability supplement equivalent amount—Category A residential care homes

The viability supplement equivalent amount for a Category A residential care home for a day is:

- (a) if the home is located in a Statistical Local Area with a classification under the RRMA Classification mentioned in an item of the following table—the amount specified in the item in the table that relates to that classification and the number of residential care places for the home that are in effect on the day; or
- (b) if paragraph (a) does not apply—\$3.87.

Viability supplement equivalent amounts—Category A residential care homes			
Item	Column 1 Statistical Local Area classification for the home's location	Column 2 Number of residential care places for the home that are in effect	Column 3 Amount (\$)
1	Other Remote	less than 16	62.09
2	Other Remote	more than 15 but less than 30	38.18
3	Other Remote	more than 29	3.87
4	Remote Centre	less than 16	29.65
5	Remote Centre	more than 15 but less than 30	21.06
6	Remote Centre	more than 29	3.87
7	(a) Other Rural; or (b) Small Rural Centre	less than 16	12.49
8	(a) Other Rural; or (b) Small Rural Centre	more than 15 but less than 30	3.87
9	(a) Other Rural; or (b) Small Rural Centre	more than 29	3.87

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Amount of subsidy—Multi-Purpose Service Program **Division 2**

Section 249-55

249-55 Viability supplement equivalent amount—Category B residential care homes

- (1) The viability supplement equivalent amount for a Category B residential care home for a day is the amount specified in the following table for the score attained by the home on the day under the scoring system set out in the table in subsection (2).

Viability supplement equivalent amounts—Category B residential care homes		
Item	Column 1 Score	Column 2 Amount (\$)
1	40	3.87
2	50	4.32
3	60	12.49
4	70	21.06
5	80	29.65
6	90	38.18
7	100	62.09

- (2) The following table sets out the scoring system for Category B residential care homes.

Category B residential care homes—scoring		
Item	Column 1 Criterion	Column 2 Points
1	ARIA value for the home's location:	
	(a) more than 9.08 but not more than 12;	60
	(b) more than 5.8 but not more than 9.08;	50
	(c) more than 3.51 but not more than 5.8;	40
	(d) more than 1.84 but not more than 3.51;	30
	(e) 1.84 or less	0
2	Residential care places for the home that are in effect:	
	(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 individuals accessing funded aged care services in the home are diverse individuals	10

249-60 Viability supplement equivalent amount—Category C residential care homes

- (1) The viability supplement equivalent amount for a Category C residential care home for a day is the amount specified in the following table for the score attained by the home on the day under the scoring system set out in the table in subsection (2).

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Viability supplement equivalent amounts—Category C residential care homes		
Item	Column 1 Score	Column 2 Amount (\$)
1	50	9.32
2	55	13.97
3	60	20.90
4	65	25.54
5	70	37.26
6	75	46.42
7	80	57.99
8	85	69.71
9	90	81.27
10	95	90.55
11	100	102.17

- (2) The following table sets out the scoring system for Category C residential care homes.

Category C residential care homes—scoring		
Item	Column 1 Criterion	Column 2 Points
1	ARIA value for the home's location:	
	(a) more than 9.08 but not more than 12;	65
	(b) more than 5.8 but not more than 9.08;	55
	(c) more than 3.51 but not more than 5.8;	40
	(d) more than 1.84 but not more than 3.51;	30
	(e) 1.84 or less	0
2	Residential care places for the home that are in effect:	
	(a) less than 20;	30
	(b) more than 19 but less than 25;	25
	(c) more than 24 but less than 30;	20
	(d) more than 29 but less than 35;	15
	(e) more than 34 but less than 40;	10
	(f) more than 39 but less than 45	5
3	More than 50% of individuals accessing funded aged care services in the home are diverse individuals	5

249-65 Viability supplement equivalent amount—Category D residential care homes

- (1) The viability supplement equivalent amount for a Category D residential care home for a day is the amount specified in the following table for the score

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attained by the home on the day under the scoring system set out in the table in subsection (2).

Viability supplement equivalent amounts—Category D residential care homes		
Item	Column 1 Score	Column 2 Amount (\$)
1	50	9.32
2	55	13.97
3	60	20.90
4	65	25.54
5	70	37.26
6	75	46.42
7	80	57.99
8	85	69.71
9	90	81.27
10	95	90.55
11	100	102.17

- (2) The following table sets out the scoring system for Category D residential care homes.

Category D residential care homes—scoring		
Item	Column 1 Criterion	Column 2 Points
1	2017 MM category for the home's location:	
	(a) 2017 MM category known as MM 2;	0
	(b) 2017 MM category known as MM 3;	0
	(c) 2017 MM category known as MM 4;	30
	(d) 2017 MM category known as MM 5;	40
	(e) 2017 MM category known as MM 6;	55
	(f) 2017 MM category known as MM 7	65
2	Residential care places for the home that are in effect:	
	(a) less than 20;	30
	(b) more than 19 but less than 25;	25
	(c) more than 24 but less than 30;	20
	(d) more than 29 but less than 35;	15
	(e) more than 34 but less than 40;	10
	(f) more than 39 but less than 45	5
3	More than 50% of individuals accessing funded aged care services in the home are diverse individuals	5

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Part 9 Subsidy for certain specialist aged care programs

Division 3 Amount of subsidy—Transition Care Program

Section 249-90

Division 3—Amount of subsidy—Transition Care Program

249-90 Amount of subsidy

For the purposes of subsection 249(1) of the Act, the amount of subsidy a registered provider is eligible for under section 248 of the Act on a day in relation to funded aged care services delivered to an individual through a service group under the TCP on the day is \$255.47.

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Subsidy claims and payment **Part 10**

Home support, assistive technology and home modifications (other than under specialist aged care programs) **Division 1**

Section 251-5

Part 10—Subsidy claims and payment

Division 1—Home support, assistive technology and home modifications (other than under specialist aged care programs)

251-5 Relevant period—assistive technology and home modifications

Assistive technology

- (1) For the purposes of paragraph 251(2)(c) of the Act, the relevant period for ongoing funded aged care services delivered to an individual through the service group assistive technology is the account period for the notional assistive technology account established for the individual for the delivery of those services.

Home modifications

- (2) For the purposes of paragraph 251(2)(c) of the Act, the relevant period for ongoing funded aged care services delivered to an individual through the service group home modifications is the account period for the notional home modifications account established for the individual for the delivery of those services.

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Part 10 Subsidy claims and payment

Division 2 Specialist aged care programs

Section 260-5

Division 2—Specialist aged care programs

260-5 Purpose of this Division

For the purposes of subsection 260(2) of the Act, this Division prescribes requirements relating to claims for, and payment of, subsidy under subsection 260(1) of the Act.

260-10 Multi-Purpose Service Program—timing of payments

Subsidy payable under subsection 260(1) of the Act to a registered provider for a day in a quarter in relation to the delivery of funded aged care services under the MPSP is payable by the Commonwealth:

- (a) within 14 days after the start of the subsequent quarter; or
- (b) on a day in that quarter or a subsequent quarter agreed between the System Governor and the provider.

260-15 Transition Care Program—claims

For the purposes of obtaining payment of subsidy in relation to the delivery by a registered provider of funded aged care services under the TCP, the provider must, as soon as practicable after the end of each calendar month, give to the System Governor a claim, in the approved form, for subsidy that is payable to the provider under subsection 260(1) of the Act for the days in that month.

260-20 Transition Care Program—payments

- (1) This section applies to subsidy payable under subsection 260(1) of the Act to a registered provider in relation to the delivery of funded aged care services under the TCP.

Timing of payments

- (2) Subsidy payable for a day in a calendar month is payable by the Commonwealth for the month at such times as the System Governor thinks fit.

Separate payments for each service delivery branch and approved residential care home

- (3) Subsidy payable in relation to funded aged care services delivered through each service delivery branch or approved residential care home of the registered provider is separately payable by the Commonwealth.

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Funding of aged care services—Commonwealth contributions **Chapter 7**
Subsidy claims and payment **Part 10**
Miscellaneous provisions **Division 3**

Section 262-5

Division 3—Miscellaneous provisions

Subdivision A—Multiple claims

262-5 Multiple claims

- (1) This section is made for the purposes of subsection 262(4) of the Act.
- (2) This section applies if the System Governor is given for a day for an individual, by one or more registered providers:
 - (a) a claim for subsidy for a classification type for a service group (the **initial claim**); and
 - (b) either or both of the following (a **subsequent claim**):
 - (i) a claim for subsidy for any other classification type for the service group;
 - (ii) a claim for any classification type for another service group.
- (3) The following table sets out the circumstances in which, if the System Governor accepts the initial claim, the System-Governor must accept a subsequent claim.

Multiple claims

Item	Column 1 If the initial claim is for subsidy for the classification type ...	Column 2 for the service group ...	Column 3 the System Governor must accept a subsequent claim for subsidy if ...
1	Ongoing	Residential care	the subsequent claim is for the individual's start day at an approved residential care home, for any of the following: (a) the classification type ongoing or short-term for the service group home support; (b) the classification type ongoing or short-term for the service group assistive technology; (c) the classification type short-term for the service group home modifications; (d) the classification type hospital transition for any service group, if the individual is on hospital transition leave or extended hospital leave on that day
2	Short-term	Residential care	the subsequent claim is for any of the following: (a) the classification type ongoing or short-term for the service group home support; (b) the classification type ongoing or short-term for the service group assistive technology; (c) the classification type short-term for the service group home modifications

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Part 10 Subsidy claims and payment

Division 3 Miscellaneous provisions

Section 262-5

Multiple claims			
Item	Column 1 If the initial claim is for subsidy for the classification type ...	Column 2 for the service group ...	Column 3 the System Governor must accept a subsequent claim for subsidy if ...
3	Ongoing	Home support	the subsequent claim is: (a) for the classification type short-term for the service group home support, if the individual's classification level for the classification type is SAH restorative care pathway; or (b) for the classification type ongoing or short-term for the service group assistive technology; or (c) for the classification type short-term for the service group home modifications; or (d) for the individual's start day at an approved residential care home, for the classification type ongoing for the service group residential care; or (e) for the classification type short-term for the service group residential care
4	Short-term	Home support	the subsequent claim is: (a) for the classification type ongoing for the service group home support, if the individual's classification level for the classification type short-term for the service group home support is SAH restorative care pathway; or (b) for the classification type ongoing or short-term for the service group assistive technology; or (c) for the classification type short-term for the service group home modifications; or (d) for the individual's start day at an approved residential care home, for the classification type ongoing for the service group residential care; or (e) for the classification type short-term for the service group residential care
5	Ongoing	Assistive technology	the subsequent claim is: (a) for the classification type ongoing or short-term for the service group home support; or (b) for the classification type short-term for the service group assistive technology; or (c) for the classification type short-term for the service group home modifications; or (d) for the individual's start day at an approved residential care home, for the classification type ongoing for the service group residential care; or (e) for the classification type short-term for the service group residential care; or

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Multiple claims

Item	Column 1 If the initial claim is for subsidy for the classification type ...	Column 2 for the service group ...	Column 3 the System Governor must accept a subsequent claim for subsidy if ...
			(f) for the classification type hospital transition for any service group
6	Short-term	Assistive technology	the subsequent claim is: (a) for the classification type ongoing or short-term for the service group home support; or (b) for the classification type ongoing for the service group assistive technology; or (c) for the classification type short-term for the service group home modifications; or (d) for the individual's start day at an approved residential care home, for the classification type ongoing for the service group residential care; or (e) for the classification type short-term for the service group residential care; or (f) for the classification type hospital transition for any service group
7	Short-term	Home modifications	the subsequent claim is: (a) for the classification type ongoing or short-term for the service group home support; or (b) for the classification type ongoing or short-term for the service group assistive technology; or (c) for the individual's start day at an approved residential care home, for the classification type ongoing for the service group residential care; or (d) for the classification type short-term for the service group residential care; or (e) for the classification type hospital transition for any service group

Subdivision B—Transfers of service delivery branches

263-5 Purpose of this Subdivision

For the purposes of paragraph 263(1)(a) of the Act, this Subdivision makes provision for, and in relation to, the transfer of a service delivery branch of a registered provider to another registered provider.

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263-10 Application for approval to transfer service delivery branch

Application for approval

- (1) A registered provider (the **proposed transferor**) may apply, in the approved form, to the System Governor for approval to transfer a service delivery branch of the proposed transferor to another registered provider (the **proposed transferee**) at least 60 days before the day proposed in the application for the transfer of the service delivery branch.
- (2) The System Governor must:
 - (a) consider an application made in accordance with subsection (1) and any further information given in accordance with a request under section 588 of the Act; and
 - (b) make a decision on the application within 28 days of receiving the application.

Note: For the consequence of not giving any requested further information in the requested time, and the extension of the decision-making period if requested information is given in the requested time, see section 588 of the Act.

Notice of decision

- (3) The System Governor must give notice of the System Governor's decision to the proposed transferor and the proposed transferee.
- (4) The notice under subsection (3) must:
 - (a) be given as soon as practicable after the System Governor makes the decision; and
 - (b) if the System Governor decides not to approve the transfer of the service delivery branch—include the reasons for the decision and how the proposed transferor or the proposed transferee may apply for reconsideration of the decision.

263-15 Transfer of service delivery branch

- (1) This section applies if the System Governor approves the transfer of a service delivery branch of a registered provider (the **transferor**) to another registered provider (the **transferee**).

Claims for subsidy for days before transfer day

- (2) The transferor must take all reasonable steps to ensure that, before the day (the **transfer day**) the transfer takes effect, the transferor has given to the System Governor claims under section 251 of the Act for subsidy payable to the transferor under section 250 of the Act for days before the transfer day.

Home support—transfer of balance of transferor's service delivery account for the branch

- (3) At the end of 60 days after the end of the period mentioned in subsection 251(3) of the Act for the last relevant period in which the transferor delivered funded aged care services to individuals through the service group home support through

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the service delivery branch, the available balance of the notional service delivery account for the transferor in relation to the branch is credited to the notional service delivery account for the transferee in relation to the branch.

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Part 11 Grants [to be drafted]

Section 263-15

Part 11—Grants [to be drafted]

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**Chapter 8—Funding of aged care services—
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Part 1—Introduction

272-5 Simplified outline of this Chapter

[to be drafted]

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Part 2—Individual fees and contributions

Division 1—Fees and contributions payable in a home or community setting

Subdivision A—Individual contributions

273-5 Working out individual contribution for assistive technology or home modifications—prescribed day

For the purposes of paragraph (b) of Step 1 of the method statement in subsection 273(2) of the Act (for working out the individual contribution for the delivery of a funded aged care service to an individual on a day), the day the individual agreed to the delivery of the service is prescribed.

273-10 Working out individual contributions—circumstances and amounts

For the purposes of paragraph (b) of Step 3 of the method statement in subsection 273(2) of the Act (for working out the individual contribution for the delivery of a funded aged care service to an individual on a day), the following table sets out circumstances and amounts for those circumstances.

Amounts used to work out individual contributions in certain circumstances

Column 1		Column 2
Item	For the following circumstances ...	the amount is ...
1	(a) the funded aged care service is any of the following (which involve the sourcing and supply to the individual of products listed in the AT-HM List): (i) managing body functions; (ii) self-care products; (iii) mobility products; (iv) domestic life products; (v) communication and information management products; (vi) home modification products; and (b) the individual has an access approval in effect for, and the service is delivered to the individual through, the classification type ongoing or short-term for the service group assistive technology or home modifications	the amount of the cost of the products listed in the AT-HM List that are supplied to the individual
2	(a) a classification decision establishing the classification level HM High in a classification type for the service group home modifications is in effect for the individual; and (b) the service is delivered to the individual through that classification type for the service group; and (c) the individual resides at a street address, or in a suburb or locality, that is in the 2019 MM category known as MM 6 or 7	the amount that is 66.6% of the cost of the service

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273-15 Requirements for prices charged

For the purposes of subsection 273(4) of the Act, the requirements for the price charged by a registered provider to an individual for the delivery of a funded aged care service are that:

- (a) if the subsidy basis for the service is efficient price or unit price—the price charged by the registered provider must not exceed the final efficient price for the service; and
- (b) if the individual directly sourced the delivery of the service at a particular price from an associated provider of the registered provider—the price charged by the registered provider must not exceed 110% of that particular price.

Commented [A12]: The term “directly sourced” needs to be clarified here or in supporting guidance material.

273-20 When individual contribution is zero—other contributions or fees

For the purposes of paragraph 273(5)(c) of the Act, for an individual who was approved as a recipient of aged care under the old Act, the following contributions and fees are prescribed:

- (a) the means tested care fees (within the meaning of section 52C-3(3) of the old Act) (if any) for the individual under the old Act;
- (b) the income tested care fees (within the meaning of subsection 52D-2(3) of the old Act) (if any) for the individual under the old Act;
- (c) for an individual in the post-2014 home contribution class or the post-2014 residential contribution class—the means tested care fees for the individual.

Subdivision B—Unspent care recipient portions

273A-5 Unspent care recipient portions

For the purposes of subsection 273A(2) of the Act, this Subdivision prescribes requirements relating to unspent care recipient portions.

273A-10 Agreement with individual

A registered provider that holds an unspent care recipient portion for an individual must, within 70 days after the transition time, agree in writing one of the following with the individual:

- (a) that the provider will return the portion to the individual;
- (b) that the provider will retain the portion and will deal with the portion in accordance with this Subdivision.

273A-15 If agreement is to return portion

If the provider agrees that the provider will return the portion to the individual, the provider must:

- (a) return the portion to the individual within 14 days after the day the agreement is made; or

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- (b) if the individual dies on or after the day the agreement is made and before the provider returns the portion to the individual—return the portion to the individual’s estate within 14 days after the provider is shown the probate of the individual’s will or letters of administration of the individual’s estate.

273A-20 If agreement is to retain portion

If the provider agrees with the individual as mentioned in paragraph 273A-10(b) of this instrument, the provider must:

- (a) reduce (but not below zero) the amount of the portion by the individual contributions charged to the individual by the provider under section 273 of the Act; and
- (b) if the provider ceases to deliver funded aged care services to the individual and the balance of the portion is not zero:
 - (i) if the cessation of delivery of services is because the individual dies—pay the balance of the portion to the individual’s estate within 14 days after the provider is shown the probate of the individual’s will or letters of administration of the individual’s estate; or
 - (ii) otherwise—pay the balance of the portion to the individual within 70 days after the cessation of delivery of services.

Note: For obligations relating to providing information about unspent care recipient portions, see [rules to be drafted under section 149 of the Act (starting and ceasing the provision of funded aged care services and continuity of those services) and section 155 of the Act (provision of information to individuals)].

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Subdivision A—Contributions for delivery of funded aged care services—ongoing residential care

276-5 Resident contribution—amounts for working out maximum

For the purposes of paragraph 276(2)(b) of the Act, the amounts are the following:

- (a) the amount of any extra service fee charged under section 285-15 of this instrument;
- (b) the amount of any additional service fee charged under section 285-20 of this instrument.

Subdivision B—Maximum daily amount of resident contribution

277-5 Basic daily fee

For the purposes of paragraph 277(2)(a) of the Act, the basic daily fee is:

- (a) for an individual in the pre-2014 residential contribution class:
 - (i) if the individual was a protected resident within the meaning of the *Aged Care (Transitional Provisions) Act 1997* immediately before the transition time—the amount obtained by rounding down to the nearest cent an amount equal to 77.5% of the basic age pension amount (worked out on a per day basis); or
 - (ii) if section 58-3C of the *Aged Care (Transitional Provisions) Act 1997* applied to the individual immediately before the transition time—the amount obtained by rounding down to the nearest cent an amount equal to 96.5% of the basic age pension amount (worked out on a per day basis); or
- (b) for any other individual—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis).

277-10 Maximum daily amount—individuals in pre-2014 residential contribution class

For the purposes of subsection 277(4) of the Act, the maximum daily amount of the resident contribution for an individual in the pre-2014 residential contribution class is worked out as follows:

- Step 1. Work out the basic daily fee for the individual.
- Step 2. Add the compensation payment fee for the individual for the day.
- Step 3. Add the income tested fee for the individual for the day.

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277-15 Maximum daily amount—individuals in post-2014 home contribution class or post-2014 residential contribution class

For the purposes of subsection 277(4) of the Act, the maximum daily amount of the resident contribution for an individual in the post-2014 home contribution class or the post-2014 residential contribution class is worked out as follows:

- | |
|--|
| <p>Step 1. Work out the basic daily fee for the individual.</p> <p>Step 2. Add the compensation payment fee for the individual for the day.</p> <p>Step 3. Add the means tested care fee for the individual for the day.</p> |
|--|

277-20 Amounts to be reduced—individuals in pre-2014 residential contribution class

For the purposes of paragraph 277(5)(b) of the Act, the amounts for an individual in the pre-2014 residential contribution class are:

- (a) the basic daily fee for the individual; and
- (b) the income tested fee for the individual.

277-25 Amounts to be reduced—individuals in post-2014 home contribution class or post-2014 residential contribution class

For the purposes of paragraph 277(5)(b) of the Act, the amounts for an individual in the post-2014 home contribution class or the post-2014 residential contribution class are:

- (a) the basic daily fee for the individual; and
- (b) the means tested care fee for the individual.

Subdivision C—Hotelling contribution and non-clinical care contribution

278-5 Classes of individuals to which hotelling contribution does not apply

For the purposes of subsection 278(3) of the Act, the classes are:

- (a) the pre-2014 residential contribution class; and
- (b) the post-2014 home contribution class; and
- (c) the post-2014 residential contribution class.

279-5 Maximum non-clinical care contribution

For the purposes of subsection 279(3) of the Act, the amount is \$101.16.

279-10 When non-clinical care contribution is zero—number of days

For the purposes of subsection 279(4) of the Act, the number of days is 1,460.

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279-15 When non-clinical care contribution is zero—other contributions or fees

For the purposes of paragraph 279(5)(c) of the Act, for an individual who was approved as a recipient of aged care under the old Act, the following contributions and fees are prescribed:

- (a) the means tested care fees (within the meaning of section 52C-3(3) of the old Act) (if any) for the individual under the old Act;
- (b) the income tested care fees (within the meaning of subsection 52D-2(3) of the old Act) (if any) for the individual under the old Act;
- (c) for an individual in the post-2014 home contribution class or the post-2014 residential contribution class—the means tested care fees (if any) for the individual.

279-20 Classes of individuals to which non-clinical care contribution does not apply

For the purposes of subsection 279(6) of the Act, the classes are:

- (a) the pre-2014 residential contribution class; and
- (b) the post-2014 home contribution class; and
- (c) the post-2014 residential contribution class.

280-5 Hotelling contribution and non-clinical care contribution taken to be zero in some circumstances—classes of individuals

For the purposes of paragraph 280(1)(b) of the Act:

- (a) a class of individuals for whom the hotelling contribution is taken to be zero for a day is individuals for whom the hotelling contribution for the day is less than \$1; and
- (b) a class of individuals for whom the non-clinical care contribution is taken to be zero for a day is individuals for whom the non-clinical care contribution for the day is less than \$1; and
- (c) the classes of individuals for whom both the hotelling contribution and non-clinical care contribution are taken to be zero for a day are the following:
 - (i) individuals who cease accessing funded aged care services in an approved residential care home, without starting to access funded aged care services in another approved residential care home, before the registered provider of the home has been informed of the individual's hotelling contribution and non-clinical care contribution;
 - (ii) individuals who start accessing funded aged care services in an approved residential care home, but who die before the registered provider of the home has been informed of the individual's hotelling contribution and non-clinical care contribution;
 - (iii) individuals whose start day was more than 6 months before the day they are informed of their daily means tested amount;
 - (iv) individuals who have one or more dependent children;
 - (v) individuals who are described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war).

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281-5 Fees for pre-entry period—ongoing residential care—maximum amount of pre-entry fee chargeable

For the purposes of paragraph 281(4)(a) of the Act, the amount for a day for an individual is the basic daily fee for the individual.

Subdivision D—Fees for reserving a bed—ongoing residential care

282-5 Maximum amount of bed reservation fee chargeable

- (1) For the purposes of subsection 282(3) of the Act, subsection (2) prescribes the maximum amount of the bed reservation fee that a registered provider delivering ongoing funded aged care services through the service group residential care to an individual in an approved residential care home may charge the individual under section 282 of the Act for a day.
- (2) The amount is the sum of the following amounts, calculated as if the registered provider delivered an ongoing funded aged care service to the individual through that service group in that approved residential care home on the day:
 - (a) the maximum daily amount of the resident contribution that would have been payable by the individual for the day;
 - (b) the standard base provider amount for a day for the individual.

Subdivision E—Fees for delivery of funded aged care services—short-term residential care

283-10 Resident respite fee—amounts for working out maximum

For the purposes of paragraph 283(2)(b) of the Act, the other amounts are:

- (a) the amount of any extra service fee charged under section 285-15 of this instrument;
- (b) the amount of any additional service fee charged under section 285-20 of this instrument.

Subdivision F—Fees for delivery of funded aged care services—short-term residential care

283-15 Booking fee

Purpose

- (1) For the purposes of subsection 283(4) of the Act, this section makes provision in relation to the charging of a booking fee by a registered provider for or in connection with the delivery of short-term funded aged care services through the service group residential care to an individual for a period (the **respite period**).

Maximum amount of booking fee

- (2) The booking fee must not exceed the lesser of:

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- (a) the total of the resident respite fees that the provider would charge the individual for or in connection with those services for a period of 7 days; and
- (b) 25% of the total of the resident respite fees that the provider will charge the individual for the days in the respite period.

When booking fee must be refunded in full

- (3) The provider must refund the whole of the booking fee if any of the following events occur:
 - (a) the individual enters hospital before the respite period;
 - (b) the individual dies before the respite period;
 - (c) the individual cancels the booking for the respite period more than 7 days before the start of the respite period.

When booking fee must be refunded in part

- (4) The provider must refund the part of the booking fee referred to in subsection (5) if, during the lesser of the following (the **booking fee period**):
 - (a) the first 7 days of the respite period;
 - (b) the first 25% of the respite period;any of the following events occur:
 - (c) the individual enters hospital;
 - (d) the individual dies;
 - (e) the provider requires the individual to leave the approved residential care home in which the services are being delivered.
- (5) For the purposes of subsection (4), the part of the booking fee required to be refunded is the amount equal to the proportion of the booking fee that corresponds to the proportion of the booking fee period that remains after the event occurs.
- (6) The provider must pay a refund required by subsection (3) or (4):
 - (a) if the individual has died:
 - (i) if, within 14 days after the provider becomes aware of the individual's death, the provider is shown the probate of the will of the individual or letters of administration of the estate of the individual—to the individual's estate within 14 days after the day on which the provider was so shown; or
 - (ii) if subparagraph (i) does not apply—to a person that the provider is reasonably satisfied that it is appropriate to pay the refund to within 28 days after the provider becomes aware of the individual's death; or
 - (b) otherwise—to the individual within 14 days after the later of:
 - (i) the day the event mentioned in subsection (3) or (4) (as applicable) occurs; and
 - (ii) the day the provider becomes aware of the event.

Commented [A13]: This reflects the current Act however it needs to be made clear that respite will automatically end if the resident goes to hospital. If a provider is required to refund the booking fee (and not charge any fees or receive subsidy), the provider should not be required to "hold the bed".

Commented [A14]: What if the provider knows the person has died, but cannot find someone "that the provider is reasonably satisfied that it is appropriate to pay the refund to within 28 days"? Or, there are competing claims from family? There should be a fallback that applies in this situation.

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When booking fee is not required to be refunded in whole or in part

- (7) The provider is not required to refund the booking fee (in whole or in part) if:
- (a) the booking for the respite period is cancelled within 7 days before the start of the period for a reason other than that the individual enters hospital or dies; or
 - (b) the individual chooses to leave the approved residential care home in which the services are being delivered before the end of the respite period.

Subdivision G—Fees for higher everyday living

284-5 Requirements for entering into higher everyday living agreements

- (1) For the purposes of paragraph 284(2)(a) of the Act, this section prescribes requirements for entering into a higher everyday living agreement.

Fees for services must be for services at a higher standard

- (2) A registered provider and an individual must not enter into a higher everyday living agreement that contains an agreed amount for a funded aged care service unless the agreement requires the provider to deliver the service to the individual at a standard, specified in the agreement, that is higher than the standard that the Act requires the service to be delivered at.

Fees in connection with services must be for additional connected services

- (3) A registered provider and an individual must not enter into a higher everyday living agreement that contains an agreed amount in connection with a funded aged care service unless the agreement requires the provider to deliver an additional service, specified in the agreement, that is connected to the funded aged care service, to the individual.

Information to be provided before entering into agreement

- (4) A registered provider and an individual must not enter into a higher everyday living agreement unless, before the agreement is entered into, the provider gave the individual the following:
- (a) the higher everyday living fee fact sheet published by the Department;
 - (b) a list of all the funded aged care services for which the provider charges higher everyday living fees and the standards at which the provider delivers those services;
 - (c) a list of all the funded aged care services in connection with which the provider charges higher everyday living fees and the additional services that the provider delivers in connection with those funded aged care services;
 - (d) information about how the provider bundles the charging of those higher everyday living fees (if applicable).

Commented [A15]: It should be made clear what services are everyday living services that are covered by the requirements in this Subdivision. For example is it intended to apply to all funded aged care services or only the services defined as “Residential everyday living” items (section 58 items 1-9).

Commented [A16]: It is vague and unclear what is the “standard that the Act requires”. Where is that specified? Is it the Aged Care Quality Standards? It is very difficult to set and describe a higher standard when the base standard expected to be delivered is not defined in the legislation. The uncertainty is amplified by the fact sheet which includes statements not aligned to the rules - for example, it describes the higher everyday living fee as “... an optional fee charged for additional goods and services not otherwise required to be provided under the Aged Care Rules (the Rules) and in line with the Aged Care Quality Standards. This enables the resident to tailor additional goods and services to suit them. The goods and services must be of a quality significantly higher than what is required by the Rules.” Where does the requirement for a “significantly higher” quality derive from?

Commented [A17]: Is “additional connected services” any item that is not an everyday living item? Or is it any item that is not on the service list that is provided by the registered provider for a fee?

Commented [A18]: Can the higher everyday living fee agreement be included in the standard residential care agreement to be activated after commencement, if the individual wants the services?

Commented [A19]: The fact sheet published on 20 December 2024 contains a number of statements that are inconsistent with the Aged Care Act and the rules - we provided feedback on the fact sheet separately to the Department on 17 February 2025.

Commented [A20]: Is the difference here that one is a higher standard of service that is explicitly listed on the service list and the second is a service that is connected to a listed service but is not explicitly listed?

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284-10 Requirements that higher everyday living agreements must comply with

- (1) For the purposes of paragraph 284(2)(b) of the Act, this section prescribes requirements that a higher everyday living agreement must comply with.

General

- (2) The agreement must be expressed in plain language and be readily understandable by the individual.

Agreed amounts

- (3) The agreement must:
- (a) specify each agreed amount, the funded aged care service that it is charged for or in connection with, and the frequency at which it is charged; and
 - (b) for an agreed amount for a funded aged care service—specify the standard at which the provider must deliver the service; and
 - (c) for an agreed amount in connection with a funded aged care service—specify the additional service, connected to the funded aged care service, that the provider must deliver; and
 - (d) state that the agreed amounts are subject to indexation in accordance with section 284-15 of this instrument; and
 - (e) require the provider to notify the individual of the replacement agreed amounts as soon as practicable after each indexation day (within the meaning of section 284-15 of this instrument); and
 - (f) state that the agreed amounts will not be charged, and the services will not be delivered at the specified standard or the additional services will not be delivered (as applicable), in the circumstances referred to in section 284-20 of this instrument.

Variation and termination—general

- (4) The agreement must provide that:
- (a) the individual may vary or terminate the agreement within 28 days after the agreement is entered into without giving notice to the provider and without the provider charging a fee for the termination; and
 - (b) the individual or the provider may vary or terminate the agreement with 28 days' notice to the other party, and without the provider charging a fee for the variation or termination, at any time after the end of 28 days after the agreement is entered into; and
 - (c) if the agreement is terminated, the provider must, within 14 days after the agreement is terminated, refund to the individual any agreed amounts paid in advance in respect of a period after the agreement is terminated; and
 - (d) if the agreement is varied in a way that reduces any of the agreed amounts, the provider must, within 14 days after the agreement is varied, refund to the individual the amount of the reductions in the agreed amounts paid in advance in respect of a period after the agreement is varied.

Commented [A21]: There should be some form of communication of the termination or change. It should be clear that the variation cannot be a unilateral binding variation.

Commented [A22]: Is it intended that any variation is subject to consent? It would be unusual that a party can vary an agreement without consent to the terms of the variation.

Commented [A23]: Flexibility should be available for refunds to offset future payments or other amounts owed (e.g. daily accommodation payments, resident contributions).

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Variation and termination—provider can no longer deliver a service at the specified standard

- (5) The agreement must provide that, if the provider can no longer deliver a funded aged care service at the specified standard:
- (a) the individual may terminate the agreement without giving notice to the provider and without the provider charging a fee for the termination; or
 - (b) the individual and provider may agree to vary the agreement to remove the service and the agreed amount for the service; or
 - (c) the individual and provider may agree to vary the agreement to specify a different standard at which the provider must deliver the service (which must still be a standard that is higher than the standard that the Act requires the service to be delivered at), and specify a different agreed amount for the service.

Commented [A24]: Is it intended that this provision applies only to agreements for the delivery of a single service? It does not appear fit for purpose in relation to bundled services.

Variation and termination—provider can no longer deliver additional service

- (6) The agreement must provide that, if the provider can no longer deliver an additional service, connected to a funded aged care service:
- (a) the individual may terminate the agreement without giving notice to the provider and without the provider charging a fee for the termination; or
 - (b) the individual and provider may agree to vary the agreement to remove the additional service and the agreed amount in connection with the funded aged care service; or
 - (c) the individual and provider may agree to vary the agreement to specify a different additional service, and specify a different agreed amount in connection with the funded aged care service.

Commented [A25]: Is it intended that this provision applies only to agreements for the delivery of a single service? It does not appear fit for purpose in relation to bundled services.

Refunds relating to termination or variation referred to in subsection (5) or (6)

- (7) The agreement must provide that:
- (a) if the individual terminates the agreement as mentioned in paragraph (5)(a) or (6)(a), the provider must, within 14 days after the agreement is terminated, refund to the individual any agreed amounts paid in advance in respect of a period after the agreement is terminated; and
 - (b) if the agreement is varied as mentioned in paragraph (5)(b) or (6)(b) to remove an agreed amount, the provider must, within 14 days after the agreement is varied, refund to the individual any amount of the removed agreed amount paid in advance in respect of a period after the agreement is varied; and
 - (c) if the agreement is varied as mentioned in paragraph (5)(c) or (6)(c) in a way that reduces an agreed amount, the provider must, within 14 days after the agreement is varied, refund to the individual the amount of any reductions in the agreed amount paid in advance in respect of a period after the agreement is varied.

CONSULTATION DRAFT

Funding of aged care services—individual fees and contributions **Chapter 8**
Individual fees and contributions **Part 2**
Fees and contributions payable in an approved residential care home **Division 2**

Section 284-15

Annual review—individuals accessing ongoing funded aged care services

- (8) If the provider is delivering ongoing funded aged care services to the individual, the agreement must provide for an annual review of the funded aged care services for or in connection with which agreed amounts are charged.

Term of agreements—individuals accessing short-term funded aged care services

- (9) If the provider is delivering short-term funded aged care services to the individual, the agreement must provide that the term of the agreement is the period for which the provider delivers those services to the individual.

Commented [A26]: It is unclear whether this applies only to agreements to provide everyday living services at an additional cost for a higher standard, or to any listed services delivered at a higher standard for fee, or any non-listed services provided.

284-15 Indexation of agreed amounts

- (1) For the purposes of subsection 284(3) of the Act, if the indexation factor on 1 July 2026 or a later 1 July (an **indexation day**) is greater than 1, an agreed amount specified in a higher everyday living agreement is replaced by the amount worked out using the following formula:

Agreed amount immediately before the indexation day $\times$ Indexation factor for the indexation day

- (2) The amount worked out under subsection (1) is to be rounded to the nearest whole dollar (rounding 50 cents upwards).

Indexation factor

- (3) The **indexation factor** for an indexation day is the number worked out using the following formula:

$$\frac{\text{Index number for the reference quarter}}{\text{Index number for the base quarter}}$$

where:

base quarter means the March quarter that has the highest index number of the March quarters before the reference quarter (but not earlier than the March quarter 2025).

index number, for a quarter, means the All Groups Consumer Price Index number (being the weighted average of the 8 capital cities) published by the Australian Statistician for that quarter.

March quarter means a period of 3 months starting on 1 January.

reference quarter means the last March quarter before the indexation day.

- (4) The indexation factor is to be worked out to 3 decimal places (rounding up if the fourth decimal place is 5 or more).

CONSULTATION DRAFT

Chapter 8 Funding of aged care services—individual fees and contributions

Part 2 Individual fees and contributions

Division 2 Fees and contributions payable in an approved residential care home

Section 284-20

Changes to CPI index reference period and publication of substituted index numbers

- (5) Amounts are to be worked out under this section:
- (a) using only the index numbers published in terms of the most recently published index reference period for the Consumer Price Index; and
 - (b) disregarding index numbers published in substitution for previously published index numbers (except where the substitution is to transition to a new index reference period).

Application of replacement agreed amounts—services delivered on or after indexation day

- (6) If an agreed amount for or in connection with a funded aged care service is replaced on an indexation day in accordance with subsection (1), the replacement agreed amount applies to delivery of the funded aged care service on or after the indexation day.

284-20 Circumstances in which higher everyday living fee not to be charged to individuals

For the purposes of paragraph 284(6)(a) of the Act:

- (a) each of the following are circumstances in which a registered provider must not charge the individual a higher everyday living fee:
 - (i) the fee reduction supplement under section 231 of the Act applies to the individual;
 - (ii) the individual has applied for a decision under section 231-15 of this instrument;
 - (iii) the fee is not agreed between the provider and the individual in a higher everyday living agreement that is in effect; and
- (b) each of the following are circumstances in which a registered provider must not charge the individual a higher everyday living fee for or in connection with a particular aged care service:
 - (i) the individual is not able to use the service;
 - (ii) the provider charges the individual an extra service fee for or in connection with the service;
 - (iii) the provider charges the individual an additional service fee for or in connection with the service.

Commented [A27]: Does this mean that a registered provider cannot charge a higher everyday living fee for a higher everyday living service delivered to a low means or partially low means client? Even if the individual has agreed to pay the higher everyday living fee, or if a third party has agreed to pay the higher everyday living fee for the individual? Also it needs to be made clear that a registered provider is not required to provide higher everyday living services or additional services when a higher everyday living fee cannot be charged.

Commented [A28]: How will the provider know if the individual has applied?

284-25 Circumstances in which higher everyday living agreement not to be entered into with individuals

For the purposes of paragraph 284(6)(b) of the Act, each of the following are circumstances in which a registered provider must not enter into a higher everyday living agreement with an individual:

- (a) the fee reduction supplement under section 231 of the Act applies to the individual;
- (b) the individual has applied for a decision under section 231-15 of this instrument.

CONSULTATION DRAFT

Funding of aged care services—individual fees and contributions **Chapter 8**
Individual fees and contributions **Part 2**
Fees and contributions payable in an approved residential care home **Division 2**

Section 285-5

Subdivision H—Other matters

285-5 Refund of amounts paid in advance if individual dies or stops accessing services

For the purposes of subsection 285(3) of the Act, if an individual dies or stops accessing funded aged care services, and has paid an amount that the individual may be charged under Division 2 of Part 3 of Chapter 4 of the Act in advance for a day occurring after the individual dies or stops accessing those services, the registered provider to whom the individual paid the amount must refund the amount:

- (a) if the individual has died:
 - (i) if, within 14 days after the provider becomes aware of the individual's death, the provider is shown the probate of the will of the individual or letters of administration of the estate of the individual—to the individual's estate within 14 days after the day on which the provider was so shown; or

(ii) if subparagraph (i) does not apply—to a person that the provider is reasonably satisfied that it is appropriate to pay the refund to within 28 days after the provider becomes aware of the individual's death; or

- (b) otherwise—to the individual within 14 days after the individual stops accessing those services.

Commented [A29]: As above, what happens if the provider can't find a person to refund to within 28 days or there are competing claims etc.

285-10 Resident respite fees to be reduced by booking fee

For the purposes of subsection 285(4) of the Act, if a registered provider charges an individual a booking fee for or in connection with the delivery of short-term funded aged care services through the service group residential care to the individual for a period (the **respite period**), the total amount of the resident respite fees charged by the provider to the individual for the days in the respite period must be reduced by the amount of the booking fee.

285-15 Extra service fees

- (1) This section applies in relation to a registered provider and an individual if:
 - (a) the registered provider is delivering funded aged care services to the individual in an approved residential care home; and
 - (b) immediately before the transition time, under the old Act, an extra service agreement was in force between the individual and the provider that was entered into in accordance with section 36-2 of the old Act and that met the requirements of section 36-3 of the old Act.
- (2) The registered provider may charge the individual an extra service fee in accordance with this section.
- (3) The extra service fee may be charged only for days in the period of 12 months beginning at the transition time.
- (4) The amount of the extra service fee may be no more than the amount of the extra service fee under the old Act immediately before the transition time.

Commented [A30]: These arrangements should be grandfathered

Commented [A31]: Should be deleted as the arrangements that were entered into may have allowed for an increase in fees after 30 June 2025

CONSULTATION DRAFT

Chapter 8 Funding of aged care services—individual fees and contributions

Part 2 Individual fees and contributions

Division 2 Fees and contributions payable in an approved residential care home

Section 285-20

285-20 Additional service fees

- (1) This section applies in relation to a registered provider and an individual if:
 - (a) the registered provider is delivering funded aged care services to the individual in an approved residential care home; and
 - (b) immediately before the transition time, under the old Act:
 - (i) the registered provider was an approved provider in respect of residential care; and
 - (ii) the individual was approved as a recipient of residential care; and
 - (iii) the provider was providing residential care to the individual through a residential care service; and
 - (iv) an agreement for charging an amount for other care or services (as mentioned in paragraph 56-1(e) of the old Act) was in effect between the provider and the individual.
- (2) The registered provider may charge the individual an additional service fee in accordance with this section.
- (3) The additional service fee may be charged only for days in the period of 12 months beginning at the transition time.
- (4) The amount of the additional service fee may be no more than the amount agreed as mentioned in subparagraph (1)(b)(iv) immediately before the transition time.

Commented [A32]: These arrangements should be grandfathered

Commented [A33]: Should be deleted as the arrangements that were entered into may have allowed for an increase in fees after 30 June 2025

CONSULTATION DRAFT

Funding of aged care services—individual fees and contributions **Chapter 8**

Individual fees and contributions **Part 2**

Fees and contributions for specialist aged care programs **Division 3**

Section 286-5

Division 3—Fees and contributions for specialist aged care programs

286-5 Fees and contributions for delivery of funded aged care services

For the purposes of subsections 286(1), (4) and (5) of the Act, this Division makes provision for:

- (a) the amounts that a registered provider delivering funded aged care services through a service group under a specialist aged care program to an individual may charge the individual; and
- (b) refunds of amounts paid in advance if the individual dies or stops accessing funded aged care services; and
- (c) other requirements relating to amounts that may be charged under section 286 of the Act.

286-10 Amounts that may be charged—specialist aged care program fee (for programs other than CHSP)

- (1) A registered provider delivering funded aged care services through a service group under a specialist aged care program other than the CHSP on a day to an individual may charge the individual an amount (the ***specialist aged care program fee***) for or in connection with those services.
- (2) Subject to subsection (3), the specialist aged care program fee for an individual for a day is the amount agreed between the registered provider and the individual in a written agreement.
- (3) The specialist aged care program fee for an individual for a day must not exceed:
 - (a) if the funded aged care services are delivered through the residential care service group—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis); or
 - (b) if the funded aged care services are delivered through the home support, assistive technology or home modifications service group—the amount obtained by rounding down to the nearest cent the amount equal to 17.5% of the basic age pension amount (worked out on a per day basis).

286-15 Amounts that may be charged—CHSP contribution (for CHSP only)

- (1) A registered provider delivering funded aged care services through a service group under the CHSP on a day to an individual may charge the individual an amount (the ***CHSP contribution***) for or in connection with those services.
- (2) The CHSP contribution for the delivery of the funded aged care service to the individual on the day is the amount agreed between the registered provider and the individual in a written agreement.
- (3) The written agreement must include how and when CHSP contributions are to be paid.

CONSULTATION DRAFT

Chapter 8 Funding of aged care services—individual fees and contributions

Part 2 Individual fees and contributions

Division 3 Fees and contributions for specialist aged care programs

Section 285-17

285-17 Refund of amounts paid in advance if individual dies or stops accessing services

If an individual dies or stops accessing funded aged care services, and has paid an amount that the individual may be charged under section 286 of the Act in advance for a day occurring after the individual dies or stops accessing those services, the registered provider to whom the individual paid the amount must refund the amount:

- (a) if the individual has died:
 - (i) if, within 14 days after the provider becomes aware of the individual's death, the provider is shown the probate of the will of the individual or letters of administration of the estate of the individual—to the individual's estate within 14 days after the day on which the provider was so shown; or
 - (ii) if subparagraph (i) does not apply—to a person that the provider is reasonably satisfied that it is appropriate to pay the refund to within 28 days after the provider becomes aware of the individual's death; or
- (b) otherwise—to the individual within 14 days after the individual stops accessing those services.

286-20 Other requirements—financial hardship policy

- (1) A registered provider delivering funded aged care services through a service group under a specialist aged care program must have a financial hardship policy that covers the following:
 - (a) how an individual can apply for a waiver or reduction of the specialist aged care program fee or CHSP contribution for the individual due to financial hardship;
 - (b) what evidence of financial hardship the individual must submit to the provider, and how that evidence must be submitted;
 - (c) the principles or calculations the provider will use to determine the amount and duration of the waiver or reduction of the fee or contribution if the individual's application is successful.
- (2) The registered provider must make the financial hardship policy publicly available.

286-25 Other requirements—CHSP and NATSIFACP—consumer contribution policy

- (1) A registered provider delivering funded aged care services through a service group under the CHSP or the NATSIFACP must:
 - (a) have a consumer contribution policy that takes into account the capacity of individuals to contribute toward the cost of the services delivered to them; and
 - (b) set their specialist aged care program fees and CHSP contributions in accordance with that policy.
- (2) The registered provider must make the consumer contribution policy publicly available.

CONSULTATION DRAFT

Funding of aged care services—accommodation payments and accommodation contributions [to be drafted] **Chapter 9**

Section 286-25

Chapter 9—Funding of aged care services— accommodation payments and accommodation contributions [to be drafted]

CONSULTATION DRAFT

Chapter 10 Funding of aged care services—means testing

Part 1 Introduction

Section 314-5

Chapter 10—Funding of aged care services—means testing

Part 1—Introduction

314-5 Simplified outline of this Chapter

[to be drafted]

CONSULTATION DRAFT

Funding of aged care services—means testing Chapter 10
Means testing Part 2
Means testing in a home or community setting Division 1

Section 314-10

Part 2—Means testing

Division 1—Means testing in a home or community setting

Subdivision A—Determination of individual contribution rates for individuals for means testing categories

314-10 Method for determining individual contribution rate

- (1) For the purposes of paragraph 314(1)(a) of the Act, the method for determining the individual contribution rate for an individual for a means testing category is as follows:

Step 1.	Work out the individual’s means testing class in accordance with Subdivision B.
Step 2.	Work out the percentage for the category and the class under subsection (2), (3) or (4) (as applicable).

General

- (2) The following table sets out percentages for individual contribution rates for individuals for means testing classes and categories, for an individual not covered by subsection (3), (4) or (5).

Percentages for individual contribution rates—general				
Item	Column 1 For an individual in the following means testing class ...	Column 2 the percentage for the means testing category clinical supports is ...	Column 3 and the percentage for the means testing category independence is ...	Column 4 and the percentage for the means testing category everyday living is ...
1	Full-pensioner	0%	5%	17.5%
2	Part-pensioner	0%	the amount of the percentage calculated in accordance with section 314-55	the amount of the percentage calculated in accordance with section 314-55
3	Seniors health card holder	0%	the amount of the percentage calculated in accordance with section 314-55	the amount of the percentage calculated in accordance with section 314-55
4	Self-funded retiree	0%	50%	80%

CONSULTATION DRAFT

Chapter 10 Funding of aged care services—means testing

Part 2 Means testing

Division 1 Means testing in a home or community setting

Section 314-10

Individuals in the post-2014 home contribution class who were not continuing home care recipients under the old Act

- (3) The following table sets out percentages for individual contribution rates for individuals for means testing classes and categories, for an individual in the post-2014 home contribution class who:
- (a) immediately before the transition time, was not a continuing home care recipient within the meaning of the old Act; and
 - (b) is not covered by subsection (5).

Percentages for individual contribution rates—individuals in the post-2014 home contribution class

Item	Column 1 For an individual in the following means testing class ...	Column 2 the percentage for the means testing category clinical supports is ...	Column 3 and the percentage for the means testing category independence is ...	Column 4 and the percentage for the means testing category everyday living is ...
1	Full-pensioner	0%	0%	0%
2	Part-pensioner	0%	the amount of the percentage calculated in accordance with section 314-55	the amount of the percentage calculated in accordance with section 314-55
3	Seniors health card holder	0%	the amount of the percentage calculated in accordance with section 314-55	the amount of the percentage calculated in accordance with section 314-55
4	Self-funded retiree	0%	25%	25%

Individuals in the post-2014 home contribution class who were continuing home care recipients under the old Act

- (4) The percentage for the individual contribution rate for each means testing category is 0% for an individual in the post-2014 home contribution class who:
- (a) immediately before the transition time, was a continuing home care recipient within the meaning of the old Act; and
 - (b) is not covered by subsection (5).

Individuals with classification level STRC class in classification type short-term for service group home support

- (5) The percentage for the individual contribution rate for each means testing category is 0% for an individual who:
- (a) is accessing funded aged care services through the service group home support; and
 - (b) has the classification level STRC class in the classification type short-term for that service group.

CONSULTATION DRAFT

CONSULTATION DRAFT

Funding of aged care services—means testing **Chapter 10**
Means testing **Part 2**
Means testing in a home or community setting **Division 1**

Section 314-15

314-15 Period for determining individual contribution rate

Purpose

- (1) For the purposes of paragraph 314(1)(b) of the Act, this section sets out the period for determining the individual contribution rate for an individual for each means testing category.

Application

- (2) This section applies to an individual if a registered provider provides a start notification on a day (the **start notification day**) to the System Governor and the Commissioner about the delivery of funded aged care services to the individual.

If System Governor has sufficient information

- (3) If, on the start notification day, the System Governor has sufficient information to work out the individual's means testing class in accordance with Subdivision B, the period is 28 days from the start notification day.

If individual provides sufficient information without request from System Governor

- (4) If:
- (a) on the start notification day, the System Governor does not have sufficient information to work out the individual's means testing class in accordance with Subdivision B; and
 - (b) within 3 days from the start notification day, the individual provides information to the System Governor that is sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B;
- the period is 28 days from the day the individual provided the information.

If individual provides sufficient information on request from System Governor

- (5) If:
- (a) on the start notification day, the System Governor does not have sufficient information to work out the individual's means testing class in accordance with Subdivision B; and
 - (b) within 3 days from the start notification day, either:
 - (i) the individual does not provide information to the System Governor that is sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B; or
 - (ii) the individual provides information to the System Governor, but that information is not sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B; and
 - (c) the System Governor requests information or documents from the individual under subsection 343(1) of the Act to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B; and

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Chapter 10 Funding of aged care services—means testing

Part 2 Means testing

Division 1 Means testing in a home or community setting

Section 314-20

- (d) within 28 days from the day the System Governor requested information or documents, the individual provides information or documents that are sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B;
- the period is 28 days from the day the individual provided the information or documents as mentioned in paragraph (d).

If individual does not provide sufficient information or makes an election under section 314B of the Act

- (6) If:
 - (a) paragraphs (5)(a) to (c) apply to the individual; and
 - (b) either:
 - (i) the individual does not, within the period mentioned in paragraph (5)(d), provide information or documents that are sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B; or
 - (ii) the individual makes an election under section 314B of the Act before the end of the period mentioned in paragraph (5)(d);
- the period is 3 days from the end of the period mentioned in paragraph (5)(d).

314-20 Other matters to be included in notice of determination

For the purposes of paragraph 314(3)(e) of the Act, the other matters that must be included in a notice under subsection 314(2) of the Act in relation to an individual contribution rate determination for an individual are as follows:

- (a) the previous individual contribution rate (if any) for the individual for each means testing category;
- (b) the date of effect of the determination as worked out in accordance with section 314-25 of this instrument.

314-25 Day determination takes effect

For the purposes of subsection 314(4) of the Act, the day at the start of which an individual contribution rate determination for an individual takes effect is:

- (a) if, on the day the determination was made, an individual contribution rate determination was not in force for the individual—the day the start notification mentioned in subsection 314-15(2) of this instrument relating to the individual was provided to the System Governor and the Commissioner; or
- (b) if the determination is a new determination made in accordance with paragraph 316(2)(c) of the Act, and the new determination results in an increase to the individual contribution rate—the day after the end of the quarter in which the determination was made; or
- (c) if the determination is a new determination made in accordance with paragraph 316(2)(c) of the Act, and the new determination results in a decrease to the individual contribution rate—the day the determination was made; or
- (d) in any other case—the day the determination was made.

CONSULTATION DRAFT

Funding of aged care services—means testing **Chapter 10**
Means testing **Part 2**
Means testing in a home or community setting **Division 1**

Section 314-30

Subdivision B—Working out means testing classes for individuals

314-30 Full-pensioner

Individuals not permanently blind and receiving maximum income support payments

- (1) An individual is in the means testing class full-pensioner on a day if:
 - (a) the individual is not permanently blind; and
 - (b) the individual is receiving an income support payment; and
 - (c) the individual's payment rate for the income support payment is the maximum payment rate for that payment for that individual.

Note: For example, the maximum payment rate for age and disability support pensions and carer payment for people who are not blind is the rate worked out at step 4 of the method statement in Module A of Pension Rate Calculator A.

Individuals permanently blind or not receiving income support payments

- (2) An individual is in the means testing class full-pensioner on a day if:
 - (a) either:
 - (i) the individual is permanently blind; or
 - (ii) the individual is not receiving an income support payment; and
 - (b) if the individual were receiving age pension calculated in accordance with Pension Rate Calculator A, the individual's payment rate would be the maximum payment rate for age pension under that calculator for that individual if the value of the individual's assets were worked out in accordance with Division 1 of Part 3.12 of the Social Security Act.

Individuals in the post-2014 home contribution class for whom the income tested care fee under section 52D-2 of the old Act was nil

- (3) An individual is in the means testing class full-pensioner on a day if:
 - (a) the individual is in the post-2014 home contribution class; and
 - (b) immediately before the transition time, the income tested care fee for the individual under section 52D-2 of the old Act was nil.

314-35 Part-pensioner

Individuals not permanently blind and receiving income support payments at less than maximum payment rates

- (1) An individual is in the means testing class part-pensioner on a day if:
 - (a) the individual is not permanently blind; and
 - (b) the individual is receiving an income support payment; and
 - (c) the individual's payment rate for the income support payment is less than the maximum payment rate for that payment for that individual.

Note: For example, the maximum payment rate for age and disability support pensions and carer payment for people who are not blind is the rate worked out at step 4 of the method statement in Module A of Pension Rate Calculator A.

CONSULTATION DRAFT

Chapter 10 Funding of aged care services—means testing

Part 2 Means testing

Division 1 Means testing in a home or community setting

Section 314-40

Individuals permanently blind or not receiving income support payments

- (2) An individual is in the means testing class part-pensioner on a day if:
- (a) either:
 - (i) the individual is permanently blind; or
 - (ii) the individual is not receiving an income support payment; and
 - (b) if the individual were receiving age pension calculated in accordance with Pension Rate Calculator A, the individual's payment rate would be less than the maximum payment rate for age pension under that calculator for that individual, but not nil, if the value of the individual's assets were worked out in accordance with Division 1 of Part 3.12 of the Social Security Act.

314-40 Seniors health card holder

Holders of seniors health cards

- (1) An individual is in the means testing class seniors health card holder on a day if:
- (a) the individual is not receiving age pension; and
 - (b) the individual holds a seniors health card.

Individuals who are not holders of seniors health cards

- (2) An individual is in the means testing class seniors health card holder on a day if:
- (a) the individual is not receiving age pension; and
 - (b) the individual does not hold a seniors health card; and
 - (c) the individual would satisfy the seniors health card income test in section 1071 of the Social Security Act if the value of the individual's assets were worked out in accordance with Division 1 of Part 3.12 of that Act.

314-45 Self-funded retiree

An individual is in the means testing class self-funded retiree on a day if:

- (a) the individual is not in the means testing class full-pensioner, part-pensioner or seniors health card holder; or
- (b) the individual has means not disclosed status.

Subdivision C—Calculating amounts of percentages for the means testing categories independence and everyday living

314-55 Calculation method

General

- (1) For the purposes of columns 3 and 4 of items 2 and 3 in the table in subsection 314-10(2), the method for calculating the amounts of the percentages is as follows:

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Funding of aged care services—means testing **Chapter 10**
Means testing **Part 2**
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Section 314-60

- Step 1. Work out the income reduction amount under section 314-60.
- Step 2. Work out the assets reduction amount under section 314-65.
- Step 3. Work out the maximum reduction amount under section 314-70.
- Step 4. Work out the input contribution rate under section 314-75.
- Step 5. Work out the amount of the percentage:
 - (a) for the means testing category independence—under subsection 314-80(1); and
 - (b) for the means testing category everyday living—under subsection 314-85(1).

Individuals in the post-2014 home contribution class who were not continuing home care recipients under the old Act

- (2) For the purposes of columns 3 and 4 of items 2 and 3 in the table in subsection 314-10(3), the method for calculating the amounts of the percentages is as follows:

- Step 1. Work out the income reduction amount under section 314-60.
- Step 2. Work out the assets reduction amount under section 314-65.
- Step 3. Work out the maximum reduction amount under section 314-70.
- Step 4. Work out the input contribution rate under section 314-75.
- Step 5. Work out the amount of the percentage:
 - (a) for the means testing category independence—under subsection 314-80(2); and
 - (b) for the means testing category everyday living—under subsection 314-85(2).

314-60 Working out the income reduction amount

The method for working out the income reduction amount is as follows:

- Step 1. Work out the amount that would be worked out as the individual's ordinary income for the purpose of applying Module E of Pension Rate Calculator A.
- Step 2. Work out the amount that would be worked out as the individual's ordinary income free area under point 1064-E4 of that Module.

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Chapter 10 Funding of aged care services—means testing

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Division 1 Means testing in a home or community setting

Section 314-65

Step 3. Subtract the amount under Step 2 from the amount under Step 1.

Step 4. Multiply the amount under Step 3 by 0.5 and round to the nearest dollar.

The result is the income reduction amount.

314-65 Working out the assets reduction amount

The method for working out the assets reduction amount is as follows:

Step 1. Work out the value of the individual's assets in accordance with Division 1 of Part 3.12 of the Social Security Act.

Step 2. Work out the amount that would be worked out as the individual's assets value limit under point 1064-G3 of Module G of Pension Rate Calculator A.

Step 3. Subtract the amount under Step 2 from the amount under Step 1.

Step 4. Multiply the amount under Step 3 by 0.078 and round to the nearest dollar.

The result is the assets reduction amount.

314-70 Working out the maximum reduction amount

The method for working out the maximum reduction amount is as follows:

Step 1. Work out the individual's senior's health card income limit under point 1071-12 of the Seniors Health Card Income Test Calculator at the end of section 1071 of the Social Security Act.

Step 2. Subtract the individual's ordinary income free area (worked out under Step 2 of the method statement in section 314-60 of this instrument) from the individual's senior's health card income limit.

Step 3. Multiply the amount under Step 2 by 0.5 and round to the nearest dollar.

The result is the maximum reduction amount.

314-75 Working out the input contribution rate

The method for working out the input contribution rate is as follows:

Step 1. Divide the greater of the income reduction amount and the assets reduction amount by the maximum reduction amount.

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Step 2. Multiply the Step 1 amount by 100.
The result is the input contribution rate.

314-80 Working out the amount of the percentage for the means testing category independence

General

- (1) The method for working out the percentage for the means testing category independence for individuals covered by subsection 314-10(2) is as follows:

Step 1. Multiply the input contribution rate by 0.45.
Step 2. Add 5 to the Step 1 amount and round to 2 decimal places.
The result is the amount of the percentage for the means testing category independence.

Individuals in the post-2014 home contribution class who were not continuing home care recipients under the old Act

- (2) The method for working out the percentage for the means testing category independence for individuals covered by subsection 314-10(3) is as follows:

Step 1. Multiply the input contribution rate by 0.25 and round to 2 decimal places.
The result is the amount of the percentage for the means testing category independence.

314-85 Working out the amount of the percentage for the means testing category everyday living

General

- (1) The method for working out the percentage for the means testing category everyday living for individuals covered by subsection 314-10(2) is as follows:

Step 1. Multiply the input contribution rate by 0.625.
Step 2. Add 17.5 to the Step 1 amount and round to 2 decimal places.
The result is the amount of the percentage for the means testing category everyday living.

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Individuals in the post-2014 home contribution class who were not continuing home care recipients under the old Act

- (2) The method for working out the percentage for the means testing category everyday living for individuals covered by subsection 314-10(3) is as follows:

Step 1. Multiply the input contribution rate by 0.25 and round to 2 decimal places.

The result is the amount of the percentage for the means testing category everyday living.

Subdivision D—Means not disclosed status

314A-5 Determination that individuals have means not disclosed status

For the purposes of paragraph 314A(1)(a) of the Act, the System Governor may determine that an individual has means not disclosed status if paragraph 314-15(6)(a) and subparagraph 314-15(6)(b)(i) of this instrument apply to the individual.

314A-10 Day determination takes effect

For the purposes of subsection 314A(3) of the Act, the day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 314-15(2) of this instrument for the individual relates.

Subdivision E—Requirement to notify event or change in circumstances

315-5 Circumstances in which notification of event or change in circumstances is required

For the purposes of subsection 315(1) of the Act, the circumstances in which an individual for whom an individual contribution rate determination is in force must notify the System Governor of the occurrence of an event or a change in the individual's circumstances are as follows:

- (a) a decision under the social security law (within the meaning of the Social Security Act) relating to the individual has been made;
- (b) the individual's income changes;
- (c) the individual's partner's income changes;
- (d) the value of the individual's assets changes;
- (e) the value of the individual's partner's assets changes;
- (f) the individual starts or stops being a member of a couple;
- (g) the individual is a member of a couple that stops or starts being an illness separated couple (within the meaning of the Social Security Act);
- (h) the individual is a member of a couple that stops or starts being a respite care couple (within the meaning of the Social Security Act);

Commented [A34]: Is there a minimum here otherwise every minor change (e.g. assets or income increase or decrease by a dollar) will be required to be notified

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- (i) the individual leaves Australia permanently.

315-10 Period for notification of event or change in circumstances

For the purposes of paragraph 315(2)(a) of the Act, the period within which an individual must notify the System Governor of the occurrence of an event or a change in the individual's circumstances is 14 days from the day the event or change of circumstances occurs.

315-15 Manner for notification of event or change in circumstances

For the purposes of paragraph 315(2)(b) of the Act, the manner in which an individual must notify the System Governor of the occurrence of an event or a change in the individual's circumstances is the approved form.

Subdivision F—Varying or revoking individual contribution rate determination

316-5 Other matters to be included in notice of determination

For the purposes of paragraph 316(4)(f) of the Act, the other matter that must be included in a notice under subsection 316(3) of the Act in relation to a varied individual contribution rate determination for an individual is the individual contribution rate for the individual for each means testing category specified in the notice given under subsection 314(2) of the Act in relation to the old determination for the individual.

317-5 Period for deciding if individual contribution rate determination is no longer correct following certain social security decisions

For the purposes of subsection 317(2) of the Act, the period is 28 days from the day the System Governor is satisfied as mentioned in paragraph 317(1)(b) of the Act.

318-5 Period for deciding whether to vary or revoke individual contribution rate determination following event or change in circumstances

For the purposes of subsection 318(2) of the Act, the period is 28 days from the day the System Governor is:

- (a) notified as mentioned in subparagraph 318(1)(b)(i) of the Act; or
 - (b) satisfied as mentioned in subparagraph 318(1)(b)(ii) of the Act;
- (as applicable).

318-10 Variation or new determination following event or change in circumstances to take effect on specified day in specified circumstances

For the purposes of subsection 318(6) of the Act, in the circumstances that:

- (a) a variation or new determination for an individual is made following the System Governor being notified, as mentioned in

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subparagraph 318(1)(b)(i) of the Act, of the occurrence of an event or change after the end of the period prescribed by section 315-10 of this instrument; and

- (b) the variation or new determination results in an increase to the individual contribution rate for the individual for a means testing category;

the variation or new determination takes effect on the day the System Governor was notified as mentioned in subparagraph 318(1)(b)(i) of the Act of the event or change.

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Subdivision A—Daily means tested amounts

319-10 Working out the daily means tested amount—classes of individuals

For the purposes of subsection 319(5) of the Act, the classes are the following:

- (a) the pre-2014 residential contribution class;
- (b) the post-2014 residential contribution class.

319-15 Working out the daily means tested amount—individuals in pre-2014 residential contribution class

For the purposes of subsection 319(5) of the Act, the daily means tested amount for an individual in the pre-2014 residential contribution class is worked out as follows:

- | | |
|---------|--|
| Step 1. | Work out the individual's total assessable income (which is determined under section 322 of the Act). |
| Step 2. | Work out the individual's total assessable income free area (see subsection 319(2) of the Act). |
| Step 3. | If the individual's total assessable income does not exceed the individual's total assessable income free area, the daily means tested amount is zero. |
| Step 4. | If the individual's total assessable income exceeds the individual's total assessable income free area, the smallest of the following amounts (rounded down to the nearest cent), is the daily means tested amount: <ul style="list-style-type: none">(a) the amount equal to $\frac{5}{12}$ of that excess, divided by 364;(b) the amount equal to 135% of the basic age pension amount for that day, divided by 364;(c) the sum of the base rate for the individual for the day and the standard base provider amount for the day for the individual. |

319-20 Working out the daily means tested amount—individuals in post-2014 home contribution class or post-2014 residential contribution class

Daily means tested amount

- (1) For the purposes of subsection 319(5) of the Act, the daily means tested amount for an individual in the post-2014 home contribution class or the post-2014 home residential class is the sum of:
 - (a) the per day income tested amount worked out under subsection (2); and
 - (b) the per day asset tested amount worked out under subsection (3).

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Per day income tested amount

(2) The per day income tested amount is worked out as follows:

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|---------|---|
| Step 1. | Work out the individual's total assessable income (which is determined under section 322 of the Act). |
| Step 2. | Work out the individual's total assessable income free area (see subsection 319(2) of the Act). |
| Step 3. | If the individual's total assessable income does not exceed the individual's total assessable income free area, the per day income tested amount is zero. |
| Step 4. | If the individual's total assessable income exceeds the individual's total assessable income free area, the per day income tested amount is 50% of that excess divided by 364. |

Per day asset tested amount

(3) The per day asset tested amount is worked out as follows:

- | | |
|---------|--|
| Step 1. | Work out the value of the individual's assets (which is determined under section 329 of the Act). |
| Step 2. | If the value of the individual's assets does not exceed the asset free area, the per day asset tested amount is zero. |
| Step 3. | If the value of the individual's assets exceeds the asset free area but not the first asset threshold, the per day asset tested amount is 17.5% of the excess, divided by 364. |
| Step 4. | If the value of the individual's assets exceeds the first asset threshold but not the second asset threshold, the per day asset tested amount is the sum of the following, divided by 364: <ul style="list-style-type: none">(a) 1% of the excess;(b) 17.5% of the difference between the asset free area and the first asset threshold. |
| Step 5. | If the value of the individual's assets exceeds the second asset threshold, the per day asset tested amount is the sum of the following, divided by 364: <ul style="list-style-type: none">(a) 2% of the excess;(b) 1% of the difference between the first asset threshold and the second asset threshold; |

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| (c) 17.5% of the difference between the asset free area and the first asset threshold. |
|--|

Subdivision B—Means not disclosed status

320-5 Determination that individuals have means not disclosed status

For the purposes of paragraph 320(1)(a) of the Act, the System Governor may determine that an individual has means not disclosed status if paragraph 322-5(6)(a) and subparagraph 322-5(6)(b)(i) of this instrument apply to the individual.

320-10 Day determination takes effect

For the purposes of subsection 320(3) of the Act, the day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 322-5(2) of this instrument for the individual relates.

Subdivision C—Determining an individual's total assessable income

322-5 Period for determining an individual's total assessable income

Purpose

- (1) For the purposes of subsection 322(1) of the Act, this section sets out the period for determining an individual's total assessable income.

Application

- (2) This section applies to an individual if a registered provider provides a start notification on a day (the **start notification day**) to the System Governor and the Commissioner about the delivery of funded aged care services to the individual.

If System Governor has sufficient information

- (3) If, on the start notification day, the System Governor has sufficient information to determine the individual's total assessable income, the period is 28 days from the start notification day.

If individual provides sufficient information without request from System Governor

- (4) If:
- (a) on the start notification day, the System Governor does not have sufficient information to determine the individual's total assessable income; and
 - (b) within 3 days from the start notification day, the individual provides information to the System Governor that is sufficient to enable the System Governor to determine the individual's total assessable income;
- the period is 28 days from the day the individual provided the information.

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If individual provides sufficient information on request from System Governor

- (5) If:
- (a) on the start notification day, the System Governor does not have sufficient information to determine the individual's total assessable income; and
 - (b) within 3 days from the start notification day, either:
 - (i) the individual does not provide information to the System Governor that is sufficient to enable the System Governor to determine the individual's total assessable income; or
 - (ii) the individual provides information to the System Governor, but that information is not sufficient to enable the System Governor to determine the individual's total assessable income; and
 - (c) the System Governor requests information or documents from the individual under subsection 343(1) of the Act to enable the System Governor to determine the individual's total assessable income; and
 - (d) within 28 days from the day the System Governor requested information or documents, the individual provides information or documents that are sufficient to enable the System Governor to determine the individual's total assessable income;

the period is 28 days from the day the individual provided the information or documents as mentioned in paragraph (d).

If individual does not provide sufficient information or makes an election under section 321 of the Act

- (6) If:
- (a) paragraphs (5)(a) to (c) apply to the individual; and
 - (b) either:
 - (i) the individual does not, within the period mentioned in paragraph (5)(d), provide information or documents that are sufficient to enable the System Governor to determine the individual's total assessable income; or
 - (ii) the individual makes an election under section 321 of the Act before the end of the period mentioned in paragraph (5)(d);
- the period is 3 days from the end of the period mentioned in paragraph (5)(d).

322-10 Day determination takes effect

For the purposes of subsection 322(6) of the Act, the day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 322-5(2) of this instrument for the individual relates.

322-15 Other matters to be included in notice of determination

For the purposes of paragraph 322(9)(g) of the Act, the other matters that must be included in a notice under subsection 322(8) of the Act are as follows:

- (a) a summary of the individual's sources of income;

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(b) the assessed amounts for each of those sources of income.

Subdivision D—Working out an individual’s total assessable income—excluded amounts

323-5 Purpose of this Subdivision

For the purposes of subsection 323(7) of the Act, this Subdivision prescribes amounts that are to be taken, in relation to specified kinds of individuals, to be excluded from a determination under subsection 323(1) of the Act or paragraph 323(2)(b), (3)(b), (4)(b) or (5)(b) of the Act.

323-10 Disability pensions and permanent impairment compensation payments

Certain amounts of disability pensions under the Veterans’ Entitlements Act

- (1) In relation to an individual who has qualifying service under section 7A of the Veterans’ Entitlements Act, or the partner of such an individual, the amount (if any) of disability pension (within the meaning of subsection 5Q(1) of the Veterans’ Entitlements Act) paid to the individual that is exempt under section 5H of that Act is prescribed.

Compensation for permanent impairment or Special Rate Disability Pensions

- (2) In relation to an individual who is a member or former member (within the meaning of the MRC Act) or the partner of such an individual, each of the following is prescribed:
 - (a) any amount of compensation for permanent impairment paid to the individual under Part 2 of Chapter 4 of the MRC Act;
 - (b) any amount of Special Rate Disability Pension paid to the individual under Part 6 of Chapter 4 of the MRC Act.

323-15 Gifts

Disposal of ordinary income

- (1) In relation to an individual 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 individual’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 prescribed.

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.

Disposal of assets

- (2) In relation to an individual who, on or before 20 August 1996, disposed of assets, the amount of ordinary income the individual is taken to receive because assets disposed of on or before 20 August 1996 are assessed as financial assets under:

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- (a) section 1076, 1077 or 1078 of the Social Security Act; or
 - (b) sections 46D and 46E of the Veterans' Entitlements Act;
- is prescribed.

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.

323-20 Rent receipts

- (1) This section applies to an individual:
 - (a) for whom an accommodation contribution or an accommodation payment is payable; and
 - (b) who first entered residential care (within the meaning of the old Act) on or before 31 December 2015; and
 - (c) for whom, since the individual first entered residential care, there has not been a continuous period of more than 28 days in which the individual was not either:
 - (i) receiving residential care (other than because the person was on leave) (within the meaning of the old Act); or
 - (ii) accessing funded aged care services in an approved residential care home.
- (2) The amount of any income received by the individual, or the individual's partner, from rental of the individual's principal home to another person is prescribed.

323-25 GST compensation

- (1) This section applies in relation to:
 - (a) an individual 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 an individual receiving a disability pension payable at the general rate—section 22;
 - (ii) for an individual 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 an individual receiving a disability pension payable at the intermediate rate—section 23;
 - (iv) for an individual 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 an individual receiving a disability pension payable at the special rate—section 24;
 - (vi) for an individual receiving a war widow or widower pension—subsection 30(1); and
 - (b) an individual receiving a pension under Part 6 of Chapter 4, or a weekly amount of compensation under Part 2 of Chapter 5, of the MRC Act at a rate determined under or by reference to the following provisions of that Act:

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- (i) for an individual receiving a Special Rate Disability Pension—sections 198 and 204;
 - (ii) for an individual receiving a weekly amount of compensation for the death of the individual'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 an individual under a provision referred to in subsection (1), as applicable from time to time, is prescribed.
- 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 MRC Act 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 MRC Act 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.

323-30 Energy payments

In relation to an individual to whom funded aged care services are being delivered through the service group residential care, each of the following is prescribed:

- (a) any amount of clean energy advance, energy supplement or quarterly energy supplement paid to the individual under the Social Security Act;
- (b) any amount of clean energy advance, energy supplement or quarterly energy supplement paid to the individual under the Veterans' Entitlements Act.

Subdivision E—Working out an individual's total assessable income—application of social security law provisions

323-35 Application of Social Security Act provisions

- (1) This section applies to an individual:
- (a) who first entered residential care (within the meaning of the old Act) on or after 1 January 2016; and
 - (b) for whom, since the individual first entered residential care, there has not been a continuous period of more than 28 days in which the individual was not either:
 - (i) receiving residential care (other than because the person was on leave) (within the meaning of the old Act); or
 - (ii) accessing funded aged care services in an approved residential care home.
- (2) For the purposes of subparagraph 323(8)(c)(ii) of the Act, paragraph 8(8)(znaa) of the Social Security Act is prescribed.

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323-40 Application of Veterans' Entitlements Act provisions

- (1) This section applies to an individual:
 - (a) who first entered residential care (within the meaning of the old Act) on or after 1 January 2016; and
 - (b) for whom, since the individual first entered residential care, there has not been a continuous period of more than 28 days in which the individual was not either:
 - (i) receiving residential care (other than because the person was on leave) (within the meaning of the old Act); or
 - (ii) accessing funded aged care services in an approved residential care home.
- (2) For the purposes of subparagraph 323(9)(b)(ii) of the Act, paragraph 5H(8)(nf) of the Veterans' Entitlements Act is prescribed.

Subdivision F—Varying or revoking an income determination

324-5 Day variation of income determination takes effect

Purpose

- (1) For the purposes of subsection 324(5) of the Act, the day specified by the System Governor as the day a variation of an income determination in relation to an individual takes effect must be in accordance with this section.

Variation on notification of event or change in circumstances—general

- (2) Subject to subsection (3), if the income determination is varied under section 325 of the Act (on notification of an event or change in circumstances), the day specified must be the day the event or change in circumstances occurred.

Variation on notification of event or change in circumstances—certain circumstances

- (3) If:
 - (a) the income determination is varied under section 325 of the Act (on notification of an event or change in circumstances); and
 - (b) the System Governor received the notification of the event or change after the end of 14 days from the day the event or change of circumstances occurred; and
 - (c) the variation results in a decrease to:
 - (i) the amount of person-centred subsidy reduction for the individual for a day under section 235 of the Act; or
 - (ii) the amount of provider-based subsidy reduction for the registered provider for the individual for a day under section 242 of the Act; or
 - (iii) the amount of accommodation contribution that the individual may be charged under section 298 of the Act;the day specified must be the day the notification was made.

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Variation on application by individual

- (4) If the income determination is varied under section 326 of the Act (on application by the individual), the day specified must be the day the application was made.

Variation on System Governor's initiative

- (5) If:
- (a) the income determination is varied under section 327 of the Act (on the System Governor's initiative); and
 - (b) a registered provider delivering funded aged care services to the individual has, under section 337 of the Act, notified the System Governor of an amount of refundable deposit paid by the individual before the transition time;
- the day specified must be the day the System Governor decided to vary the income determination.

325-5 Period for varying or revoking income determination—on notification of event or change in circumstances

For the purposes of subsection 325(2) of the Act, the period for making a decision following the notification of the occurrence of an event or a change in the individual's circumstances under Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act is 28 days from the day the notification is made.

326-5 Period for varying or revoking income determination—on application

For the purposes of paragraph 326(2)(b) of the Act, the period for making a decision on an application by an individual for the purposes of paragraph 324(2)(b) of the Act is 28 days from the day the application is made.

327-5 Period for varying or revoking income determination—on System Governor's initiative

For the purposes of paragraph 327(6)(b) of the Act, the period for making a decision under that paragraph is 28 days from:

- (a) if no submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act—the end of the period specified in the notice (including that period as extended (if applicable) under subsection 327(5) of the Act); or
- (b) the later of:
 - (i) if a submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act and no further information is requested under subsection 327(4) of the Act—the day the submission is made; and
 - (ii) if a submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act and further information is requested under subsection 327(4) of the Act—the day the individual gives the System Governor the further information.

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328-10 Other matters to be included in notices of decisions other than reviewable decisions

For the purposes of paragraph 328(4)(b) of the Act, a notice given under subsection 328(3) of the Act must include the reasons for the decision.

Subdivision G—The value of an individual's assets

329-5 Period for determining the value of an individual's assets

Purpose

- (1) For the purposes of subsection 329(1) of the Act, this section sets out the period for determining the value of an individual's assets.

Application

- (2) This section applies to an individual if a registered provider provides a start notification on a day (the **start notification day**) to the System Governor and the Commissioner about the delivery of funded aged care services to the individual.

If System Governor has sufficient information

- (3) If, on the start notification day, the System Governor has sufficient information to determine the value of the individual's assets, the period is 28 days from the start notification day.

If individual provides sufficient information without request from System Governor

- (4) If:
- (a) on the start notification day, the System Governor does not have sufficient information to determine the value of the individual's assets; and
 - (b) within 3 days from the start notification day, the individual provides information to the System Governor that is sufficient to enable the System Governor to determine the value of the individual's assets;
- the period is 28 days from the day the individual provided the information.

If individual provides sufficient information on request from System Governor

- (5) If:
- (a) on the start notification day, the System Governor does not have sufficient information to determine the value of the individual's assets; and
 - (b) within 3 days from the start notification day, either:
 - (i) the individual does not provide information to the System Governor that is sufficient to enable the System Governor to determine the value of the individual's assets; or
 - (ii) the individual provides information to the System Governor, but that information is not sufficient to enable the System Governor to determine the value of the individual's assets; and

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- (c) the System Governor requests information or documents from the individual under subsection 343(1) of the Act to enable the System Governor to determine the value of the individual's assets; and
 - (d) within 28 days from the day the System Governor requested information or documents, the individual provides information or documents that are sufficient to enable the System Governor to determine the value of the individual's assets;
- the period is 28 days from the day the individual provided the information or documents as mentioned in paragraph (d).

If individual does not provide sufficient information or makes an election under section 321 of the Act

- (6) If:
 - (a) paragraphs (5)(a) to (c) apply to the individual; and
 - (b) either:
 - (i) the individual does not, within the period mentioned in paragraph (5)(d), provide information or documents that are sufficient to enable the System Governor to determine the value of the individual's assets; or
 - (ii) the individual makes an election under section 321 of the Act before the end of the period mentioned in paragraph (5)(d);
- the period is 3 days from the end of the period mentioned in paragraph (5)(d).

329-10 Day determination takes effect

For the purposes of subsection 329(6) of the Act, the day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 322-5(2) of this instrument for the individual relates.

Subdivision H—Working out the value of an individual's assets—excluded amounts

330-5 Value of home

For the purposes of subsection 330(7) of the Act, the amount is \$206,039.20.

330-10 Other amounts

- (1) For the purposes of subsection 330(9) of the Act, this section prescribes amounts that are to be taken, in relation to specified kinds of individuals, to be excluded from a determination under paragraph 330(2)(a) or (b) or (3)(a) or (b) or subsection 330(4) of the Act.
- (2) In relation to all individuals, the following are prescribed:
 - (a) any compensation payments received by the individual under the following:

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- (i) the *Compensation (Japanese Internment) Act 2001*;
- (ii) the *Veterans' Entitlements (Compensation—Japanese Internment) Regulations 2001*;
- (iii) Part 2 of the *Veterans' Entitlements (Clarke Review) Act 2004*;
- (iv) Schedule 5 to the *Social Security and Veterans' Affairs Legislation Amendment (One-off Payments and Other 2007 Budget Measures) Act 2007*;
- (b) any redress payment paid to the individual, or to an administrator for the individual, under section 48 of the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018*.

Subdivision J—Varying or revoking an asset determination

331-5 Day variation of asset determination takes effect

Purpose

- (1) For the purposes of subsection 331(5) of the Act, the day specified by the System Governor as the day a variation of an asset determination in relation to an individual takes effect must be in accordance with this section.

Variation on notification of event or change in circumstances—general

- (2) Subject to subsection (3), if the asset determination is varied under section 332 of the Act (on notification of an event or change in circumstances), the day specified must be the day the event or change in circumstances occurred.

Variation on notification of event or change in circumstances—certain circumstances

- (3) If:
 - (a) the asset determination is varied under section 332 of the Act (on notification of an event or change in circumstances); and
 - (b) the System Governor received the notification of the event or change after the end of 14 days from the day the event or change of circumstances occurred; and
 - (c) the variation results in a decrease to:
 - (i) the amount of person-centred subsidy reduction for the individual for a day under section 235 of the Act; or
 - (ii) the amount of provider-based subsidy reduction for the registered provider for the individual for a day under section 242 of the Act; or
 - (iii) the amount of accommodation contribution that the individual may be charged under section 298 of the Act;the day specified must be the day the notification was made.

Variation on application by individual

- (4) If the asset determination is varied under section 333 of the Act (on application by the individual), the day specified must be the day the application was made.

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Variation on System Governor's initiative

- (5) If:
- (a) the asset determination is varied under section 334 of the Act (on the System Governor's initiative); and
 - (b) a registered provider delivering funded aged care services to the individual has, under section 337 of the Act, notified the System Governor of an amount of refundable deposit paid by the individual before the transition time;
- the day specified must be the day the System Governor decided to vary the asset determination.

332-5 Period for varying or revoking asset determination—on notification of event or change in circumstances

For the purposes of subsection 332(2) of the Act, the period for making a decision following the notification of the occurrence of an event or a change in an individual's circumstances under Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act is 28 days from the day the notification is made.

333-5 Period for varying or revoking asset determination—on application

For the purposes of paragraph 333(2)(b) of the Act, the period for making a decision on an application by an individual for the purposes of paragraph 331(2)(b) of the Act is 28 days from the day the application is made.

334-5 Period for varying or revoking asset determination—on System Governor's initiative

For the purposes of paragraph 334(6)(b) of the Act, the period for making a decision under that paragraph is 28 days from:

- (a) if no submission is made in accordance with the invitation in the notice under paragraph 334(2)(b) of the Act—the end of the period specified in the notice (including that period as extended (if applicable) under subsection 334(5) of the Act); or
- (b) the later of:
 - (i) if a submission is made in accordance with the invitation in the notice under paragraph 334(2)(b) of the Act and no further information is requested under subsection 334(4) of the Act—the day the submission is made; and
 - (ii) if a submission is made in accordance with the invitation in the notice under paragraph 334(2)(b) of the Act and further information is requested under subsection 334(4) of the Act—the day the individual gives the System Governor the further information.

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335-10 Other matters to be included in notices of decisions other than reviewable decisions

For the purposes of paragraph 335(4)(b) of the Act, a notice given under subsection 335(3) of the Act must include the reasons for the decision.

Subdivision K—Notifying of event or change in circumstances

336-5 Notifications by individuals—manner and period

For the purposes of subsection 336(2) of the Act:

- (a) the manner in which an individual must make a notification of the occurrence of an event or a change in the individual's circumstances under subsection 336(1) of the Act is in the approved form; and
- (b) the period in which the notification must be made is 14 days from the day the event or change of circumstances occurs.

337-5 Notifications by registered providers—manner and period

For the purposes of subsection 337(2) of the Act:

- (a) the manner in which a registered provider must make a notification of the occurrence of an event or a change in an individual's circumstances under subsection 337(1) of the Act is:
 - (i) in a claim made under section 251 of the Act (claim for subsidy); or
 - (ii) in the approved form; and
- (b) the period in which the notification must be made is as soon as practicable after the end of the payment period in which the event or change of circumstances occurs.