Subsidy Principles 2014

made under section 96-1 of the

Aged Care Act 1997

Compilation No. 21

Compilation date: 23 January 2024

Includes amendments: F2024L00092

Registered: 2 February 2024

Prepared by the Office of Parliamentary Counsel, Canberra

About this compilation

This compilation

This is a compilation of the *Subsidy Principles 2014* that shows the text of the law as amended and in force on 23 January 2024 (the ***compilation date***).

The notes at the end of this compilation (the ***endnotes***) include information about amending laws and the amendment history of provisions of the compiled law.

Uncommenced amendments

The effect of uncommenced amendments is not shown in the text of the compiled law. Any uncommenced amendments affecting the law are accessible on the Register (www.legislation.gov.au). The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. For more information on any uncommenced amendments, see the Register for the compiled law.

Application, saving and transitional provisions for provisions and amendments

If the operation of a provision or amendment of the compiled law is affected by an application, saving or transitional provision that is not included in this compilation, details are included in the endnotes.

Editorial changes

For more information about any editorial changes made in this compilation, see the endnotes.

Modifications

If the compiled law is modified by another law, the compiled law operates as modified but the modification does not amend the text of the law. Accordingly, this compilation does not show the text of the compiled law as modified. For more information on any modifications, see the Register for the compiled law.

Self-repealing provisions

If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.

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Chapter 1—Preliminary

1 Name of principles

These principles are the *Subsidy Principles 2014*.

3 Authority

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

4 Definitions

In these principles:

1997 scheme service: see section 64.

2001 scheme service: see section 65.

2005 scheme service: see section 66.

2017 scheme service: see section 66A.

ACAP code, in relation to a health condition specified in the table in Schedule 1, means the Aged Care Assessment Program code specified in the table for that health condition.

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

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

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

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

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

(a) a building;

(b) a floor or level of a building;

(c) an annex to a building;

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

accreditation application means an application under section 27 of the Quality and Safety Commission Rules.

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Act means the *Aged Care Act 1997*.

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

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

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

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

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

available home care fees amount has the meaning given by section 99A.

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

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

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

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

COVID-19 support payment period: each of the following is a ***COVID-19 support payment period***:

(a) the payment period beginning on 1 February 2020;
(b) the payment period beginning on 1 June 2020.

day of eligible residential care: see subsection 70AM(2).

domain has the same meaning as in the *Classification Principles 2014*.

domain category has the same meaning as in the *Classification Principles 2014*.

episode of short-term restorative care: see section 111C.

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episode of transition care: see section 111AA.

essential expenses:

(a) for a recipient of residential care: see section 61; and

(b) for a recipient of home care: see section 96.

exceptional circumstances determination application means an application to the Secretary by an approved provider of a residential care service for a determination under subsection 42-5(1) of the Act that the service is taken, for the purposes of Division 42 of the Act, to meet its accreditation requirement.

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

hardship reduction amount has the meaning given by section 99AA.

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

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

home care fees has the meaning given by subsection 52D-1(1) of the Act.

home care setting: short-term restorative care or transition care is provided in a ***home care setting*** if it is provided other than in a facility where residential care is provided through a residential care service.

homeowner: see section 48.

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

(a) is admitted to a hospital; and

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

innovative care service: see section 105.

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

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

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

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

Note: Examples of low intensity therapy include the following:

(a) occupational therapy;

(b) physiotherapy;

(c) social work.

low-means care recipient: see section 5.

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

minimum monetary spend amount, in relation to a refurbished residential care service: see section 6.

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

Modified Monash Model classification:

(a) for a street address—means the classification given to that street address in accordance with the Modified Monash Model classification system; and

(b) for a suburb or locality—means the classification for that suburb or locality set out in, or worked out in accordance with the method set out in, the document published by the Health Department titled *Modified Monash Model Suburb and Locality Classification—Home Care Subsidy*, as that document exists on 1 January 2017.

Note 1: In 2017, the Modified Monash Model classification for a street address was available at http://www.doctorconnect.gov.au. This is relevant for residential care subsidy and flexible care subsidy.

Note 2: In 2017, the document referred to in paragraph (b) was available at http://www.health.gov.au. This is relevant for home care subsidy.

Modified Monash Model classification system means the Modified Monash Model geographical classification system developed by the Health 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 that system exists on 1 January 2017.

multi-purpose service: see section 104.

newly built residential care service has the meaning given by section 50 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

non-registered entity means an entity that:

(a) is not a registered entity; and

(b) has incurred a liability to pay payroll tax to a registered entity in relation to residential care provided to care recipients through a residential care service.

Example: An approved provider will be more likely to be a non-registered entity if it is operated by a charitable, religious or government provider.

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

operational places has the same meaning as in Chapter 2A of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

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payment period, in relation to flexible care provided as short-term restorative care, means a period under section 111B in respect of which flexible care subsidy is payable in respect of flexible care provided as short-term restorative care.

post-2008 reform resident has the meaning given by section 44-5C of the *Aged Care (Transitional Provisions) Act 1997*.

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

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

qualifying facility, for a payment period: see subsection 70AM(1).

Quality and Safety Commission Rules means the *Aged Care Quality and Safety Commission Rules 2018*.

quarter means a period of 3 months.

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

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

Example: An approved provider will be more likely to be a registered entity if it is operated on a for profit basis.

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

residential care setting: short-term restorative care or transition care is provided in a ***residential care setting*** if it is provided in a facility where residential care is provided through a residential care service.

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

short-term restorative care: see section 106A.

significantly refurbished residential care service means a residential care service in relation to which a determination under subsection 52(1) or 53(1) is in effect.

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

STRC Programme means the program administered by the Commonwealth and known as the Short-term Restorative Care Programme.

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

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

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

transition care: see section 106.

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

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

veteran means a person:

(a) who is taken to have rendered eligible war service under section 7 of the Veterans' Entitlements Act; or
(b) in respect of whom a pension is payable under subsection 13(6) of that Act; or
(c) who is:
  (i) a member of the Forces within the meaning of subsection 68(1) of that Act; or
  (ii) a member of a Peacekeeping Force within the meaning of that subsection; or
(d) who is:
  (i) a member within the meaning of the *Military Rehabilitation and Compensation Act 2004*; or
  (ii) a former member within the meaning of that Act; or
(e) who is an employee within the meaning of the *Safety, Rehabilitation and Compensation Act 1988*.

Note: The Acts mentioned in paragraphs (d) and (e) provide that, in some cases:
(a) a member of the Forces, or a member of a Peacekeeping Force, includes a person who is no longer serving; and
(b) an employee includes a person who has ceased to be an employee.

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

Note: A number of expressions used in these principles are defined in the Act, including the following:
(a) payment period;
(b) respite care.

5 Meaning of *low-means care recipient*

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

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

(b) either:

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

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

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

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

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

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

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

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

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

(2) If:

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

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

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

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

where:

A is the total cost of the refurbishment.

B is the cost of the fire safety improvements.

C is the amount that is 25% of the minimum monetary spend amount in relation to the service.

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Chapter 2—Residential care subsidy

Part 1A—Meaning of residential care

7A Purpose of this Part

For paragraph 41-3(2)(d) of the Act, this Part specifies care that is not residential care.

7B Care that is not residential care

For paragraph 41-3(2)(d) of the Act, flexible care in the form of short-term restorative care or transition care is not residential care.

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Part 1—Who is eligible for residential care subsidy?

Division 1—Purpose of this Part

8 Purpose of this Part

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

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

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

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Division 2—Leave from residential care services

9 Care recipient provided with transition care

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

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

(2) The care recipient must be in an episode of transition care.

Note: ***Episode of transition care*** is defined in section 111AA.

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Division 3—Exceptional circumstances determinations

10 Determination by Secretary

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

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

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

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

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

11 Application for determination

(1) The Secretary may give a written request to the Quality and Safety Commissioner for the following information about a residential care service:

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

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

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

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

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

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

(3) Subsection (2) applies whether or not the accreditation application complies with subsection 28(1) of the Quality and Safety Commission Rules.

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

12 Matters the Secretary must take into account

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

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

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

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

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

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

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Part 2—How is residential care subsidy paid?

Division 1—Purpose of this Part

13 Purpose of this Part

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

(a) working out the proportion of the amounts equal to the capital payments that are to be deducted for the purposes of subsection 43-6(3) of the Act;

(b) the kinds of payments that are capital payments for the purposes of subsection 43-6(5) of the Act.

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Division 2—Capital repayment deductions

14 Kinds of payments that are capital payments

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

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

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

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

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

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

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

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

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

(2) The proportion is:

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

where:

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

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

P (short for proportion) is:

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

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

(3) For subsection (2):

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

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

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

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

Division 1—Purpose of this Part

20 Purpose of this Part

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

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

(b) the following primary supplements that may apply to the care recipient (Division 3):
  (i) the respite supplement;
  (ii) the oxygen supplement;
  (iii) the enteral feeding supplement;

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

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

(e) the following other supplements that may apply to the care recipient (Division 5):
  (i) the viability supplement;
  (ii) the veterans' supplement;
  (iii) the homeless supplement;
  (iv) the COVID-19 support supplement;
  (v) the residential care support supplement;
  (vi) the 2021 basic daily fee supplement;
  (vii) the initial entry adjustment supplement;
  (viii) the hotelling supplement;
  (ix) the registered nurse supplement;
  (x) the outbreak management support supplement.

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Division 2—Basic subsidy amount

21 Matter on which determination of basic subsidy amount may be based

For purposes of paragraph 44-3(3)(e) of the Act, the Minister may determine a basic subsidy amount (including a nil amount) for a care recipient for a day based on whether:

(a) the recipient has previously been provided with residential care as respite care on a number of days during the financial year in which the day occurs; and

(b) that number of days is equal to, or greater than, the number applicable under paragraph 23(1)(c) of these principles.

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Division 3—Primary supplements

Subdivision A—Respite supplement

22 Respite supplement

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

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

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

23 Eligibility for respite supplement

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

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

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

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

(i) 63; or

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

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

(a) carer stress;

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

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

(d) any other relevant matter.

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

Subdivision B—Oxygen supplement

24 Oxygen supplement

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

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

25 Eligibility for oxygen supplement—determination by Secretary

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

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

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

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

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

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

26 Circumstances relating to provision of oxygen

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

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27 Reviewable decision

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

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

Subdivision C—Enteral feeding supplement

28 Enteral feeding supplement

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

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

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

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

29 Eligibility for enteral feeding supplement—determination by Secretary

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

(2) The application must:

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

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

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

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

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

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

30 Circumstances relating to provision of enteral feeding

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

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(a) a medical practitioner must have certified, in writing, that the care recipient has a medical need for enteral feeding;
(b) the care recipient must have been given a liquid dietary formula (not including food supplements or any supplementary feeding connected with the administration of the dietary formula) administered by a nasogastric, gastrostomy or jejeunostomy feeding method;
(c) a medical practitioner or dietician must have certified, in writing, that the dietary formula is a nutritionally complete formula;
(d) the enteral feeding must not be intermittent or supplementary enteral feeding given in addition to oral feeding;
(e) the enteral feeding must be provided in the most economical way available, taking into account the medical needs of the care recipient.

31 Reviewable decision

(1) A decision under subsection 29(3) to refuse to make a determination that a care recipient is eligible for an enteral feeding supplement is a reviewable decision under section 85-1 of the Act.

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

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Division 4—Reductions in subsidy

Subdivision A—Compensation payment reduction

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

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

(a) the amount of the judgment or settlement;

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

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

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

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

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

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

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

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

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

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

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

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

(ii) is likely to be liable for.

38 Determination by Secretary if compensation information not given on request

(1) For subsection 44-20A(5) of the Act, in determining compensation payment reductions for a care recipient if information or a document requested about a judgment, settlement or reimbursement arrangement is not produced or given, the Secretary must take into account the amounts spent on residential care at the time of the judgment, settlement or reimbursement arrangement.

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

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

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

Subdivision B—Care subsidy reduction—general

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

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

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

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

(1) For subsection 44-23(4) of the Act, in deciding whether to determine that the care subsidy reduction in respect of a care recipient is to be taken to be zero, the Secretary must have regard to the following matters:

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(a) the care recipient's total assessable income (worked out in accordance with section 44-24 of the Act and section 41 of these principles) and assets (worked out in accordance with section 44-26A of the Act and section 47 of these principles);
(b) the care recipient's financial arrangements;
(c) the care recipient's entitlement to income support:
(i) under the Social Security Act; or
(ii) under the Veterans' Entitlements Act; or
(iii) from any other source;
(d) whether the care recipient has taken steps to obtain information about his or her entitlement to pension, benefit or other income support payments;
(e) whether the care recipient has access to financial assistance:
(i) under section 1129 of the Social Security Act (relating to access to financial hardship rules for pensions); or
(ii) under the pension loans scheme under Division 4 of Part 3.12 of the Social Security Act; or
(iii) from any other source;
(f) whether any income of the care recipient is income that the care recipient does not reasonably have access to;
(g) whether there is a charge on the care recipient's income over which the payment of resident fees cannot practically take precedence;
(h) whether any assets of the care recipient are unrealisable assets;
(i) whether the care recipient is in Australia on a temporary basis.

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

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

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

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

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

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

(a) disability pensions and permanent impairment compensation payments mentioned in section 42;
(b) gifts mentioned in section 43;
(c) rent receipts mentioned in section 44;
(d) GST compensation mentioned in section 45;
(e) clean energy payments mentioned in section 46.

42 Excluded amounts—disability pensions and permanent impairment compensation payments

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

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

(a) any amount of compensation for permanent impairment paid to the person under Part 2 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004*;
(b) any amount of Special Rate Disability Pension paid to the person under Part 6 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004*.

43 Excluded amounts—gifts

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

(a) sections 1106, 1107, 1108 and 1109 of the Social Security Act; or
(b) sections 48, 48A, 48B and 48C of the Veterans' Entitlements Act;

is an excluded amount.

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

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

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

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

is an excluded amount.

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

44 Excluded amounts—rent receipts

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

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

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

(2) Subject to subsection (3), this section only applies to care recipients who first entered residential care on or before 31 December 2015.

(3) This section does not apply if the care recipient re-entered residential care after 31 December 2015, having previously ceased residential care for a continuous period of more than 28 days (other than because the person was on leave).

45 Excluded amounts—GST compensation

(1) This section applies in relation to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46 Excluded amounts—clean energy payments

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

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

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

Subdivision CA—Care subsidy reduction—amounts included in total assessable income

46A Included amounts—rent receipts and the *Social Security Act 1991*

(1) For subsection 44-24(6) of the Act, the provisions of the *Social Security Act 1991* apply as if paragraph 8(8)(znaa) of that Act were omitted.

(2) This section only applies to care recipients who, on or after 1 January 2016:

(a) first entered residential care; or

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(b) re-entered residential care having previously ceased residential care for a continuous period of more than 28 days (other than because the person was on leave).

46B Included amounts—rent receipts and the *Veterans Entitlements Act 1986*

(1) For subsection 44-24(7) of the Act, the provisions of the *Veterans Entitlements Act 1986* apply as if paragraph 5H(8)(nf) of that Act were omitted.

(2) This section only applies to care recipients who, on or after 1 January 2016:
(a) first entered residential care; or
(b) re-entered residential care having previously ceased residential care for a continuous period of more than 28 days (other than because the person was on leave).

Subdivision D—Care subsidy reduction—value of assets

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

(1) For subsection 44-26A(1) of the Act, the value of a person's assets is the value worked out in accordance with Division 1 of Part 3.12 of the Social Security Act, reduced by any compensation payments received by the person under:
(a) the *Compensation (Japanese Internment) Act 2001*; or
(b) the *Veterans' Entitlements (Compensation—Japanese Internment) Regulations 2001*; or
(c) Part 2 of the *Veterans' Entitlements (Clarke Review) Act 2004*; or
(d) Schedule 5 to the *Social Security and Veterans' Affairs Legislation Amendment (One-off Payments and Other 2007 Budget Measures) Act 2007*.

(2) However, the following provisions of Division 1 of Part 3.12 of the Social Security Act do not apply for the purposes of working out the person's assets:
(a) paragraphs 1118(1)(a), (b) and (g), subparagraphs 1118(1)(ga)(ii) and (gb)(ii), paragraphs 1118(1)(u) and (v) and subsection 1118(4) (Certain assets to be disregarded in calculating the value of a person's assets);
(b) section 1118AB (Value of person's assets reduced: certain transactions to do with aged care accommodation bonds);
(c) section 1118AC (Value of person's assets reduced: refunds to charge exempt residents).

(2A) Also, subsection 1121(1) of the Social Security Act does not apply, for the purposes of working out the value of the person's assets, to a charge or encumbrance over the amount of any refundable deposit balance in respect of a refundable deposit paid by the person.

Value of home

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

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48 Meaning of *homeowner*

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

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

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

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

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

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

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

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

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

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

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

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Division 5—Other supplements

Subdivision A—Accommodation supplement

49 Purpose of this Subdivision

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

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

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

(a) whether the service is:
  (i) a newly built residential care service; or
  (ii) a significantly refurbished residential care service;
(b) whether the service meets the building requirements specified in Schedule 1 to the *Aged Care (Transitional Provisions) Principles 2014*;
(c) whether or not the residential care percentage (within the meaning of subsection 64ZP(3) of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*) for the service for the payment period in which the day occurs is 40% or more.

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

51 Application for determination

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) a significant proportion of the areas of the service that have been refurbished are areas that are accessible to, and for the use of, care recipients who are being provided with residential care through the service;

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

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

(i) the refurbishment consisted of structural improvements; or

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

(f) the refurbishment:

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

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

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

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

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

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

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

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

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

(a) if the refurbishment consisted solely of the building of a new accommodation wing—the date when the occupancy certificate (or equivalent) was issued for the new wing;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) a significant proportion of the areas of the service that are proposed to be refurbished are areas that are accessible to, and for the use of, care recipients who will be provided with residential care through the service;

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

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

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

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

(e) the proposed refurbishment:

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

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

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

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

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

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

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

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

(a) the proposed refurbishment has been completed;

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

(c) a significant proportion of the areas of the service that have been refurbished are areas that are accessible to, and for the use of, care recipients who are being provided with residential care through the service;

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

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

(i) the refurbishment consisted of structural improvements; or

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

(f) the refurbishment:

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

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

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

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

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

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

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

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

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

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

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

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

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

54 Circumstances in which Secretary must not make determination

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

(a) routine repairs; or

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

(c) replacement of furniture; or

(d) fire safety improvements.

55 Requests for further information etc.

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

(2) The application is taken to be withdrawn if:

(a) further information is requested under subsection (1); and

(b) the information is not given within the period referred to in that subsection.

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

56 Notification of Secretary's decision

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

(2) If:

(a) the decision relates to an application made under subsection 51(1) in relation to a residential care service that has been significantly refurbished; and

(b) the decision is to make the determination;

the notice must state the day on which the determination takes effect, as provided by subsection 57(1).

(3) If:

(a) the decision relates to an application made under subsection 51(2) in relation to a residential care service that is proposed to be significantly refurbished; and

(b) the decision is to make the determination;

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the notice must include a statement setting out the condition referred to in subsection 53(1) (including the information referred to in subsection 53(3)).

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

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

57 Day of effect of determination

(1) A determination under subsection 52(1) in relation to a residential care service that has been significantly refurbished takes effect:
  (a) if the refurbishment was completed before 1 July 2014 and the application for the determination was received on or before 31 July 2014—on 1 July 2014; or
  (b) in any other case—on the day the application was received.

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

58 Determinations are not legislative instruments

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

59 Reviewable decisions

(1) Each of the following is a reviewable decision under section 85-1 of the Act:
  (a) a decision under subsection 52(1) or 53(1) to refuse to make a determination in relation to a residential care service;
  (b) a decision under paragraph 53(5)(a) that the Secretary is not satisfied as referred to in paragraph 53(1)(b) in relation to a refurbished service.

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

Subdivision B—Hardship supplement

60 Eligibility for hardship supplement—determination by Secretary

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

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

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

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

(i) the basic age pension amount;

(ii) the pension supplement amount;

(iii) the clean energy supplement amount; or

(c) the care recipient has gifted:

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

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

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

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

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

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

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

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

(c) the financial arrangements of the care recipient;

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

(i) under the Social Security Act; or

(ii) under the Veterans' Entitlements Act; or

(iii) from any other source;

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

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

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

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

(iii) from any other source;

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

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

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

(j) any other matters the Secretary considers relevant.

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

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

(a) resident fees;

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

(c) private health insurance;

(d) ambulance cover;

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

(f) transport costs to attend medical appointments;

(g) dental care;

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

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

(j) wheelchair and mobility aids;

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

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

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

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

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

62 Circumstances in which Secretary may revoke financial hardship determination

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

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

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

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

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Subdivision C—Viability supplement for payment periods beginning before 1 October 2022

63 Viability supplement

For paragraph 44-27(1)(c) of the Act, the viability supplement for a care recipient in respect of a payment period beginning before 1 October 2022 is the sum of all the viability supplements for the days during the period on which:

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

(b) the residential care service was:

(i) a 1997 scheme service; or

(ii) a 2001 scheme service; or

(iii) a 2005 scheme service; or

(iv) a 2017 scheme service; and

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

64 Meaning of *1997 scheme service*

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

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

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

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

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

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

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

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

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1997 scheme services—scoring		
Item	**Criterion**	**Points**
1	Location:	
	(a) remote zone;	40
	(b) other rural area;	30
	(c) small rural centre;	20
	(d) large rural centre.	10
2	Beds:	
	(a) less than 30;	20
	(b) less than 16.	30
3	Service not co-located with another service and unable to co-locate.	20
4	Supported, concessional or assisted residents:	
	(a) over 70%;	20
	(b) 50% to 70%.	10
5	Caters largely for care recipients who are people with special needs (other than people with special needs only because they live in a rural or remote area or are financially or socially disadvantaged).	10

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

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

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

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

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

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

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

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

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

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65 Meaning of *2001 scheme service*

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

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

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

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

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

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

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

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

2001 scheme services—scoring

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

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

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

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(a) the service commenced operating on or after 1 January 2005 and before 1 July 2005; and

(b) on the day that the service commenced operating, the point score of the service was at least 40 points, under the scoring system set out in the table in subsection (2); and

(c) also, on the day that the service commenced operating, the point score of the service was either:

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

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

66 Meaning of *2005 scheme service*

(1) A residential care service is a ***2005 scheme service*** on a day if, on that day, the service:

(a) meets the requirements of subsection (2), (6) or (7); and

(b) does not meet the requirements of subsection 66A(8).

(2) A residential care service meets the requirements of this subsection if, on or after 1 January 2005, the service:

(a) is not a 1997 scheme service or a 2001 scheme service; and

(b) scores at least 50 points, worked out as follows:

2005 scheme service points calculator

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

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

(a) high ADL domain category;

(b) high CHC domain category;

(c) high behaviour domain category;

(d) a medium domain category in at least 2 domains.

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Step 3. Add an additional 60 points if subsection (4) applies to the service (care for homeless people, people from Aboriginal and Torres Strait Islander communities, or both).

Step 4. If the total of steps 1, 2 and 3 is more than 65, reduce the total to 65 points.

Step 5. Add the number of points (if any) applicable to the service in respect of its number of places that are occupied under subsection (5).

Step 6. Add an additional 5 points if more than 50% of care recipients are people with special needs (other than people who are people with special needs only because they live in rural or remote areas or are financially or socially disadvantaged).

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

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

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

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

2005 scheme services—locations

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

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

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

(a) the places allocated in respect of the residential care service are subject to a condition of allocation under section 14-5 of the Act relating to the care of

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people with a background as homeless persons or persons from an Aboriginal or Torres Strait Islander community; or

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

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

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

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

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

2005 scheme service—occupied places

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

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

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

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

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

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

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

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66A Meaning of 2017 scheme service

(1) A residential care service is a ***2017 scheme service*** on a day if, on that day, the service meets the requirements of subsection (2), (6), (7) or (8).

(2) A residential care service meets the requirements of this subsection if, on or after 1 January 2017, the service:

(a) is not a 1997 scheme service, a 2001 scheme service or a 2005 scheme service; and

(b) scores at least 50 points, worked out as follows:

2017 scheme service points calculator

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

Step 2. Add an additional 15 points if the classification for the street address of the service is MMM 5, MMM 6 or MMM 7, and more than 50% of care recipients of the service (other than care recipients receiving respite care) are classified at a classification level that does not include any of the following domain categories:

(a) high ADL domain category;

(b) high CHC domain category;

(c) high behaviour domain category;

(d) a medium domain category in at least 2 domains.

Step 3. Add an additional 60 points if subsection (4) applies to the service (care for homeless people, people from Aboriginal and Torres Strait Islander communities, or both).

Step 4. If the total of steps 1, 2 and 3 is more than 65, reduce the total to 65 points.

Step 5. Add the number of points (if any) applicable to the service in respect of its number of places that are occupied under subsection (5).

Step 6. Add an additional 5 points if more than 50% of care recipients are people with special needs (other than people who are people with special needs only because they live in rural or remote areas or are financially or socially disadvantaged).

The result is the points score for the 2017 scheme service.

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Note 1: In 2017, the Modified Monash Model classification for a street address was available at http://www.doctorconnect.gov.au.

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

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

2017 scheme services—street addresses

Item	Modified Monash Model classification	Points
1	MMM 1	0
2	MMM 2	0
3	MMM 3	0
4	MMM 4	30
5	MMM 5	40
6	MMM 6	55
7	MMM 7	65

Note: In 2017, the Modified Monash Model classification for a street address was available at http://www.doctorconnect.gov.au.

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

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

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

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

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

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

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

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2017 scheme service—occupied places		
Item	**Occupied places**	**Points**
1	Less than 20	30
2	More than 19 but less than 25	25
3	More than 24 but less than 30	20
4	More than 29 but less than 35	15
5	More than 34 but less than 40	10
6	More than 39 but less than 45	5

(6) A residential care service meets the requirements of this subsection if the service was a 1997 scheme service and, on at least 1 day on or after 1 January 2017:

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

(b) the amount of viability supplement payable in accordance with a determination made under subsection 44-27(3) of the Act, for a day in respect of a care recipient to whom care is provided through the service as a 2017 scheme service is the same as or greater than the amount of viability supplement payable in respect of the care recipient for the day if the service was taken to be a 1997 scheme service.

(7) A residential care service meets the requirements of this subsection if the service was a 2001 scheme service and, on at least 1 day on or after 1 January 2017:

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

(b) the amount of viability supplement payable in accordance with a determination made under subsection 44-27(3) of the Act, for a day in respect of a care recipient to whom care is provided through the service as a 2017 scheme service is the same as or greater than the amount of viability supplement payable in respect of the care recipient for the day if the service was taken to be a 2001 scheme service.

(8) A residential care service meets the requirements of this subsection if the service was a 2005 scheme service and, on at least 1 day on or after 1 January 2017:

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

(b) the amount of viability supplement payable in accordance with a determination made under subsection 44-27(3) of the Act, for a day in respect of a care recipient to whom care is provided through the service as a 2017 scheme service is the same as or greater than the amount of viability supplement payable in respect of the care recipient for the day if the service was taken to be a 2005 scheme service.

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Subdivision D—Veterans' supplement

67 Veterans' supplement

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

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

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

68 Eligibility for veterans' supplement

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

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

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

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

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

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

Subdivision E—Homeless supplement for payment periods beginning before 1 October 2022

69 Homeless supplement

For paragraph 44-27(1)(c) of the Act, the homeless supplement for a care recipient in respect of a payment period beginning before 1 October 2022 is the sum of all the homeless supplements for the days during the period on which:

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

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

70 Eligibility for homeless supplement

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

(a) more than 50% of care recipients provided with residential care (other than respite care) through the service have been appraised using appraisal tool A in subclause 2(1) of Schedule 2 as demonstrating complex behavioural needs and social disadvantage associated with their background as a homeless person; and

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(b) either:
(i) the allocation of places to the approved provider in respect of the service was made (under section 14-5 of the Act) subject to conditions relating to care of people with a background as homeless persons; or
(ii) the approved provider or its key personnel have demonstrated experience in providing, or the capacity to provide, specialist services for such persons, including programs and interventions to manage complex behavioural needs, or programs to promote social engagement and participation.

Subdivision F—COVID-19 support supplement (for COVID-19 support payment periods)

70AA COVID-19 support supplement (for COVID-19 support payment periods)

For the purposes of paragraph 44-27(1)(c) of the Act, the COVID-19 support supplement for a care recipient in respect of a COVID-19 support payment period is the sum of all the COVID-19 support supplements for the days during the period on which:

(a) the care recipient was provided with residential care through the residential care service in question; and
(b) the care recipient was eligible for a COVID-19 support supplement under section 70AB.

70AB Eligibility for COVID-19 support supplement

(1) A care recipient is eligible for a COVID-19 support supplement on a particular day if, on that day, the care recipient is being provided with residential care other than as respite care.

(2) A care recipient is eligible for a COVID-19 support supplement on a particular day if, on that day:
(a) the care recipient is being provided with residential care as respite care; and
(b) under Division 2 of Part 1 of Chapter 2 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*, the basic subsidy amount for the day for the care recipient is not nil.

Subdivision G—Residential care support supplement (for February 2021 payment period)

70AC Residential care support supplement (for February 2021 payment period)

For the purposes of paragraph 44-27(1)(c) of the Act, the residential care support supplement for a care recipient in respect of the payment period beginning on 1 February 2021 is the sum of all the residential care support supplements for the days during the period on which:

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(a) the care recipient was provided with residential care through the residential care service in question; and
(b) the care recipient was eligible for a residential care support supplement under section 70AD.

70AD Eligibility for residential care support supplement

(1) A care recipient is eligible for a residential care support supplement on a particular day if, on that day, the care recipient is being provided with residential care other than as respite care.

(2) A care recipient is eligible for a residential care support supplement on a particular day if, on that day:
(a) the care recipient is being provided with residential care as respite care; and
(b) under Division 2 of Part 1 of Chapter 2 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*, the basic subsidy amount for the day for the care recipient is not nil.

Subdivision H—2021 basic daily fee supplement (for payment periods July 2021 to September 2022)

70AE 2021 basic daily fee supplement (for payment periods July 2021 to September 2022)

For the purposes of paragraph 44-27(1)(c) of the Act, the 2021 basic daily fee supplement for a care recipient in respect of a payment period beginning on or after 1 July 2021 and before 1 October 2022 is the sum of all the 2021 basic daily fee supplements for the days during the period on which:
(a) the care recipient was provided with residential care through the residential care service in question; and
(b) the care recipient was eligible for a 2021 basic daily fee supplement under section 70AF; and
(c) the approved provider of the service met the requirements for eligibility for a 2021 basic daily fee supplement under section 70AG.

70AF Eligibility for 2021 basic daily fee supplement—care recipients

(1) A care recipient is eligible for a 2021 basic daily fee supplement on a particular day if, on that day, the care recipient is being provided with residential care other than as respite care.

(2) A care recipient is eligible for a 2021 basic daily fee supplement on a particular day if, on that day:
(a) the care recipient is being provided with residential care as respite care; and

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(b) under Division 2 of Part 1 of Chapter 2 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*, the basic subsidy amount for the day for the care recipient is not nil.

70AG Eligibility for 2021 basic daily fee supplement—approved providers

Notice to Secretary

(1) An approved provider may give the Secretary a notice in accordance with subsection (2), but may give such a notice only once.

(2) The notice must:
(a) be in writing, in a form approved by the Secretary; and
(b) include an undertaking to give the Secretary reports in accordance with subsection (10) relating to the quarter in which the notice is given and each subsequent quarter; and
(c) include any other statements or information required by the approved form.

Eligibility based on giving notice—initial quarter

(3) If the notice is given on or before the 21st day of a quarter (the ***initial quarter***), the approved provider meets the requirements for eligibility for a 2021 basic daily fee supplement on each day between the first day of the initial quarter and:
(a) if paragraph (b) does not apply—the 21st day of the following quarter; or
(b) if the initial quarter begins on 1 July 2022—30 September 2022.

(4) If the notice is given after the 21st day of a quarter (the ***initial quarter***) and before the end of the initial quarter, the approved provider meets the requirements for eligibility for a 2021 basic daily fee supplement on each day between the day the notice is given and:
(a) if paragraph (b) does not apply—the 21st day of the following quarter; or
(b) if the initial quarter begins on 1 July 2022—30 September 2022.

Eligibility based on giving reports—later quarters

(5) Subsections (6) to (9) apply to an approved provider that has given a notice in accordance with subsection (2) in a quarter.

(6) Subject to subsection (7), if, on or before the 21st day of a later quarter (the ***current quarter***), the approved provider gives the Secretary a report relating to the previous quarter in accordance with subsection (10), the approved provider meets the requirements for eligibility for a 2021 basic daily fee supplement on each day between the 22nd day of the current quarter and the 21st day of the following quarter.

(7) If, on or before 21 July 2022, the approved provider gives the Secretary a report relating to the quarter beginning on 1 April 2022 in accordance with subsection (10), the approved provider meets the requirements for eligibility for a 2021 basic daily fee supplement on each day between 22 July 2022 and 30 September 2022.

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(8) Subject to subsection (9), if, after the 21st day of a later quarter (the ***current quarter***) and on or before the 21st day of the immediately following quarter (the ***following quarter***), the approved provider gives the Secretary a report relating to the quarter immediately before the current quarter in accordance with subsection (10), the approved provider meets the requirements for eligibility for a 2021 basic daily fee supplement on each day between the day the report is given and the 21st day of the following quarter.

(9) If, after 21 July 2022 and on or before 30 September 2022, the approved provider gives the Secretary a report relating to the quarter beginning on 1 April 2022 in accordance with subsection (10), the approved provider meets the requirements for eligibility for a 2021 basic daily fee supplement on each day between the day the report is given and 30 September 2022.

Reports

(10) For the purposes of paragraph (2)(b) and subsections (6) to (9), a report relating to a quarter must:
(a) be in writing, in a form approved by the Secretary; and
(b) include the information required by the approved form about the quality and quantity of daily living services, with a focus on food and nutrition, provided in the quarter by each residential care service through which the approved provider provides residential care.

*Meaning of **quarter***

(11) In this section:

quarter means a quarter beginning on 1 July 2021, 1 October 2021, 1 January 2022, 1 April 2022 or 1 July 2022.

Subdivision I—Initial entry adjustment supplement

70AH Initial entry adjustment supplement

For the purposes of paragraph 44-27(1)(c) of the Act, the initial entry adjustment supplement applies to a care recipient in respect of a payment period if:
(a) the payment period begins on or after 1 October 2022; and
(b) the first day on which the recipient entered the residential care service in question to be provided with residential care as non-respite care occurred during the payment period; and
(c) the recipient was provided with that care on that day through that service.

Subdivision J—Hotelling supplement

70AI Hotelling supplement

For the purposes of paragraph 44-27(1)(c) of the Act, the hotelling supplement for a care recipient in respect of a payment period beginning on or after 1 July

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2023 is the sum of all the hotelling supplements for the days during the period on which:

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

(b) the care recipient was eligible for a hotelling supplement under section 70AJ.

70AJ Eligibility for hotelling supplement

(1) A care recipient is eligible for a hotelling supplement on a particular day if, on that day, the care recipient is being provided with residential care other than as respite care.

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

(a) the care recipient is being provided with residential care as respite care; and

(b) under Division 3 of Part 3 of Chapter 2A of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*, the basic subsidy amount for the day for the care recipient is not nil.

Subdivision K—Registered nurse supplement

70AK Registered nurse supplement

For the purposes of paragraph 44-27(1)(c) of the Act, the registered nurse supplement for a care recipient in respect of a payment period beginning on or after 1 July 2023 is the sum of all the registered nurse supplements for the days during the period on which:

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

(b) the care recipient was eligible for a registered nurse supplement under section 70AL.

70AL Eligibility for registered nurse supplement

(1) A care recipient is eligible for a registered nurse supplement on a particular day during a payment period if:

(a) on that day, the care recipient is being provided with residential care other than as respite care through a residential care service; and

(b) during the period, residential care is provided through the residential care service at at least one residential facility that is a qualifying facility for the period.

(2) A care recipient is eligible for a registered nurse supplement on a particular day during a payment period if:

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

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(b) under Division 3 of Part 3 of Chapter 2A of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*, the basic subsidy amount for the day for the care recipient is not nil; and

(c) during the period, residential care is provided through the residential care service at at least one residential facility that is a qualifying facility for the period.

70AM Meaning of *qualifying facility*

(1) A residential facility is a ***qualifying facility*** for a payment period if all of the following criteria are met:

(a) an exemption from section 54-1A of the Act in relation to the facility is not in force at any time during the period;

(b) a report in relation to the facility and the period has been submitted in accordance with section 44B of the *Accountability Principles 2014*;

(c) the total number of days of eligible residential care provided in respect of care recipients at the facility during the period, divided by the number of days in the period, is no more than 60;

(d) the total number of hours, on days during the period on which residential care was provided at the facility, that a registered nurse was not on site and on duty at the facility is no more than the number of such days in the period multiplied by 4.

Note: Residential care might be provided at a facility through more than one residential care service.

(2) A ***day of eligible residential care*** is provided in respect of a care recipient if:

(a) residential care is provided to the care recipient during a day:

(i) other than as respite care; or

(ii) as respite care and, under Division 3 of Part 3 of Chapter 2A of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*, the basic subsidy amount for the day for the care recipient is not nil; and

(b) the approved provider of the residential care service through which the care is provided is eligible for residential care subsidy in respect of the day.

(3) If, during a payment period, days of eligible residential care are provided in respect of care recipients through the same residential care service at more than one residential facility, then, for the purposes of paragraph (1)(c), the total number of days of eligible residential care provided at each facility is taken to be proportional to the number of operational places allocated in respect of the service, on the last day of the payment period, in respect of the location of each facility.

Subdivision L—Outbreak management support supplement

70AN Outbreak management support supplement

For the purposes of paragraph 44-27(1)(c) of the Act, the outbreak management support supplement for a care recipient in respect of a payment period beginning

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on or after 1 February 2024 is the sum of all the outbreak management support supplements for the days during the period on which:

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

(b) the care recipient was eligible for an outbreak management support supplement under section 70AO.

70AO Eligibility for outbreak management support supplement

(1) A care recipient is eligible for an outbreak management support supplement on a particular day if, on that day, the care recipient is being provided with residential care other than as respite care.

(2) A care recipient is eligible for an outbreak management support supplement on a particular day if, on that day:

(a) the care recipient is being provided with residential care as respite care; and

(b) under Division 3 of Part 3 of Chapter 2A of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*, the basic subsidy amount for the day for the care recipient is not nil.

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Chapter 3—Home care subsidy

Part 1A—Meaning of home care

70A Purpose of this Part

For paragraph 45-3(2)(b) of the Act, this Part specifies care that does not constitute home care.

70B Care that does not constitute home care

For paragraph 45-3(2)(b) of the Act, flexible care in the form of short-term restorative care or transition care does not constitute home care.

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Part 1—Who is eligible for home care subsidy?

Division 1—Purpose of this Part

71 Purpose of this Part

For Division 46 of the Act, this Part specifies requirements relating to the suspension, on a temporary basis, of the provision of home care to a care recipient in accordance with a home care agreement.

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Division 2—Suspension of home care

72 Suspension of home care

(1) For subsection 46-2(3) of the Act, this section specifies requirements relating to the suspension, on a temporary basis, of the provision of home care to a care recipient in accordance with a home care agreement.

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

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

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

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Part 1B—On what basis is home care subsidy paid?

Division 1—Purpose of this Part

72A Purpose of this Part

For the purposes of Division 47 of the Act, this Part specifies the period within which an approved provider may vary a claim made in respect of a payment period for home care subsidy.

Division 2—Variation of claims for home care subsidy

72B Variation of claims for home care subsidy

(1) For the purposes of subparagraph 47-4A(1)(a)(i) of the Act, this section provides for the period within which an approved provider may vary a claim made in respect of a payment period.

(2) This section applies to a variation to the extent that it relates to a care recipient to whom the approved provider has ceased to provide home care.

(3) The period is 70 days after:
  (a) if Subdivision D of Division 3A of Part 3 of the *User Rights Principles 2014* applies—the home care cessation day (within the meaning of section 21D of those Principles); or
  (b) if Subdivision F of Division 3A of Part 3 of those Principles applies—the home care service cessation day (within the meaning of section 21JA of those Principles).

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

Division 1—Purpose of this Part

73 Purpose of this Part

For the purposes of Division 48 of the Act, this Part sets out matters in relation to the amount of home care subsidy payable to an approved provider for a home care service in respect of a payment period, including the following:

(a) primary supplements for care recipients (Division 2);
(b) reductions in subsidy for care recipients (Division 3);
(c) other supplements for care recipients (Division 4);
(d) matters relating to working out the shortfall amount for care recipients (Division 5);
(e) matters relating to home care accounts for care recipients (Division 6).

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Division 2—Primary supplements

Subdivision A—Oxygen supplement

74 Oxygen supplement

(1) The oxygen supplement for a care recipient in respect of a payment period is the sum of all the oxygen supplements for the days during the period on which:
  (a) there was in force a home care agreement under which the care recipient was to be provided with home care through the home care service in question (whether or not home care was provided); and
  (b) a determination was in force under subsection 75(3) in relation to the care recipient; and
  (c) the home care provided through the home care service included providing oxygen to the care recipient in circumstances specified in section 76.

(2) However, a day is to be disregarded for the purposes of subsection (1) if:
  (a) more than one approved provider is eligible for home care subsidy for the day for the care recipient; and
  (b) the approved provider for the home care service in question was not the first of the approved providers referred to in paragraph (a) to have entered into a home care agreement with the care recipient.

75 Eligibility for oxygen supplement—determination by Secretary

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

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

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

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

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

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

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76 Circumstances relating to provision of oxygen

For paragraph 74(1)(c), the circumstances for the provision of oxygen are as follows:

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

(b) the oxygen must not be provided:

(i) because of a medical emergency; or

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

(c) a medical practitioner or a nurse practitioner must have certified, in writing, that the care recipient has a continual need for the provision of oxygen;

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

77 Reviewable decision

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

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

Subdivision B—Enteral feeding supplement

78 Enteral feeding supplement

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

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

(b) a determination was in force under subsection 79(3) in relation to the care recipient; and

(c) the home care provided through the home care service included providing enteral feeding to the care recipient in circumstances specified in section 80.

(2) However, a day is to be disregarded for the purposes of subsection (1) if:

(a) more than one approved provider is eligible for home care subsidy for the day for the care recipient; and

(b) the approved provider for the home care service in question was not the first of the approved providers referred to in paragraph (a) to have entered into a home care agreement with the care recipient.

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79 Eligibility for enteral feeding supplement—determination by Secretary

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

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

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

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

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

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

80 Circumstances relating to provision of enteral feeding

For paragraph 78(1)(c), the circumstances for the provision of enteral feeding are as follows:
  (a) a medical practitioner must have certified, in writing, that the care recipient has a medical need for enteral feeding;
  (b) the care recipient must have been given a liquid dietary formula (not including food supplements or any supplementary feeding connected with the administration of the dietary formula) administered by a nasogastric, gastrostomy or jejeunostomy feeding method;
  (c) a medical practitioner or dietician must have certified, in writing, that the dietary formula is a nutritionally complete formula;
  (d) the enteral feeding must not be intermittent or supplementary enteral feeding given in addition to oral feeding;
  (e) the enteral feeding must be provided in the most economical way available, taking into account the medical needs of the care recipient.

81 Reviewable decision

(1) A decision under subsection 79(3) to refuse to make a determination that a care recipient is eligible for an enteral feeding supplement is a reviewable decision under section 85-1 of the Act.

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

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Subdivision C—Dementia and cognition supplement

82 Dementia and cognition supplement

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

(2) However, a day is to be disregarded for the purposes of subsection (1) if:
  (a) more than one approved provider is eligible for home care subsidy for the day for the care recipient; and
  (b) the approved provider for the home care service in question was not the first of the approved providers referred to in paragraph (a) to have entered into a home care agreement with the care recipient.

83 Eligibility for dementia and cognition supplement

(1) A care recipient is eligible for a dementia and cognition supplement on a particular day if, on that day:
  (a) subsection (2), (3), (4) or (5) applied to the care recipient; and
  (b) if subsection (2), (3) or (4) applied to the care recipient—the approved provider had a record of the assessment mentioned in the relevant subsection; and
  (c) the care recipient was not eligible for a veterans' supplement under section 85.

(2) This subsection applies to a care recipient on a day if:
  (a) the care recipient has been assessed in accordance with the Psychogeriatric Assessment Scales; and
  (b) the assessment was conducted by a registered nurse, clinical nurse consultant, nurse practitioner, clinical psychologist or medical practitioner; and
  (c) the assessment resulted in a score of 10 or more.

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

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

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(d) the assessment resulted in a score of 22 or less.

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

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

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

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

Subdivision D—Veterans' supplement

84 Veterans' supplement

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

(2) However, a day is to be disregarded for the purposes of subsection (1) if:
(a) more than one approved provider is eligible for home care subsidy for the day for the care recipient; and
(b) the approved provider for the home care service in question was not the first of the approved providers referred to in paragraph (a) to have entered into a home care agreement with the care recipient.

85 Eligibility for veterans' supplement

A care recipient is eligible for a veterans' supplement on a particular day if:
(a) on that day, the care recipient is a veteran with an accepted mental health condition; and
(b) the care recipient has before, on or after that day, authorised either, or both, of the following to disclose to the approved provider that the care recipient is a veteran with an accepted mental health condition:

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

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

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

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Division 3—Reductions in subsidy

Subdivision A—Compensation payment reduction

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

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

(a) the amount of the judgment or settlement;

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

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

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

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

(a) loss of income;

(b) costs of future care.

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

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

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

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

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

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

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

(ii) is likely to be liable for.

87 Determination by Secretary if compensation information not given on request

(1) For subsection 48-6(5) of the Act, in determining compensation payment reductions for a care recipient if information or a document requested about a judgment, settlement or reimbursement arrangement is not produced or given, the Secretary must take into account the amounts spent on home care at the time of the judgment, settlement or reimbursement arrangement.

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

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

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

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

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

Subdivision B—Care subsidy reduction—general

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

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

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

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

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

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

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

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

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

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

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

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

(2) For subsection 44-24(5) of the Act, the amounts (in this Subdivision called ***excluded amounts***) that are to be taken, in relation to the kinds of care recipients specified in sections 91 to 94, to be excluded from determinations by the Secretary under subsection 44-24(1) or paragraph 44-24(2)(b), (3)(b) or (4)(b) of the Act are the following:

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(a) disability pensions and permanent impairment compensation payments mentioned in section 91;
(b) gifts mentioned in section 92;
(c) GST compensation mentioned in section 93;
(d) clean energy payments mentioned in section 94.

91 Excluded amounts—disability pensions and permanent impairment compensation payments

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

(2) For a person who is a member or former member (within the meaning of the *Military Rehabilitation and Compensation Act 2004*) or the partner of such a person, each of the following is an excluded amount:
(a) any amount of compensation for permanent impairment paid to the person under Part 2 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004*;
(b) any amount of Special Rate Disability Pension paid to the person under Part 6 of Chapter 4 of the *Military Rehabilitation and Compensation Act 2004*.

92 Excluded amounts—gifts

(1) For a person who, on or before 20 August 1996, disposed of ordinary income, the amount of ordinary income disposed of on or before 20 August 1996 that is included in the person's ordinary income under:
(a) sections 1106, 1107, 1108 and 1109 of the Social Security Act; or
(b) sections 48, 48A, 48B and 48C of the Veterans' Entitlements Act;
is an excluded amount.

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

(2) For a person who, on or before 20 August 1996, disposed of assets, the amount of ordinary income the person is taken to receive because assets disposed of on or before 20 August 1996 are assessed as financial assets under:
(a) section 1076, 1077 or 1078 of the Social Security Act; or
(b) sections 46D and 46E of the Veterans' Entitlements Act;
is an excluded amount.

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

93 Excluded amounts—GST compensation

(1) This section applies in relation to:

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(a) a person receiving a pension under Part II or IV of the Veterans' Entitlements Act at a rate determined under or by reference to the following provisions of that Act:
  (i) for a person receiving a disability pension payable at the general rate—section 22;
  (ii) for a person receiving a disability pension payable at the general rate including an increased rate for a war-caused injury or disease—sections 22 and 27;
  (iii) for a person receiving a disability pension payable at the intermediate rate—section 23;
  (iv) for a person receiving a disability pension payable at the intermediate rate including an increased rate for a war-caused injury or disease—sections 23 and 27;
  (v) for a person receiving a disability pension payable at the special rate—section 24;
  (vi) for a person receiving a war widow or widower pension—subsection 30(1); and

(b) a person receiving a pension under Part 6 of Chapter 4, or a weekly amount of compensation under Part 2 of Chapter 5, of the *Military Rehabilitation and Compensation Act 2004* at a rate determined under or by reference to the following provisions of that Act:
  (i) for a person receiving a Special Rate Disability Pension—sections 198 and 204;
  (ii) for a person receiving a weekly amount of compensation for the death of the person's partner—subsection 234(5).

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

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

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

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

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

94 Excluded amounts—clean energy payments

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

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

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

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Division 4—Other supplements

Subdivision A—Hardship supplement

95 Eligibility for hardship supplement—determination by Secretary

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

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

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

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

(i) the basic age pension amount;

(ii) the pension supplement amount;

(iii) the clean energy supplement amount; or

(c) the care recipient has gifted:

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

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

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

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

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

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

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

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

(c) the financial arrangements of the care recipient;

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

(i) under the Social Security Act; or

(ii) under the Veterans' Entitlements Act; or

(iii) from any other source;

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

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(f) whether the care recipient has access to financial assistance:
  (i) under section 1129 of the Social Security Act (relating to access to financial hardship rules for pensions); or
  (ii) under the pension loans scheme under Division 4 of Part 3.12 of the Social Security Act; or
  (iii) from any other source;
(g) whether any income of the care recipient is income that the care recipient does not reasonably have access to;
(h) whether there is a charge on the care recipient's income over which the payment of home care fees cannot practically take precedence;
(i) whether the care recipient is in Australia on a temporary basis;
(j) any other matters that the Secretary considers relevant.

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

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

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

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97 Circumstances in which Secretary may revoke financial hardship determination

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

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

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

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

Subdivision B—Viability supplement

98 Viability supplement

(1A) Viability supplement for a care recipient in respect of a payment period is a supplement for the purposes of paragraph 48-9(1)(b) of the Act.

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

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

(b) the service meets the eligibility requirements under section 99.

(2) However, a day is to be disregarded for the purposes of subsection (1) if:

(a) more than one approved provider is eligible for home care subsidy for the day for the care recipient; and

(b) the approved provider for the home care service in question was not the first of the approved providers referred to in paragraph (a) to have entered into a home care agreement with the care recipient.

99 Eligibility for viability supplement

MMM classification system eligibility—care recipients who were not provided with home care in a particular location before 1 January 2017

(1) A home care service meets the eligibility requirements for a viability supplement on a particular day if, on that day:

(a) home care is provided through the home care service to the care recipient in a suburb or locality that has a Modified Monash Model classification of MMM 4 or greater; and

(b) before 1 January 2017, home care had not been provided through a home care service to the care recipient in that suburb or locality.

Note: ***Modified Monash Model classification*** is defined in section 4.

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MMM classification system eligibility—care recipients who were provided with home care in the same suburb or locality before 1 January 2017

(2) A home care service meets the eligibility requirements for a viability supplement on a particular day if, on that day:

(a) home care is provided through the home care service to the care recipient in a suburb or locality that has a Modified Monash Model classification of MMM 4 or greater; and

(b) before 1 January 2017, home care had been provided through a home care service to the care recipient in that suburb or locality; and

(c) on or after 1 January 2017, home care has not been provided by a home care service to the care recipient in another suburb or locality.

Note: ***Modified Monash Model classification*** is defined in section 4.

ARIA value eligibility—care recipients who were provided with home care before 1 January 2017

(3) A home care service meets the eligibility requirements for a viability supplement on a particular day if:

(a) on that day, the home care service does not meet the eligibility requirements under subsection (1) or (2); and

(b) on that day, home care is provided through the home care service to the care recipient in a location that has an ARIA value of 3.52 or greater; and

(c) immediately before 1 January 2017, home care was provided through a home care service to the care recipient in that location; and

(d) on or after 1 January 2017, home care has not been provided by a home care service to the care recipient in another location.

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

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Division 5—Shortfall amount

99A Meaning of *available home care fees amount*

The ***available home care fees amount*** for a care recipient in respect of a payment period is worked out as follows.

Available home care fees amount **calculator**

Step 1. Work out the amount of home care fees paid or payable by the care recipient in respect of the payment period (if any).

Step 2. Subtract the care recipient contribution amount worked out under section 99C for the care recipient in respect of the payment period. If the result is negative, the amount is taken to be nil.

The result (including a nil amount) is the ***available home care fees amount*** for the care recipient in respect of the payment period.

99AA Meaning of *hardship reduction amount*

The ***hardship reduction amount*** for a care recipient in respect of a payment period in which the care recipient receives home care through a home care service is worked out as follows.

Hardship reduction amount **calculator**

Step 1. Work out the hardship supplement (if any) for the care recipient in respect of the payment period under subsection 48-10(1) of the Act.

Step 2. Subtract the amount that is the sum of all the basic daily care fees for the care recipient, under section 52D-3 of the Act, for the days during the payment period on which the care recipient is provided with home care through the home care service.

The result (including a nil amount) is the ***hardship reduction amount*** for the care recipient in respect of the payment period. If the result is negative, the amount is taken to be nil.

Note: For step 2, if the provision of home care to a care recipient is suspended on a temporary basis as mentioned in section 46-2 of the Act, the care recipient is taken to be provided with home care on each day that the provision of home care is suspended (see subsection 72(3)).

99B *Price* for home care

For the purposes of step 1 of the shortfall amount calculator in subsection 48-13(1) of the Act, the ***price*** for the home care provided during a

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payment period to a care recipient by an approved provider is worked out as follows.

Calculator for *price* for home care

Step 1. Work out the total amount of the prices that the approved provider charged for the care and services provided to the care recipient during the payment period.

Step 2. Work out the total amount of the prices (if any) that the approved provider charged for the matters mentioned in paragraphs 19B(1)(b) and (d) of the *User Rights Principles 2014* (certain travel and package management) in respect of the care recipient in the payment period.

Step 3. Add the total amounts worked out under steps 1 and 2.

Step 4. Subtract the available home care fees amount for the care recipient in respect of the payment period from the total amount worked out under step 3. If the result is negative, the amount is taken to be nil.

The result (including a nil amount) is the ***price*** for the home care provided during the payment period to the care recipient by the approved provider.

Note: For the care and services that an approved provider may provide, see the *Quality of Care Principles 2014* (Part 3 and Schedule 3).

99C Care recipient contribution amount

For the purposes of step 2 of the shortfall amount calculator in subsection 48-13(1) of the Act, the ***care recipient contribution amount*** for a care recipient in respect of a payment period is worked out as follows.

***Care recipient contribution amount* calculator**

Step 1. Work out the care subsidy reduction (if any) for the care recipient in respect of the payment period using subsection 48-7(1) of the Act.

Step 2. Subtract the hardship reduction amount for the care recipient in respect of the payment period.

The result (including a nil amount) is the ***care recipient contribution amount*** for the care recipient in respect of the payment period. If the result is negative, the amount is taken to be nil.

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Division 6—Home care accounts

99D Home care credits

For the purposes of item 2 of the table in section 48-15 of the Act, the following table specifies circumstances in which a credit arises in a care recipient's home care account, the amount of the credit and the time the credit arises.

Home care credits

Item	Column 1 In the following circumstances …	Column 2 the amount of the credit is …	Column 3 and the time the credit arises is …
1	Both: (a) in a payment period, an approved provider ceases to provide home care to the care recipient; and (b) item 3 of the table in subsection 21F(2) of the *User Rights Principles 2014* applies	an amount equal to the amount payable to the Commonwealth under subsection 21F(3) of those Principles	when the amount payable to the Commonwealth under subsection 21F(3) of those Principles is paid.
2	Both: (a) in a payment period, the approved provider ceases to provide home care to a care recipient through a particular home care service; and (b) Subdivision F of Division 3A of Part 3 of the *User Rights Principles 2014* applies	an amount equal to the amount payable to the Commonwealth under section 21JB of those Principles	when the amount payable to the Commonwealth under section 21JB of those Principles is paid.
3	Both: (a) an approved provider ceased to provide home care to the care recipient before 1 September 2021; and (b) section 37 of the *User Rights Principles 2014* applies	an amount equal to the amount payable to the Commonwealth under subsection 37(3) of those Principles	when the amount payable to the Commonwealth under subsection 37(3) of those Principles is paid.

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Chapter 4—Flexible care subsidy

Part 1—Who is eligible for flexible care subsidy?

Division 1—Purpose of this Part

100 Purpose of this Part

For Division 50 of the Act, this Part specifies:

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

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

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

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Division 2—Eligibility for flexible care subsidy

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

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

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

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

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

102 Circumstances in which flexible care is taken to be provided—places held for provision of care through multi-purpose service

For subparagraph 50-1(1)(b)(iii) of the Act, an approved provider is taken to provide flexible care during a day if the provider holds, in respect of that day, an allocated place that is in force under Part 2.2 of the Act (other than a provisional allocation) for the provision of care through a multi-purpose service.

102A Circumstances in which flexible care is taken to be provided to certain care recipients with disabilities

(1) This section applies in relation to a care recipient with a disability if:

(a) the care recipient is being provided with flexible care by an approved provider through an innovative care service; and

(b) the flexible care is provided in disability supported accommodation that is funded by a State or Territory; and

(c) the care recipient was receiving aged care services under the Aged Care Innovative Pool Disability Aged Care Programme on 25 May 2006.

(2) For subparagraph 50-1(1)(b)(iii) of the Act, the approved provider is taken to provide flexible care to the care recipient on each day during which the care recipient is on leave under this section from the premises where the accommodation is provided.

(3) The care recipient is on leave under this section from the premises on each day of any period of continuous days (up to a maximum of 30 continuous days in each period) during which the care recipient attends a hospital for the purpose of receiving hospital treatment.

(4) The care recipient is on leave under this section from the premises on each day (up to a maximum of 52 days in a financial year) during which the care recipient is absent from the premises, other than to attend a hospital for the purpose of receiving hospital treatment.

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(5) In working out the days on which a care recipient is on leave under this section from the premises:
  (a) include the day on which the period of leave commenced; and
  (b) do not include the day on which the provision of flexible care to the care recipient recommenced.

Note 1: Absences that do not include an overnight absence are not counted as leave because of paragraph (5)(b).

Note 2: If a care recipient is not taken to have been provided with flexible care by the approved provider on a day because the maximum number of days under subsection (3) or (4) has been exceeded, the approved provider will not be eligible for flexible care subsidy in respect of the care recipient and the day.

(6) If the care recipient permanently leaves the premises where the accommodation is provided:
  (a) the care recipient is not on leave under this section from the premises on the day the care recipient leaves the premises; and
  (b) the approved provider is taken not to provide flexible care to the care recipient on that day.

102B Circumstances in which flexible care is taken to be provided—transition care

For the purposes of subparagraph 50-1(1)(b)(iii) of the Act, an approved provider is taken to provide flexible care to a care recipient on any day that is disregarded for the purposes of subsection 111AA(1).

Note: Certain days are disregarded when working out whether a care recipient is provided with a continuous period of transition care for the purposes of an ***episode of transition care***: see subsections 111AA(1) and (2).

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

103 Kinds of care

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

(a) flexible care provided through a multi-purpose service;
(b) flexible care provided through an innovative care service;
(c) flexible care provided as transition care;
(d) flexible care provided as short-term restorative care.

104 Multi-purpose services

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

(a) residential care is provided through the service;
(b) at least one of the following services is also provided through the service:
  (i) a health service;
  (ii) a home and community care service;
  (iii) a dental service;
  (iv) a transport service;
  (v) a home care service;
  (vi) a service for which a Medicare benefit is payable under the *Health Insurance Act 1973*;
  (vii) a service that provides a pharmaceutical benefit under the *National Health Act 1953*;
  (viii) a service that the Minister nominates, in an agreement with the responsible Minister of the State or Territory in which the service is located, as an appropriate service.

105 Innovative care services

(1) An ***innovative care service*** is a flexible care service through which any of the following is provided:
  (a) care that, by its nature, provides alternative care options, including care for older persons:
    (i) with complex conditions; or
    (ii) who require coordination and integration of care;
  (b) care provided in circumstances that require the delivery of alternative care options, including care provided:
    (i) in an emergency such as a natural disaster involving fire or flood; or
    (ii) as part of an initiative to address access by older persons to, or the viability of, aged care services; or

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

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

(c) care provided in a location that, by its nature, requires the delivery of alternative care options, including care provided in an area that is not a major city;

(d) care provided to a group of people who are in need of alternative care options, including care provided to older persons who:

(i) require coordination and integration of care; or

(ii) have complex, chronic conditions; or

(iii) need short term aged care following hospitalisation;

(e) care provided for a limited period to facilitate alternative care options, including care provided:

(i) by a pilot service or project; or

(ii) to care recipients in places that have been allocated for a limited time in an emergency;

(f) other kinds of care that, to the satisfaction of the Secretary:

(i) are provided in a residential or community setting; and

(ii) provide alternative care options.

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

106 Transition care

Transition care is a form of flexible care that:

(a) is provided to a care recipient:

(i) after the conclusion of a hospital episode; and

(ii) in the form of a package of services that includes at least low intensity therapy and nursing support or personal care; and

(b) can be characterised as:

(i) goal-oriented; and

(ii) time-limited; and

(iii) therapy-focussed; and

(iv) targeted towards older people; and

(v) necessary to complete the care recipient's restorative process, optimise the care recipient's functional capacity and assist the care recipient, and his or her family or carer (if any), to make long-term arrangements for his or her care.

Note: ***Hospital episode*** and ***low intensity therapy*** are defined in section 4.

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106A Short-term restorative care

Short-term restorative care is a form of flexible care that:

(a) is aimed at reversing or slowing functional decline in older people through the provision of a package of care and services designed for, and approved by, the care recipient who is to receive the care and services; and

(b) depending on the needs of the care recipient, is provided in either or both of the following settings:

(i) a residential care setting;

(ii) a home care setting; and

(c) can be characterised as:

(i) goal-oriented; and

(ii) multidisciplinary; and

(iii) time-limited.

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Part 2—Basis on which flexible care subsidy is paid

Division 1—Purpose of this Part

107 Purpose of this Part

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

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

(b) for flexible care subsidy in respect of flexible care provided as short-term restorative care:

(i) the payment of flexible care subsidy in advance; and

(ii) the way in which claims for flexible care subsidy are to be made;

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

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Division 2—Flexible care provided through a multi-purpose service

108 Flexible care provided through multi-purpose service

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

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

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

(3) An approved provider is eligible for flexible care subsidy in respect of a day if:
(a) during that day, there is in force an agreement between the Secretary and the approved provider for the provision of flexible care through a multi-purpose service; and
(b) the approved provider has complied with the agreement.

109 Decision by Secretary to enter multi-purpose service agreement

(1) The Secretary must not enter into an agreement with an approved provider for the provision of flexible care through a multi-purpose service unless:
(a) the approved provider has demonstrated to the Secretary the matters mentioned in subsection (2); and
(b) the Secretary is satisfied of the matters mentioned in subsection (3).

(2) For paragraph (1)(a), the matters in relation to the multi-purpose service that the approved provider must demonstrate to the Secretary are as follows:
(a) that the approved provider will, in relation to the service:
(i) improve access to care; and
(ii) increase coordination, flexibility and innovation in the delivery of care in the area; and
(iii) provide care that is cost-effective; and
(iv) provide care that is culturally appropriate;
(b) that the service:
(i) is, or will be, in an area that is not a major city; and
(ii) is, or will be, in an area that is able to sustain a viable multi-purpose service; and
(iii) has, or is likely to have, the broad support of the community within the area in which the service is, or will be, located;
(c) that the Commonwealth, State and Territory agencies that administer existing aged care or health programs in the area agree to take part in the service;
(d) that the Commonwealth and the State or Territory in which the service is located agree that the area needs a multi-purpose service.

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

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

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

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

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

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

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

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

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

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

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Division 3—Flexible care provided through an innovative care service

110 Flexible care provided through innovative care service—general

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

(2) However, flexible care subsidy in respect of flexible care that is provided through an innovative care service in accordance with a joint initiative of the Commonwealth and a State or Territory is payable to the approved provider only if:

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

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

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

110A Flexible care provided through innovative care service to certain care recipients with disabilities

(1) This section applies if:

(a) an approved provider (the ***first approved provider***) is taken to provide flexible care to a care recipient with a disability during a day (the ***leave day***) when the care recipient is on leave under section 102A from the premises where the flexible care is provided; and

(b) the first approved provider is eligible for flexible care subsidy in respect of the flexible care provided to the care recipient during the leave day; and

(c) another approved provider is also eligible for flexible care subsidy in respect of flexible care provided to the care recipient during the leave day; and

(d) the first provider started providing flexible care to the care recipient before the other approved provider.

(2) Flexible care subsidy is not payable to the other approved provider in respect of the flexible care provided to the care recipient during the leave day.

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Division 4—Flexible care provided as transition care

111 Flexible care provided as transition care

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

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

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

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

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

(5) The maximum number of days for which flexible care subsidy is payable in respect of an episode of transition care is:

(a) 84 days; or

(b) such greater number of days, to a maximum of 126 days, as is necessary to ensure that the further transition care needs of the care recipient, as assessed by an Aged Care Assessment Team, or a member of such a team, are met.

Note: ***Further transition care needs*** is defined in section 4.

111AA Meaning of *episode of transition care*

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

(2) In working out whether a period is a continuous period for the purposes of subsection (1), disregard any day, up to a total of 7 days, during which the care is not provided.

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Division 5—Flexible care provided as short-term restorative care

111A Periods in respect of which flexible care subsidy is payable

(1) Flexible care subsidy in respect of flexible care provided by an approved provider as short-term restorative care is payable to the approved provider in respect of each payment period during which the approved provider is eligible under this section. However, it is not payable in respect of any days during that period on which the approved provider is not eligible.

(2) Flexible care subsidy is separately payable in respect of each flexible care service through which an approved provider provides flexible care as short-term restorative care.

(3) An approved provider is eligible for flexible care subsidy if the approved provider provides short-term restorative care to an approved care recipient in accordance with an agreed care plan.

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

(4) The maximum number of days for which flexible care subsidy is payable in respect of an episode of short-term restorative care that the approved provider provides to the care recipient is 56 days.

111B Meaning of *payment period*

For flexible care subsidy in respect of flexible care provided as short-term restorative care, a ***payment period*** is a calendar month.

111C Meaning of *episode of short-term restorative care*

(1) An ***episode of short-term restorative care*** consists of a period during which an approved provider provides a care recipient with flexible care in the form of short-term restorative care.

(2) The period must be:
(a) continuous; or
(b) broken only by 1 or more days for which the provision of the care is suspended in accordance with subsections (3) to (5).

(3) The care recipient may request the approved provider to suspend the provision of short-term restorative care on a temporary basis for one or more days (specified in the request) during the episode of short-term restorative care if, on that day or those days, the care recipient will be absent overnight from the residential care setting or home care setting where the short-term restorative care is being provided.

(4) The approved provider must comply with the request.

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(5) However, the provision of short-term restorative care must not be suspended during an episode of short-term restorative care on more than a total of 7 days.

111D Payments of flexible care subsidy in advance

(1) Subject to subsection (2), flexible care subsidy in respect of flexible care provided as short-term restorative care is payable in advance, in respect of a payment period, at such times as the Secretary thinks fit.

(2) The Secretary must work out the amount of an advance to be paid to an approved provider in respect of the first payment period for a flexible care service by estimating the amount of flexible care subsidy that will be payable for the days in that period and in the following payment period.

(3) The Secretary must work out the amount of an advance to be paid to an approved provider in respect of subsequent payment periods for a flexible care service by:
  (a) estimating the amount of flexible care subsidy that will be payable for the days in the period; and
  (b) increasing or reducing that amount to make any adjustments that the Secretary reasonably believes are necessary to take account of likely underpayments or overpayments in respect of advances previously paid under this section.

111E Claims for flexible care subsidy

(1) For the purpose of obtaining payment of flexible care subsidy in respect of a flexible care service through which an approved provider provides flexible care as short-term restorative care, the approved provider must, as soon as practicable after the end of each payment period, give to the Secretary:
  (a) a claim, in the form approved by the Secretary, for flexible care subsidy that is, or may become, payable in respect of the service for that payment period; and
  (b) any information relating to the claim that is stated in the form to be required, or that the Secretary requests.

(2) An advance of flexible care subsidy is not payable in respect of a payment period for the flexible care service if the approved provider has not given to the Secretary, under subsection (1), a claim relating to the second last preceding payment period for the service.

Note: For example, an advance of subsidy is not payable for March if the Secretary has not been given a claim for January of the same year.

111F Variations of claims for flexible care subsidy

(1) An approved provider may vary the claim made in respect of a payment period within:
  (a) 2 years after the end of that payment period; or
  (b) such longer period as is determined in respect of the claim by the Secretary.

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(2) In determining a longer period for the purposes of paragraph (1)(b), the Secretary must be satisfied that a variation is required:

(a) due to an administrative error made by the Commonwealth or an agent of the Commonwealth; or

(b) because the Commonwealth or an agent of the Commonwealth considers that the circumstances of a care recipient are different from those on the basis of which subsidy was claimed; or

(c) in order to manage STRC programme expenditure, including overpayments.

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Chapter 5—Application, saving and transitional provisions

Part 1—Amendments made by the Aged Care Legislation Amendment (Capping Home Care Charges) Principles 2022

112 Application of amendments

The amendment of section 99B made by the *Aged Care Legislation Amendment (Capping Home Care Charges) Principles 2022* applies in relation to a payment period beginning on or after 1 January 2023.

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Schedule 1—ACAP codes

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

1 ACAP codes

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

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

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ACAP Codes	
ACAP Code	**Health condition**
0553	Other psychoses (includes paranoid states)
0560	**Neurotic, stress related and somatoform disorders**
0561	Phobic and anxiety disorders (includes agoraphobia, panic disorder)
0562	Nervous tension/stress
0563	Obsessive-compulsive disorder
0564	Other neurotic, stress related and somatoform disorders
0570	**Intellectual and developmental disorders**
0571	Mental retardation/intellectual disability
0572	Other development disorders (includes autism, Rett syndrome, Asperger's syndrome, developmental learning disorders, specific development disorders of speech and language, specific developmental disorder of motor function (for example, dyspraxia))
0580	**Other mental and behavioural disorders**
0581	Mental and behavioural disorders due to alcohol and other psychoactive substance use (includes alcoholism, Korsakov's psychosis (alcoholic))
0582	Adult personality and behavioural disorders
0583	Speech impediment (for example, stuttering or stammering)
0599	Other mental and behavioural disorders not elsewhere classified or not otherwise specified (includes harmful use of non-dependent substances such as laxatives, analgesics and antidepressants, eating disorders such as anorexia nervosa and bulimia nervosa, and mental disorders not otherwise specified)

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

Note: See subsections 66(4) and 66A(4), and paragraph 70(a).

1 Appraisal procedures

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

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

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

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

(5) If:

(a) the appraisal is for the purposes of subsection 66(4) or 66A(4); and

(b) notification of the outcome of the appraisal is received by the Secretary before the end of the period specified in subclause (3);

any points that may be added under:

(c) subsection 66(4) (for the purposes of step 3 of the 2005 scheme service points calculator in subsection 66(2)); or

(d) subsection 66A(4) (for the purposes of step 3 of the 2017 scheme service points calculator in subsection 66A(2));

as a result of the outcome of the appraisal take effect on the care recipient's entry day.

(6) If:

(a) the appraisal is for the purposes of subsection 66(4) or 66A(4); and

(b) notification of the outcome of the appraisal is received by the Secretary after the end of the period specified in subclause (3);

any points that may be added under:

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(c) subsection 66(4) (for the purposes of step 3 of the 2005 scheme service points calculator in subsection 66(2)); or

(d) subsection 66A(4) (for the purposes of step 3 of the 2017 scheme service points calculator in subsection 66A(2));

as a result of the outcome of the appraisal take effect on the day the notification of the outcome of the appraisal is received by the Secretary.

2 Appraisal tool A—homelessness—additional special needs

(1) The care recipient must:

(a) demonstrate one or both of the following:

(i) complex behavioural needs;

(ii) complex social support needs; and

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

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

Table—Appraisal tool A—homelessness

Item	Criteria	Tick if Yes
1	**Homelessness background** The person has a history of homelessness or is at severe risk of homelessness, including that the person, immediately prior to entering care at the current or a previous residential aged care home:	
	(a) was living in a public place or temporary shelter; short-term crisis, emergency or transitional accommodation; boarding house, rooming house or private hotel; or supported community accommodation; or	☐
	(b) had no recent housing address; or	☐
	(c) had a long history of unsuccessful tenancies or unstable housing arrangements.	☐
2	**Financial status** The person is eligible for:	
	(a) the maximum basic rate of social security pension or benefit as defined in the Social Security Act; or	☐
	(b) service pension or disability pension as defined in the Veterans' Entitlements Act.	☐
3	**Relevant behavioural diagnosis** The person has mental and behavioural diagnosis associated with one of the following disorders:	
	(a) dementia in Alzheimer's disease including early onset dementia, late onset dementia, atypical or mixed type or unspecified dementia (ACAP code 0500);	☐
	(b) vascular dementia including acute onset dementia, multi-infarct dementia, subcortical vascular dementia, mixed cortical and subcortical vascular	☐

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Clause 2

Table—Appraisal tool A—homelessness

Item	Criteria	Tick if Yes
	dementia, other vascular or unspecified dementia (ACAP code 0510);	
	(c) dementia in other diseases classified elsewhere including Pick's Disease, Creutzfeldt-Jakob disease, Huntington's disease, Parkinson's disease, human immunodeficiency virus (HIV) (ACAP code 0520);	☐
	(d) other dementia including alcoholic dementia or unspecified dementia (such as presenile and senile dementia) (ACAP code 0530);	☐
	(e) delirium including delirium not superimposed on dementia, delirium superimposed on dementia, other delirium or unspecified delirium (ACAP code 0540);	☐
	(f) psychoses and depression/mood affective disorders including schizophrenia or other psychoses (such as paranoid states) (ACAP code 0550);	☐
	(g) neurotic, stress-related and somatoform disorders including phobic and anxiety disorders (such as agoraphobia and panic disorder), nervous tension/stress or obsessive-compulsive disorder (ACAP code 0560);	☐
	(h) intellectual and developmental disorders including mental retardation, intellectual disability or other developmental disorders (such as autism, Rett syndrome, Asperger's syndrome, developmental learning disorders, specific developmental disorders of speech and language, specific development disorder of motor function such as dyspraxia) (ACAP code 0570);	☐
	(i) other mental and behavioural disorders including mental and behavioural disorders due to alcohol and other psychoactive substance use (such as alcoholism, Korsakov's psychosis (alcoholic), adult personality and behavioural disorders, speech impediment (stuttering or stammering)) or other mental and behavioural disorders not otherwise specified or not elsewhere classified (such as harmful use of non-dependant substances (for example, laxatives, analgesics or antidepressants), eating disorders (for example, anorexia nervosa or bulimia nervosa) or mental disorders not otherwise specified) (ACAP code 0580).	☐
4	**Challenging behaviours and need for intensive social support**	
	(a) The person displays challenging behaviours which require ongoing management and prevention including one or both of the following:	
	(i) episodic catastrophic behaviours such as severe physical and verbal abuse, violent mood swings, aggression;	☐
	(ii) the person is considered at high risk of leaving without warning with ongoing staff intervention required to prevent this from occurring;	☐
	(b) The person requires intensive social support or intensive assistance with continuing to perform activities of daily living including initiation of and assistance with:	
	(i) personal care and hygiene matters (for example, shows aversion to showering and washing hands, has problems with toileting and dressing, requires assistance or guidance with meals); or	☐
	(ii) social and recreational activities, with significant one-on-one staff intervention necessary to enable the person to participate in community activities.	☐

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

(1) The care recipient must:

(a) demonstrate one or both of the following:

(i) complex behavioural needs;

(ii) complex social support needs; and

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

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

Table—Appraisal tool B—Aboriginal and Torres Strait Islanders

Item	Criteria	Tick if Yes
1	**Indigenous status** The person is of Aboriginal or Torres Strait Islander origin.	☐
2	**Financial status** The person is eligible for:	
	(a) the maximum basic rate of social security pension or benefit as defined in the Social Security Act; or	☐
	(b) service pension or disability pension as defined in the Veterans' Entitlements Act.	☐
3	**Relevant behavioural diagnosis** The person has mental and behavioural diagnosis associated with one of the following disorders:	
	(a) dementia in Alzheimer's disease including early onset dementia, late onset dementia, atypical or mixed type or unspecified dementia (ACAP code 0500);	☐
	(b) vascular dementia including acute onset dementia, multi-infarct dementia, subcortical vascular dementia, mixed cortical and subcortical vascular dementia, other vascular or unspecified dementia (ACAP code 0510);	☐
	(c) dementia in other diseases classified elsewhere including Pick's Disease, Creutzfeldt-Jakob disease, Huntington's disease, Parkinson's disease, human immunodeficiency virus (HIV) (ACAP code 0520);	☐
	(d) other dementia including alcoholic dementia or unspecified dementia (such as presenile and senile dementia) (ACAP code 0530);	☐
	(e) delirium including delirium not superimposed on dementia, delirium superimposed on dementia, other delirium or unspecified delirium (ACAP code 0540);	☐
	(f) psychoses and depression/mood affective disorders including schizophrenia or other psychoses (such as paranoid states) (ACAP code 0550);	☐
	(g) neurotic, stress-related and somatoform disorders including phobic and anxiety disorders (such as agoraphobia and panic disorder), nervous tension/stress or obsessive-compulsive disorder (ACAP code 0560);	☐

Table—Appraisal tool B—Aboriginal and Torres Strait Islanders

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

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Endnotes

Endnote 1—About the endnotes

The endnotes provide information about this compilation and the compiled law.

The following endnotes are included in every compilation:

Endnote 1—About the endnotes
Endnote 2—Abbreviation key
Endnote 3—Legislation history
Endnote 4—Amendment history

Abbreviation key—Endnote 2
The abbreviation key sets out abbreviations that may be used in the endnotes.

Legislation history and amendment history—Endnotes 3 and 4
Amending laws are annotated in the legislation history and amendment history.

The legislation history in endnote 3 provides information about each law that has amended (or will amend) the compiled law. The information includes commencement details for amending laws and details of any application, saving or transitional provisions that are not included in this compilation.

The amendment history in endnote 4 provides information about amendments at the provision (generally section or equivalent) level. It also includes information about any provision of the compiled law that has been repealed in accordance with a provision of the law.

Editorial changes
The *Legislation Act 2003* authorises First Parliamentary Counsel to make editorial and presentational changes to a compiled law in preparing a compilation of the law for registration. The changes must not change the effect of the law. Editorial changes take effect from the compilation registration date.

If the compilation includes editorial changes, the endnotes include a brief outline of the changes in general terms. Full details of any changes can be obtained from the Office of Parliamentary Counsel.

Misdescribed amendments
A misdescribed amendment is an amendment that does not accurately describe how an amendment is to be made. If, despite the misdescription, the amendment can be given effect as intended, then the misdescribed amendment can be incorporated through an editorial change made under section 15V of the *Legislation Act 2003*.

If a misdescribed amendment cannot be given effect as intended, the amendment is not incorporated and "(md not incorp)" is added to the amendment history.

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Endnote 2—Abbreviation key

ad = added or inserted

am = amended

amdt = amendment

c = clause(s)

C[x] = Compilation No. x

Ch = Chapter(s)

def = definition(s)

Dict = Dictionary

disallowed = disallowed by Parliament

Div = Division(s)

ed = editorial change

exp = expires/expired or ceases/ceased to have effect

F = Federal Register of Legislation

gaz = gazette

LA = *Legislation Act 2003*

LIA = *Legislative Instruments Act 2003*

(md) = misdescribed amendment can be given effect

(md not incorp) = misdescribed amendment cannot be given effect

mod = modified/modification

No. = Number(s)

o = order(s)

Ord = Ordinance

orig = original

par = paragraph(s)/subparagraph(s) /sub-subparagraph(s)

pres = present

prev = previous

(prev…) = previously

Pt = Part(s)

r = regulation(s)/rule(s)

reloc = relocated

renum = renumbered

rep = repealed

rs = repealed and substituted

s = section(s)/subsection(s)

Sch = Schedule(s)

Sdiv = Subdivision(s)

SLI = Select Legislative Instrument

SR = Statutory Rules

Sub-Ch = Sub-Chapter(s)

SubPt = Subpart(s)

underlining = whole or part not commenced or to be commenced

Endnote 3—Legislation history

Name	Registration	Commencement	Application, saving and transitional provisions
Subsidy Principles 2014	27 June 2014 (F2014L00862)	1 July 2014 (s 2)	
Aged Care Legislation Amendment (Removal of Certification and Other Measures) Principles 2015	30 June 2015 (F2015L00998)	Sch 1 (items 12–15): 1 July 2015 (s 2(1) item 1)	—
Subsidy Amendment Principles 2015 (No. 1)	25 Nov 2015 (F2015L01841)	26 Nov 2015 (s 2)	—
Aged Care Legislation Amendment (Short-term Restorative Care) Principles 2016	5 May 2016 (F2016L00670)	6 May 2016 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Increasing Consumer Choice) Principles 2016	23 Sept 2016 (F2016L01492)	Sch 1 (items 33–44): 27 Feb 2017 (s 2(1) item 3)	—
Subsidy Amendment (Flexible Care Subsidy and Other Measures) Principles 2016	14 Oct 2016 (F2016L01619)	Sch 1 (items 1–5): 15 Oct 2016 (s 2(1) item 1)	—
Subsidy Amendment (Viability Supplement) Principles 2016	16 Dec 2016 (F2016L01985)	1 Jan 2017 (s 2(1) item 1)	—
Australian Aged Care Quality Agency Legislation Amendment (Unannounced Re-accreditation Audits) Principles 2018	16 Mar 2018 (F2018L00264)	Sch 1 (item 33): 17 Mar 2018 (s 2(1) item 1)	—
Aged Care Quality and Safety Commission (Consequential Amendments) Rules 2018	24 Dec 2018 (F2018L01840)	Sch 1 (items 9–15): 1 Jan 2019 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Subsidies—COVID-19 Support) Instrument 2020	26 May 2020 (F2020L00615)	Sch 1 (items 7, 8): 27 May 2020 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Subsidies—COVID-19 Support Supplement and Workforce Continuity Funding Measures No. 2) Instrument 2020	18 Sept 2020 (F2020L01183)	Sch 1 (items 12–15): 19 Sept 2020 (s 2(1) item 2)	—
Aged Care Legislation Amendment (Subsidies—Residential Care Support Supplement) Instrument 2021	29 Mar 2021 (F2021L00355)	Sch 1 (items 6, 7): 30 Mar 2021 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Transition Care) Instrument 2021	15 June 2021 (F2021L00753)	Sch 1 (items 5–8): 16 June 2021 (s 2(1) item 2) Sch 1 (items 14–18): 1 July 2021 (s 2(1) item 3)	—

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Endnote 3—Legislation history

Name	Registration	Commencement	Application, saving and transitional provisions
Aged Care Legislation Amendment (Subsidies—Royal Commission Response) Instrument 2021	30 June 2021 (F2021L00913)	Sch 1 (items 18, 19): 1 July 2021 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Improved Home Care Payment Administration) Instrument 2021	18 Aug 2021 (F2021L01133)	Sch 1 (items 4–7): 1 Sept 2021 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Improved Home Care Payment Administration) Principles 2022	30 Aug 2022 (F2022L01142)	Sch 1 (items 1–4): 1 Sept 2022 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Residential Aged Care Funding) Instrument 2022	29 Sept 2022 (F2022L01276)	Sch 1 (items 21–34): 1 Oct 2022 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Transition Care) Instrument 2022	11 Nov 2022 (F2022L01453)	Sch 1 (items 10–13): 1 Dec 2022 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Capping Home Care Charges) Principles 2022	19 Dec 2022 (F2022L01700)	Sch 1 (items 11, 12): 1 Jan 2023 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Subsidies) Instrument 2023	27 June 2023 (F2023L00872)	Sch 1 (items 1–3): 1 July 2023 (s 2(1) item 1)	—
Aged Care Legislation Amendment (September Indexation and Other Measures) Instrument 2023	18 Sept 2023 (F2023L01261)	Sch 1 (items 8, 9): 20 Sept 2023 (s 2(1) item 1)	—
Aged Care Legislation Amendment (Outbreak Management Support Supplement) Instrument 2024	22 Jan 2024 (F2024L00092)	Sch 1 (items 8, 9): 23 Jan 2024 (s 2(1) item 1)	—

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Endnote 4—Amendment history

Provision affected	How affected
Chapter 1	
s 2	rep LIA s 48D
s 4	am F2015L00998; F2016L00670; F2016L01985; F2018L01840; F2020L01183; F2021L00753; F2021L01133; F2022L01142; F2022L01276; F2022L01453; F2023L00872
Chapter 2	
Part 1A	
Part 1A heading	ad F2016L00670
s 7A	ad F2016L00670
s 7B	ad F2016L00670
	am F2022L01453
Part 1	
Division 2	
s 9	am F2021L00753
Division 3	
s 11	am F2018L00264; F2018L01840
Part 2	
Division 1	
s 13	am F2022L01276
Division 3	rep F2022L01276
s 16	rep F2022L01276
s 17	rep F2022L01276
s 18	rep F2022L01276
s 19	rep F2022L01276
Part 3	
Division 1	
s 20	(b)(iv) rep 1 Nov 2014 (s 112(1)(a))
	(b)(v) rep 1 Apr 2015 (s 112(2)(a))
	am F2020L00615; F2021L00355; F2021L00913; F2022L01276; F2023L00872; F2024L00092
Division 2	
s 21	rs F2022L01276
Division 3	
Subdivision B	
s 26	am F2023L01261
Subdivision D	rep 1 Nov 2014 (s 112(1)(b))
s 32	rep 1 Nov 2014 (s 112(1)(b))
s 33	rep 1 Nov 2014 (s 112(1)(b))

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Endnote 4—Amendment history

Provision affected	How affected
s 34	rep 1 Nov 2014 (s 112(1)(b))
Subdivision E	rep 1 Apr 2015 (s 112(2)(b))
s 35	rep 1 Apr 2015 (s 112(2)(b))
s 36	rep 1 Apr 2015 (s 112(2)(b))
Division 4	
Subdivision C	
s 44	am F2015L01841
Subdivision CA	
s 46A	ad F2015L01841
s 46B	ad F2015L01841
Subdivision D	
s 47	am F2016L01619
Division 5	
Subdivision A	
s 50	rs F2015L00998
	am F2022L01276
Subdivision C	
Subdivision C heading	am F2022L01276
s 63	am F2016L01985; F2022L01276
s 64	am F2016L01985
s 65	am F2016L01985
s 66	am F2016L01985
s 66A	ad F2016L01985
Subdivision E	
Subdivision E heading	am F2022L01276
s 69	am F2022L01276
s 70	am F2016L01985
Subdivision F	
Subdivision F heading	am F2020L01183
Subdivision F	ad F2020L00615
s 70AA	ad F2020L00615
	am F2020L01183
s 70AB	ad F2020L00615
Subdivision G	
Subdivision G	ad F2021L00355
s 70AC	ad F2021L00355
s 70AD	ad F2021L00355
Subdivision H	
Subdivision H	ad F2021L00913
s 70AE	ad F2021L00913

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Provision affected	How affected
s 70AF	ad F2021L00913
s 70AG	ad F2021L00913
Subdivision I	
Subdivision I	ad F2022L01276
s 70AH	ad F2022L01276
Subdivision J	
Subdivision J	ad F2023L00872
s 70AI	ad F2023L00872
s 70AJ	ad F2023L00872
Subdivision K	
Subdivision K	ad F2023L00872
s 70AK	ad F2023L00872
s 70AL	ad F2023L00872
s 70AM	ad F2023L00872
Subdivision L	
Subdivision L	ad F2024L00092
s 70AN	ad F2024L00092
s 70AO	ad F2024L00092
Chapter 3	
Part 1A	
Part 1A heading	ad F2016L00670
s 70A	ad F2016L00670
s 70B	ad F2016L00670
	am F2022L01453
Part 1B	
Part 1B	ad F2021L01133
Division 1	
s 72A	ad F2021L01133
Division 2	
s 72B	ad F2021L01133
Part 2	
Division 1	
s 73	rs F2021L01133
Division 2	
Subdivision A	
s 74	am F2016L01492
s 76	am F2016L01492; F2023L01261
Subdivision B	
s 78	am F2016L01492
s 80	am F2016L01492

Endnote 4—Amendment history

Provision affected	How affected
Subdivision C	
s 82	am F2016L01492
s 83	am F2015L00998
Subdivision D	
s 84	am F2016L01492
Division 4	
Subdivision B	
s 98	am F2016L01492
	rs F2016L01985
s 99	rs F2016L01985
Division 5	
Division 5	ad F2021L01133
s 99A	ad F2021L01133
	am F2022L01142
s 99AA	ad F2022L01142
s 99B	ad F2021L01133
	am F2022L01700
s 99C	ad F2021L01133
	rs F2022L01142
Division 6	
Division 6	ad F2021L01133
s 99D	ad F2021L01133
Chapter 4	
Part 1	
Division 2	
s 102	am F2016L01619
s 102A	ad F2016L01619
s 102B	ad F2021L00753
Division 3	
s 103	am F2016L00670
s 106	am F2021L00753
s 106A	ad F2016L00670
Part 2	
Division 1	
s 107	rs F2016L00670
Division 2	
Division 2 heading	ad F2016L00670
Division 3	
Division 3 heading	ad F2016L00670
s 110	am F2016L01619

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Endnote 4—Amendment history

Provision affected	How affected
s 110A	ad F2016L01619
Division 4	
Division 4 heading	ad F2016L00670
s 111	am F2021L00753
s 111AA	ad F2021L00753
Division 5	
Division 5	ad F2016L00670
s 111A	ad F2016L00670
s 111B	ad F2016L00670
s 111C	ad F2016L00670
s 111D	ad F2016L00670
s 111E	ad F2016L00670
s 111F	ad F2016L00670
Chapter 5	
Chapter 5	rep F2022L01276
	ad F2022L01700
Part 1	
s 112	rep F2022L01276
	ad F2022L01700
Schedule 2	
Schedule 2	am F2016L01985

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