Aged Care Rules 2025

made under the

Aged Care Act 2024

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About this compilation

This compilation

This is a compilation of the *Aged Care Rules 2025* that shows the text of the law as amended and in force on 6 June 2026 (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. The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. Any uncommenced amendments affecting the law are accessible on the Register (www.legislation.gov.au).

Application, saving and transitional provisions

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.

Presentational changes

The *Legislation Act 2003* provides for First Parliamentary Counsel to make presentational changes to a compilation. Presentational changes are applied to give a more consistent look and feel to legislation published on the Register, and enable the user to more easily navigate those documents.

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. Any modifications affecting the law are accessible on the Register.

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If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.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

Part 1—Preliminary

1-5 Name

This instrument is the *Aged Care Rules 2025*.

3-5 Authority

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

4-5 Simplified outline of this instrument

This instrument provides for matters for the purposes of the Act that relate to the delivery of funded aged care services to individuals under the Commonwealth aged care system.

Chapter 2 provides for matters relating to entry to the Commonwealth aged care system.

Chapter 3 provides for matters relating to provider registration.

Chapter 4 provides for matters relating to conditions on provider registration.

Chapter 5 provides for matters relating to registered provider, responsible person and aged care worker obligations.

Chapter 6 provides for matters relating to obligations of operators of aged care digital platforms.

Chapter 7 provides for matters relating to Commonwealth contributions for funding of aged care services.

Chapter 8 provides for matters relating to individual fees and contributions for funding of aged care services.

Chapter 9 provides for matters relating to accommodation payments and accommodation contributions for funding of aged care services.

Chapter 10 provides for matters relating to means testing for funding of aged care services.

Chapter 11 provides for matters relating to governance of the aged care system.

Chapter 12 provides for matters relating to regulatory mechanisms.

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Section 4-5

Chapter 13 provides for matters relating to information management.

Chapter 14 provides for the review and reconsideration of certain decisions made under this instrument.

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Part 2—Definitions

Division 1—Definitions—general

5-5 Definitions

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

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

In this instrument:

2023 MM category means a category for an area provided for by the Modified Monash Model, as the model existed on 13 April 2025, and known as MM 1, MM 2, MM 3, MM 4, MM 5, MM 6 or MM 7.

Aboriginal or Torres Strait Islander Health Practitioner means a person who is registered under the National Law in the Aboriginal and Torres Strait Islander health practice profession.

Aboriginal or Torres Strait Islander Health Worker means a person who:

(a) is:
  (i) a full member of the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners; and
  (ii) not an Aboriginal or Torres Strait Islander Health Practitioner; or
(b) holds a Certificate II or higher in Aboriginal or Torres Strait Islander Primary Health Care Practice from a registered training organisation.

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

(a) the Repatriation Commission has accepted liability to pay a pension under the Veterans' Entitlements Act; or
(b) the Military Rehabilitation and Compensation Commission has accepted liability to pay compensation under the MRC Act or the *Safety, Rehabilitation and Compensation Act 1988*.

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accommodation bond agreement means an agreement between an individual in the pre-2014 accommodation class and a registered provider in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider that meets the requirements set out in section 287-25.

accommodation bond retention amount means an amount that a registered provider may deduct from an accommodation bond balance in accordance with section 287-95.

accommodation charge agreement means an agreement between an individual in the pre-2014 accommodation class and a registered provider in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider that meets the requirements set out in section 287-115.

accommodation wing, of an approved residential care home, includes any of the following:

(a) a building;
(b) a floor or level of a building;
(c) an annex to a building;

that is used to provide accommodation for an individual to whom funded aged care services are being delivered in the home.

ACN has the same meaning as in the *Corporations Act 2001*.

Act means the *Aged Care Act 2024*.

ad hoc higher everyday living agreement: see section 284-2.

AFM assessment item means the Australian Modified Functional Independence Measure assessment item of the AN-ACC Assessment Tool.

AFM cognition score, for an individual, means the individual's total score for communication and social cognition on the AFM assessment item.

AFM communication score, for an individual, means the individual's total score for communication on the AFM assessment item.

AFM eating score, for an individual, means the individual's score for eating on the AFM assessment item.

AFM motor score, for an individual, means the individual's total score for self-care, sphincter control, transfers and locomotion on the AFM assessment item.

AFM social cognition score, for an individual, means the individual's total score for social cognition on the AFM assessment item.

AFM transfers score, for an individual, means the individual's total score for transfers on the AFM assessment item.

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Aged Care Assessment Manual means the Aged Care Assessment Manual, published by the Department, as existing on 23 March 2026.

Note: The Aged Care Assessment Manual could in 2026 be viewed on the Department's website (https://www.health.gov.au).

aged care financial report, for a registered provider, means the report required by section 166-310.

age pension has the same meaning as in Part 2.2 of the Social Security Act.

agitation score, for an individual, means the individual's score for physically aggressive or inappropriate behaviour on the Behaviour Resource Utilisation Assessment assessment item of the AN-ACC Assessment Tool.

AKPS assessment item means the Australia-modified Karnofsky Performance Status assessment item of the AN-ACC Assessment Tool.

AKPS score, for an individual, means the individual's score on the AKPS assessment item.

allied health assistant means a person who holds a Certificate IV in Allied Health Assistance from a registered training organisation.

allied health profession means a health profession other than the following:

(a) dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist);
(b) medical;
(c) midwifery;
(d) nursing.

allied health professional means a person who is any of the following:

(a) a registered health practitioner who:
  (i) is registered under the National Law to practise an allied health profession, other than as a student (within the meaning of the National Law); or
  (ii) holds non-practising registration under the National Law in an allied health profession;
(b) an Aboriginal or Torres Strait Islander Health Worker;
(c) an art therapist;
(d) an audiologist;
(e) a certified practicing nutritionist;
(f) a counsellor;
(g) a dietitian;
(h) an exercise physiologist;
(i) a genetic counsellor;
(j) a music therapist;
(k) an orthoptist;
(l) an orthotist;

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(m) a pedorthist;
(n) a prosthetist;
(o) a recreational therapist;
(p) a rehabilitation counsellor;
(q) a social worker;
(r) a sonographer;
(s) a speech pathologist.

AN-ACC Assessment Tool means the Australian National Aged Care Classification Assessment Tool, published by the Department, as existing on 1 April 2021.

Note: The AN-ACC Assessment Tool could in 2025 be viewed on the Department's website (https://www.health.gov.au).

AN-ACC Reference Manual means the Australian National Aged Care Classification Reference Manual, published by the Department, as existing on 1 April 2021.

Note: The AN-ACC Reference Manual could in 2025 be viewed on the Department's website (https://www.health.gov.au).

annual accountability report, for a registered provider, means the report required under section 166-745.

annual activity report, for a registered provider, means the report required under section 166-725.

annual financial declaration statement, for a registered provider, means the statement required by section 166-605.

annual prudential compliance statement, for a registered provider, means the statement required by section 166-360.

annual statement of financial compliance and income and expenditure, for a registered provider, means the statement required by section 166-730.

annual wellness and reablement report, for a registered provider, means the report required under section 166-615.

antipsychotic medication, in relation to medication management, means the prescription of medications to an individual for the purposes of the treatment of a diagnosed condition of psychosis.

approval year, for an approved higher maximum accommodation payment amount, means the period of 1 year beginning on:
(a) the day the approval takes effect under section 290-25 or 290-30 (as applicable); or
(b) any later anniversary of that day.

approved health practitioner means a medical practitioner, nurse practitioner or registered nurse.

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approved higher maximum accommodation payment amount means a higher maximum accommodation payment amount (expressed as a refundable accommodation deposit amount) approved by the Pricing Authority under subsection 290(6) of the Act.

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

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

art therapist means a person who is registered with the Australian, New Zealand and Asian Creative Arts Therapies Association as a Creative Art Therapist.

assistance dog means a dog that is an assistance animal within the meaning of the *Disability Discrimination Act 1992*.

AT-HM List means the Assistive Technology and Home Modifications list published by the Department, as existing on 1 November 2025.

Note: The AT-HM List could in 2025 be viewed on the Department's website (https://www.health.gov.au).

audiologist means a person who:

(a) is both:
  (i) a full member of Audiology Australia; and
  (ii) certified by Audiology Australia as an accredited audiologist; or
(b) is a full or ordinary member, or fellow audiologist, of the Australian College of Audiology incorporating the Hearing Aid Audiology Society of Australia with a certificate of recognition of competency, issued by that College, as both a hearing rehabilitation specialist and a diagnostic rehabilitation specialist.

audited income and expenditure report, for a registered provider, means the report required under section 166-640.

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

Australian Commission on Safety and Quality in Health Care means the Commission established by subsection 8(1) of the *National Health Reform Act 2011*.

Australia New Zealand Food Standards Code has the same meaning as in the *Food Standards Australia New Zealand Act 1991*.

Australian Privacy Principle has the same meaning as in the *Privacy Act 1988*.

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banning orders register means the register of banning orders established and maintained under section 507 of the Act.

Barthel Index means the questions used in the Barthel Index of Activities of Daily Living set out in Collin C, Wade DT, Davies S, Horne V. The Barthel ADL Index: a reliability study. Int Disabil Stud. 1988;10(2):61-3. doi: 10.3109/09638288809164103. PMID: 3403500.

Note: The Barthel Index could in 2026 be viewed in the Quality Indicator Program Manual on the Department's website (https://www.health.gov.au).

base interest rate, on a day in a month, means the rate (expressed as a percentage) that is the sum of the following:

(a) the below threshold rate on the first day of the month;
(b) 2%.

below threshold rate, on a day, means the below threshold rate under subsection 1082(1) of the Social Security Act on the day.

Braden activity score, for an individual, means the individual's score for activity on the Braden Scale assessment item of the AN-ACC Assessment Tool.

Braden total score, for an individual, means the individual's total score on the Braden Scale assessment item of the AN-ACC Assessment Tool.

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

calculation day, for a quarter, means the 15th day of the calendar month before the calendar month in which the quarter begins.

care minute: a minute is a ***care minute*** if it is spent delivering direct care, other than the following:

(a) the planning or delivery of activities to a group of individuals;
(b) the provision or maintenance of aids, appliances or equipment.

care minutes performance statement, for a registered provider, means the statement required by section 166-335.

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

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

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

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service within the meaning of section 90 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

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

certified practicing nutritionist means a person who is registered with the Australasian Association and Register of Practicing Nutritionists as a Certified Practicing Nutritionist.

chemical restraint: see subsection 17-5(2).

child safety compliance statement, for a registered provider, means the statement required by section 166-628.

CHSP is short for the program known as the Commonwealth Home Support Program.

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

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

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

complainant: see subsection 361-10(1).

complaint determination has the same meaning as in paragraph 361(1A)(d) of the Act.

compliance report, for a registered provider, means the report required under section 166-620.

conditionally included AT-HM item means a product, item of equipment or home modification:

(a) that is listed in the part of the AT-HM List headed "Conditional inclusions"; and
(b) that is not an excluded AT-HM item.

conditionally included communication and information management item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Conditional inclusions" under "Communication and information management"; and
(b) that is not an excluded AT-HM item.

conditionally included domestic life item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Conditional inclusions" under "Domestic life"; and
(b) that is not an excluded AT-HM item.

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consecutive unplanned weight loss, in relation to unplanned weight loss, means a decrease in the weight of an individual of any amount, as determined by comparing the weight of an individual from the finishing weight of the previous quarter against the starting weight, middle weight and finishing weight for the current quarter.

Consumer Experience Assessment means an assessment using the Quality-of-Care Experience questions.

contact includes physical contact, face-to-face contact, oral communication, written communication and electronic communication.

continuing service delivery branch: see subsection 263A-5(1).

continuity of care plan: see section 149-75.

Co-operatives National Law means the Law set out in the appendix to the *Co-operatives (Adoption of National Law) Act 2012* (NSW), and applying in a State or Territory under the following:

(a) *Co-operatives (Adoption of National Law) Act 2012* (NSW);
(b) *Co-operatives National Law Application Act 2013* (Vic.);
(c) *Co-operatives National Law Act 2020* (Qld);
(d) *Co-operatives National Law (South Australia) Act 2013* (SA);
(e) *Co-operatives National Law (Tasmania) Act 2015* (Tas.);
(f) *Co-operatives National Law (ACT) Act 2017* (ACT);
(g) *Co-operatives (National Uniform Legislation) Act 2015* (NT).

counsellor means a person who:

(a) is registered as a registered counsellor with:
  (i) the Australian Counselling Association; or
  (ii) the Psychotherapy and Counselling Federation of Australia; and
(b) has a qualification covered by level 7, 8, 9 or 10 of the Australian Qualifications Framework (within the meaning of the *Higher Education Support Act 2003*).

counted mainstream individual: see subsection 176-15(5).

counted NATSIFACP individual: see subsection 176-35(5).

current wait time, for the allocation of a place for a classification type for a service group to an individual, on a day (the ***current day***) before the place is allocated to the individual, means the time starting at the time the individual's access approval for the classification type for the service group was given and ending at the end of the day before the current day.

daily remaining income amount, for an individual for a day: see subsection 231-17(5).

daily total essential expenses, for an individual for a day: see subsection 231-17(4).

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DAP index number, for an indexation day: see section 302-15.

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

day of recognised residential care: see subsections 176-20(4) and (5).

DEMMI score, for an individual, means the individual's total score on the De Morton Mobility Index assessment item.

De Morton Mobility Index assessment item means the De Morton Mobility Index assessment item of the AN-ACC Assessment Tool.

dietitian means a person who is accredited by Dietitians Australia as an Accredited Practising Dietitian.

disruptiveness score, for an individual, means the individual's score for verbally disruptive or noisy behaviour on the Behaviour Resource Utilisation Assessment assessment item of the AN-ACC Assessment Tool.

diverse cultural activities includes cultural activities for the following:

(a) Aboriginal or Torres Strait Islander persons;
(b) individuals from culturally, ethnically and linguistically diverse backgrounds;
(c) individuals who are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations, gender diverse or bodily diverse.

diverse individual, means an individual who is:

(a) an Aboriginal or Torres Strait Islander person, including an Aboriginal or Torres Strait Islander person from the stolen generations; or
(b) a veteran or war widow; or
(c) from a culturally, ethnically and linguistically diverse background; or
(d) experiencing homelessness or at risk of experiencing homelessness; or
(e) a parent or child who is or was separated by forced adoption or removal; or
(f) an adult survivor of institutional child sexual abuse; or
(g) a care-leaver, including a Forgotten Australian or former child migrant placed in out of home care; or
(h) lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or is gender diverse or bodily diverse; or
(i) an individual with disability or mental ill-health; or
(j) neurodivergent; or
(k) deaf, deafblind, vision impaired or hard of hearing.

diversional therapist means a person who holds any of the following qualifications from a registered training organisation:

(a) Certificate IV in Leisure and Health;
(b) Diploma in Leisure and Health;
(c) Bachelor of Health Science;
(d) Bachelor of Applied Science with a major in:

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(i) Leisure and Health; or
(ii) Therapeutic Recreation.

emergency department presentation means when an individual presents to an emergency department or an urgent care centre including where that presentation is in person or via a technology enabled platform.

end-of-life care means the care provided in what is sometimes referred to as the terminal phase of life, where death is imminent and likely to occur within 3 months.

environmental restraint: see subsection 17-5(3).

excluded AT-HM item means a product, item of equipment or home modification that is listed in the part of the AT-HM List headed "Exclusions".

exercise physiologist means a person who is accredited by Exercise & Sports Science Australia as an Accredited Exercise Physiologist.

fall means an event that results in an individual coming to rest inadvertently on the ground, floor or other lower level.

fall resulting in major injury means a fall that results in one or more of the following:
(a) bone fracture;
(b) joint dislocation;
(c) closed head injury with altered consciousness;
(d) closed head injury with subdural haematoma.

fee reduction supplement daily threshold amount for a day means the amount obtained by rounding down to the nearest cent the amount equal to 15% of the basic age pension amount (worked out on a per day basis) for the day.

fee reduction supplement fortnightly threshold amount for a fortnight means the amount obtained by rounding down to the nearest cent the amount equal to 15% of the basic age pension amount (worked out on a per fortnight basis) for the fortnight.

financial support statement, for a registered provider, means the statement required by section 166-315.

finishing weight, in relation to unplanned weight loss, means the weight of an individual recorded in the third month of a quarter.

first asset threshold: see subsection 319-5(6).

first income threshold: see subsection 319-5(2).

formal agreement has the same meaning as in the old Act.

fortnightly base AT-HM individual amount, for an individual for a fortnight: see subsection 197-10(10).

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fortnightly base home support individual amount, for an individual for a fortnight: see subsection 197-10(9).

fortnightly base individual amount, for an individual for a fortnight: see subsection 197-10(8).

fortnightly individual contribution cap, for an individual for a fortnight: see subsection 197-10(7).

fortnightly remaining income amount, for an individual for a fortnight: see subsection 197-10(6).

fortnightly total essential expenses, for an individual for a fortnight: see subsection 197-10(4).

fortnightly total income amount, for an individual for a fortnight: see subsection 197-10(5).

fourth asset threshold: see subsection 319-5(9).

fourth income threshold: see subsection 319-5(5).

general purpose financial report, for a registered provider, means the report required by section 166-345.

genetic counsellor means a person who is registered with the Human Genetics Society of Australasia as a Certified Genetic Councillor.

Ghent Global Incontinence Associated Dermatitis Categorisation Tool means the *Ghent Global IAD Categorisation Tool (GLOBIAD)*, version 1.0 (June 2017), developed by Skin Integrity Research Group, at Ghent University.

Note: The Ghent Global Incontinence Associated Dermatitis Categorisation Tool could in 2025 be viewed in the Quality Indicator Program Manual on the Department's website (https://www.health.gov.au).

giving day, for a financial support statement: see subsection 166-320(3).

grant agreement means one or more grants of financial assistance to a registered provider for the delivery of funded aged care services entered into by the System Governor on behalf of the Commonwealth under section 264 of the Act.

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

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

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

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

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health profession has the same meaning as in the National Law.

health professional means a person who is registered under the National Law in a health profession.

health service standards assessment: see subsection 109-10(4).

higher cognitive ability: an individual who is mobile only with assistance has ***higher cognitive ability*** if the individual's AFM cognition score is 22 or more.

higher everyday living agreement: see section 284 of the Act.

higher function: an individual who is not mobile has ***higher function*** if the individual's RUG total score is 16 or less.

higher pressure sore risk: an individual who is not mobile has ***higher pressure sore risk*** if the individual's Braden total score is 13 or less.

home or community fee reduction supplement determination, for an individual, means a determination made under section 197-10 in relation to the individual (including as varied).

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

home support compounding factors: see section 81-7.

home support functional independence score, for an individual, means the individual's total score for:

(a) the questions in the sections of the Integrated Assessment Tool headed "Function", other than the following:
  (i) questions in the form "Is the need being met?";
  (ii) the question headed "Upper body strength"; and
(b) the questions in the section of the Integrated Assessment Tool headed "De Morton Mobility Index (DEMMI) - Modified".

home support needs met score, for an individual, means the individual's total score for the questions in the Integrated Assessment Tool in the form "Is the need being met?".

hospital admission means when an individual is accepted by a hospital inpatient speciality service for ongoing management, whether planned or unplanned and including an admission of any length and occurring in any location.

ICD-10 Australian Modified Pressure Injury Classification System means the classification system contained in the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)*, as published by the Independent Health and Aged Care Pricing Authority, and as existing on 1 November 2025.

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Note: The ICD-10-AM could in 2025 be viewed on the website of the Independent Health and Aged Care Pricing Authority (https://www.ihacpa.gov.au).

illness separated couple has the same meaning as in the Social Security Act.

in a service group: a funded aged care service is ***in a service group*** if the service is in a service type that is in the service group.

Note: See Part 3.

included AT-HM item means a product, item of equipment or home modification:

(a) that is listed in the part of the AT-HM List headed "Inclusions"; and

(b) that is not an excluded AT-HM item.

included communication and information management item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Inclusions" under "Communication and information management"; and

(b) that is not an excluded AT-HM item.

included domestic life item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Inclusions" under "Domestic life"; and

(b) that is not an excluded AT-HM item.

included home modifications item means a product, item of equipment or home modification:

(a) that is listed in the part of the AT-HM List headed "Inclusions" under "Home modifications"; and

(b) that is not an excluded AT-HM item.

included managing body functions item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Inclusions" under "Managing body functions"; and

(b) that is not an excluded AT-HM item.

included mobility item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Inclusions" under "Mobility"; and

(b) that is not an excluded AT-HM item.

included self-care item means a product or item of equipment:

(a) that is listed in the part of the AT-HM List headed "Inclusions" under "Self-care"; and

(b) that is not an excluded AT-HM item.

income tested fee, for an individual in the pre-2014 residential contribution class for a day: see subsection 285A-13(1).

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

Incontinence Associated Dermatitis means a type of irritant contact dermatitis characterised by erythema and oedema of the perianal or genital skin, and may be accompanied by bullae, erosion or secondary cutaneous infection.

Note: This definition is consistent with the Ghent Global Incontinence Associated Dermatitis Categorisation Tool.

independently mobile: an individual is ***independently mobile*** if the individual's DEMMI score is 13 or more.

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

individual nominee: see subsection 6-15(2).

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

(a) means a room, or a part of a room, in the home that:
  (i) is intended to be occupied as personal space by an individual to whom funded aged care services are delivered in the home; and
  (ii) contains a bed to be used by the individual; and
(b) includes:
  (i) the areas that are in the immediate vicinity of the bed in the room or the part of the room; and
  (ii) the contents of the room or the part of the room; and
  (iii) an ensuite, or a shared bathroom and toilet, that is for the use of the individual.

Injune means the Injune Multi-Purpose Service, 7 Fifth Avenue, Injune Queensland 4454.

Integrated Assessment Tool means the Integrated Assessment Tool published by the Department, as existing on the day this instrument commences.

Note: The Integrated Assessment Tool could in 2025 be viewed on the Department's website (https://www.health.gov.au).

Integrated Health and Aged Care Services Module means the Integrated Health and Aged Care Services Module published by the Australian Commission on Safety and Quality in Health Care, as existing on 30 June 2025.

Note: The Integrated Health and Aged Care Services Module could in 2025 be viewed on the website of the Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au).

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

key personnel of a person or body to which the Grantee Code of Conduct applies means:

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(a) if the person or body is a registered provider—a responsible person of the registered provider;
(b) if the body is not a registered provider—any person who:
  (i) is responsible for the executive decisions of the person or body; or
  (ii) has authority or responsibility for (or significant influence over) planning, directing, operating or controlling the activities of the person or body.

Note: For ***responsible person*** of a registered provider, see section 12 of the Act.

local region means an aged care planning region specified in the document titled *2018 Aged Care Planning Regions by Statistical Areas Level 2 (SA2) 2016 - Australia* published by the Department, as existing on the day this instrument commences.

Note: The document titled *2018 Aged Care Planning Regions by Statistical Areas Level 2 (SA2) 2016 - Australia* could in 2025 be viewed on the Department's website (https://www.health.gov.au).

lower cognitive ability: an individual who is mobile only with assistance has ***lower cognitive ability*** if the individual's AFM cognition score is 10 or less.

lower function: an individual who is not mobile has ***lower function*** if the individual's RUG total score is 17 or more.

lower pressure sore risk: an individual who is not mobile has ***lower pressure sore risk*** if the individual's Braden total score is 14 or more.

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

low means resident: see section 230-13.

low means resident percentage: see 230-13.

maximum daily amount of the transitional resident contribution: see subsection 285A-10(1).

maximum permissible interest rate for a day, means the maximum rate for the day worked out in accordance with section 301-5.

maximum possible daily accommodation payment amount for an individual for a day: see step 3 of the method statement in subsection 296-5(3).

means tested care fee, for an individual in the post-2014 residential contribution class: see subsection 285A-14(1).

means testing class: each of the following is a ***means testing class***:
(a) full-pensioner;
(b) part-pensioner;

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(c) seniors health card holder;
(d) self-funded retiree.

mechanical restraint: see subsection 17-5(4).

medical or psychological treatment, in relation to a priority 1 reportable incident under section 165A-25, means treatment that may only be provided by a medical practitioner, nurse practitioner, registered nurse, psychologist or social worker.

medical practitioner has the same meaning as in the National Law.

medical treatment authority, for an individual (the ***individual concerned***), means an individual or body that, under an appointment in writing that is in effect under the law of the State or Territory in which the individual concerned accesses funded aged care services, can give informed consent to the provision of medical treatment (however described) to the individual concerned if the individual concerned lacks capacity to give that consent.

medication, in relation to medication management, means a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical or mental health of an individual.

medium cognitive ability: an individual who is mobile only with assistance has ***medium cognitive ability*** if the individual's AFM cognition score is between 11 and 21 (inclusive).

member of a couple has the same meaning as in the Social Security Act.

merging service delivery branch: see subsection 263A-5(1).

middle weight, in relation to unplanned weight loss, means the weight of an individual recorded in the second month of a quarter.

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

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

mobile only with assistance: an individual is ***mobile only with assistance*** if the individual's DEMMI score is between 4 and 12 (inclusive).

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

Note: In 2025, the Modified Monash Model categorisation for a location could be viewed on the Department's website (https://www.health.gov.au).

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monthly performance report, for a registered provider, means the report required under section 166-610.

MPSP is short for Multi-Purpose Service Program.

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

music therapist means a person who is registered with the Australian Music Therapy Association as a Registered Music Therapist.

national efficient price: the ***national efficient price*** for residential care activity is $295.64.

National Law has the same meaning as in the *Health Insurance Act 1973*.

National Safety and Quality Health Service Standards means the standards of that name developed by the Australian Commission on Safety and Quality in Health Care under paragraph 9(1)(e) of the *National Health Reform Act 2011*, as existing on 31 May 2021.

Note: The National Safety and Quality Health Service Standards could in 2025 be viewed on the website of the Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au).

NATSIFACP is short for the program known as the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

NDIS screening application means a screening application within the meaning of paragraph 181Y(5)(a) of the NDIS Act.

newly built home: see section 230-20.

nominated entity: see subsection 95-5(1).

no-show circumstances: see subsections 11A-5(3) and (4).

not mobile: an individual is ***not mobile*** if the individual's DEMMI score is 3 or less.

nurse practitioner has the same meaning as in the *Health Insurance Act 1973*.

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

occupational therapist means a person who is registered under the National Law in the occupational therapy profession.

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

offline bed, for an approved residential care home, means a bed covered by the approval of the home that is covered by a notice under section 167 of the Act given in accordance with section 167-70 of this instrument.

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old Act wait time, for an individual who, immediately before the transition time, was approved under section 22-1 of the old Act as a recipient of home care but was not a prioritised home care recipient (within the meaning of the old Act), means the time starting at the time the individual's approval as a recipient of home care was given and ending immediately before the transition time.

old Principles means Principles made under section 96-1 of the old Act.

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

orthoptist means a person who is registered with the Australian Orthoptic Board.

orthotist means a person who:

(a) is a certified member of the Australian Orthotic Prosthetic Association; and

(b) is certified by that Association as a qualified orthotist.

pedorthist means a person who is registered with the Pedorthic Association of Australia as a Certified Pedorthist.

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

permitted uses reconciliation has the meaning given by section 166-325.

physical restraint: see subsection 17-5(5).

physiotherapist means a person who is registered under the National Law in the physiotherapy profession.

police certificate, for a person, means:

(a) a report about the person's criminal conviction record prepared by:

(i) the Australian Federal Police; or

(ii) the Australian Criminal Intelligence Commission; or

(iii) an agency accredited by the Australian Criminal Intelligence Commission; or

(iv) the police force or police service of a State or Territory; or

(b) for a responsible person of a registered provider that delivers funded aged care services in South Australia, or an aged care worker delivering funded aged care services in South Australia—the screening check known as the Aged Care Sector Employment Check issued to the person by the Department administered by the Minister administering the *Child Safety (Prohibited Persons) Act 2016* (SA).

polypharmacy, in relation to medication management, means the prescription of 9 or more medications to an individual.

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

(a) the individual entered a flexible care service (within the meaning of the old Act) before the transition time; and

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(b) the approved provider of the service charged the individual an accommodation payment (within the meaning of the old Act); and

(c) if, at the transition time, the individual is not accessing funded aged care services through the residential care service group under a specialist aged care program:

(i) the individual has a transition break period; and

(ii) the transition break period is not more than 28 days; and

(d) since the transition time, the individual has not ceased accessing funded aged care services through the residential care service group under a specialist aged care program for a continuous period of more than 28 days.

post-2014 home contribution class: an individual is in the ***post-2014 home contribution class*** if, on 12 September 2024, the individual was approved as a recipient of home care (within the meaning of the old Act).

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

(a) at the transition time, the individual is in the post-2014 residential contribution class; and

(b) since the transition time, the individual has not:

(i) both:

(A) elected, in the approved form, to cease being a member of the post-2014 residential contribution class; and

(B) ceased accessing funded aged care services in an approved residential care home and started accessing funded aged care services in another approved residential care home; or

(ii) ceased accessing funded aged care services in an approved residential care home for a continuous period of more than 28 days.

post-2014 residential contribution class: an individual is in the ***post-2014 residential contribution class*** if the individual has not elected, in the approved form, to cease being a member of the class, and:

(a) all of the following apply to the individual:

(i) before the transition time, the individual entered residential care (within the meaning of the old Act) other than as a recipient of respite care (within the meaning of that Act) and other than residential care provided through a multi-purpose service (within the meaning of the *Subsidy Principles 2014*);

(ii) immediately before the transition time, the individual was not a continuing residential care recipient (within the meaning of the old Act);

(iii) if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home:

(A) the individual has a transition break period; and

(B) the transition break period is not more than 28 days; or

(b) all of the following apply to the individual:

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(i) the individual is a member of the post-2014 home contribution class at the transition time;
(ii) the individual has entered residential care after the transition time;
(iii) the individual has not elected, in the approved form, to cease being a member of the post-2014 home contribution class.

pre-2014 accommodation class: an individual is in the ***pre-2014 accommodation class*** at a particular time (the ***test time***) that is on or after the transition time if:

(a) immediately before the transition time, any of the following agreements were in effect for the individual:
(i) a formal agreement (within the meaning of the old Act);
(ii) an accommodation bond agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*);
(iii) an accommodation charge agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*); or

(b) all of the following apply to the individual:
(i) immediately before the transition time, an agreement of a kind mentioned in paragraph (a) was not in effect for the individual;
(ii) at the transition time, the individual was not accessing funded aged care services in an approved residential care home, but had previously received residential care through a residential care service (within the meaning of the old Act), and the most recent agreement of any kind under the old Act that had been in effect for the individual was an agreement of a kind mentioned in paragraph (a);
(iii) at the test time, the individual has a transition break period and the transition break period is not more than 28 days; or

(c) both of the following apply to the individual:
(i) immediately before the transition time, an agreement of a kind mentioned in subparagraph (a)(ii) or (iii) was not in effect for the individual, but the individual was eligible under the old Act to enter into such an agreement;
(ii) at the transition time, the individual was accessing funded aged care services in an approved residential care home;

unless, before the test time, the individual:

(d) had ceased accessing funded aged care services in an approved residential care home (the ***first home***); and
(e) had started accessing funded aged care services in another approved residential care home (the ***second home***); and
(f) had elected in the approved form, before starting to access funded aged care services in the second home, to cease being a member of the pre-2014 residential contribution class.

pre-2014 maximum permissible interest rate: see section 287-165.

pre-2014 minimum permissible asset value: see subsection 287-45(3).

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

(a) immediately before the transition time, the individual was a continuing residential care recipient (within the meaning of the old Act); and

(b) if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home:

(i) the individual has a transition break period; and

(ii) the transition break period is not more than 28 days; and

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

pressure injury means a localised injury to the skin or underlying tissue, or both, usually over a bony prominence as a result of pressure, shear or a combination of these factors.

previous weight, in relation to unplanned weight loss by an individual in a quarter, means the individual's finishing weight for the previous quarter.

price agreement day, for an individual and an approved residential care home, means:

(a) the day on which the registered provider for the approved residential care home and the individual enter into an accommodation agreement for the approved residential care home in accordance with section 293 of the Act; or

(b) if the accommodation agreement between the registered provider for the approved residential care home and the individual is varied because the individual proposes to change the individual's room and the proposed move is voluntary—the day on which the accommodation agreement is varied in relation to the individual's room; or

(c) if the individual is notified by the registered provider for the approved residential care home that the individual's room is to be changed for 28 days or longer, and the proposed move is not voluntary—the day on which the notice is given.

Pricing Authority advice activity means an activity mentioned in paragraph 131A(1)(c) of the *National Health Reform Act 2011* conducted for the purpose of performing a function mentioned in paragraph 131A(1)(a) of that Act.

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

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

priority 1 notice: see section 165A-25.

priority 1 reportable incident: see section 165A-25.

priority 2 notice: see section 165A-30.

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priority 2 reportable incident: see section 165A-30.

priority category waiting proportion, for a priority category for a classification type for the service group home support on a day, means the number of waiting individuals who have that priority category for the classification type for the service group divided by the total number of waiting individuals for all priority categories for the classification type for the service group on the day.

prosthetist means a person who:

(a) is a certified member of the Australian Orthotic Prosthetic Association; and
(b) is certified by that Association as a qualified prosthetist.

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

quality indicators report, for a registered provider, means the report required by Subdivision B of Division 3 of Part 2 of Chapter 5.

Quality-of-Care Experience questions means the questions in the Quality of Care Experience Aged Care Consumers (QCE-ACC) Tool (2020) developed by Flinders University, as existing on 20 March 2026.

Note: The Quality-of-Care Experience questions could in 2026 be viewed in the Quality Indicator Program Manual on the Department's website (https://www.health.gov.au).

Quality of Life Assessment means an assessment using the Quality of Life questions.

Quality of Life questions means the questions in the Quality of Life Aged Care Consumers (QOL-ACC) Tool (2021) developed by Flinders University, as existing on 20 March 2026.

Note: The Quality of Life questions could in 2026 be viewed in the Quality Indicator Program Manual on the Department's website (https://www.health.gov.au).

quarterly financial report, for a registered provider, means the report required by section 166-340.

queue rate means:

(a) for the priority category high for the classification type ongoing for the service group home support—0.25; or
(b) for the priority category medium for the classification type ongoing for the service group home support—1.5; or
(c) for the priority category standard for the classification type ongoing for the service group home support—2.

recreational therapist means a person who is a certified member of the Australian Recreational Therapy Association.

reduced daily amount of the resident contribution, for an individual for a day: see subsection 231-17(7).

reference period, for a quarter, has the meaning given by subsection 176-20(6).

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refunding event means:

(a) in relation to the refund of a refundable deposit balance—an event referred to in paragraph 311(1)(a) or (b) of the Act; or

(b) in relation to the refund of an accommodation bond balance—an event referred to in paragraph 287-102(1)(a) or (b) of this instrument.

refund period means:

(a) in relation to the refund of a refundable deposit balance—the period within which the refundable deposit balance must be refunded in accordance with section 311 of the Act; or

(b) in relation to the refund of an accommodation bond balance—the period within which the accommodation bond balance must be refunded in accordance with section 287-102 of this instrument.

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

(a) unless paragraph (b) applies—the total cost of the refurbishment or proposed refurbishment of the home; or

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

registered health practitioner has the same meaning as in the National Law.

registered nurse staff member means a staff member of a registered provider who is a registered nurse.

registered training organisation has the same meaning as in the *National Vocational Education and Training Regulator Act 2011*.

rehabilitation counsellor means a person who is a member of the Australian Society of Rehabilitation Counsellors.

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

remedial massage therapist means a person who holds either of the following qualifications from a registered training organisation:

(a) a Diploma of Remedial Massage Therapy;

(b) a Certificate IV in Massage Therapy.

required combined staff average number of care minutes, per individual per day in respect of an approved residential care home for a quarter: see subsection 176-20(1).

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required registered nurse average number of care minutes, per individual per day in respect of an approved residential care home for a quarter: see subsection 176-20(2).

residential care compounding factors: see section 81-8.

residential care fee reduction supplement determination, for an individual, means a determination made under subsection 231-16(2) in relation to the individual (including as varied).

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

restorative care means an intensive short-term period of care after an illness or injury to help an individual maintain or regain independence.

restorative care partner: see subsection 148-40(4).

restrictive practices nominee: see subsection 6-15(1).

restrictive practices substitute decision-maker: see section 6-20.

Rockwood frailty score, for an individual, means the individual's score on the Rockwood Frailty Score assessment item of the AN-ACC Assessment Tool.

RRMA Classification means the document titled *Rural, Remote and Metropolitan Area Classification*, as existing at the transition time, setting out certain categories of areas in Australia that have been determined by the Department by reference to population size and remoteness of locality on the basis of 1991 census data published by the Australian Bureau of Statistics in 1994.

Note: The RRMA Classification for a location could in 2025 be viewed on the Department's website (https://www.health.gov.au).

RUG total score, for an individual, means the individual's total score on the Resource Utilisation Group - Activities of Daily Living assessment item of the AN-ACC Assessment Tool.

seclusion: see subsection 17-5(6).

second asset threshold:

(a) for an individual in the post-2014 residential contribution class: see paragraph 319-5(7)(a); or
(b) in any other case: see paragraph 319-5(7)(b).

second income threshold: see subsection 319-5(3).

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

serious offence conviction: a person has a ***serious offence conviction*** if the person has been:

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(a) convicted of murder or sexual assault; or
(b) convicted of, and sentenced to imprisonment for, any other form of assault.

service activity report, for a registered provider, means the report required under section 166-645.

service delivery report, for a registered provider, means the report required under section 166-625.

service demographics report, for a registered provider, means the report required under section 166-735.

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

significant compounding factors:
(a) for a classification assessment for an individual for a classification type for the service group home support—the individual has ***significant compounding factors*** if the home support compounding factors for the individual, considered together, indicate that the individual has significantly higher care needs relative to the needs of other individuals with similar home support functional independence scores and home support needs met scores; and
(b) for a classification assessment for an individual for the classification type ongoing for the service group residential care—an individual mentioned in an item of the table in section 81-8 has ***significant compounding factors*** if the residential care compounding factors for the individual, considered together, indicate that the individual has significantly higher care needs relative to the needs of other individuals mentioned in that item.

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

significant unplanned weight loss, in relation to unplanned weight loss, means a decrease in the weight of an individual that is equal to or greater than 5%, as determined by comparing the finishing weight of the previous quarter against the finishing weight for the current quarter.

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

social worker means a person who is certified by the Australian Association of Social Workers as an Accredited Social Worker.

sonographer means a person who is registered with the Australian Sonographer Accreditation Registry as an Accredited Medical Sonographer.

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

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

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

specialist homeless programs means specialist programs for persons with a background as a homeless person and includes, but is not limited to, the following:
(a) programs and interventions to manage complex behavioural needs of persons with that background;
(b) programs to promote social engagement and participation of persons with that background.

speech pathologist means a person who is certified by Speech Pathology Australia as a Certified Practising Speech Pathologist.

standing higher everyday living agreement: see section 284-2.

starting weight, in relation to unplanned weight loss, means the weight of an individual recorded in the first month of a quarter.

Statement of Accounting Concepts SAC 1 means Statement of Accounting Concepts SAC 1 "Definition of the Reporting Entity" published by the Australian Accounting Standards Board, as existing on 6 March 2020.

Note: The Statement of Accounting Concepts SAC 1 could in 2025 be viewed on the website of the Australian Accounting Standards Board (https://www.aasb.gov.au).

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

surplus and uncommitted funds, for a registered provider and a financial year, means financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider in the financial year relating to the same or similar activities and that are:
(a) surplus and uncommitted; and
(b) confirmed by provided financial statements.

target classification type wait time: see section 93-14.

target priority category wait time, for a priority category for a classification type for the service group home support on a day, means:
(a) for the priority category urgent—1 month; or
(b) for the priority category high, medium or standard—the result of multiplying the wait time factor on the day by the queue rate for the priority category.

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TCP is short for Transition Care Program.

third asset threshold: see subsection 319-5(8).

third income threshold: see subsection 319-5(4).

transitional agreed amount: see subsection 285A-25(2).

transitional basic daily fee: see subsection 285A-11(1).

transitional bed reservation fee: see subsection 285A-20(1).

transitional compensation payment fee: see subsection 285A-10(2).

transitional higher everyday living agreement: see subsection 285A-25(2).

transitional higher everyday living fee: see subsection 285A-25(1).

transitional pre-entry fee: see subsection 285A-15(1).

transitional pre-entry period: see subsection 285A-15(1).

transitional resident contribution: see subsection 285A-5(1).

transition break period, for an individual, means the sum of:

(a) the number of days in a continuous period that ended immediately before the transition time during which the individual was not being provided with residential care through a residential care service (within the meaning of the old Act) other than because the person was on leave (within the meaning of that Act); and

(b) the number of days in a continuous period beginning at the transition time during which the individual was not accessing funded aged care services in an approved residential care home.

The period mentioned in paragraph (a) and the period mentioned in paragraph (b) must each be a period of at least one day.

unavoidable service cost: see subsections 284-11(16) and (17).

unplanned weight loss means:

(a) significant unplanned weight loss; or

(b) consecutive unplanned weight loss.

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

unreduced daily amount of the resident contribution, for an individual for a day: see subsection 231-17(6).

unreduced individual contribution, for the delivery of a funded aged care service to an individual on a day, means the amount that would be the individual contribution for the delivery of the service to the individual on the day if step 4 in the method statement in subsection 273(2) of the Act were disregarded.

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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 MRC Act; or

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

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

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

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

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

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

waiting individual, for a priority category for a classification type for a service group on a day, means an individual who:

(a) has an access approval in effect for the classification type for the service group; and

(b) has been assigned the priority category for the classification type for the service group; and

(c) has not been allocated a place for the classification type for the service group.

wait time factor: see section 93-13.

6-5 References to actions taken or statements given

In this instrument, a reference to an action taken or a statement given by one of the following persons is a reference to such actions or statements that are within the person's professional scope of practice:

(a) an allied health assistant;

(b) an allied health professional;

(c) a diversional therapist;

(d) a registered health practitioner;

(e) a remedial massage therapist.

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6-15 Nominating restrictive practices nominees

(1) ***Restrictive practices nominee***, for a restrictive practice in relation to an individual, means:

(a) if there is only a single individual nominee for the restrictive practice in relation to the individual—that individual nominee; or

(b) if there is only a nominee group for the restrictive practice in relation to the individual—that nominee group; or

(c) if there is more than one individual nominee, or a nominee group and one or more individual nominees, for the restrictive practice in relation to the individual—the individual nominee or nominee group (as applicable) that takes precedence (see paragraph (9)(a)).

(2) ***Individual nominee***, for a restrictive practice in relation to an individual (the ***individual concerned***), means an individual:

(a) who has been nominated by the individual concerned, in accordance with this section, as an individual who can give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent; and

(b) who has agreed, in writing, to the nomination (and has not withdrawn that agreement); and

(c) who has capacity to give the informed consent mentioned in paragraph (a).

(3) ***Nominee group***, for a restrictive practice in relation to an individual (the ***individual concerned***), means a group of individuals:

(a) who have been nominated by the individual concerned, in accordance with this section, as a group of individuals who can jointly give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent; and

(b) each of whom has agreed, in writing, to the nomination (and has not withdrawn that agreement); and

(c) each of whom has capacity to give the informed consent mentioned in paragraph (a).

(4) An individual may make, vary or revoke a nomination only if the individual concerned has capacity to do so.

(5) A nomination, or a variation or revocation of a nomination, must be made in writing.

(6) A nomination (or varied nomination) of a group may nominate not more than 3 individuals as members of the group.

(7) A nomination (or varied nomination) may include only one nomination of a group.

(8) An individual may be nominated as an individual, or as a member of a group, but not both.

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(9) If a nomination (or a varied nomination) nominates more than one individual nominee, or both one or more individual nominees and a nominee group, the nomination (or varied nomination) must:
  (a) state the order of precedence in which the individual nominees and nominee group (as applicable) are nominated; and
  (b) if a nominee group is nominated—state the rules that will apply if the members of the group cannot agree on whether to give informed consent as mentioned in paragraph (3)(a) in a particular case.

(10) An individual (the ***individual concerned***) may nominate, as an individual or a member of a group, an aged care worker of a registered provider that is delivering funded aged care services to the individual concerned only if the aged care worker is the partner or a relative of the individual concerned.

6-20 Meaning of *restrictive practices substitute decision-maker*

(1) An individual or body is the ***restrictive practices substitute decision-maker*** for a restrictive practice in relation to an individual (the ***individual concerned***) if:
  (a) the individual or body is appointed by the law of the State or Territory in which the individual concerned accesses funded aged care services as an individual or body that can give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent; or
  (b) under an appointment in writing that is in effect under the law of the State or Territory in which the individual concerned accesses funded aged care services, the individual or body can give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent.

(2) The following table has effect if:
  (a) there is no such individual or body appointed for the restrictive practice in relation to the individual concerned under the law of the State or Territory in which the individual concerned accesses funded aged care services; and
  (b) either:
    (i) there is no clear mechanism for appointing such an individual or body under the law of the State or Territory; or
    (ii) an application has been made for an appointment under the law of the State or Territory in relation to the use of the restrictive practice in relation to the individual concerned, but there is a significant delay in deciding the application.

Meaning of *restrictive practices substitute decision-maker*

Item	Column 1 **For a restrictive practice in relation to the individual concerned, if …**	Column 2 **the *restrictive practices substitute decision-maker* for that restrictive practice in relation to the individual concerned is …**
1	there is a restrictive practices nominee for	that restrictive practices nominee.

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Meaning of *restrictive practices substitute decision-maker*

Item	Column 1 For a restrictive practice in relation to the individual concerned, if …	Column 2 the *restrictive practices substitute decision-maker* for that restrictive practice in relation to the individual concerned is …
	the restrictive practice in relation to the individual concerned	
2	item 1 does not apply to the restrictive practice in relation to the individual concerned, but the individual concerned has a partner: (a) with whom the individual concerned has a close continuing relationship; and (b) who has agreed, in writing, to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned (and has not withdrawn that agreement); and (c) who has capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned	that partner.
3	items 1 and 2 do not apply to the restrictive practice in relation to the individual concerned, but the individual concerned has a relative or friend: (a) who, immediately before the individual concerned entered an approved residential care home, was an unpaid carer for the individual; and (b) who has a personal interest in the welfare of the individual concerned on an unpaid basis; and (c) with whom the individual concerned has a close continuing relationship; and (d) who has agreed, in writing, to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned (and has not withdrawn that agreement); and (e) who has capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned	(a) if there is one such relative or friend—that relative or friend; or (b) if there are 2 or more such relatives or friends—the eldest of those relatives or friends.
4	items 1, 2 and 3 do not apply to the	(a) if there is one such relative or friend—that

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Meaning of *restrictive practices substitute decision-maker*

Item	Column 1 For a restrictive practice in relation to the individual concerned, if …	Column 2 the *restrictive practices substitute decision-maker* for that restrictive practice in relation to the individual concerned is …
	restrictive practice in relation to the individual concerned, but the individual concerned has a relative or friend: (a) who has a personal interest in the welfare of the individual concerned on an unpaid basis; and (b) with whom the individual concerned has a close continuing relationship; and (c) who has agreed, in writing, to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned (and has not withdrawn that agreement); and (d) who has capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned	relative or friend; or (b) if there are 2 or more such relatives or friends—the eldest of those relatives or friends.
5	items 1, 2, 3 and 4 do not apply to the restrictive practice in relation to the individual concerned, but there is a medical treatment authority for the individual concerned	(a) if there is one such medical treatment authority—that medical treatment authority; or (b) if there are 2 or more such medical treatment authorities and the law of the State or Territory in which the individual concerned accesses funded aged care services provides for the order of precedence of the medical treatment authorities—the medical treatment authority that takes precedence under that law; or (c) if: (i) there are 2 or more medical treatment authorities; and (ii) the law of the State or Territory in which the individual concerned accesses funded aged care services does not provide for the order of precedence of the medical treatment authorities; and (iii) one of the medical treatment authorities is an individual; that individual; or (d) if: (i) there are 2 or more medical treatment authorities; and

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Meaning of *restrictive practices substitute decision-maker*		
Item	**Column 1** **For a restrictive practice in relation to the individual concerned, if …**	**Column 2** **the *restrictive practices substitute decision-maker* for that restrictive practice in relation to the individual concerned is …**
		(ii) the law of the State or Territory in which the individual concerned accesses funded aged care services does not provide for the order of precedence of the medical treatment authorities; and (iii) one or more of the medical treatment authorities are individuals; the eldest of those individuals.

(3) For the purposes of paragraph (a) of column 1 of item 3 of the table in subsection (2), a person was an unpaid carer for the individual concerned if:

(a) the person was not employed, hired, retained or contracted (whether directly or through an employment or recruiting agency) as a carer for the individual concerned; and

(b) no payment or benefit other than one or more of the following was or will be made or given to the person for being a carer for the individual concerned:

(i) a carer payment or equivalent benefit;

(ii) payment in kind;

(iii) a payment or benefit as a beneficiary under the will of the individual concerned.

(4) For the purposes of paragraph (b) of column 1 of item 3 of the table and paragraph (a) of column 1 of item 4 of the table in subsection (2), a person has a personal interest in the welfare of the individual concerned on an unpaid basis if:

(a) the person is not employed, hired, retained or contracted (whether directly or through an employment or recruiting agency) to have that interest; and

(b) no payment or benefit other than one or more of the following is or will be made or given to the person for having that interest:

(i) a carer payment or equivalent benefit;

(ii) payment in kind;

(iii) a payment or benefit as a beneficiary under the individual's will.

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Division 2—Matters prescribed for definitions in section 7 of the Act

7-1 Accommodation bond

For the purposes of the definition of ***accommodation bond*** in section 7 of the Act, an ***accommodation bond*** means an amount that does not accrue daily and that is paid or payable by an individual in the pre-2014 accommodation class in accordance with an accommodation bond agreement.

7-2 Accommodation bond balance

For the purposes of the definition of ***accommodation bond balance*** in section 7 of the Act, an ***accommodation bond balance*** is, at a particular time, an amount equal to the difference between:

(a) an accommodation bond, other than:
  (i) an accommodation bond that is to be paid by periodic payment; or
  (ii) the part of an accommodation bond that is to be paid by periodic payment; and

(b) the sum of any amounts that have been, or are permitted to be, deducted from the accommodation bond in accordance with Subdivision D of Division 3 of Part 2 of Chapter 9 of this instrument as at that time.

7-3 Accommodation charge

For the purposes of the definition of ***accommodation charge*** in section 7 of the Act, an ***accommodation charge*** means an amount that accrues daily and that is paid or payable by an individual in the pre-2014 accommodation class in accordance with an accommodation charge agreement.

7-8 Approved needs assessors

Approving entities

(1) For the purposes of paragraph (a) of the definition of ***approved needs assessor*** in section 7 of the Act, the kind of entity is an entity specified in the document titled *Single Assessment System assessment organisations by service area, region, state and territory*, published by the Department, as existing on the day this instrument commences.

Note: The document titled *Single Assessment System assessment organisations by service area, region, state and territory* could in 2025 be viewed on the Department's website (https://www.health.gov.au).

Criteria

(2) For the purposes of paragraph (b) of the definition of ***approved needs assessor*** in section 7 of the Act, the criteria for a person are that the person is an individual who is employed or otherwise engaged by an entity prescribed by subsection (1) of this section.

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Note: An individual engaged by an entity includes an independent contractor.

7-11 Cost

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

7-12 Direct care

For the purposes of the definition of ***direct care*** in section 7 of the Act, the following funded aged care services are prescribed:

(a) the funded aged care services listed and described in items 2, 3, 4, 5, 6 and 7 of the table in section 8-150 of this instrument;

(b) the funded aged care services listed and described in items 3, 4, 5 and 6 of the table in section 8-155 of this instrument.

7-13 Entry contribution

For the purposes of the definition of ***entry contribution*** in section 7 of the Act, an ***entry contribution*** means a payment that was made before 1 October 1997 by an individual in the pre-2014 accommodation class in accordance with a formal agreement.

7-14 Entry contribution balance

For the purposes of the definition of ***entry contribution balance*** in section 7 of the Act, an ***entry contribution balance*** is, at a particular time, an amount equal to the difference between:

(a) the amount of an entry contribution; and

(b) the sum of any amounts that have been, or are permitted to be, deducted from the entry contribution in accordance with a formal agreement as at that time.

7-17 Entry day

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

Classification type ongoing

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

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

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

Classification type short-term for the service group residential care

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

Classification type hospital transition

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

7-19 Homeowner

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

(a) an individual who is not a member of a couple is a ***homeowner*** if:
  (i) the individual has a right or interest in the individual's principal home; and
  (ii) the individual's right or interest in the individual's principal home gives the individual reasonable security of tenure in the home; and

(b) an individual who is a member of a couple is a ***homeowner*** if:
  (i) the individual, or the individual's partner, has a right or interest in one residence that is the individual's principal home, or the partner's principal home, or the principal home of both of them; and
  (ii) the individual's right or interest, or the partner's right or interest, in the home gives the individual, or the individual's partner, reasonable security of tenure in the home.

7-20 Lifetime cap

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

(a) unless paragraph (b) applies—$137,917.01; or

(b) for an individual in the post-2014 home contribution class or the post-2014 residential contribution class—$86,185.23.

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7-21 Price charged

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

7-22 Serious injury or illness

For the purposes of the definition of ***serious injury or illness*** in section 7 of the Act, each of the following is a serious injury or illness:

(a) malnutrition;

(b) dehydration.

7-23 Service delivery branch

For the purposes of the definition of ***service delivery branch*** in section 7 of the Act, a ***service delivery branch*** of a registered provider means a place of business of the registered provider through which the provider delivers funded aged care services to an individual through the service group home support, assistive technology or home modifications.

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Part 3—Aged care service list

Division 1—Preliminary

8-5 Aged care service list

For the purposes of subsection 8(1) of the Act:

(a) each service listed and described in an item of a table in a section of Division 2, 4, 6 or 8 of this Part is a service for which funding may be payable under the Act; and

(b) this Part lists and describes each service, and specifies the service type that the service is in; and

(c) this Part specifies, for each service type:

(i) the service group the service type is in; and

(ii) any specialist aged care program under which the service type can be delivered; and

(iii) whether the service type can only be delivered under a specialist aged care program; and

(iv) each provider registration category under which the service type can be delivered; and

(d) this Part specifies, for each service mentioned in paragraph 8(1)(g) of the Act:

(i) the means testing category for the service; and

(ii) the subsidy basis for the service; and

(e) this Part specifies, for the service groups home support, assistive technology and home modifications, that all service types in those service groups must be delivered in a home or community setting; and

(f) this Part specifies, for the service group residential care, that all service types in the service group must be delivered in a residential care home.

8-10 Subsidy basis

The subsidy basis for each funded aged care service referred to in paragraph 8(1)(g) of the Act is cost.

8-12 Service types

For the purposes of subsection 8(2) of the Act, the following service types are prescribed:

(a) allied health and therapy;

(b) assistance with transition care;

(c) care management;

(d) community cottage respite;

(e) domestic assistance;

(f) equipment and products;

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(g) hoarding and squalor assistance;
(h) home adjustments;
(i) home maintenance and repairs;
(j) home or community general respite;
(k) meals;
(l) nursing care;
(m) nutrition;
(n) personal care;
(o) residential accommodation;
(p) residential clinical care;
(q) residential everyday living;
(r) residential non-clinical care;
(s) restorative care management;
(t) social support and community engagement;
(u) therapeutic services for independent living;
(v) transport.

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Division 2—Home support service types

8-15 Allied health and therapy

(1) A service listed and described in an item of the following table is in the service type allied health and therapy.

(2) The service requirements for a service listed and described in an item of the following table are that:
  (a) the service is for the individual to regain or maintain physical, functional or cognitive abilities that support the individual to remain safe and independent at home; and
  (b) the service is within the parameters specified in subsection (3); and
  (c) the service is for the management of conditions related to age-related disability or decline.

(3) For the purposes of paragraph (2)(b), the parameters for a service are the following:
  (a) the service may include clinical intervention, expertise, care and treatment, review, education (including techniques for self-management), and advice and supervision to improve capacity;
  (b) the service aims to give the individual the skills and knowledge to manage their own condition and promote independent recovery where appropriate;
  (c) the service may be delivered in person or via telehealth, as appropriate;
  (d) the service may be delivered individually or in a group-based format (such as clinically supervised group exercise classes), as appropriate;
  (e) for a service other than the services listed and described in items 6 and 7 of the following table—the service may be delivered:
    (i) directly by a registered health practitioner or allied health professional (as applicable); or
    (ii) by an allied health assistant or aged care worker, under the supervision of a registered health practitioner or allied health professional where safe and appropriate to do so;
  (f) for the service listed and described in item 6 of the following table—the service may be delivered:
    (i) directly by an Aboriginal or Torres Strait Islander Health Practitioner; or
    (ii) by an allied health assistant or aged care worker, under the supervision of an Aboriginal or Torres Strait Islander Health Practitioner, where safe and appropriate to do so;
  (g) for a service listed and described in item 7 of the following table—the service may be delivered:
    (i) directly by an Aboriginal or Torres Strait Islander Health Worker; or
    (ii) by an allied health assistant or aged care worker, under the supervision of an Aboriginal or Torres Strait Islander Health Worker, where safe and appropriate to do so.

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Services in the service type allied health and therapy		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Allied health assistance	Allied health therapy assistance that meets the service requirements specified in subsection (2)
2	Podiatry	Podiatry that meets the service requirements specified in subsection (2)
3	Social work	Social work activities that meet the service requirements specified in subsection (2)
4	Speech pathology	Speech pathology that meets the service requirements specified in subsection (2)
5	Diet or nutrition	Assistance with diet or nutrition that meets the service requirements specified in subsection (2)
6	Aboriginal or Torres Strait Islander Health Practitioner assistance	Assistance provided by an Aboriginal or Torres Strait Islander Health Practitioner that meets the service requirements specified in subsection (2)
7	Aboriginal or Torres Strait Islander Health Worker assistance	Assistance provided by an Aboriginal or Torres Strait Islander Health Worker that meets the service requirements specified in subsection (2)
8	Physiotherapy	Physiotherapy that meets the service requirements specified in subsection (2)
9	Psychology	Psychology that meets the service requirements specified in subsection (2)
10	Exercise physiology	Exercise physiology that meets the service requirements specified in subsection (2)
11	Occupational therapy	Occupational therapy that meets the service requirements specified in subsection (2)
12	Counselling or psychotherapy	Counselling or psychotherapy that meets the service requirements specified in subsection (2)
13	Music therapy	Music therapy that meets the service requirements specified in subsection (2)

8-20 Assistance with transition care

A service listed and described in the following table is in the service type assistance with transition care.

Services in the service type assistance with transition care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Transition care management	Initial and ongoing assessment, planning and management, and coordination and monitoring, of the individual's movement from hospital,

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Services in the service type assistance with transition care		
Item	**Column 1** **Service**	**Column 2** **Description**
		through the TCP and back into the community or into a residential care home, including the following: (a) ensuring that: (i) the individual's care and services plan is carried out; and (ii) progress against the care and services plan goals is monitored; (b) acting as a central point of contact; (c) liaising with and organising all care requirements provided by external service providers (including registered health practitioners and allied health professionals); (d) administration and operation of the TCP, including documentation relating to the individual; (e) arranging for another aged care assessment if needed prior to the completion of the individual's transition care episode; (f) managing the individual's transition into their post transition care arrangements, including a comprehensive written and verbal handover Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
2	Assistance to access medical practitioner	Transport for the individual to visit a medical practitioner, or assistance in arranging a home visit by a medical practitioner
3	Transition care medication management	The following: (a) implementation of a safe and efficient system to manage prescribing, procuring, dispensing, supplying, packaging, storing and administering of both prescription and over-the-counter medicines; (b) administration of, and monitoring the effects of, medication (including injections), including supervision and physical assistance with taking both prescription and over-the-counter medication under the delegation and clinical supervision of a registered nurse or other appropriate registered health practitioner
4	Transition care emergency or after hours assistance	Having at least one suitably skilled employee of the registered provider or an appropriate agency continuously on call to give emergency assistance when needed
5	Transition care continence management	The following: (a) assisting the individual to: (i) maintain continence or manage incontinence; and (ii) use aids and appliances designed to assist continence management; (b) the supply of aids and appliances designed to assist continence management to meet the individual's needs, including the following: (i) commode chairs, over-toilet chairs, bed-pans, uridomes, and catheter and urinary drainage appliances; (ii) as many continence aids (such as disposable urinal covers,

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Services in the service type assistance with transition care		
Item	**Column 1** **Service**	**Column 2** **Description**
		pants, pads, chair pads and enemas) as are needed to meet the individual's needs
6	Waste disposal	Safe disposal of transition care related organic and inorganic waste material

8-25 Care management

A service listed and described in an item of the following table is in the service type care management.

Services in the service type care management		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Home support care management	Activities that ensure funded aged care services contribute to the overall wellbeing of the individual, including implementing the care and services plan for the individual, service coordination, monitoring, review and evaluation, advocacy, support and education, but not including administrative costs funded through prices on services Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.

8-30 Community cottage respite

A service listed and described in the following table is in the service type community cottage respite.

Services in the service type community cottage respite		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Cottage respite	Overnight care for the individual that is provided: (a) in a cottage-style respite facility; and (b) in a community setting (other than in the individual's home, the home of a carer of the individual or the home of a host family); and (c) to provide respite for a carer of the individual

8-35 Domestic assistance

A service listed and described in an item of the following table is in the service type domestic assistance.

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Services in the service type domestic assistance		
Item	**Column 1** **Service**	**Column 2** **Description**
1	General house cleaning	The following: (a) the provision of, or assistance with, light household cleaning, including mopping, vacuuming, washing dishes, and general tidying of surface areas, that ensure the individual remains safe at home; (b) the supply of equipment or consumables required for cleaning mentioned in paragraph (a); but not including professional cleaning that would usually be paid for by an individual (such as carpet cleaning, pest control, dry cleaning or pet care)
2	Laundry services	The following: (a) the provision of, or assistance with, laundry activities including but not limited to the laundering of clothing and bedding and the ironing of clothing; (b) the supply of consumables required for laundry activities mentioned in paragraph (a); but not including dry cleaning
3	Shopping assistance	The provision of shopping, or assistance with shopping activities, including developing a shopping list, online shopping, driving to a shop and assisting with the collection of shopping, but not including the cost of the shopping

8-40 Hoarding and squalor assistance

A service listed and described in the following table is in the service type hoarding and squalor assistance.

Services in the service type hoarding and squalor assistance		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Hoarding and squalor supports	Services for an individual who is experiencing symptoms of hoarding disorder or who is living in severe domestic squalor, including, for example, the following: (a) implementing the care and services plan for the individual; (b) a one-off clean-up; (c) review and evaluation; (d) linking the individual to specialist support services Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.

8-45 Home maintenance and repairs

A service listed and described in an item of the following table is in the service type home maintenance and repairs.

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Services in the service type home maintenance and repairs		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Gardening	The provision of, or assistance with, maintenance of a residential garden, including essential light gardening such as mowing lawns, pruning shrubs and clearing yards that contribute to maintaining the individual's home in a safe and habitable condition, but not including the following: (a) professional gardening services that would usually be paid for by an individual (such as tree removal, landscaping or farm or water-feature maintenance); (b) gardening services that relate to visual appeal rather than safety or accessibility (such as installing and maintaining plants, garden beds and compost); (c) services that are the responsibility of other parties (such as landlords or government housing authorities)
2	Assistance with home maintenance and repairs	Essential minor repairs and maintenance: (a) that the individual used to be able to do themselves, or that are required to maintain safety (such as cleaning gutters, replacing lightbulbs and repairing broken door handles); or (b) that are required to address an imminent age-related safety risk (such as repairing uneven flooring that poses a falls risk or a section of carpet damaged by a wheelchair); but not including the following: (c) professional maintenance and repair services that would usually be paid for by an individual (such as professional pest extermination, installing cabinetry or replacing carpets due to usual wear and tear); (d) services that are the responsibility of other parties (such as landlords or government housing authorities)
3	Expenses for home maintenance and repairs	The supply of equipment or consumables required for that service

8-50 Home or community general respite

A service listed and described in an item of the following table is in the service type home or community general respite.

Services in the service type home or community general respite		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Flexible respite	Support and assistance for the individual that is provided: (a) during the day or overnight; and (b) in the individual's home; and (c) to provide respite for a carer of the individual

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Services in the service type home or community general respite		
Item	**Column 1** **Service**	**Column 2** **Description**
2	Community and centre-based respite	Small day outings or structured group activities for the individual that are provided: (a) to enable the individual to develop, maintain or support independent living and social interaction; and (b) in a community setting; and (c) to provide respite for a carer of the individual

8-55 Meals

A service listed and described in an item of the following table is in the service type meals.

Services in the service type meals		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Meal delivery	Preparation, packaging and delivery of pre-prepared meals, but not including the following: (a) the cost of ingredients; (b) takeaway food delivery; (c) meal delivery for other members of the household
2	Meal preparation	Support to prepare meals in the home or community, but not including the cost of ingredients

8-60 Nursing care

(1) A service listed and described in an item of the following table is in the service type nursing care.

Clinical care matters

(2) For items 1 to 3 of the following table, the clinical care matters are the following:
- (a) the assessment, treatment and monitoring of clinical conditions;
- (b) administration of medications;
- (c) wound care;
- (d) clinical continence management;
- (e) management of skin integrity;
- (f) education;
- (g) specialist service linkage.

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Services in the service type nursing care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Registered nurse clinical care	Clinical care provided by a registered nurse, including but not limited to the clinical care matters specified in subsection (2)
2	Enrolled nurse clinical care	Clinical care provided by an enrolled nurse, including but not limited to the clinical care matters specified in subsection (2)
3	Nursing assistant clinical care	Clinical care provided by a nursing assistant, including but not limited to the clinical care matters specified in subsection (2)
4	Nursing care consumables	The supply of consumables used in delivering the clinical care mentioned in items 1 to 3, including oxygen and specialised products for wound care, continence management and skin integrity

8-65 Nutrition

A service listed and described in an item of the following table is in the service type nutrition.

Services in the service type nutrition		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Nutrition supports	The supply of: (a) supplementary dietary products (enteral and oral); and (b) aids; that are: (c) required for conditions related to age-related functional decline or impairment; and (d) prescribed by a dietitian or registered health practitioner

8-70 Personal care

A service listed and described in an item of the following table is in the service type personal care.

Services in the service type personal care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Assistance with self-care and activities of daily living	Attendant care to meet essential and ongoing needs (such as mobility, eating and hygiene), but not including professional services that would usually be paid for by an individual (such as waxing or hairdressing)
2	Assistance with	Assistance with self-administration of medications, including arranging

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Services in the service type personal care		
Item	**Column 1** **Service**	**Column 2** **Description**
	self-administration of medications	for medications to be dispensed by a pharmacist, but not including prescribing or administering medications
3	Continence management (non-clinical)	Attendant non-clinical care to manage continence needs (such as support to access advice or funding, or assistance changing aids)

8-75 Restorative care management

A service listed and described in an item of the following table is in the service type restorative care management.

Services in the service type restorative care management		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Home support restorative care management	The provision of specialist coordination services for individuals with the classification level SAH restorative care pathway for the classification type short-term for the service group home support, but not including administrative costs funded through prices on services

8-80 Social support and community engagement

(1) A service listed and described in an item of the following table is in the service type social support and community engagement.

Excluded costs

(2) For items 2, 3 and 4 of the following table, the excluded costs are fees associated with participation in an activity (such as tickets, accommodation and membership fees).

Services in the service type social support and community engagement		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Group social support	Support in a group setting to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), including service and activity identification and linkage
2	Individual social support	Support on an individual basis to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), including the following: (a) service and activity identification and linkage; (b) assistance to participate in social interactions (in-person or online); (c) assistance to visit services or participate in telephone and web-based

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Services in the service type social support and community engagement		
Item	**Column 1** **Service**	**Column 2** **Description**
		check-in services; but not including the excluded costs specified in subsection (2)
3	Accompanied activities	Accompanying the individual to facilitate: (a) meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), but not including the excluded costs specified in subsection (2); or (b) the individual's attendance at medical or other appointments, but not including the cost of the appointments
4	Cultural support	Culturally focused support to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), including the following: (a) service and activity identification and linkage; (b) assistance to access translating and interpreting services and translation of information into the individual's chosen language; (c) referral pathways to advocacy or community organisations; (d) assistance in attending cultural and community events; but not including the excluded costs specified in subsection (2)
5	Digital education and support	Technology-focused support to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), including provision of or assistance with access to training, or direct assistance in the use of technologies to improve digital literacy to aid independence and participation (such as paying bills online, accessing telehealth services and connecting with digital social programs), but not including the purchase of smart devices for the purpose of online engagement
6	Assistance to maintain personal affairs	Support for maintaining the individual's financial and legal affairs to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities), but not including service fees (such as funeral plans or accountant's fees)
7	Expenses to maintain personal affairs	An internet or phone service (or both) for an individual who is homeless or is at risk of homelessness, and who needs support to maintain connection to funded aged care services

8-85 Therapeutic services for independent living

(1) A service listed and described in an item of the following table is in the service type therapeutic services for independent living.

(2) For a service listed and described in the following table, the service requirements are that:

(a) the service uses evidence-based techniques to manage social, mental and physical wellbeing in support of the individual remaining safe and independent at home; and

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(b) the service is within the parameters specified in subsection (3); and
(c) the service is for the management of conditions related to age-related disability or decline; and
(d) the service does not include relaxation massage or fees associated with participation in an activity (such as tickets, accommodation, membership fees, or supplies for an activity such as craft materials).

(3) For the purposes of paragraph (2)(b), the parameters for a service are the following:
(a) the service may include treatment, education and advice;
(b) the service aims to give the individual the skills and knowledge to manage their own condition and promote independent recovery where appropriate;
(c) the service may be delivered in person or via telehealth, as appropriate;
(d) the service may be delivered individually or in a group-based format, as appropriate;
(e) the service may be delivered:
(i) directly by a registered health practitioner or allied health professional (as applicable); or
(ii) by an allied health assistant or aged care worker, under the supervision of a registered health practitioner or allied health professional, where safe and appropriate to do so.

Services in the service type therapeutic services for independent living

Item	Column 1 Service	Column 2 Description
1	Acupuncture	Acupuncture: (a) provided by a registered health practitioner; and (b) that meets the service requirements specified in subsection (2); but not including herbal medicine
2	Chiropractics	Chiropractic therapy: (a) provided by a registered health practitioner; and (b) that meets the service requirements specified in subsection (2)
3	Diversional therapy	Diversional therapy: (a) provided by an allied health professional or a diversional therapist; and (b) that meets the service requirements specified in subsection (2)
4	Remedial massage	Remedial massage: (a) prescribed by an allied health professional; and (b) provided by an allied health professional or a remedial massage therapist; and (c) that meets the service requirements specified in subsection (2)
5	Art therapy	Art therapy: (a) provided by an allied health professional; and (b) that meets the service requirements specified in subsection (2)
6	Osteopathy	Osteopathy:

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Services in the service type therapeutic services for independent living		
Item	**Column 1** **Service**	**Column 2** **Description**
		(a) provided by a registered health practitioner; and (b) that meets the service requirements specified in subsection (2)

8-90 Transport

(1) A service listed and described in an item of the following table is in the service type transport.

Excluded things

(2) For the items of the following table, the excluded things are the following:
- (a) an individual's purchase of a vehicle;
- (b) an individual's vehicle running costs;
- (c) licence costs;
- (d) professional transit services (such as public transport, flights or ferries);
- (e) travel for holidays.

Services in the service type transport		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Direct transport	Provision of a car and driver for group and individual transport services to connect the individual with their usual activities, and including fuel, but not including the excluded things specified in subsection (2)
2	Indirect transport	Supply of a service voucher for taxi or rideshare services for group and individual transport services to connect the individual with their usual activities, but not including the excluded things specified in subsection (2)

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Division 3—Other specified matters for home support service types

8-95 All service types must be delivered in a home or community setting

All service types in the service group home support must be delivered in a home or community setting.

8-100 Other specified matters—service types that can only be delivered under specialist aged care programs

A service type mentioned in column 1 of an item of the following table:

(a) is in the service group home support; and

(b) can only be delivered under a specialist aged care program mentioned in column 2 of the item; and

(c) can be delivered under a provider registration category mentioned in column 3 of the item.

Other specified matters

Item	Column 1 Service type	Column 2 Specialist aged care programs	Column 3 Provider registration categories
1	Assistance with transition care	TCP	Nursing and transition care
2	Community cottage respite	(a) CHSP; (b) MPSP; (c) NATSIFACP	Personal and care support in the home or community
3	Hoarding and squalor assistance	(a) CHSP; (b) MPSP; (c) NATSIFACP	Advisory and support services

8-105 Other specified matters—other service types

Service group, specialist aged care programs and provider registration categories

(1) A service type mentioned in column 1 of an item of the following table:

(a) is in the service group home support; and

(b) can be delivered under a specialist aged care program mentioned in column 2 of the item; and

(c) can be delivered under a provider registration category mentioned in column 3 of the item.

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Means testing categories

(2) The means testing category for a service in a service type mentioned in column 1 of an item of the following table is the means testing category mentioned in column 4 of the item.

Other specified matters

Item	Column 1 Service type	Column 2 Specialist aged care programs	Column 3 Provider registration categories	Column 4 Means testing category
1	Allied health and therapy	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Personal and care support in the home or community	Clinical supports
2	Care management	(a) MPSP; (b) NATSIFACP	Personal and care support in the home or community	Clinical supports
3	Domestic assistance	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Home and community services	Everyday living
4	Home maintenance and repairs	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Home and community services	Everyday living
5	Home or community general respite	(a) CHSP; (b) MPSP; (c) NATSIFACP	Personal and care support in the home or community	Independence
6	Meals	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Home and community services	Everyday living
7	Nursing care	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Nursing and transition care	Clinical supports
8	Nutrition	(a) MPSP; (b) NATSIFACP; (c) TCP	Personal and care support in the home or community	Clinical supports
9	Personal care	(a) CHSP; (b) MPSP; (c) NATSIFACP; (d) TCP	Personal and care support in the home or community	Independence
10	Restorative care	(a) MPSP;	Personal and care support	Clinical supports

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Other specified matters

Item	Column 1 Service type	Column 2 Specialist aged care programs	Column 3 Provider registration categories	Column 4 Means testing category
	management	(b) NATSIFACP	in the home or community	
11	Social support and community engagement	(a) CHSP; (b) MPSP; (c) NATSIFACP	Advisory and support services	Independence
12	Therapeutic services for independent living	(a) CHSP; (b) MPSP; (c) NATSIFACP	Personal and care support in the home or community	Independence
13	Transport	(a) CHSP; (b) MPSP; (c) NATSIFACP	Home and community services	Independence

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Division 4—Assistive technology service types

8-110 Equipment and products

(1) A service listed and described in an item of the following table is in the service type equipment and products.

Means testing category

(2) For a service listed and described in any of items 1 to 10 of the following table, the means testing category is independence.

(3) For the service listed and described in item 11 of the following table, the means testing category is clinical supports.

Services in the service type equipment and products

Item	Column 1 Service	Column 2 Description
1	Managing body functions items (non-loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, other than on loan, of included managing body functions items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
2	Managing body functions items (loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, on loan, of included managing body functions items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
3	Self-care items (non-loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, other than on loan, of included self-care items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
4	Self-care items (loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, on loan, of included self-care items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
5	Mobility items (non-loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, other than on loan, of included mobility items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
6	Mobility items (loan)	A service: (a) that consists of the sourcing, supply and provision to the individual,

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Services in the service type equipment and products		
Item	**Column 1** **Service**	**Column 2** **Description**
		on loan, of included mobility items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
7	Domestic life items (non-loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, other than on loan, of either or both of the following: (i) included domestic life items; (ii) conditionally included domestic life items, if the conditions specified for the items in the AT-HM List are satisfied; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
8	Domestic life items (loan)	A service: (a) that consists of the sourcing, supply and provision to the individual, on loan, of either or both of the following: (i) included domestic life items; (ii) conditionally included domestic life items, if the conditions specified for the items in the AT-HM List are satisfied; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
9	Communication and information management items (non-loan)	A service that: (a) consists of the sourcing, supply and provision to the individual, other than on loan, of either or both of the following: (i) included communication and information management items, other than items that the individual is able to access under the Hearing Services Program administered by the Department; (ii) conditionally included communication and information management items, if the conditions specified for the items in the AT-HM List are satisfied and the individual is not able to access the items under the Hearing Services Program administered by the Department; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
10	Communication and information management items (loan)	A service that: (a) consists of the sourcing, supply and provision to the individual, on loan, of either or both of the following: (i) included communication and information management items, other than items that the individual is able to access under the Hearing Services Program administered by the Department; (ii) conditionally included communication and information management items, if the conditions specified for the items in the AT-HM List are satisfied and the individual is not able to access the items under the Hearing Services Program administered by the Department; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies

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Services in the service type equipment and products		
Item	**Column 1** **Service**	**Column 2** **Description**
11	Assistive technology prescription and clinical support	Either: (a) the following, delivered by a registered health practitioner or an allied health professional: (i) identifying an issue or problem that restricts the individual's physical, functional or cognitive ability; (ii) assessing the level of assistive technology needed for the individual to regain or maintain physical, functional or cognitive ability; (iii) identifying included AT-HM items and conditionally included AT-HM items (other than included home modifications items) that will assist the individual to regain or maintain physical, functional or cognitive ability; or (b) any of the following wraparound activities for the supply to an individual of an included AT-HM item or a conditionally included AT-HM item under a service listed and described in any of items 1 to 10 of this table: (i) setting up, fitting or providing training on the use of the item; (ii) providing support and troubleshooting to minimise abandonment of the item; (iii) maintenance and follow up for the item (including evaluating the effects on the individual's functioning); (iv) if the supply of the item to the individual is covered by a service listed and described in any of item 2, 4, 6, 8 or 10 of this table—maintenance, repair and refurbishment of the item or, at the end of the item's safe working life, disposal of the item; (v) administrative activities relating to the supply of the item

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Division 5—Other specified matters for assistive technology service types

8-115 All service types must be delivered in a home or community setting

All service types in the service group assistive technology must be delivered in a home or community setting.

8-120 Other specified matters for assistive technology service types

The service type equipment and products:

(a) is in the service group assistive technology; and

(b) can be delivered under any of the following specialist aged care programs:

(i) CHSP;

(ii) MPSP;

(iii) NATSIFACP;

(iv) TCP; and

(c) can be delivered under the provider registration category assistive technology and home modifications.

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Division 6—Home modifications service types

8-125 Home adjustments

(1) Each service listed and described in the following table is in the service type home adjustments.

Means testing category

(2) For the service listed and described in item 1 of the following table, the means testing category is independence.

(3) For the service listed and described in item 2 of the following table, the means testing category is clinical supports.

Services in the service type home adjustments

Item	Column 1 Service	Column 2 Description
1	Home modifications items	A service: (a) that consists of the sourcing, supply and provision to the individual of included home modifications items; and (b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
2	Home modifications prescription and clinical support	Either: (a) the following, delivered by a registered health practitioner or an allied health professional: (i) identifying an issue or problem that restricts the individual's physical, functional or cognitive ability; (ii) assessing the level of home modification needed for the individual to regain or maintain physical, functional or cognitive ability; (iii) identifying included home modifications items that will assist the individual to regain or maintain physical, functional or cognitive ability; or (b) any of the following wraparound activities for the supply to an individual of an included home modifications item under the service listed and described in item 1 of this table: (i) setting up, fitting or providing training on the use of the item; (ii) coordination activities relating to the supply of the item

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Division 7—Other specified matters for home modifications service types

8-130 All service types must be delivered in a home or community setting

All service types in the service group home modifications must be delivered in a home or community setting.

8-135 Other specified matters for home modifications service types

The service type home adjustments:

(a) is in the service group home modifications; and

(b) can be delivered under any of the following specialist aged care programs:

(i) CHSP;

(ii) MPSP;

(iii) NATSIFACP; and

(c) can be delivered under the provider registration category assistive technology and home modifications.

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Division 8—Residential care service types

8-140 Residential accommodation

Each service listed and described in the following table is in the service type residential accommodation.

Services in the service type residential accommodation

Item	Column 1 Service	Column 2 Description
1	Accommodation	The following: (a) capital infrastructure costs and depreciation of buildings and grounds used by individuals; (b) communal areas for living, dining and recreation, as well as personal accommodation in either individual or shared rooms; (c) refurbishments and replacements of fixtures, fittings and infrastructure; (d) maintenance, of buildings and grounds used by individuals, to address normal wear and tear
2	Accommodation administration	Administration relating to the general operation of the residential care home, including accommodation agreements, accommodation bond agreements and accommodation charge agreements

8-145 Residential everyday living

Each service listed and described in the following table is in the service type residential everyday living.

Services in the service type residential everyday living

Item	Column 1 Service	Column 2 Description
1	Operational administration and emergency assistance	The following: (a) administration relating to: (i) the delivery of the other services listed and described in this table; and (ii) service agreements; (b) emergency assistance, including the following: (i) at all times, having at least one suitable employee of the registered provider onsite and able to take action in an emergency; (ii) if an individual is in need of urgent medical attention—providing emergency assistance in accordance with the registered provider's protocol for providing such assistance; (iii) activation of emergency plans in the case of fire, floods or other emergency;

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Services in the service type residential everyday living		
Item	**Column 1** **Service**	**Column 2** **Description**
		(iv) contingency planning for emergencies; (v) staff training for emergencies
2	Communication services	Access for individuals to an external telecommunications mechanism in the residential care home (and in individuals' rooms if requested), such as telephone, internet or wi-fi services, but not including any usage charges or device costs
3	Utilities	The following: (a) utility running costs for the residential care home (such as electricity, water and gas); (b) heating and cooling for bedrooms and common areas to a comfortable temperature; (c) testing and tagging of all electrical equipment provided by the registered provider; but not including electrical equipment brought into the residential care home by individuals
4	Cleaning services and waste disposal	The following: (a) cleanliness and tidiness of the entire residential care home, including the individual's personal area unless the individual chooses to and is able to maintain their personal area themselves; (b) safe disposal of organic and inorganic waste material
5	Communal furnishings	Fit-for-purpose communal lounge and dining furniture, including the following: (a) televisions; (b) if the residential care home has a communal outdoor space—outdoor furniture
6	Bedroom and bathroom furnishings	The following (other than bedroom and bathroom furnishings that are customised or that the individual chooses to provide): (a) a bed and a mattress that meet the individual's care, safety and comfort needs, including, if required, a bed that is adjustable to cater for the individual's needs and accommodates the individual's height and weight; (b) equipment or technologies used to ensure the safety of the individual in bed and to avoid injury to the individual and to aged care workers; (c) pillows (including, if required, pressure cushions, tri pillows and wedge pillows); (d) a bedside table, bedside locker or bedside chest of drawers, wardrobe space, draw screens (for shared rooms), a visitor chair (if required) and an over bed table (if required); (e) a fixture or item of furniture where the individual can safely lock and store valuables, if this is not provided by the furniture items mentioned in paragraph (d); (f) a chair, with arms, that meets the individual's care, safety and comfort needs, including, if required, a chair with particular features, such as an air, water or gel chair;

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Services in the service type residential everyday living		
Item	**Column 1** **Service**	**Column 2** **Description**
		(g) a shower chair (if required), containers for personal laundry, and waste collection containers or bins for bedrooms and bathrooms; (h) bed linen, blankets or doonas, air or ripple mattresses (if required), absorbent or waterproof covers, sheeting and bed pads (if required), bath towels, hand towels and face washers; (i) laundering of all products mentioned in paragraph (h)
7	Toiletry goods	The supply of the following goods (or substitutes if needed to meet the individual's medical needs, including specialist products for conditions such as dermatitis) but not including alternative items requested on the basis of the individual's personal preferences: (a) facial cleanser (or alternatives such as facial wipes), shower gel or soap, shower caps, shampoo and conditioner; (b) toothpaste, toothbrushes and mouthwash; (c) hairbrush or comb, shaving cream and disposable razors; (d) tissues and toilet paper; (e) moisturiser and deodorant; (f) cleaning products for dentures, hearing aids, glasses and artificial limbs (and their storage containers)
8	Personal laundry	The following: (a) laundering (other than by a special cleaning process such as dry cleaning or hand washing) items that can be machine washed, using laundry detergents that meet the individual's medical needs, such as skin sensitivities; (b) if requested, ironing of machine washed clothes (other than underwear and socks); (c) a labelling system for the individual's clothing, but not including alternate labelling systems requested on the basis of the individual's personal preferences; (d) return of personal laundry to the individual's clothing storage space
9	Meals and refreshments	The following: (a) at least 3 meals served each day (including the option of dessert with either lunch or dinner) plus morning tea, afternoon tea and supper, of adequate variety, quality and quantity to meet the individual's nutritional and hydration needs; (b) special diets where required to meet the individual's medical, cultural or religious needs, including but not limited to enteral feeding, nutritional supplements, texture modified meals and thickened fluids, diets to address food allergies and intolerances, and vegetarian, vegan, kosher and halal diets (but not for meeting the individual's social preferences on food source such as non-genetically modified and organic); (c) reasonable flexibility in mealtimes, if requested, so the individual can exercise choice; (d) a variety of non-alcoholic beverages available at all times (such as

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Services in the service type residential everyday living		
Item	**Column 1** **Service**	**Column 2** **Description**
		water, milk, fruit juice, tea and coffee); (e) eating and drinking utensils and eating aids if needed; (f) snack foods of adequate variety, including fruit and options suitable for texture modified diets, available at all times in the residential care home

8-150 Residential non-clinical care

Each service listed and described in the following table is in the service type residential non-clinical care.

Services in the service type residential non-clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Care and services administration	Administration related to: (a) the delivery of the other services listed and described in the other items of this table; and (b) the delivery of the services in the service type residential clinical care
2	Personal care assistance	Personal assistance, including individual attention, individual supervision and physical assistance, with the following: (a) bathing, showering, personal hygiene and grooming (other than hairdressing); (b) dressing, undressing and using dressing aids; (c) eating and drinking, and using utensils and eating aids (including actual feeding if necessary); (d) cleaning of personal items (and their storage containers) needed for daily living, including dentures, hearing aids, glasses, mobility aids and artificial limbs
3	Communication	Assistance with daily communication, including the following: (a) assistance to address difficulties arising from impaired hearing, sight or speech, cognitive impairment, or lack of common language (for example, visual aids such as cue cards, paper-based photo or alphabet spelling communication boards or books, photo based easy language written information, and menu and activity choice boards or learning of key phrases); (b) fitting sensory communication aids and checking hearing aid batteries
4	Emotional support	The following: (a) if the individual is experiencing social isolation, loneliness or emotional distress—ongoing emotional support to, and supervision of, the individual (including pastoral support); (b) if the individual is new to the residential care home—assisting the

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Services in the service type residential non-clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		individual to adjust to their new living environment; (c) provision of culturally safe supports that have been determined in consultation with the individual and their supporters (if required)
5	Mobility and movement needs	The following (other than the provision of motorised wheelchairs, electric mobility scooters, customised aids, or mobility aids requested on the basis of the individual's personal preferences): (a) assisting the individual with moving, walking and wheelchair use; (b) assisting the individual with using devices and appliances designed to aid mobility; (c) the fitting of artificial limbs and other personal mobility aids; (d) supply and maintenance of crutches, quadruped walkers, walking frames, wheeled walkers, standing walkers, walking sticks, wheelchairs and tilt-in-space chairs; (e) aids and equipment used by aged care workers to move the individual, including for individuals with bariatric needs; taking into account: (f) the individual's care, safety and comfort needs; and (g) the individual's ability to use aids, appliances, devices and equipment; and (h) the safety of other individuals and of aged care workers and visitors to the residential care home
6	Continence management	The following: (a) assisting the individual to: (i) maintain continence or manage incontinence; and (ii) use aids and appliances designed to assist continence management; (b) the supply of aids and appliances designed to assist continence management to meet the individual's needs, including the following: (i) commode chairs, over-toilet chairs, bed-pans, uridomes, and catheter and urinary drainage appliances; (ii) as many continence aids (such as disposable urinal covers, pants, pads, chair pads and enemas) as are needed to meet the individual's needs
7	Recreational and social activities	Tailored recreational programs and leisure activities (including communal recreational equipment and products) aimed at preventing loneliness and boredom, creating an enjoyable and interesting environment, and maintaining and improving the social interaction of the individual. These programs and activities must include the option of: (a) at least one recreational or social activity each day that is not screen-based, television-based or meal-based; and (b) regular outings into the community (but not including the cost of entry tickets, transport or purchased food and beverages associated

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Services in the service type residential non-clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		with the outings)

8-155 Residential clinical care

Each service listed and described in the following table is in the service type residential clinical care.

Services in the service type residential clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Care and services plan oversight	Ensuring that: (a) the individual's care and services plan is carried out; and (b) progress against the care and services plan goals is monitored Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
2	Allied health, rehabilitation and therapeutic exercise therapy programs	Allied health, rehabilitation and therapeutic exercise therapy programs that are: (a) designed by: (i) appropriate registered health practitioners; or (ii) appropriate allied health professionals; or (iii) appropriate registered health practitioners and appropriate allied health professionals; and (b) designed in consultation with the individual and their supporters (if required); and (c) delivered in individual or group settings; and (d) delivered by, or under the supervision, direction or appropriate delegation of: (i) registered health practitioners; or (ii) allied health professionals; or (iii) registered health practitioners and allied health professionals; and (e) aimed at maintaining and restoring the individual's physical, functional and communication abilities to perform daily tasks for themselves, including through: (i) maintenance therapy that is designed to provide ongoing therapy services to prevent reasonably avoidable physical and functional decline and maintain and improve levels of independence in everyday living; and (ii) if required, more focused restorative care therapy on a time-limited basis that is designed to allow the individual to reach a level of independence at which maintenance therapy will meet their needs;

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Services in the service type residential clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		but not including the following: (f) intensive, long-term rehabilitation services required following (for example) serious illness or injury, surgery or trauma; (g) allied health services and appointments made for or by the individual or their supporters that are in addition to those required to meet the individual's care needs under programs covered by paragraphs (a) to (e)
3	Medication management	The following: (a) implementation of a safe and efficient system to manage prescribing, procuring, dispensing, supplying, packaging, storing and administering of both prescription and over-the-counter medicines; (b) administration and monitoring of the effects of medication (via all routes (including injections)), including supervision and physical assistance with taking both prescription and over-the-counter medication, under the delegation and clinical supervision of a registered nurse or other appropriate registered health practitioner; (c) reviewing the appropriateness of medications as needed under the delegation and clinical supervision of a registered nurse, or other appropriate registered health practitioner; but not including the cost of prescription and over-the-counter medications
4	Nursing	Services provided by or under the supervision of a registered nurse, including but not limited to the following: (a) initial comprehensive clinical assessment for input to the care and services plan for the individual, carried out: (i) in line with the individual's needs, goals and preferences; and (ii) by a registered nurse; and (iii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals; (b) ongoing regular comprehensive clinical assessment of the individual, including identifying and responding appropriately to change or deterioration in function, behaviour, condition or risk, carried out: (i) in line with the individual's needs, goals and preferences; and (ii) by a registered nurse, or an enrolled nurse under appropriate delegation by a registered nurse; and (iii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals; (c) all other nursing services, carried out: (i) by a registered nurse, or an enrolled nurse under appropriate delegation by a registered nurse; and (ii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied

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Services in the service type residential clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		health professionals Note 1: Examples of services include (but are not limited to) the following: (a) ongoing monitoring and evaluation of the individual, and identification where care may need to be escalated or altered due to the changing health or needs of the individual; (b) maintaining accurate, comprehensive, and up-to-date clinical documentation of the individual's care; (c) assistance with, or provision of support for, personal hygiene, including oral health management and considerations for bariatric care needs; (d) chronic disease management, including blood glucose monitoring; (e) if the individual is living with cognitive decline—support and supervision of the individual; (f) if the individual is living with mental health decline—support and supervision of the individual; (g) establishment and supervision of a pain management plan, including the management and monitoring of chronic pain; (h) medication management (as listed and described in item 3 of this table); (i) insertion, maintenance, monitoring and removal of devices, including intravenous lines, naso-gastric tubes, catheters and negative pressure devices; (j) if the individual has identified feeding and swallowing needs—support for the individual; (k) skin assessment and the prevention and management of pressure injury wounds; (l) establishment and supervision of a continence management plan; (m) stoma care; (n) wound management, including of complex and chronic wounds; (o) provision of bandages, dressings, swabs, saline, drips, catheters, tubes and other medical items required as a part of nursing services; (p) assistance with, and ongoing supervision of, breathing, including oxygen therapy, suctioning of airways and tracheostomy care; (q) required support and observations for peritoneal dialysis treatment; (r) assisting or supporting an individual to use appropriate healthcare technology in support of their care, including telehealth; (s) risk management relating to infection prevention and control; (t) advance care planning, palliative care and end-of-life care. Note 2: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
5	Dementia and cognition management	If the individual has dementia or other cognitive impairments: (a) development of an individual therapy and support program designed and carried out to: (i) prevent or manage a particular condition or behaviour; and (ii) enhance the individual's quality of life; and (iii) enhance care for the individual; and (b) ongoing support (including specific encouragement) to motivate or enable the individual to take part in general activities of the residential

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Services in the service type residential clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		care home (if appropriate)
6	General access to medical and allied health services	The following: (a) making arrangements for registered health practitioners to visit the individual for any necessary registered health practitioner appointments (but not the cost of the appointments or any gap payments charged for the appointments); (b) making arrangements for the individual to attend any necessary registered health practitioner appointments (but not the cost of the appointments or any gap payments charged for the appointments, or transport or escort costs); (c) if required, making arrangements for allied health professionals to visit the individual, or for the individual to visit an allied health professional, for any services or appointments mentioned in paragraph (f) of item 2 of this table (but not the cost of the appointments or any gap payments charged for the appointments, or transport or escort costs); (d) if required, provision of audio-visual equipment for use with telehealth appointments; (e) arranging for an ambulance in emergency situations

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Division 9—Other specified matters for residential care service types

8-160 Service types must be delivered in a residential care home

Each service type in the service group residential care must be delivered in a residential care home.

8-165 Other specified matters for residential care service types

Each service type set out in Division 8:

(a) is in the service group residential care; and

(b) can be delivered under the following specialist aged care programs:

(i) NATSIFACP;

(ii) MPSP;

(iii) TCP; and

(c) can be delivered under the provider registration category residential care.

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Part 4—Other key concepts

11-5 Provider registration categories

For the purposes of paragraph 11(3)(b) of the Act, the following categories are prescribed:

(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care.

Note: The category residential care is a provider registration category (see paragraph 11(3)(a) of the Act).

11A-5 Delivery of funded aged care services

Late cancellations

(1) For the purposes of subparagraph 11A(3)(a)(ii) of the Act, the period of 2 business days is prescribed.

Prescribed circumstances—no-show circumstances

(2) For the purposes of paragraph 11A(3)(b) of the Act, the prescribed circumstances are that no-show circumstances apply in relation to the service.

(3) ***No-show circumstances*** apply in relation to the service if:
(a) the service was to be delivered by the registered provider to the individual through the service group home support, assistive technology or home modifications; and
(b) the service was scheduled to be delivered by the registered provider to the individual on the day referred to in paragraph 11A(2)(b) of the Act at an agreed time and place; and
(c) the only reason that the service was not delivered was:
(i) the individual was required to be present (whether physically, by video link or other means) for the delivery of the service; and
(ii) the individual was not present as agreed for the delivery of the service on that day and at that time and place; and
(iii) the individual did not cancel the delivery of the service before the agreed time.

(4) ***No-show circumstances*** also apply in relation to the service if:
(a) the service was to be delivered by the registered provider to the individual through the service group home support, assistive technology or home modifications; and

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(b) the service was scheduled to be delivered by the registered provider to the individual on the day referred to in paragraph 11A(2)(b) of the Act at an agreed time and place; and

(c) the only reason that the service was not delivered was because the individual refused, or refused or failed to facilitate, access to the agreed place necessary for the delivery of the service.

Circumstances in which subsection 11A(2) of the Act does not apply to a service

(5) For the purposes of paragraph 11A(5)(a) of the Act, the circumstances in which subsection 11A(2) of the Act does not apply to a service is that the service was to have been delivered under a specialist aged care program.

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Part 5—Aged Care Code of Conduct

14-1 Purpose of this Part

For the purposes of section 14 of the Act, this Part prescribes requirements relating to the conduct of the following:

(a) registered providers;
(b) aged care workers of registered providers;
(c) responsible persons of registered providers.

Note: These requirements are the ***Aged Care Code of Conduct***: see section 7 of the Act.

14-5 Requirements

When delivering funded aged care services to individuals, I must:

(a) act with respect for individuals' rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions; and
(b) act in a way that treats individuals with dignity and respect, and values their diversity; and
(c) act with respect for the privacy of individuals; and
(d) deliver funded aged care services in a safe and competent manner, with care and skill; and
(e) act with integrity, honesty and transparency; and
(f) promptly take steps to raise and act on concerns about matters that may impact the quality and safety of funded aged care services; and
(g) deliver funded aged care services free from:
    (i) all forms of violence, discrimination, exploitation, neglect and abuse; and
    (ii) sexual misconduct; and
(h) take all reasonable steps to prevent and respond to:
    (i) all forms of violence, discrimination, exploitation, neglect and abuse; and
    (ii) sexual misconduct.

14-10 Application of requirements

(1) The requirements apply to the following in accordance with this section:
    (a) registered providers;
    (b) aged care workers of registered providers;
    (c) responsible persons of registered providers.

(2) The requirements apply as if the reference to "I" in section 14-5 was a reference to all of the following:
    (a) a registered provider;

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(b) an aged care worker of a registered provider;
(c) a responsible person of a registered provider.

(3) For the purposes of the application of requirements to the delivery of funded aged care services to individuals by a responsible person of a registered provider, the requirements apply to the performance by the responsible person of the responsibilities and functions of the responsible person.

Note: Provisions relevant to compliance with the Aged Care Code of Conduct include the following:
(a) section 142 of the Act (civil penalties for non-compliance with conditions of registration of registered providers);
(b) section 145 of the Act (condition of registration of registered providers);
(c) section 173 of the Act (civil penalties for aged care workers);
(d) section 174 of the Act (civil penalties for responsible persons);
(e) subparagraph 498(2)(d)(i) of the Act (grounds for banning orders against individuals who are or were aged care workers or responsible persons of a registered provider).

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Part 6—Aged Care Quality Standards

Division 1—Purpose and application

15-1 Purpose of this Division

For the purposes of subsection 15(1) of the Act, this Division:

(a) prescribes standards relating to the quality of funded aged care services delivered by a registered provider; and

(b) provides for the application of the standards to registered providers in specified provider registration categories.

15-5 Application of standards

(1) Standards 1 to 4 apply to a registered provider in any of the following provider registration categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

(2) Standard 5 applies to a registered provider in either of the following provider registration categories:

(a) nursing and transition care;

(b) residential care.

(3) Subsections 15-30(1) and (2) (Standard 5—*Outcome 5.1—Clinical governance*) apply to a registered provider in the provider registration category personal and care support in the home or community that delivers, or intends to deliver, either of the following service types:

(a) care management;

(b) restorative care management.

(4) Standards 6 and 7 apply to a registered provider in the provider registration category residential care.

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Division 2—The standards

15-10 Standard 1—The individual

Outcome 1.1—Person-centred care

(1) The registered provider demonstrates that the provider understands that the safety, health, wellbeing and quality of life of individuals is the primary consideration in the delivery of funded aged care services.

Note: See also subsection 144(2) of the Act (rights and principles).

(2) The provider demonstrates that the provider understands and values individuals, including their identity, culture, ability, diversity, beliefs and life experiences.

Note: See also section 23 of the Act (Statement of Rights) and section 144 of the Act (rights and principles).

(3) The provider demonstrates that the provider develops funded aged care services with, and tailored to, individuals, taking into account their needs, goals and preferences.

Outcome 1.2—Dignity, respect and privacy

(4) The provider must deliver funded aged care services to individuals in a way that:
(a) is free from all forms of discrimination, abuse and neglect; and
(b) treats individuals with dignity and respect; and
(c) respects the personal privacy of individuals.

Note: See section 23 of the Act (Statement of Rights) and section 144 of the Act (rights and principles).

(5) The provider:
(a) demonstrates that the provider understands the rights of individuals under the Statement of Rights; and
(b) must have practices in place to ensure that the provider acts compatibly with the Statement of Rights, in accordance with subsection 24(2) of the Act (acting compatibly with the Statement of Rights).

Note: See also section 144 of the Act (rights and principles).

Outcome 1.3—Choice, independence and quality of life

(6) The provider must support individuals to exercise choice and make decisions about their funded aged care services, and provide them with support to exercise choice and make decisions when they want or need it.

(7) The provider must provide individuals with timely, accurate, tailored and sufficient information about their funded aged care services, in a way they understand.

Note: See also section 29 of the Act (giving information and documents to supporters).

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(8) The provider must support individuals to exercise dignity of risk to achieve their goals and maintain independence and quality of life.

Outcome 1.4—Transparency and agreements

(9) Before entering into any agreements with individuals about the delivery of funded aged care services, the provider must provide individuals with:
  (a) the opportunity to exercise autonomy; and
  (b) the time they need to consider the agreement; and
  (c) an opportunity to seek advice.

Note: Refer to sections 148-65 and 148-70 of this instrument in relation to the requirements for entering into a service agreement, details and contents of such an agreement.

(10) The provider must support individuals to understand and make informed decisions about their agreements, fees and invoices.

15-15 Standard 2—The organisation

Outcome 2.1—Partnering with individuals

(1) The registered provider must engage in meaningful and active partnerships with individuals to inform organisational priorities and continuous improvement.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

Outcome 2.2a—Quality, safety and inclusion culture to support aged care workers to deliver quality care

(2) The governing body must lead a culture of quality, safety and inclusion that supports aged care workers to provide quality funded aged care services by:
  (a) focussing on continuous improvement; and
  (b) embracing diversity; and
  (c) prioritising the safety, health and wellbeing of aged care workers.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

Outcome 2.2b—Quality, safety and inclusion culture to support individuals

(3) The governing body must lead a culture of quality, safety and inclusion that supports individuals accessing quality funded aged care services by:
  (a) focussing on continuous improvement; and
  (b) embracing diversity; and
  (c) prioritising the safety, health and wellbeing of individuals.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

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Outcome 2.3—Accountability, quality system and policies and procedures

(4) The governing body is accountable for the delivery of quality funded aged care services and must maintain oversight of all aspects of the provider's operations.

(5) The provider must use a quality system to enable and drive continuous improvement of the provider's delivery of funded aged care services.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

(6) The provider must:
(a) maintain current policies and procedures that guide the way aged care workers undertake their roles; and
(b) require aged care workers to follow the policies and procedures.

Outcome 2.4—Risk management

(7) The provider must use a risk management system to identify, manage and continuously review risks to individuals, aged care workers and the provider's operations.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

Outcome 2.5—Incident management

(8) The provider must use an incident management system to:
(a) safeguard individuals; and
(b) acknowledge, respond to, effectively manage and learn from incidents.

Note: See also section 164 of the Act and Division 1 of Part 10 of Chapter 4 of this instrument (conditions of registration relating to incident management).

Outcome 2.6a—Complaints and feedback management—for aged care workers

(9) The provider must encourage and support aged care workers to make complaints and give feedback about the provider's delivery of funded aged care services without reprisal.

Note: See also section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument (conditions of registration relating to complaints, feedback and whistleblowers).

Outcome 2.6b—Complaints and feedback management—for individuals

(10) The provider must encourage and support individuals and others to make complaints and give feedback about the provider's delivery of funded aged care services without reprisal.

Note: See also section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument (conditions of registration relating to complaints, feedback and whistleblowers).

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Outcomes 2.6a and 2.6b—Complaints and feedback management

(11) The provider must:
  (a) acknowledge and transparently manage all complaints and feedback; and
  (b) use complaints and feedback to contribute to the continuous improvement of funded aged care services.

Note: See also section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument (conditions of registration relating to complaints, feedback and whistleblowers), and section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

Outcome 2.7—Information management

(12) The provider must ensure that information recorded about an individual:
  (a) is accurate and current; and
  (b) is able to be accessed and understood by the individual, supporters of the individual, aged care workers, registered health practitioners, allied health professionals, allied health assistants and others involved in the individual's care.

Note: See also section 155 of the Act (provision of information to individuals) which sets out conditions applicable to registered providers to allow access to records and information to individuals and explain those records and information to those individuals. Subsection 156(3) of the Act in specified circumstances allows independent aged care advocates access to records and information held by a registered provider about an individual.

(13) The provider must ensure that the information of individuals is kept confidential and is managed appropriately, in line with their informed consent.

Note: See also section 154 of the Act (personal information and record keeping) which requires registered providers as a condition of their registration to keep and retain kinds of records in accordance with requirements set out in this instrument, and section 168 of the Act (protection of personal information) which requires registered providers to ensure the protection of personal information.

Outcome 2.8—Workforce planning

(14) The provider must demonstrate that the provider understands and manages their workforce needs and plans for the future.

Outcome 2.9—Human resource management

(15) The provider must deliver funded aged care services to individuals by aged care workers who:
  (a) are skilled and competent in their roles; and
  (b) hold relevant qualifications for their roles; and
  (c) have expertise and experience relevant to delivering quality funded aged care services.

Note: See also section 152 of the Act (workforce and aged care worker requirements) which requires registered providers as a condition of their registration to comply with workforce screening and other requirements in relation to the employment of aged care workers.

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(16) The provider must provide aged care workers with training and supervision to enable them to effectively perform their roles.

Outcome 2.10—Emergency and disaster management

(17) The provider must demonstrate that emergency and disaster management planning considers and manages risks to the health, safety and wellbeing of individuals and aged care workers.

15-20 Standard 3—The care and services

Outcome 3.1—Assessment and planning

(1) The registered provider must actively engage with:
  (a) individuals to whom the provider delivers funded aged care services; and
  (b) supporters of individuals (if any); and
  (c) any other persons involved in the care of individuals;

in developing and reviewing the individual's care and services plans through ongoing communication.

(2) Care and services plans must:
  (a) describe the current care needs, goals and preferences of individuals; and
  (b) include strategies for risk management and preventative care.

(3) The provider must ensure that care and services plans are regularly reviewed and are used by aged care workers to guide the delivery of funded aged care services.

Note: See also section 148-80 of this instrument (requirements for care and services plans-general) which provides details in relation to the development of care and services plans for an individual.

Outcome 3.2—Delivery of funded aged care services

(4) The provider must ensure that individuals receive quality funded aged care services that:
  (a) meet their care needs, goals and preferences; and
  (b) optimise their quality of life, reablement and maintenance of function.

(5) The provider must ensure that funded aged care services are delivered in a way that is culturally safe and culturally appropriate for individuals with specific needs and diverse backgrounds.

Outcome 3.3—Communicating for safety and quality

(6) The provider must ensure that critical information relevant to the delivery of funded aged care services to individuals is communicated effectively:
  (a) to the individuals; and
  (b) between aged care workers delivering the services; and
  (c) to supporters of the individuals and other persons supporting the individuals; and

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(d) to registered health practitioners, allied health professionals, allied health assistants and others involved with the individual's care.

(7) The provider must ensure that risks to individuals, and changes and deterioration in the condition of individuals, are escalated and communicated as appropriate.

Outcome 3.4—Planning and coordination of funded aged care services

(8) The provider must ensure that individuals receive funded aged care services that are planned and coordinated, including where multiple health providers and registered providers, supporters of individuals and other persons supporting individuals are involved.

15-25 Standard 4—The environment

Outcome 4.1a—Environment—services delivered in the individual's home

(1) When delivering funded aged care services to individuals in their homes, the registered provider must support the individuals to mitigate environmental risks relevant to the services.

Outcome 4.1b—Environment—services delivered other than in the individual's home

(2) Where the provider delivers funded aged care services to individuals other than in their homes, the provider must ensure that individuals are able to access funded aged care services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function.

Outcomes 4.1a and 4.1b—Equipment

(3) Where the provider uses equipment in the delivery of any funded aged care services to individuals, or provides equipment to individuals, the equipment must be safe and must meet the needs of the individuals.

Outcome 4.2—Infection prevention and control

(4) The provider must have an appropriate infection prevention and control system.

(5) The provider must ensure that aged care workers use hygienic practices and take appropriate infection prevention and control precautions when delivering funded aged care services.

15-30 Standard 5—Clinical care

Outcome 5.1—Clinical governance

(1) The governing body must ensure:

(a) that the governing body continuously improves the safety and quality of clinical care services delivered to individuals; and

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(b) that the provider delivers safe and quality clinical care services to individuals.

Note: See also section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument (conditions of registration relating to continuous improvement).

(2) The registered provider must integrate clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care services delivered to individuals.

Outcome 5.2—Preventing and controlling infections in delivering clinical care services

(3) The provider must ensure that individuals, aged care workers, registered health practitioners and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance.

(4) The provider must ensure that infection risks are minimised and, if they occur, are controlled effectively.

Outcome 5.3—Safe and quality use of medicines

(5) The provider must encourage and support individuals, aged care workers, registered health practitioners and allied health professionals to use medicines in a way that maximises benefits and minimises the risks of harm.

(6) The provider must ensure that:
(a) before administering medicine to an individual, the medicine has been prescribed for the individual; and
(b) medicines are appropriately and safely administered, monitored and reviewed by registered health practitioners, considering the clinical needs and informed decisions of the individual.

(7) The provider must ensure that medicine-related adverse events are monitored and reported, and are used to inform safety and quality improvement.

Outcome 5.4—Comprehensive care

(8) The provider must ensure that individuals receive comprehensive, safe and quality clinical care services that are evidence-based, person-centred and delivered by registered health practitioners, allied health professionals, allied health assistants or nursing assistants.

(9) Clinical care delivered by the provider must encompass clinical assessment, prevention, planning, treatment, management and review to minimise harm and optimise quality of life, reablement and maintenance of function.

(10) The provider must have systems and processes that support coordinated and multidisciplinary clinical care services:
(a) that are delivered to individuals, in partnership with individuals, supporters of individuals and other persons supporting individuals; and
(b) that are aligned with the individuals' needs, goals and preferences.

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(11) The provider must support early identification of, and response to, changing clinical needs.

Outcome 5.5—Safety of clinical care services

(12) The provider must identify, monitor and manage high impact and high prevalence risks in the delivery of clinical care services:
  (a) to ensure the delivery of safe and quality clinical care services; and
  (b) to reduce the risk of harm to individuals.

Outcome 5.6—Cognitive impairment

(13) The provider must ensure that individuals who experience cognitive impairment (whether acute, chronic or transitory) receive comprehensive funded aged care services that:
  (a) optimise clinical outcomes; and
  (b) are aligned with the individuals' needs, goals and preferences.

(14) The provider must identify situations and events that may lead to changes in behaviours.

Outcome 5.7—Palliative care and end-of-life care

(15) The provider must recognise and address the needs, goals and preferences of individuals for palliative care and end-of-life care, and must preserve the dignity of individuals in those circumstances.

(16) The provider must ensure that the pain and symptoms of individuals are actively managed, with access to specialist palliative and end-of-life care when required.

(17) The provider must ensure that supporters of individuals and other persons supporting individuals are informed and supported, including during the last days of life.

Note: See also section 29 of the Act (giving information and documents to supporters).

15-35 Standard 6—Food and nutrition

Outcome 6.1—Partnering with individuals on food and drinks

(1) The registered provider must partner with individuals to deliver a quality food and drinks service that includes appetising and varied food and drinks and an enjoyable dining experience.

Note: See also item 9 of the table in section 8-145 of this instrument (residential everyday living—meals and refreshments).

Outcome 6.2—Assessment of nutritional needs and preferences

(2) The provider must demonstrate that the provider understands the specific nutritional needs of individuals and assesses the current needs, abilities and preferences of individuals in relation to what and how they eat and drink.

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Outcome 6.3—Provision of food and drinks

(3) The provider must provide individuals with:
  (a) food and drinks that meet their nutritional needs and are appetising and flavoursome; and
  (b) variation and choice about what they eat and drink; and
  (c) choice about how much they eat and drink.

Outcome 6.4—Dining experience

(4) The provider must support individuals to eat and drink.

(5) The provider must ensure that the dining experience meets the needs and preferences of individuals to support social engagement, function and quality of life.

15-40 Standard 7—The residential community

Outcome 7.1—Daily living

(1) The registered provider must ensure that individuals receive funded aged care services that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do.

(2) The provider must ensure that individuals feel safe in their residential care home.

Outcome 7.2—Transitions

(3) The provider must ensure that individuals experience a well-coordinated transition, whether planned or unplanned, to or from a provider.

Note: See also section 149 of the Act (starting and ceasing the provision of funded aged care services and continuity of those services).

(4) The provider must set out clear responsibility and accountability for the delivery of funded aged care services to individuals between aged care workers, registered health practitioners, allied health professionals and allied health assistants, and across organisations.

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Part 7—Reportable incidents and restrictive practices

Division 1—Reportable incidents

16-5 Defining and clarifying expressions relating to reportable incidents

(1) For the purposes of subsection 16(2) of the Act, this section prescribes definitions or clarifications of expressions used in paragraphs 16(1)(a), (b), (c), (d), (e), (f) and (h) of the Act (which deal with incidents that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the delivery of funded aged care services to an individual by a registered provider).

Unreasonable use of force

(2) In paragraph 16(1)(a) of the Act, the expression "unreasonable use of force against the individual" includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force.

(3) To avoid doubt, that expression does not cover gently touching the individual:
  (a) for the purposes of providing funded aged care services; or
  (b) to attract the individual's attention; or
  (c) to guide the individual; or
  (d) to comfort the individual when the individual is distressed.

Unlawful sexual contact, or inappropriate sexual conduct

(4) In paragraph 16(1)(b) of the Act, the expression "unlawful sexual contact, or inappropriate sexual conduct, inflicted on the individual" includes the following:
  (a) if the contact or conduct is inflicted by a person who is an aged care worker of the registered provider—the following:
    (i) any conduct or contact of a sexual nature inflicted on the individual, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the individual;
    (ii) any touching of the individual's genital area, anal area or breast in circumstances where this is not necessary to deliver funded aged care services to the individual;
  (b) any non-consensual contact or conduct of a sexual nature, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the individual;
  (c) engaging in conduct relating to the individual with the intention of making it easier to procure the individual to engage in sexual contact or conduct.

(5) However, that expression does not include consensual contact or conduct of a sexual nature between the individual and a person who is not an aged care worker of the registered provider, including another individual to whom the registered provider delivers funded aged care services.

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Psychological or emotional abuse

(6) In paragraph 16(1)(c) of the Act the expression "psychological or emotional abuse of the individual" includes conduct that:
  (a) has caused the individual psychological or emotional distress; or
  (b) could reasonably have been expected to have caused an individual psychological or emotional distress.

(7) Conduct covered by subsection (6) includes (without limitation) the following:
  (a) taunting, bullying, harassment or intimidation;
  (b) threats of maltreatment;
  (c) humiliation;
  (d) unreasonable refusal to interact with the individual or acknowledge the individual's presence;
  (e) unreasonable restriction of the individual's ability to engage socially or otherwise interact with people;
  (f) repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which:
    (i) has caused the individual psychological or emotional distress; or
    (ii) could reasonably have been expected to have caused an individual psychological or emotional distress.

Unexpected death

(8) In paragraph 16(1)(d) of the Act the expression "unexpected death of the individual" includes death in circumstances where:
  (a) the individual was accessing funded aged care services in an approved residential care home of a registered provider and reasonable steps were not taken by the registered provider to prevent the death; or
  (b) the death was a result of:
    (i) funded aged care services delivered by the registered provider; or
    (ii) a failure of the registered provider to deliver funded aged care services.

Stealing or financial coercion

(9) In paragraph 16(1)(e) of the Act the expression "stealing from, or financial coercion of, the individual by an aged care worker of the provider" includes the following:
  (a) stealing from the individual by an aged care worker of the registered provider;
  (b) conduct by an aged care worker of the registered provider that:
    (i) is coercive or deceptive in relation to the individual's financial affairs; or
    (ii) unreasonably controls the individual's financial affairs.

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Neglect

(10) In paragraph 16(1)(f) of the Act the expression "neglect of the individual" means circumstances in which a registered provider, aged care worker, or responsible person of the registered provider:

(a) has delivered funded aged care services to the individual that exposes the individual to the risk of serious injury or illness; or

(b) has caused or contributed (including through reckless or intentional behaviour) to:

(i) a significant failure to deliver funded aged care services to the individual; or

(ii) a systematic pattern of conduct; or

(c) has delivered a grossly inadequate funded aged care services to the individual; or

(d) has been reckless or intentionally negligent in delivering funded aged care services to the individual.

Unexplained absence

(11) In paragraph 16(1)(h) of the Act the expression "unexplained absence of the individual in the course of the delivery of funded aged care services to the individual" means:

(a) for an individual accessing funded aged care services in an approved residential care home—an absence of the individual from the home in circumstances where there are reasonable grounds to report the absence to police; or

(b) for an individual accessing funded aged care services in a home or community setting—an absence of the individual from the setting during the delivery of funded aged care services to the individual in circumstances where there are reasonable grounds to report the absence to police.

16-10 Acts, omissions and events that are not reportable incidents—general

(1) For the purposes of paragraph 16(3)(b) of the Act, an act, omission or event covered by one of the following subsections is not a ***reportable incident***.

Approved residential care homes—incidents resulting from refusal by individuals of delivery of services

(2) This subsection covers an incident if the incident results from an individual accessing funded aged care services in an approved residential care home deciding to refuse the delivery of funded aged care services.

Home or community settings—incidents resulting from choices made by individuals about services to be delivered

(3) This subsection covers an incident if:

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(a) the incident occurred, is alleged to have occurred, or is suspected of having occurred, in connection with the delivery of funded aged care services in a home or community setting to an individual by a registered provider; and

(b) apart from this subsection, the incident would be a reportable incident under paragraph 16(1)(f) of the Act (neglect of the individual), but would not otherwise be a reportable incident; and

(c) the incident results from a choice made by the individual about the funded aged care services the registered provider is to deliver to the individual, or how the services are to be delivered by the provider; and

(d) before the incident occurred, is alleged to have occurred, or is suspected of having occurred, the individual had communicated the individual's choice to the provider, and the provider had recorded the individual's choice in writing.

16-15 Acts, omissions and events that are not reportable incidents—use of restrictive practices in a home or community setting

For the purposes of paragraph 16(3)(b) of the Act, the use of a restrictive practice in relation to an individual is not a ***reportable incident*** if:

(a) the restrictive practice is used in connection with the delivery of funded aged care services to the individual in a home or community setting; and

(b) before the restrictive practice is used, the following matters were set out in the care and services plan for the individual:

(i) the circumstances in which the restrictive practice may be used in relation to the individual, including the individual's behaviours of concern that are relevant to the need for the use;

(ii) the manner in which the restrictive practice is to be used, including its duration, frequency and intended outcome; and

(c) the restrictive practice is used:

(i) in the circumstances set out in the plan; and

(ii) in the manner set out in the plan; and

(iii) in accordance with any other provisions of the plan that relate to the use; and

(d) details about the use of the restrictive practice are documented as soon as practicable after the restrictive practice is used.

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Division 2—Restrictive practices

17-5 Practices and interventions that are restrictive practices in relation to individuals

(1) For the purposes of subsection 17(2) of the Act, each of the following is a restrictive practice in relation to an individual:
  (a) chemical restraint;
  (b) environmental restraint;
  (c) mechanical restraint;
  (d) physical restraint;
  (e) seclusion.

(2) ***Chemical restraint*** is a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing an individual's behaviour, but does not include the use of medication prescribed for:
  (a) the treatment of, or to enable treatment of, the individual for:
    (i) a diagnosed mental disorder; or
    (ii) a physical illness; or
    (iii) a physical condition; or
  (b) end-of-life care for the individual.

(3) ***Environmental restraint*** is a practice or intervention that restricts, or that involves restricting, an individual's free access to all parts of the individual's environment (including items and activities) for the primary purpose of influencing the individual's behaviour.

(4) ***Mechanical restraint*** is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue an individual's movement for the primary purpose of influencing the individual's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the individual.

(5) ***Physical restraint*** is a practice or intervention that:
  (a) is or involves the use of physical force to prevent, restrict or subdue movement of an individual's body, or part of an individual's body, for the primary purpose of influencing the individual's behaviour; but
  (b) does not include the use of a hands-on technique in a reflexive way to guide or redirect the individual away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the individual.

(6) ***Seclusion*** is a practice or intervention that is, or that involves, the sole confinement of an individual in a room or a physical space at any hour of the day or night where:
  (a) voluntary exit is prevented or not facilitated; or
  (b) it is implied that voluntary exit is not permitted;

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for the primary purpose of influencing the individual's behaviour.

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Part 8—Supporters

Division 1—Actions and duties of supporters

28-5 Role of guardians etc—prescribed classes of persons

For the purposes of paragraph 28(2)(d) of the Act, a prescribed class of persons is restrictive practices substitute decision-makers.

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Division 2—Registration of supporters

37-5 Registration of supporters—matters the System Governor must take into consideration

(1) For the purposes of paragraph 37(6)(c) of the Act, this section prescribes other matters the System Governor must take into consideration in deciding whether to register a person under subsection 37(1) of the Act as a supporter of an individual.

(2) Another matter is, for a person who is a person covered by subsection 28(2) of the Act, the nature of the person's decision-making authority as such a person (including the extent to which it extends to making decisions relevant to the delivery of funded aged care services to the individual).

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Chapter 2—Entry to the Commonwealth aged care system

Part 1—Introduction

55-5 Simplified outline of this Chapter

This Chapter provides for matters relating to entry to the Commonwealth aged care system under Chapter 2 of the Act.

Part 2 of this Chapter relates to eligibility of individuals for entry to the Commonwealth aged care system, and deals with:

(a) applying for access to funded aged care services; and
(b) the assessment tool for aged care needs assessments and circumstances in which reassessments are required;
(c) approval of access to funded aged care services.

Part 3 of this Chapter relates to classification, and deals with:

(a) requirements for classification assessments; and
(b) the period for making classification decisions and the period of effect of classification levels for classification types for service groups for individuals; and
(c) prescribing classification levels for classification types for service groups, including criteria used to establish certain classification levels and methods or procedures for deciding certain classification levels.

Part 4 of this Chapter relates to prioritisation, and deals with:

(a) priority category decisions; and
(b) priority categories for classification types for service groups and eligibility criteria for those priority categories; and
(c) circumstances in which urgency ratings will apply to individuals in relation to the classification type ongoing or short-term for the service group residential care.

Part 5 of this Chapter relates to place allocation, and deals with:

(a) allocation of places to individuals, including methods that the System Governor must follow in deciding the order of allocation of places to individuals for certain classification types and service groups; and
(b) allocation of places to registered providers for certain specialist aged care programs.

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Part 2—Eligibility for entry

Division 1—Applying for access to funded aged care services

56-5 Classes of persons who may apply on behalf of individuals

For the purposes of subsection 56(1) of the Act, the following classes of persons are prescribed in relation to an individual:

(a) supporters of the individual;
(b) registered health practitioners;
(c) allied health professionals;
(d) aged care workers of registered providers;
(e) registered providers;
(f) social workers (however described);
(g) individuals employed or engaged as care finders under the care finder program funded by the Department;
(h) individuals employed or engaged as elder care supporters under the elder care support program funded by the Department;
(i) family members, friends, advocates and carers of the individual;
(j) independent aged care advocates.

57-5 Period for deciding whether to make eligibility determinations

For the purposes of subsection 57(2) of the Act, the period for making a decision under subsection 57(1) of the Act on an application for access to funded aged care services is 28 days after receiving the application.

58-5 Information to be provided for eligibility determinations

For the purposes of paragraph 58(b) of the Act, each of the following is prescribed as a kind of information relating to an individual's care needs:

(a) a declaration by the individual, made orally or in writing, that the individual has care needs;
(b) a written statement by a person in a class of persons referred to in section 56-5 of this instrument that sets out the individual's care needs;
(c) written medical records of the individual's care needs.

Note: For the definition of ***care needs***, see section 7 of the Act.

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Division 2—Aged care needs assessments and reassessments

Subdivision A—Aged care needs assessments

62-5 Assessment tool

For the purposes of subsection 62(1) of the Act, the Integrated Assessment Tool is prescribed.

Subdivision B—Aged care needs reassessments

64-5 Significant changes in circumstances

For the purposes of subparagraph 64(1)(c)(i) of the Act, each of the following is prescribed as a significant change in circumstances in relation to an individual who is accessing funded aged care services other than through the service group residential care:

(a) a carer for the individual has permanently ceased to provide some or all care to the individual;

(b) the individual has experienced an event, or a decline in their condition, that is likely to mean that the individual will require:

(i) more frequent access to a funded aged care service that is covered by the individual's access approval and that the individual has been accessing; or

(ii) access to a funded aged care service that is covered by the individual's access approval but that the individual has not been accessing; or

(iii) access to a funded aged care service that is not covered by the individual's access approval.

64-10 Other circumstances

For the purposes of subparagraph 64(1)(c)(ii) of the Act, each of the following is prescribed as other circumstances in relation to an individual who is accessing funded aged care services other than through the service group residential care:

(a) a carer for the individual has temporarily ceased to provide some or all care to the individual;

(b) the individual has experienced an event, or a decline in their condition, that is likely to mean that the individual will require access to a funded aged care service that is not covered by the individual's access approval;

(c) all of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing or short-term for the service group home support;

(ii) on the date of the application for the reassessment, the individual has a prognosis of a life expectancy of 3 months or less;

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(iii) on the date of the application for the reassessment, the individual has an AKPS score of 40 or less;

(iv) the individual has not previously had the classification level SAH end-of-life pathway in effect;

(v) a notice in the approved form containing evidence of the matters referred to in subparagraphs (ii) and (iii) has been given to the System Governor;

(d) both of the following apply:

(i) the individual has an access approval in effect for the classification type short-term for the service group home support;

(ii) the individual has, or has previously had, the classification level SAH end-of-life pathway in effect;

(e) both of the following apply:

(i) the classification level SAH end-of-life pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;

(ii) the individual will require access to funded aged care services in the service group assistive technology;

(f) both of the following apply:

(i) the classification level SAH restorative care pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;

(ii) the individual will require access to funded aged care services in the service group assistive technology or home modifications;

(g) both of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) repairs or maintenance are required for an included AT-HM item or a conditionally included AT-HM item that the individual owns or has been loaned or rented under a Commonwealth aged care program (including under the old Act);

(h) both of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) the individual has a condition referred to in subsection 211-10(2) of this instrument;

(i) both of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) the individual has an assistance dog.

64-15 Information for reassessments in other circumstances

For the purposes of paragraph 64(2)(b) of the Act, each of the following is prescribed as a kind of information in relation to an individual:

(a) information in the application for the aged care needs reassessment;

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(b) information provided, orally or in writing, by any of the following about the individual's need for funded aged care services:
  (i) a registered health practitioner;
  (ii) an allied health professional;
  (iii) a registered provider delivering the funded aged care service home support care management or home support restorative care management to the individual;
(c) information provided, orally or in writing, by an approved needs assessor following a review by the assessor of the report of the most recent aged care needs assessment for the individual;
(d) information in the most recent application for a classification reassessment for the individual.

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Division 3—Approval of access to funded aged care services

Subdivision A—General

65-5 Approval of services in service types for individuals

For the purposes of subparagraph 65(2)(b)(ii) of the Act, the following service types are prescribed:

(a) allied health and therapy;

(b) therapeutic services for independent living.

65-10 Eligibility requirements—service group home support

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service group home support for an individual are that:

(a) the individual has a total score of less than 20 for the questions in the Integrated Assessment Tool with the following headings:

(i) "Climb stairs";

(ii) "Eating";

(iii) "Dressing";

(iv) "Take a bath or shower";

(v) "Grooming";

(vi) "Transfers";

(vii) "Toilet use";

(viii) "Toileting – bladder";

(ix) "Toileting – bowels";

(x) "Walk"; or

(b) the individual has a total score of less than 14 for the questions in the Integrated Assessment Tool with the following headings:

(i) "Get to places out of walking distance";

(ii) "Undertake housework (heavy/moderate)";

(iii) "Go shopping (assuming transportation)";

(iv) "Prepare meals";

(v) "Take medicine";

(vi) "Handle money";

(vii) "Use the telephone"; or

(c) the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed "Cognition" and "Medical and Medications"; or

(d) the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed "Psychological"; or

(e) the individual has a score of greater than zero for the questions in the section of the Integrated Assessment Tool headed "Physical, Personal Health and Frailty".

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65-15 Eligibility requirements—service groups assistive technology and home modifications

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service groups assistive technology and home modifications for an individual is that the service group home support is approved for the individual.

65-20 Eligibility requirements—service group residential care

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service group residential care for an individual is that the individual is not able to live in a home or community setting without support.

65-30 Period for making decisions

For the purposes of subsection 65(5) of the Act, the period for making decisions under subsections 65(1) and (2) of the Act for an individual is 14 days after receiving an assessment report for the individual provided under section 63 of the Act, or information relating to the individual that is provided to the System Governor in accordance with paragraph 64(2)(b) of the Act, as applicable.

Subdivision B—Period of effect of approval

71-5 Alternative entry—when access approval takes effect—circumstances and period for making application

For the purposes of paragraph 71(3)(b) of the Act, the following circumstances and period are prescribed for an individual:

(a) the circumstances are that a registered provider that delivers funded aged care services under the MPSP or the NATSIFACP is delivering aged care services to the individual;

(b) the period is 30 days after the first day an aged care service covered by the individual's access approval was delivered to the individual by the provider.

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Part 3—Classification

Division 1—Classification assessments

75-5 Circumstances in which classification assessment not required

For the purposes of paragraph 75(5)(a) of the Act, the circumstances in which a classification assessment otherwise required under paragraph 75(1)(b) or subsection 75(2) of the Act in relation to an individual for a classification type for a service group is not required to be undertaken are that:

(a) the classification type is ongoing or short-term for the service group residential care; and

(b) the individual is accessing funded aged care services under a specialist aged care program in an approved residential care home.

76-10 Assessment tools and other requirements for classification assessments required under subsection 75(1) or (2) of the Act and carried out by approved needs assessors

(1) This section is made for the purposes of subparagraphs 76(1)(a)(i) and (b)(i) of the Act.

Service groups home support, assistive technology and home modifications

(2) For an assessment for an individual for a classification type for the service group home support, assistive technology or home modifications:

(a) the assessment tool is the Integrated Assessment Tool; and

(b) the other requirements are that the assessment must be carried out in accordance with the Aged Care Assessment Manual.

Classification type ongoing for service group residential care

(3) For an assessment for an individual for the classification type ongoing for the service group residential care:

(a) the assessment tool is the AN-ACC Assessment Tool; and

(b) the other requirements are that the assessment must be carried out in accordance with the AN-ACC Reference Manual.

Classification type short-term for service group residential care

(4) For an assessment for an individual for the classification type short-term for the service group residential care:

(a) the assessment tool is the De Morton Mobility Index assessment item; and

(b) the other requirements are that the assessment must be carried out in accordance with the part of the AN-ACC Reference Manual that relates to that item.

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76-15 Circumstances and information for classification assessments required under paragraph 75(1)(a) or subsection 75(2) of the Act and carried out by the System Governor

(1) This section is made for the purposes of subparagraph 76(1)(a)(ii) of the Act for an assessment for an individual for a classification type for a service group.

Classification type short-term for service groups home support and assistive technology—end-of-life

(2) The following circumstances and kind of information are prescribed for the classification type short-term for the service groups home support and assistive technology:

(a) the circumstances are that:

(i) the individual has an access approval in effect for the classification type short-term for the service group home support;

(ii) on the date of the individual's application for access to funded aged care services, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less;

(iii) the individual has not previously had the classification level SAH end-of-life pathway in effect;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

(3) The following circumstances and kind of information are prescribed for the classification type short-term for the service groups assistive technology and home modifications and the classification type ongoing for the service group home support:

(a) the circumstances are that:

(i) the individual has an access approval in effect for the classification type short-term for the service group home support;

(ii) the individual has previously had the classification level SAH end-of-life pathway in effect;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

(4) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) the classification level SAH end-of-life pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;

(ii) the individual will require access to funded aged care services in the service group assistive technology;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

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Classification type short-term for service group assistive technology or home modifications—restorative care pathway

(5) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology and home modifications:

(a) the circumstances are that:

(i) the classification level SAH restorative care pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;

(ii) the individual will require access to funded aged care services in the service group assistive technology or home modifications;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

Classification type short-term for service group assistive technology—repairs or maintenance for included and conditionally included AT-HM items

(6) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) a classification level for the classification type ongoing for the service group home support has been established for the individual by a classification decision; and

(ii) repairs or maintenance are required for an included AT-HM item or a conditionally included AT-HM item that the individual owns or has been loaned or rented under a Commonwealth aged care program (including under the old Act);

(b) the kind of information is information that provides evidence of the matter mentioned in subparagraph (a)(ii).

Classification type short-term for service groups assistive technology and home modifications—progressive conditions

(7) The following circumstances and kind of information are prescribed for the classification type short-term for the service groups assistive technology and home modifications:

(a) the circumstances are that:

(i) a classification level for the classification type ongoing for the service group home support has been established for the individual by a classification decision; and

(ii) the individual has a condition referred to in subsection 211-10(2) of this instrument;

(b) the kind of information is information that provides evidence of the matter mentioned in subparagraph (a)(ii).

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Classification type ongoing for service group assistive technology —assistance dog

(8) The following circumstances and kind of information are prescribed for the classification type ongoing for the service group assistive technology:

(a) the circumstances are that:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) the individual has an assistance dog;

(b) the kind of information is information that provides evidence of the matter mentioned in subparagraph (a)(ii).

Classification type short-term for service groups assistive technology and home modifications—aged care needs reassessments in certain circumstances

(9) The following circumstances and kinds of information are prescribed for the classification type short-term for the service groups assistive technology and home modifications:

(a) the circumstances are that:

(i) a classification level for the classification type short-term for the service group home support has been established for the individual by a classification decision; and

(ii) the circumstances referred to in paragraph 64-10(b) of this instrument (aged care needs reassessments in certain circumstances) apply to the individual;

(b) the kinds of information are the kinds of information referred to in paragraphs 64-15(a), (b) and (c) of this instrument.

Classification type ongoing for service group residential care—palliative care pathway

(10) The following circumstances and kind of information are prescribed for the classification type ongoing for the service group residential care, for an individual accessing funded aged care services in the form of palliative care in an approved residential care home of a registered provider:

(a) the circumstances are that:

(i) on and after the individual's start day for the home, the provider has delivered funded aged care services in the form of palliative care to the individual in the home; and

(ii) on the individual's start day for the home, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less; and

(iii) the provider gives the System Governor a notice in the approved form containing the kind of information referred to in paragraph (b) within 14 days, or such longer period as is agreed in writing between the System Governor and the provider, after the provider gives the System Governor a start notification for the individual;

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(b) the kind of information is information that provides evidence of the matters mentioned in subparagraph (a)(ii).

76-20 Circumstances and information for classification assessments required under paragraph 75(1)(b) of the Act (on application for classification reassessment) and carried out by the System Governor

(1) This section is made for the purposes of subparagraph 76(1)(b)(ii) of the Act for an assessment for an individual for a classification type for a service group.

Classification type short-term for service group assistive technology—increased needs

(2) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) a classification level for the classification type short-term for the service group assistive technology, other than the classification level AT high, has been established for the individual by a classification decision; and

(ii) the individual needs an increased amount of assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

Classification type short-term for service group assistive technology—individuals with classification level AT transitional

(3) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) the classification level AT transitional for the classification type short-term for the service group assistive technology has been established for the individual by a classification decision; and

(ii) subsection (4) applies to the individual;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

(4) This subsection applies to the individual if:

(a) the individual has a condition referred to in subsection 211-10(2) of this instrument; or

(b) the System Governor has reviewed the report of the most recent aged care needs assessment for the individual and considers that the individual needs assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community (see paragraph (a) in column 2 of items 1 to 3 of the table in subsection 81-25(1) of this

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instrument (criteria for the classification levels AT low, AT medium and AT high)).

Classification type short-term for service group home modifications—increased needs

(5) The following circumstances and kind of information are prescribed for the classification type short-term for the service group home modifications:

(a) the circumstances are that:

(i) a classification level for the classification type short-term for the service group home modifications, other than the classification level HM high, has been established for the individual by a classification decision; and

(ii) the individual needs an increased amount of home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

Classification type short-term for service group home modifications—individuals with classification level HM transitional

(6) The following circumstances and kind of information are prescribed for the classification type short-term for the service group home modifications:

(a) the circumstances are that:

(i) the classification level HM transitional for the classification type short-term for the service group home modifications has been established for the individual by a classification decision; and

(ii) the System Governor has reviewed the report of the most recent aged care needs assessment for the individual and considers that the individual needs home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community (see paragraph (a) in column 2 of items 1 to 3 of the table in subsection 81-30(1) of this instrument (criteria for the classification levels HM low, HM medium and HM high));

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

Classification type ongoing for service group residential care—palliative care pathway

(7) The following circumstances and kind of information are prescribed for the classification type ongoing for the service group residential care, for an individual accessing funded aged care services in the form of palliative care in an approved residential care home of a registered provider:

(a) the circumstances are that:

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(i) on and after the individual's start day for the home, the provider has delivered funded aged care services in the form of palliative care to the individual in the home; and

(ii) on the individual's start day for the home, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less; and

(iii) the provider gives the System Governor a notice in the approved form containing the kind of information referred to in paragraph (b) within 14 days, or such longer period as is agreed in writing between the System Governor and the provider, after the date of the application for classification reassessment for the individual;

(b) the kind of information is information that provides evidence of the matters mentioned in subparagraph (a)(ii).

76-25 Classification assessments for classification type ongoing for service group residential care—skills, qualifications and other requirements for approved needs assessors

Skills and qualifications

(1) For the purposes of paragraph 76(2)(a) of the Act, the skills and qualifications for an approved needs assessor are that the assessor is a registered nurse, occupational therapist or physiotherapist.

Other requirements

(2) For the purposes of paragraph 76(2)(b) of the Act, the other requirements for an approved needs assessor are the following:

(a) the assessor has at least 5 years of clinical experience in the delivery of aged care services or related health services as a registered nurse, occupational therapist or physiotherapist (as the case requires);

(b) a police certificate issued for the assessor within the last 3 years does not record that the assessor has a serious offence conviction in Australia;

(c) if, at any time after turning 16, the assessor has been a citizen or permanent resident of a country other than Australia—the assessor has made a statutory declaration that the assessor does not have a serious offence conviction in that country.

Note: Approved needs assessors must carry and produce identity cards issued under subsection 343A(1) of the Act when performing functions or exercising powers under the Act as approved needs assessors (see section 343A-10 of this instrument).

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Division 2—Classification decisions

Subdivision A—Period for making classification decisions

78-5 Period for making classification decisions

For the purposes of subsection 78(4) of the Act, the period for making a decision under subsection 78(1) of the Act to establish a classification level for an individual for a classification type for a service group is 14 days after the occurrence of whichever of the events referred to in subsection 78(1) of the Act are applicable for the individual.

Subdivision B—Period of effect of classification levels

80-5 Purpose of this Subdivision

For the purposes of subsection 80(1) of the Act, this Subdivision prescribes, subject to subsection 80(3) of the Act, the period of effect for a classification level for a classification type for a service group that has been established under section 78 of the Act for an individual.

Note: For the period of effect for classification levels taken to be established for individuals by the *Aged Care (Consequential and Transitional Provisions) Determination 2025*, see the *Aged Care (Consequential and Transitional Provisions) Rules 2025*.

80-10 Service group home support—classification type ongoing

CHSP class

(1) For the classification level CHSP class for the classification type ongoing for the service group home support, established for an individual by a classification decision, the period of effect:
  (a) starts at the start of the day the individual's access approval for the classification type for the service group was given; and
  (b) ends at the end of the earlier of the following (as applicable):
    (i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
    (ii) the day the individual dies.

SAH class 1, 2, 3, 4, 5, 6, 7 or 8

(2) For the classification level SAH class 1, 2, 3, 4, 5, 6, 7 or 8 for the classification type ongoing for the service group home support, established for an individual by a classification decision, the period of effect:
  (a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and
  (b) ends at the end of the earlier of the following (as applicable):

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(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(ii) the day the individual dies.

80-15 Service group home support—classification type short-term

SAH restorative care pathway

(1) For the classification level SAH restorative care pathway for the classification type short-term for the service group home support, established for an individual by a classification decision, the period of effect:
(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and
(b) ends at the earliest of the following (as applicable):
(ii) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(iii) the end of the maximum period of effect for the classification level (see section 80-55);
(iv) the end of the day the individual dies.

SAH end-of-life pathway

(2) For the classification level SAH end-of-life pathway for the classification type short-term for the service group home support, established for an individual by a classification decision, the period of effect:
(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and
(b) ends at the earliest of the following (as applicable):
(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(ii) the end of the maximum period of effect for the classification level (see section 80-57);
(iii) the end of the day the individual dies.

80-20 Service group assistive technology—classification type ongoing

For the classification level assistance dogs for the classification type ongoing for the service group assistive technology, established for an individual by a classification decision, the period of effect:
(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and
(b) ends at the end of the earlier of the following (as applicable):

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(i) the day that the individual ceases to have an assistance dog;
(ii) the day the individual dies.

80-25 Service group assistive technology—classification type short-term

AT CHSP

(1) For the classification level AT CHSP for the classification type short-term for the service group assistive technology, established for an individual by a classification decision, the period of effect:
  (a) starts at the start of the day the individual's access approval for the classification type for the service group was given; and
  (b) ends at the end of the earlier of the following (as applicable):
    (i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
    (ii) the day the individual dies.

AT low, AT medium and AT high

(2) For the classification level AT low, AT medium or AT high for the classification type short-term for the service group assistive technology, established for an individual by a classification decision, the period of effect:
  (a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and
  (b) ends at the earliest of the following (as applicable):
    (i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
    (ii) the end of the account period for the individual's notional assistive technology account established in respect of that classification level;
    (iii) the end of the day the individual dies.

80-30 Service group home modifications—classification type short-term

HM CHSP

(1) For the classification level HM CHSP for the classification type short-term for the service group home modifications, established for an individual by a classification decision, the period of effect:
  (a) starts at the start of the day the individual's access approval for the classification type for the service group was given; and
  (b) ends at the end of the earlier of the following (as applicable):
    (i) the later of the following:
      (A) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

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(B) if the System Governor approves a later time than the time mentioned in sub-subparagraph (A) for the individual under subsection (3)—that later time;

(ii) the day the individual dies.

HM low, HM medium and HM high

(2) For the classification level HM low, HM medium or HM high for the classification type short-term for the service group home modifications, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act; and

(b) ends at the earlier of the following (as applicable):

(i) the latest of the following:

(A) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(B) the end of the account period for the individual's notional home modifications account established in respect of that classification level;

(C) if the System Governor approves a later time than the time mentioned in sub-subparagraph (A) or (B) for the individual under subsection (3)—that later time;

(ii) the end of the day the individual dies.

Approval of later time for services scheduled for delivery

(3) The System Governor must approve a time that is 12 months after the time that would otherwise apply under subparagraph (1)(b)(i) or (2)(b)(i) (as applicable) for an individual if a registered provider gives the System Governor evidence mentioned in subsection (4):

(a) in the approved form; and

(b) within the account period for the individual's notional home modifications account established in respect of that classification level.

(4) For the purposes of subsection (3), the evidence is evidence that a service in the service group home modifications to be delivered by the registered provider to the individual has been scheduled for delivery, and is in progress, but will not be delivered before the time that would otherwise apply under subparagraph (1)(b)(i) or (2)(b)(i) (as applicable).

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80-35 Service group residential care—classification type ongoing

Class 0

(1) For the classification level class 0 for the classification type ongoing for the service group residential care, established in accordance with section 81-42 of this instrument for an individual to whom paragraph 78(1)(c) of the Act applies:

(a) subject to paragraph (b), the period of effect:

(i) starts at the start of the entry day for the classification type for the service group for the individual; and

(ii) ends at the end of the day the individual dies; and

(b) if the classification level class 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 or 13 (the ***higher classification level***) is in effect for the individual on a day under subsection (2), the classification level class 0 is not in effect for the individual on the day.

Classes 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13

(2) For the classification level class 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 or 13 for the classification type ongoing for the service group residential care, established for an individual by a classification decision, the period of effect:

(a) starts:

(i) unless subparagraph (ii), (iii) or (iv) applies—at the start of the entry day for the classification type for the service group for the individual; or

(ii) unless subparagraph (iii) or (iv) applies—if, before the day the classification decision is made:

(A) the classification level class 0 is in effect for the individual under subsection (1); and

(B) the individual started accessing funded aged care services in an approved residential care home; and

(C) the individual did not cease to access funded aged care services in that home for a period of more than 28 days;

—at the start of the individual's start day for that home; or

(iii) unless subparagraph (iv) applies—if, before the day the classification decision is made:

(A) the classification level class 0 is in effect for the individual under subsection (1); and

(B) the individual started accessing funded aged care services in an approved residential care home; and

(C) the individual ceased to access funded aged care services in that home for a period of more than 28 days;

—at the start of the day after the end of that period when the individual resumed accessing ongoing funded aged care services in an approved residential care home; or

(iv) if the classification decision relates to a classification assessment undertaken in accordance with paragraph 75(1)(b) of the Act (that is,

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following an application for classification reassessment)—the day the application for classification reassessment was made; and

(b) ends at the end of the day the individual dies.

80-40 Service group residential care—classification type short-term

Respite class 0

(1) For the classification level respite class 0 for the classification type short-term for the service group residential care, established in accordance with section 81-42 of this instrument for an individual to whom paragraph 78(1)(c) of the Act applies:

(a) subject to paragraphs (b) and (c)—the period of effect consists of each day on or after the entry day for the classification type for the service group for the individual on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(b) if the classification level respite class 1, 2 or 3 (the ***higher classification level***) is in effect for the individual on a day under subsection (2), the classification level respite class 0 is not in effect for the individual on the day; and

(c) the period of effect ends at the end of the earliest of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual dies.

Respite classes 1, 2 and 3

(2) For the classification level respite class 1, 2 or 3 for the classification type short-term for the service group residential care, established for an individual by a classification decision:

(a) subject to paragraphs (b) and (c)—the period of effect consists of each day on or after the entry day for the classification type for the service group for the individual on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

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(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(b) if the classification decision relates to a classification assessment undertaken in accordance with paragraph 75(1)(b) of the Act (that is, following an application for classification reassessment)—the period of effect consists of each day on or after the day the application for classification reassessment was made on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(c) the period of effect ends at the end of the earliest of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual dies.

80-45 Service group home support, assistive technology or residential care—classification type hospital transition

Service group home support

(1) For the classification level HS HT class for the classification type hospital transition for the service group home support, established for an individual by a classification decision:

(a) the classification level does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect; and

(b) subject to paragraph (c)—the period of effect for the classification level consists of each day on or after the start day for the individual for the classification level on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group; and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service

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group is less than the maximum period of effect for the classification level (see section 80-65); and

(c) the period of effect for the classification level ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual accessed funded aged care services for the classification type for the service group;

(iii) the end of the maximum period of effect for the classification level (see section 80-65);

(iv) the end of the day the individual dies.

Service group assistive technology

(2) For the classification level AT HT class for the classification type hospital transition for the service group assistive technology, established for an individual by a classification decision:

(a) the classification level does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect; and

(b) subject to paragraph (c)—the period of effect for the classification level consists of each day on or after the start day for the individual for the classification level on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group; and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group is less than the maximum period of effect for the classification level (see section 80-65); and

(c) the period of effect for the classification level ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual

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accessed funded aged care services for the classification type for the service group;

(iii) the end of the maximum period of effect for the classification level (see section 80-65);

(iv) the end of the day the individual dies.

Service group residential care

(3) For the classification level RC HT class for the classification type hospital transition for the service group residential care, established for an individual by a classification decision:

(a) the classification level does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect; and

(b) subject to paragraph (c)—the period of effect for the classification level consists of each day on or after the start day for the individual for the classification level on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group; and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group is less than the maximum period of effect for the classification level (see section 80-65); and

(c) the period of effect for the classification level ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual accessed funded aged care services for the classification type for the service group;

(iii) the end of the maximum period of effect for the classification level (see section 80-65);

(iv) the end of the day the individual dies.

Subdivision BA—Circumstances in which classification levels resume being in effect for a period

80-47 Purpose of this Subdivision

For the purposes of subsection 80(1) of the Act, this Subdivision prescribes, subject to subsection 80(3) of the Act, circumstances in which a classification

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level for an individual that has ceased being in effect resumes being in effect for a period.

80-49 Circumstances in which classification levels resume being in effect for a period—service groups home support, assistive technology and home modifications

Service group home support

(1) A classification level for a classification type for the service group home support for an individual that has ceased being in effect because a classification level for the classification type ongoing for the service group residential care has taken effect for the individual:
  (a) resumes being in effect if the individual notifies the System Governor that the individual needs the classification level to resume being in effect; and
  (b) resumes being in effect when the individual so notifies the System Governor; and
  (c) remains in effect in accordance with section 80 of the Act and Subdivision B of Division 2 of Part 3 of Chapter 2 of this instrument.

(2) Subsection (1) does not apply to the classification level CHSP class for the classification type ongoing for the service group home support.

Classification type short-term for service group assistive technology

(3) A classification level (the ***individual's old AT classification level***) for the classification type short-term for the service group assistive technology for an individual that has ceased being in effect because a classification level for the classification type ongoing for the service group residential care has taken effect for the individual:
  (a) resumes being in effect if:
    (i) the individual notifies the System Governor that the individual needs the classification level to resume being in effect; and
    (ii) when the individual so notifies the System Governor, the account period for the individual's notional assistive technology account established in respect of the individual's old AT classification level has not ended; and
  (b) resumes being in effect when the individual so notifies the System Governor; and
  (c) remains in effect in accordance with section 80 of the Act and Subdivision B of Division 2 of Part 3 of Chapter 2 of this instrument.

Classification type short-term for service group home modifications

(4) A classification level (the ***individual's old HM classification level***) for the classification type short-term for the service group home modifications for an individual that has ceased being in effect because a classification level for the classification type ongoing for the service group residential care has taken effect for the individual:

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(a) resumes being in effect if:
  (i) the individual notifies the System Governor that the individual needs the classification level to resume being in effect; and
  (ii) when the individual so notifies the System Governor, the account period for the individual's notional home modifications account established in respect of the individual's old HM classification level has not ended; and
(b) resumes being in effect when the individual so notifies the System Governor; and
(c) remains in effect in accordance with section 80 of the Act and Subdivision B of Division 2 of Part 3 of Chapter 2 of this instrument.

Subdivision C—Maximum period of effect of classification levels

80-50 Purpose of this Subdivision

For the purposes of subsection 80(1) of the Act, this Subdivision prescribes, for certain classification levels, the maximum period of effect for the classification level.

80-55 Service group home support—classification type short-term—classification level SAH restorative care pathway

For the classification level SAH restorative care pathway for the classification type short-term for the service group home support, the maximum period of effect is 112 days.

80-57 Service group home support—classification type short-term—classification level SAH end-of-life pathway

For the classification level SAH end-of-life pathway for the classification type short-term for the service group home support, the maximum period of effect is 112 days.

80-60 Service group residential care—classification type short-term

(1) For a classification level for the classification type short-term for the service group residential care, the maximum period of effect is:
  (a) 63 days; or
  (b) for an individual for whom the System Governor has increased the number of days for the classification level under subsection (5)—the number of days as so increased (or as most recently increased).

Note: The maximum period of effect for the classification type short-term for the service group residential care relates to a financial year (see section 80-40).

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Increase in number of days for classification levels for individuals

(2) A registered provider may apply to the System Governor for a determination of an increased number of days for the classification level for an individual under subsection (5).

(3) An application under subsection (2) must be made in the approved form.

(4) The System Governor must consider an application under subsection (2) and decide whether to determine an increased number of days under subsection (5).

(5) The System Governor may increase the number of days for the classification level for the individual by up to 21 if the System Governor is satisfied that an increase in the number of days is necessary because of any of the following:
  (a) carer stress;
  (b) severity of the individual's condition;
  (c) absence of the individual's carer;
  (d) any other relevant matter.

(6) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.

(7) The notice of decision must include the day the decision takes effect, which may be before the day the decision is made.

(8) An increase under subsection (5) may be made more than once.

80-65 Service group home support, assistive technology or residential care—classification type hospital transition

(1) For a classification level for the classification type hospital transition for the service group home support, assistive technology or residential care, the maximum period of effect is:
  (a) 84 days; or
  (b) for an individual for whom the System Governor determines one or more additional periods for the classification level under subsection (5)—84 days plus those additional periods.

Extension of maximum period of effect for classification levels for individuals

(2) A registered provider may apply to the System Governor for a determination of an additional period for the classification level for an individual under subsection (5).

(3) An application under subsection (2) must be made:
  (a) in the approved form; and
  (b) within:
    (i) the period referred to in paragraph (1)(a); or
    (ii) if an additional period has been determined for the individual for the classification level under subsection (5)—that additional period.

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(4) The System Governor must consider an application under subsection (2) and decide whether to determine an additional period under subsection (5).

(5) The System Governor may determine one or more additional periods, together totalling not more than 42 days, for the classification level for the individual if the System Governor is satisfied that the individual requires access to funded aged care services for that level for the additional periods.

(6) The System Governor must give written notice to the registered provider of a decision under subsection (5) within 28 days after the application was made.

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Division 3—Classification levels and procedures

Subdivision A—Introduction

81-5 Purpose of this Division

For the purposes of section 81 of the Act, this Division prescribes:

(a) classification levels for classification types for service groups; and

(b) for certain classification levels—criteria that are to be used in establishing the classification level of an individual for a classification type for a service group; and

(c) for certain classification levels—methods or procedures that the System Governor must follow in deciding classification levels for an individual for a classification type for a service group; and

(d) for the service groups home support, assistive technology and home modifications—compounding factors (based on results against relevant assessment items mentioned in subsection 77(2) of the Act) that will be used to establish an individual's classification level; and

(e) for the service group residential care:

(i) compounding factors (based on results against relevant assessment items mentioned in subsection 77(2) of the Act) that will be used to establish an individual's classification level; and

(ii) the scientific population study that will be used by the System Governor to derive a method for establishing when these compounding factors, taken together, are significant because they indicate the individual has significantly higher care needs relative to the needs of other individuals.

81-7 Meaning of *home support compounding factors*

The home support compounding factors, for an individual, means the individual's scores for the following groups of questions in the Integrated Assessment Tool:

(a) the questions in the sections headed "Cognition" and "Medical and Medications";

(b) the questions in the section headed "Social";

(c) the questions under the headings "Toileting - Bladder" and "Toileting - Bowels";

(d) the questions in the section headed "Carer Profile";

(e) the questions in the section headed "Psychological";

(f) the questions in the section headed "Physical, Personal Health and Frailty".

81-8 Meaning of *residential care compounding factors*

The following table sets out the ***residential care compounding factors*** for individuals.

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Residential care compounding factors for individuals		
Item	**Column 1** **For an individual who …**	**Column 2** **the residential care compounding factors are the following …**
1	is independently mobile	(a) the individual's AFM cognition score; (b) the individual's agitation score; (c) the individual's AKPS score; (d) the individual's RUG total score; (e) whether the individual requires daily injections.
2	is mobile only with assistance and has higher cognitive ability	(a) the individual's AFM motor score; (b) the individual's AFM social cognition score; (c) the individual's AKPS score; (d) the individual's Braden activity score; (e) whether the individual has fallen in the last 12 months; (f) whether the individual requires daily injections.
3	is mobile only with assistance and has medium cognitive ability	(a) the individual's AFM communication score; (b) the individual's disruptiveness score; (c) the individual's Rockwood Frailty Score; (d) the individual's RUG total score; (e) whether the individual requires complex wound management; (f) whether the individual requires daily injections.
4	is not mobile and has higher function	(a) the individual's AFM transfers score; (b) the individual's Braden total score; (c) the individual's disruptiveness score; (d) whether the individual requires complex wound management; (e) whether the individual requires daily injections.
5	is not mobile and has lower function and higher pressure sore risk	(a) the individual's AFM eating score; (b) the individual's disruptiveness score; (c) whether the individual has fallen in the last 12 months; (d) whether the individual has lost more than 10% of their body weight in the last 12 months; (e) whether the individual requires daily injections.

81-9 Scientific population study for residential care compounding factors

The scientific population study to be used as mentioned in paragraph 81(4)(b) of the Act is the Resource Utilisation and Classification Study undertaken by the Australian Health Services Research Institute at the University of Wollongong.

Note: The reports of the Resource Utilisation and Classification Study could in 2025 be viewed on the Department's website (https://www.health.gov.au).

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Subdivision B—Classification levels and criteria

81-10 Service group home support—classification type ongoing

Non-transitional classification levels and criteria

(1) The following table sets out the non-transitional classification levels for the classification type ongoing for the service group home support and the criteria for those classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	CHSP class	Any of the following: (a) the individual: (i) has a functional independence score of 42-48; and (ii) has a needs met score of 35 or 36; (b) the individual: (i) has a functional independence score of 42-48; and (ii) has a needs met score of 0-34; (c) the individual: (i) has a functional independence score of 35-41; and (ii) has a needs met score of 31-36; (d) the individual: (i) has a functional independence score of 35-41; and (ii) has a needs met score of 0-30; and (iii) does not have significant compounding factors
2	SAH class 1	Either: (a) the individual: (i) has a functional independence score of 35-41; and (ii) has a needs met score of 0-30; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 30-34; and (ii) has a needs met score of 30-36; and (iii) does not have significant compounding factors
3	SAH class 2	Either: (a) the individual: (i) has a functional independence score of 30-34; and (ii) has a needs met score of 30-36; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 30-34; and (ii) has a needs met score of 0-29; and (iii) does not have significant compounding factors
4	SAH class 3	Either: (a) the individual:

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Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
		(i) has a functional independence score of 30-34; and (ii) has a needs met score of 0-29; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 25-29; and (ii) has a needs met score of 28-36; and (iii) does not have significant compounding factors
5	SAH class 4	Either: (a) the individual: (i) has a functional independence score of 25-29; and (ii) has a needs met score of 28-36; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 25-29; and (ii) has a needs met score of 0-27; and (iii) does not have significant compounding factors
6	SAH class 5	Either: (a) the individual: (i) has a functional independence score of 25-29; and (ii) has a needs met score of 0-27; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 0-24; and (ii) has a needs met score of 29-36; and (iii) does not have significant compounding factors
7	SAH class 6	Either: (a) the individual: (i) has a functional independence score of 0-24; and (ii) has a needs met score of 29-36; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 0-24; and (ii) has a needs met score of 23-28; and (iii) does not have significant compounding factors
8	SAH class 7	Either: (a) the individual: (i) has a functional independence score of 0-24; and (ii) has a needs met score of 23-28; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 0-24; and (ii) has a needs met score of 0-22; and (iii) does not have significant compounding factors
9	SAH class 8	The individual:

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Classification levels and criteria		
Item	**Column 1 Classification level**	**Column 2 Criteria**
		(a) has a functional independence score of 0-24; and (b) has a needs met score of 0-22; and (c) has significant compounding factors

Transitional classification levels

(2) The transitional classification levels for the classification type ongoing for the service group home support are the following:

(a) HCP class 1;
(b) HCP class 2;
(c) HCP class 3;
(d) HCP class 4;
(e) CHSP transitional;
(f) HSO NATSIFACP;
(g) HSO MPSP.

Note: Transitional classification levels for the classification type ongoing for the service group home support are established for certain classes of individuals to whom subsection 2(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

81-15 Service group home support—classification type short-term

Non-transitional classification levels and criteria

(1) The following table sets out the non-transitional classification levels for the classification type short-term for the service group home support and the criteria for those classification levels.

Classification levels and criteria		
Item	**Column 1 Classification level**	**Column 2 Criteria**
1	SAH restorative care pathway	The individual: (a) does not meet the criteria for the classification level CHSP class for the classification type ongoing for the service group home support; and (b) does not meet the criteria for the classification level SAH end-of-life pathway for the classification type short-term for the service group home support; and (c) is not accessing, and does not have the potential to benefit from accessing, funded aged care services delivered through the service group home support under the TCP; and (d) is residing in a home or community setting; and

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Classification levels and criteria		
Item	**Column 1 Classification level**	**Column 2 Criteria**
		(e) needs restorative care to prevent or delay the individual from needing to access ongoing funded aged care services in the service group home support in circumstances mentioned in paragraph 64-5(b); and (f) has goals in line with restorative care outcomes (for example improving function and being independent); and (g) either: (i) has not had the classification level SAH restorative care pathway in effect in the previous 90 days; or (ii) has not had an amount determined for the individual under section 195-3 during a period of effect for the classification level SAH restorative care pathway that includes a day in the previous 12 months
2	SAH end-of-life pathway	All of the following apply to the individual: (a) the individual: (i) has a prognosis of a life expectancy of 3 months or less; and (ii) has an AKPS score of 40 or less; (b) the individual has not previously had the classification level SAH end-of-life pathway in effect; (c) a notice in the approved form containing evidence of the matters referred to in paragraph (a) has been given to the System Governor

Transitional classification levels

(2) The transitional classification levels for the classification type short-term for the service group home support are the following:

(a) STRC class;

(b) HSST NATSIFACP;

(c) HSST MPSP.

Note: The transitional classification levels for the classification type short-term for the service group home support are established for certain classes of individuals to whom subsection 2(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

81-17 Service group home support—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group home support and the criteria for the classification levels.

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Classification levels and criteria		
Item	**Column 1** **Classification level**	**Column 2** **Criteria**
1	HS HT class	The individual: (a) has an access approval that includes the service type assistance with transition care; and (b) is in the concluding stage of a hospital episode; and (c) is medically stable; and (d) has the potential to benefit from accessing funded aged care services delivered through the service group home support under the TCP; and (e) was admitted to a hospital at the time the aged care needs assessment was carried out

81-20 Service group assistive technology—classification type ongoing

The following table sets out the classification levels for the classification type ongoing for the service group assistive technology and the criteria for the classification levels.

Classification levels and criteria		
Item	**Column 1** **Classification level**	**Column 2** **Criteria**
1	Assistance dogs	The individual: (a) has an assistance dog; and (b) is unable to access assistance under the Assistance Dogs Australia program for people with physical disabilities

81-25 Service group assistive technology—classification type short-term

Non-transitional classification levels and criteria

(1) The following table sets out the non-transitional classification levels for the classification type short-term for the service group assistive technology and the criteria for those classification levels.

Classification levels and criteria		
Item	**Column 1** **Classification level**	**Column 2** **Criteria**
1	AT low	The individual: (a) needs low cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group

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Classification levels and criteria		
Item	**Column 1 Classification level**	**Column 2 Criteria**
		home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway or SAH end-of-life pathway
2	AT medium	The individual: (a) needs medium cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway or SAH end-of-life pathway
3	AT high	The individual: (a) needs high cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway
4	AT CHSP	The classification level CHSP class has been established for the individual for the classification type ongoing for the service group home support

Transitional classification levels

(2) The transitional classification level for the classification type short-term for the service group assistive technology is AT transitional.

Note: The transitional classification level for the classification type short-term for the service group assistive technology is established for certain classes of individuals to whom subsection 2(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

81-27 Service group assistive technology—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group assistive technology and the criteria for the classification levels.

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Classification levels and criteria		
Item	**Column 1** **Classification level**	**Column 2** **Criteria**
1	AT HT class	The individual: (a) has an access approval that includes the service type assistance with transition care; and (b) is in the concluding stage of a hospital episode; and (c) is medically stable; and (d) has the potential to benefit from accessing funded aged care services delivered through the service group assistive technology under the TCP; and (e) was admitted to a hospital at the time the aged care needs assessment was carried out

81-30 Service group home modifications—classification type short-term

Non-transitional classification levels and criteria

(1) The following table sets out the non-transitional classification levels for the classification type short-term for the service group home modifications and the criteria for those classification levels.

Classification levels and criteria		
Item	**Column 1** **Classification level**	**Column 2** **Criteria**
1	HM low	The individual: (a) needs low cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway
2	HM medium	The individual: (a) needs medium cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and (b) has had any of the following classification levels established for the individual: (i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; (ii) for the classification type short-term for the service group home support—SAH restorative care pathway
3	HM high	The individual: (a) needs high cost home modifications to mitigate functional decline

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Classification levels and criteria		
Item	**Column 1 Classification level**	**Column 2 Criteria**
		or impairment and enable them to safely live in their home and community; and (b) has had any of the classification levels SAH class 1, 2, 3, 4, 5, 6, 7 or 8 for the classification type ongoing for the service group home support established for the individual
4	HM CHSP	The classification level CHSP class has been established for the individual for the classification type ongoing for the service group home support

Transitional classification levels

(2) The transitional classification level for the classification type short-term for the service group home modifications is HM transitional.

Note: The transitional classification level for the classification type short-term for the service group home modifications is established for certain classes of individuals to whom subsection 2(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

81-35 Service group residential care—classification type ongoing

Non-transitional classification levels and criteria

(1) The non-transitional classification levels for the classification type ongoing for the service group residential care are as follows:
(a) class 0; and
(b) the classification levels set out in the following table.

(2) The following table sets out the criteria for the classification levels set out in the table.

Classification levels and criteria		
Item	**Column 1 Classification level**	**Column 2 Criteria**
1	Class 1	The circumstances referred to in paragraph 76-15(10)(a) of this instrument (palliative care pathway) apply to the individual
2	Class 2	The individual: (a) is independently mobile; and (b) does not have significant compounding factors
3	Class 3	The individual: (a) is independently mobile; and (b) has significant compounding factors
4	Class 4	The individual: (a) is mobile only with assistance; and

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Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
		(b) has higher cognitive ability; and (c) does not have significant compounding factors
5	Class 5	The individual: (a) is mobile only with assistance; and (b) has higher cognitive ability; and (c) has significant compounding factors
6	Class 6	The individual: (a) is mobile only with assistance; and (b) has medium cognitive ability; and (c) does not have significant compounding factors
7	Class 7	The individual: (a) is mobile only with assistance; and (b) has medium cognitive ability; and (c) has significant compounding factors
8	Class 8	The individual: (a) is mobile only with assistance; and (b) has lower cognitive ability
9	Class 9	The individual: (a) is not mobile; and (b) has higher function; and (c) does not have significant compounding factors
10	Class 10	The individual: (a) is not mobile; and (b) has higher function; and (c) has significant compounding factors
11	Class 11	The individual: (a) is not mobile; and (b) has lower function; and (c) has lower pressure sore risk
12	Class 12	The individual: (a) is not mobile; and (b) has lower function; and (c) has higher pressure sore risk; and (d) does not have significant compounding factors
13	Class 13	The individual: (a) is not mobile; and (b) has lower function; and (c) has higher pressure sore risk; and (d) has significant compounding factors

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Transitional classification levels and criteria

(3) The transitional classification levels for the classification type ongoing for the service group residential care are as follows:
  (a) RCO MPSP;
  (b) RCO NATSIFACP.

Note: Transitional classification levels for the classification type ongoing for the service group residential care are established for certain classes of individuals to whom subsection 3(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

81-40 Service group residential care—classification type short-term

Non-transitional classification levels and criteria

(1) The non-transitional classification levels for the classification type short-term for the service group residential care are as follows:
  (a) respite class 0; and
  (b) the classification levels set out in the following table.

(2) The following table sets out the criteria for the classification levels set out in the table.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	Respite class 1	The individual is independently mobile
2	Respite class 2	The individual is mobile only with assistance
3	Respite class 3	The individual is not mobile

Transitional classification levels

(3) The transitional classification level for the classification type short-term for the service group residential care are as follows:
  (a) RCST MPSP;
  (b) RCST NATSIFACP.

Note: Transitional classification levels for the classification type short-term for the service group residential care are established for certain classes of individuals to whom subsection 3(2) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

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81-42 Procedure for deciding initial classification levels for individuals for the classification types ongoing and short-term for the service group residential care

Classification type ongoing

(1) The procedure for establishing a classification level for an individual to whom paragraph 78(1)(c) of the Act applies for the classification type ongoing for the service group residential care is to establish the classification level class 0 for the individual.

Classification type short-term

(2) The procedure for establishing a classification level for an individual to whom paragraph 78(1)(c) of the Act applies for the classification type short-term for the service group residential care is to establish the classification level respite class 0 for the individual.

81-45 Service group residential care—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group residential care and the criteria for the classification levels.

Classification levels and criteria

Item	Column 1 Classification level	Column 2 Criteria
1	RC HT class	The individual: (a) has an access approval that includes the service type assistance with transition care; and (b) is in the concluding stage of a hospital episode; and (c) is medically stable; and (d) has the potential to benefit from accessing funded aged care services delivered through the service group residential care under the TCP; and (e) was admitted to a hospital at the time the aged care needs assessment was carried out

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Part 4—Prioritisation

Division 1—Prioritisation assessments

84-5 When prioritisation assessments not required for classification type ongoing for service group home support

For the purposes of paragraph 84(2)(b) of the Act, the circumstances for an individual are that the classification level CHSP class for the classification type ongoing for the service group home support has been established for the individual by a classification decision.

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Division 2—Priority category decisions

86-5 All service groups—period in which priority category decisions must be made

For the purposes of subsection 86(3) of the Act, the period of 14 days after the day on which the System Governor is given a prioritisation report under section 85 of the Act for an individual is prescribed.

86-10 Service group residential care—priority category 1—areas

For the purposes of subparagraph 86(5)(a)(ii) of the Act, an area with a 2023 MM category known as MM 5, MM 6 or MM 7 is prescribed.

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Division 3—Priority categories for classification types for service groups

Subdivision A—Service group home support

87-5 Priority categories and eligibility criteria for classification type ongoing

(1) For the purposes of subsection 87(1) of the Act:

(a) column 1 of the following table prescribes the priority categories for the classification type ongoing for the service group home support; and

(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

Classification type ongoing for service group home support

Item	Column 1 Priority categories	Column 2 Eligibility criteria
1	Urgent	The individual has 5 or more points determined in accordance with subsection (2)
2	High	The individual has 4 points determined in accordance with subsection (2)
3	Medium	The individual has 2 or 3 points determined in accordance with subsection (2)
4	Standard	The individual has 1 point, or no points, determined in accordance with subsection (2)

Points

(2) For the purposes of column 2 of the table in subsection (1), an individual's points are determined by adding together the points specified in column 2 of each item of the following table in which column 1 specifies circumstances that apply to the individual (if any).

Circumstances and points for eligibility criteria

Item	Column 1 Circumstances	Column 2 Points
1	The individual lives alone	1
2	The individual has a cognitive impairment	1
3	The individual is an Aboriginal or Torres Strait Islander person	1
4	The individual is homeless, or at risk of homelessness	1
5	The individual has a need for urgent access to ongoing funded aged care services through the service group home support	2
6	The individual: (a) has waited more than 6 months from: (i) the day on which the individual applied for access to funded aged	1

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Circumstances and points for eligibility criteria		
Item	**Column 1** **Circumstances**	**Column 2** **Points**
	care services; or (ii) if the individual applied for the reassessment of the individual's need for funded aged care services—the day on which the individual applied for the reassessment; and (b) resides in an area with a 2023 MM category known as MM 5, MM6 or MM 7	
7	The individual had motor neurone disease at the time the individual's most recent aged care needs assessment was undertaken	5

Subdivision B—Service groups assistive technology and home modifications

87-7 Priority categories and eligibility criteria

Classification type ongoing or short-term for service group assistive technology

(1) For the purposes of subsection 87(1) of the Act:
(a) column 1 of the following table prescribes the priority categories for the classification types ongoing and short-term for the service group assistive technology; and
(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

Classification type ongoing or short-term for service group assistive technology		
Item	**Column 1** **Priority categories**	**Column 2** **Eligibility criteria**
1	Immediate	An approved needs assessor considers the classification type short-term for the service group home support should be approved for the individual
2	High	Two or more of the following circumstances apply to the individual: (a) the individual lives alone; (b) the individual has a mobility impairment; (c) the individual is an Aboriginal or Torres Strait Islander person; (d) the individual's current place of residence poses a moderate or severe risk to the individual's health or safety; (e) both of the following apply: (i) the individual has waited more than 6 months from the day on which the individual made the application to which the priority assessment relates; (ii) the individual resides in an area with a 2023 MM category known as MM 5, MM 6 or MM 7 Note: The application referred to in subparagraph (e)(i) could be an application for access to funded aged services under section 56 of

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Classification type ongoing or short-term for service group assistive technology		
Item	**Column 1** **Priority categories**	**Column 2** **Eligibility criteria**
		the Act or an application for an aged care needs reassessment under section 64 of the Act.
3	Medium	One circumstance referred to in column 2 of item 2 applies to the individual
4	Standard	None of the circumstances referred to in column 2 of item 2 apply to the individual

Classification type short-term for service group home modifications

(2) For the purposes of subsection 87(1) of the Act:

(a) column 1 of the following table prescribes the priority categories for the classification type short-term for the service group home modifications; and

(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

Classification type short-term for service group home modifications		
Item	**Column 1** **Priority categories**	**Column 2** **Eligibility criteria**
1	Immediate	An approved needs assessor considers the classification type short-term for the service group home support should be approved for the individual
2	High	Two or more of the following circumstances apply to the individual: (a) the individual lives alone; (b) the individual has a mobility impairment; (c) the individual is an Aboriginal or Torres Strait Islander person; (d) the individual's current place of residence poses a moderate or severe risk to the individual's health or safety; (e) both of the following apply: (i) the individual has waited more than 6 months from the day on which the individual made the application to which the priority assessment relates; (ii) the individual resides in an area with a 2023 MM category known as MM 5, MM 6 or MM 7 Note: The application referred to in subparagraph (e)(i) could be an application for access to funded aged services under section 56 of the Act or an application for an aged care needs reassessment under section 64 of the Act.
3	Medium	One circumstance referred to in column 2 of item 2 applies to the individual
4	Standard	None of the circumstances referred to in column 2 of item 2 apply to the individual

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Division 4—Circumstances for urgency ratings—service group residential care

87-10 Classification type ongoing

(1) For the purposes of subsection 87(2) of the Act, this section prescribes the circumstances in which an urgency rating of low, medium or high will apply to an individual in relation to the classification type ongoing for the service group residential care.

High

(2) An urgency rating of high will apply to the individual if the individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk.

Medium

(3) An urgency rating of medium will apply to the individual if:
  (a) the circumstances mentioned in subsection (2) do not apply to the individual; and
  (b) taking into account the individual's circumstances and preferences, the individual is expected to seek access to ongoing funded aged care services delivered in an approved residential care home within the next 6 months.

Low

(4) An urgency rating of low will apply to the individual if:
  (a) the circumstances mentioned in subsection (2) do not apply to the individual; and
  (b) the circumstances mentioned in paragraph (3)(b) do not apply to the individual.

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Part 5—Place allocation

Division 1—Allocation of places to individuals

Subdivision A—Allocation of places to individuals

92-5 When allocation of places to individuals does not apply for classification type ongoing for service group home support

For the purposes of paragraph 92(1A)(b) of the Act, the circumstances for an individual are that the classification level CHSP class for the classification type ongoing for the service group home support has been established for the individual by a classification decision.

92A-5 When a place is in effect—period for start day—service groups home support, assistive technology and home modifications

For the purposes of subsection 92A(2) of the Act, the period for a place allocated under subsection 92(1) of the Act to an individual is:

(a) 56 days from the day the place is allocated to the individual; or

(b) if, within the period referred to in paragraph (a), the individual notifies the System Governor that the individual needs an extension to that period—84 days from the day the place is allocated to the individual.

92A-10 When a place ceases to have effect—service groups home support, assistive technology and home modifications

For the purposes of subsection 92A(4) of the Act, the time when a place allocated under subsection 92(1) of the Act to an individual for a classification type for the service group home support, assistive technology or home modifications ceases to have effect is the end of the earlier of the following (as applicable):

(a) for a place allocated to an individual for whom a classification level has been established for the classification type for the service group by a classification decision—the period of effect for the classification level;

(b) the day the individual dies.

Subdivision B—Method for allocation

93-5 Purpose of this Subdivision

For the purposes of subsection 93(2) of the Act, this Subdivision prescribes methods that the System Governor must follow in deciding the order of allocation under subsection 93(1) of the Act for:

(a) the classification type ongoing for the service group home support; and

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(b) the classification types ongoing and short-term for the service group assistive technology; and
(c) the classification type short-term for the service group home modifications.

93-10 Classification type ongoing for the service group home support—method for deciding order of allocation

The method for deciding the order of allocation of a place to an individual for the classification type ongoing for the service group home support is as follows.

Step 1:	Identify the individuals (if any) to whom the circumstances referred to in paragraph 64-10(d) of this instrument apply.
Step 2:	Allocate the place to the individual who has the longest current wait time.
Step 3.	Using the method in section 93-12, identify if a place is assigned to a priority category for the classification type for the service group.
Step 4.	Identify whether the place is a full place or an interim place.
Step 5.	Identify the individuals (if any) who have that priority category for the classification type for the service group and whether those individuals have an interim place in effect for the classification type for the service group.
Step 6.	If the place is a full place, allocate the place to the individual who, of the individuals to whom a place has not already been allocated under step 2, has the longest current wait time.
Step 7.	If the place is an interim place, allocate the place to the individual who, of the individuals who do not have an interim place in effect for the classification type for the service group and to whom a place has not already been allocated under step 2, has the longest current wait time.

93-12 Classification type ongoing for the service group home support—method for assigning places to priority categories

The method for assigning a place to a priority category for the classification type ongoing for the service group home support on a day is as follows.

Step 1.	For each priority category for the classification type for the service group, identify the number of waiting individuals for whom the current wait time is equal to or greater than the target priority category wait time for that priority category on the day.
Step 2.	Add up the numbers identified for each priority category under Step 1.

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Step 3. Identify the number of places that are available to be allocated to individuals for that service group on the day (as worked out in accordance with the method determined under subsection 91(1) of the Act).

Step 4. If the number worked out under Step 2 is less than or equal to the number identified at Step 3, divide the number worked out under Step 2 by the number identified at Step 3.

Step 5. If the number worked out under Step 2 is greater than the number identified at Step 3, divide the number identified at Step 3 by the number worked out under Step 2.

Step 6. For each priority category:

(a) multiply the number identified under step 1 by the result of Step 4 or 5 (as applicable) and round down to the nearest whole number; and

(b) if the result under paragraph (a) is a number greater than zero, that number of places are assigned to that priority category on the day; and

(c) if the result under paragraph (a) is zero, no places are assigned to that priority category on the day.

93-13 Classification type ongoing for the service group home support—method for working out wait time factor

The method for working out the ***wait time factor*** is as follows.

Step 1. Reduce the target classification type wait time most recently determined by the System Governor under section 93-14 by the priority category waiting proportion for the priority category urgent.

Step 2. For each remaining priority category, multiply the priority category waiting proportion by the queue rate.

Step 3. Add up the results of step 2 for each priority category.

Step 4. Divide the result of step 1 by the result of step 3.

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93-14 Classification type ongoing for the service group home support—method for System Governor determination of target classification type wait time

The System Governor must, from time to time, determine the ***target classification type wait time*** (in months) for the classification type ongoing for the service group home support by considering:

(a) on the first occasion the System Governor does so—the average of the old Act wait times; or

(b) on any subsequent occasion:

(i) the weighted average of the current wait times for individuals who have been assigned priority categories for the classification type for the service group; and

(ii) what change needs to be made to the previous target classification type wait time to ensure that, on and after 1 November 2027, the weighted average mentioned in subparagraph (i) is not more than 3 months.

93-15 Classification types ongoing and short-term for the service group assistive technology—method for deciding order of allocation

The method for deciding the order of allocation of a place to an individual for the classification type ongoing or short-term for the service group assistive technology is as follows.

Step 1.	Identify the individuals (if any) who have, or have had, the classification level SAH end-of-life pathway for the classification type short-term for the service group home support in effect.
Step 2:	Allocate the place to the individual who has the longest current wait time.
Step 3:	Identify the waiting individuals (if any) who have the priority category immediate for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 4.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 5.	If no individuals are identified under step 3, identify the waiting individuals (if any) who have the priority category high for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 6.	Of those individuals, allocate the place to the individual who has the longest current wait time.

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Step 7.	If no individuals are identified under step 5, identify the waiting individuals (if any) who have the priority category medium for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 8.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 9.	If no individuals are identified under step 7, identify the waiting individuals who have the priority category standard for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 8.	Of those individuals, allocate the place to the individual who has the longest current wait time.

93-20 Classification type short-term for the service group home modifications—method for deciding order of allocation

The method for deciding the order of allocation of a place to an individual for the classification type short-term for the service group home modifications is as follows.

Step 1:	Identify the individuals (if any) who have had the classification level SAH end-of-life pathway for the classification type short-term for the service group home support in effect.
Step 2:	Allocate the place to the individual who has the longest current wait time.
Step 3.	Identify the waiting individuals (if any) who have the priority category immediate for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 4.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 5.	If no individuals are identified under step 3, identify the waiting individuals (if any) who have the priority category high for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 6.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 7.	If no individuals are identified under step 5, identify the waiting individuals (if any) who have the priority category medium for the

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	classification type for the service group and to whom a place has not already been allocated under step 2.
Step 8.	Of those individuals, allocate the place to the individual who has the longest current wait time.
Step 9.	If no individuals are identified under step 7, identify the waiting individuals who have the priority category standard for the classification type for the service group and to whom a place has not already been allocated under step 2.
Step 10.	Of those individuals, allocate the place to the individual who has the longest current wait time.

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Division 2—Allocation of a place to registered providers for certain specialist aged care programs

95-5 Allocation of a place—System Governor may invite application for allocation of TCP place

(1) For the purposes of subsection 95(2) of the Act, the System Governor may invite an entity to apply on its own behalf or on behalf of another entity (the ***nominated entity)*** for the allocation of a place for the delivery of funded aged care services under the TCP in a State or Territory.

(2) An application under subsection 95(2) of the Act may only be made in accordance with an invitation under subsection (1).

95-10 Allocation of a place—application for allocation of a TCP place

(1) An application under subsection 95(2) of the Act for the allocation of a place for delivering funded aged care services under the TCP in a State or Territory must specify the following:
   (a) whether the application is being made:
      (i) on an entity's own behalf; or
      (ii) on behalf of a nominated entity to which the place is to be allocated;
   (b) the number of places applied for;
   (c) the number of those places that will be used to prioritise delivery of funded aged care services to Aboriginal or Torres Strait Islander persons;
   (d) the area or areas in which the places will be used to deliver funded aged care services.

(2) For each area specified under paragraph (1)(d), the application must also specify the following:
   (a) the estimated number of persons residing in the area or areas who are aged at least 70, other than Aboriginal or Torres Strait Islander persons;
   (b) the estimated number of Aboriginal or Torres Strait Islander persons residing in the area or areas who are aged at least 50;
   (c) the estimated number of persons mentioned in paragraph (a) or (b) who are expected to be discharged from hospital;
   (d) the estimated number of persons expected to be discharged from hospital as mentioned in paragraph (c) annually, or within another relevant time period, who are expected to benefit from funded aged care services delivered under the TCP after discharge;
   (e) if the application is made on behalf of one or more nominated entities to which the places are to be allocated—the nominated entity or entities that will deliver funded aged care services under each place applied for.

(3) For the purposes of subsection (2), the number of persons for an area specified in an application is to be expressed as a whole number per thousand of the total number of persons residing in the area.

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(4) To avoid doubt:
  (a) an area specified under paragraph (1)(d) may be the whole or a part of a State or Territory; and
  (b) an application made on behalf of a nominated entity is made by the nominated entity for the purposes of the Act.

Note: The System Governor may request further information, which must be given within 14 days of the request (see section 588 of the Act and section 588-5 of this instrument).

95-15 Allocation of a place—matters of which System Governor must be satisfied before allocating TCP place

For the purposes of subparagraph 95(4)(a)(ii) of the Act, the System Governor must be satisfied of the following before allocating a place to an entity for the delivery of funded aged care services under the TCP in a State or Territory:
  (a) that the place, if allocated, will be used by the entity to which the place is allocated to deliver funded aged care services in accordance with an agreement between the Commonwealth and the State or Territory made under paragraph 247(1)(b) of the Act;
  (b) that, if the place is allocated to a nominated entity, the entity was nominated having regard to the community's needs.

97-5 When a place is in effect—basic rules

When a place comes into effect

(1) For the purposes of subsection 97(1) of the Act, a place allocated under subsection 95(1) of the Act to an entity for a specialist aged care program comes into effect on the day after the first day on which the entity satisfies the following conditions:
  (a) the entity is a registered provider that is registered for a registration category for one or more service groups through which the entity will deliver funded aged care services under the specialist aged care program;
  (b) if the place is to be used to deliver funded aged care services under the MPSP—an agreement with the entity is in force under paragraph 247(1)(a) of the Act;
  (c) if the place is to be used to deliver funded aged care services under the TCP in a State or Territory—an agreement with the State or Territory covering the arrangements for the delivery of those services is in force under paragraph 247(1)(b) of the Act;
  (d) if the place is to be used to deliver funded aged care services in an approved residential care home—the System Governor is satisfied that a bed in the approved residential aged care home is ready to be used for the delivery of funded aged care services under the place.

Note: A place may, in certain circumstances, be allocated a second time under subsection 95(1) of the Act (see section 97-25).

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Period for which a place is in effect

(2) A place that comes into effect under subsection (1) is in effect for the period:
  (a) starting on the day on which the place comes into effect; and
  (b) ending on the day on which the place ceases to be in effect under section 97-15;

but is not in effect for any period for which it is temporarily not in effect under section 97-10.

Place cannot come into effect if 5 year delay

(3) A place allocated under subsection 95(1) of the Act to an entity for a specialist aged care program does not come into effect, and can never come into effect, if the place has not come into effect under subsection (1) of this section within 5 years after the day on which the place was allocated.

Entity may be required to complete application to confirm that a bed is ready to be used

(4) For the purposes of paragraph (1)(d), the System Governor may require an entity to complete an application process published on the Department's website.

97-10 When a place is in effect—temporary cessation

(1) For the purposes of subsection 97(1) of the Act, this section prescribes the circumstances in which a place that has been allocated under subsection 95(1) of the Act to an entity, and has come into effect, is temporarily not in effect.

Entity does not have capacity to deliver funded aged care services

(2) The place is not in effect for a period during which the System Governor and the entity agree that the entity does not have the capacity to deliver funded aged care services under the place.

Note: Section 167 of the Act, and rules made under that section, require certain registered providers to give notice of certain changes in circumstances to the System Governor.

Suspension of entity's registration

(3) The place is not in effect for any period of suspension, under subsection 129(1) of the Act, of the registration of the entity.

Condition makes it impracticable to deliver funded aged care services

(4) A place is not in effect for a period if:
  (a) a condition is placed on the entity; and
  (b) the condition makes it impracticable for the entity to deliver funded aged care services under the place for that period.

(5) A place that is not in effect for a period comes back into effect immediately after the end of the period.

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97-15 When a place is in effect—permanent cessation

(1) For the purposes of subsection 97(1) of the Act, a place that has been allocated under subsection 95(1) of the Act to an entity, and has come into effect, ceases to be in effect, and can never resume to have effect, if:

(a) the entity ceases to be a registered provider; or

(b) the System Governor and the entity agree, in accordance with subsection (2) of this section, that the entity may relinquish the place; or

(c) the System Governor revokes the place under subsection (3) of this section.

Note: A place allocated under subsection 95(1) of the Act may be brought back into effect for allocation to another entity in certain circumstances (see section 97-25).

(2) The System Governor must not agree to the relinquishment of a place under paragraph (1)(b) unless the System Governor is satisfied that the entity to which the place was allocated has complied with the requirements prescribed by Division 4 of Part 4 of Chapter 4 of this instrument (which deals with continuity of delivery of funded aged care services).

(3) The System Governor may revoke a place if the entity has not used the place to deliver funded aged care services for a period of 12 months or more.

97-25 When a place is in effect—reallocation of TCP place

(1) For the purposes of subsection 97(1) of the Act, if:

(a) the Minister determines under paragraph 94(1)(a) of the Act that a place is available for allocation for use in a specified State or Territory; and

(b) the place is allocated to an entity under subsection 95(1) of the Act; and

(c) the place would, apart from this section, cease permanently to be in effect under section 97-15;

the State or Territory specified in the determination may apply to the System Governor for the place to be allocated to another entity.

(2) If the State or Territory makes an application to the System Governor under subsection (1):

(a) the System Governor may decide to allocate the place to the other entity under subsection 95(1) of the Act; and

(b) if the System Governor so decides, the place comes into effect in accordance with section 97-5.

98-5 Transfer of places

(1) For the purposes of subsection 98(1) of the Act, this section prescribes circumstances in which a place allocated under subsection 95(1) of the Act to the first entity may be transferred to the second entity.

(2) One circumstance is that:

(a) the place is for delivering funded aged care services under the TCP in a State or Territory; and

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(b) the State or Territory makes an application to the System Governor for the place to be transferred to the second entity; and
(c) the second entity is a registered provider delivering funded aged care services under the TCP in the State or Territory.

(3) Another circumstance is that:
(a) the place is for delivering funded aged care services under the MPSP in a State or Territory; and
(b) the State or Territory makes an application to the System Governor for the place to be transferred to the second entity; and
(c) the second entity is a registered provider delivering funded aged care services under the MPSP in the State or Territory; and
(d) the first entity and second entity agree to the transfer.

99-5 Conditions that apply to an allocated place

For the purposes of paragraph 99(1)(f) of the Act, the following conditions are prescribed in relation to a place allocated by the System Governor to an entity under subsection 95(1) of the Act:

(a) the entity must notify the System Governor if the entity will not be able to, or does not intend to, use the place to deliver funded aged care services for a period of 12 months or more;
(b) for a place allocated for the MPSP:
(i) if the place is used for the delivery of funded aged care services through the service group residential care—the place must only be used by the entity at the approved residential care home specified in the notice given under subsection 96(1) of the Act in relation to the allocation of the place; and
(ii) if the place is used for the delivery of funded aged care services through a service group that is not the service group residential care—the place must only be used by the entity at a location specified in the notice given under subsection 96(1) of the Act in relation to the allocation of the place.

Note: Section 167 of the Act, and rules made under that section, have the effect that this condition of place allocation can be met by giving the Commissioner and the System Governor a notice under that section.

101-5 System Governor decision on whether to vary a condition—matters to which System Governor must have regard

For the purposes of paragraph 101(2)(a) of the Act, the matters to which the System Governor must have regard in considering whether to vary a condition that applies to a place allocated to an entity under subsection 95(1) of the Act are the following:

(a) the objectives of the specialist aged care program for which the place is allocated;
(b) the needs of the communities of which individual members are expected to be able to access funded aged care services delivered under the place;

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(c) the Statement of Principles;
(d) any information or documents given by the entity in relation to the variation of the condition.

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Chapter 3—Provider registration

Part 1—Introduction

104-1 Simplified outline of this Chapter

This Chapter relates to provider registration under Chapter 3 of the Act.

Part 2 of this Chapter relates to provider registration and residential care home approval process, and deals with:

(a) applications for registration as a registered provider and applications for renewal of registration; and

(b) requirements for audits or assessments of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category; and

(c) applications for approval of a residential care home; and

(d) matters that must be included in a notice of a decision to register an entity as a registered provider or renew an entity's registration; and

(e) deeming certain classes of entities to be registered providers and matters that must be included in a determination that an entity is taken to be a registered provider.

Part 3 of this Chapter relates to variations, suspensions and revocations of the registration of a registered provider and variations of approvals of a residential care home, and deals with:

(a) the appointment by a registered provider of an eligible adviser to assist the provider to comply with the provider's conditions and obligations under Part 4 of Chapter 3 of the Act; and

(b) variations of approvals of residential care homes on the Commissioner's own initiative and on application by a registered provider; and

(c) matters that the Provider Register must include in relation to the registration of a registered provider.

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Part 2—Provider registration and residential care home approval process

Division 1—Applications for registration and registration decisions

Subdivision A—Application fees, information for applications and decision making periods

104-5 Application for registration—application fee

For the purposes of paragraph 104(2)(b) of the Act, the application fee for an application by an entity to be registered as a registered provider is the sum of:

(a) $3,270.00; and

(b) the sum of the amounts specified in column 2 of the following table for each provider registration category specified in the application as a provider registration category that the entity is applying to be registered in.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

Amounts for provider registration categories

Item	Column 1 Provider registration category	Column 2 Amount ($)
1	Home and community services	1,270.00
2	Assistive technology and home modifications	1,270.00
3	Advisory and support services	1,270.00
4	Personal and care support in the home or community	3,800.00
5	Nursing and transition care	3,800.00
6	Residential care	5,070.00

104-15 Application for registration—other information

For the purposes of paragraph 104(3)(i) of the Act, the other information that must be specified in an application by an entity for registration is, for each provider registration category that the entity is applying to be registered in under which funded aged care services are delivered in a home or community setting—each local government area in which the entity intends to deliver funded aged care services.

Note: For provider registration categories, see subsection 11(3) of the Act and section 11-5 of this instrument.

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105-5 Application for registration—period for making decision

For the purposes of subsection 105(2) of the Act, the period within which the Commissioner must make a decision on an application by an entity for registration is 90 days from the later of the following:

(a) the day the Commissioner receives the application;

(b) if an audit finding referred to in subparagraph 109(2)(d)(i) of the Act is required in relation to one or more provider registration categories specified in the application—the day the Commissioner gives a copy of the final audit report to the entity under section 110-38 of this instrument.

Note: For provider registration categories prescribed for the purposes of paragraph 109(2)(d) of the Act, see section 109-5 of this instrument. For circumstances prescribed for the purposes of subparagraph 109(2)(d)(ii) of the Act, see section 109-10 of this instrument.

107-5 Application for renewal of registration—application fee

For the purposes of paragraph 107(2)(b) of the Act, the application fee for an application by a registered provider to renew the provider's registration is the sum of:

(a) $295.00; and

(b) the sum of the amounts specified in column 2 of the following table for each provider registration category specified in the application as a provider registration category that the registered provider is applying to be registered in.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

Amounts for provider registration categories

Item	Column 1 Provider registration category	Column 2 Amount ($)
1	Home and community services	770.00
2	Assistive technology and home modifications	770.00
3	Advisory and support services	770.00
4	Personal and care support in the home or community	4,040.00
5	Nursing and transition care	4,040.00
6	Residential care	5,380.00

108-5 Application for renewal of registration—period for making decision

For the purposes of subsection 108(2) of the Act, the period within which the Commissioner must make a decision on an application by a registered provider for renewal of registration is 90 days from the later of the following:

(a) the day the Commissioner receives the application for renewal;

(b) if an audit finding referred to in subparagraph 109(2)(d)(i) of the Act is required in relation to one or more provider registration categories

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specified in the application—the day the Commissioner gives a copy of the final audit report to the registered provider under section 110-38 of this instrument.

Note: For provider registration categories prescribed for the purposes of paragraph 109(2)(d) of the Act, see section 109-5 of this instrument. For circumstances prescribed for the purposes of subparagraph 109(2)(d)(ii) of the Act, see section 109-10 of this instrument.

Subdivision B—Provider registration category specific requirements

109-5 Provider registration categories for which audit findings or prescribed circumstances are required

For the purposes of paragraph 109(2)(d) of the Act, the following provider registration categories are prescribed:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

109-10 Circumstances in which audit findings are not required—health service standards assessments

(1) For the purposes of subparagraph 109(2)(d)(ii) of the Act, the prescribed circumstances for an application by an entity for registration or renewal of registration in the following provider registration categories are:

(a) for residential care, in relation to the delivery, or proposed delivery, by the entity of funded aged care services through that provider registration category as part of an integrated service arrangement—that the entity satisfies subsection (2);

(b) for personal and care support in the home and community, and nursing or transition care, in relation to the delivery, or proposed delivery, by the entity of funded aged care services through those provider registration categories as part of an integrated service arrangement—that the entity satisfies subsection (3).

Prescribed circumstances—residential care

(2) An entity satisfies this subsection if:

(a) during the 3 years immediately preceding the date of the entity's application, a health service standards assessment was conducted; and

(b) the health service standards assessment assessed the entity's ability to comply with the Australian Health Service Safety and Quality Accreditation Scheme requirements for:

(i) the National Safety and Quality Health Service Standards; and

(ii) the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time);

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that are equivalent to the Aged Care Quality Standards that apply to the provider registration category residential care, in relation to each residential care home in which the entity delivers, or proposes to deliver, funded aged care services as part of an integrated service arrangement; and

(c) the assessment:

(i) covers all the residential care homes in which the entity delivers, or proposes to deliver, funded aged care services as part of an integrated service arrangement; and

(ii) found that the entity is able to comply with those Standards and that Module for each residential care home.

Note: The effect of this subsection is that an audit is not required for residential care homes of an entity in an integrated service arrangement for which a health service standards assessment has been conducted and has found that the entity is able to comply with those Standards and that Module.

Prescribed circumstances—personal and care support in the home or community and nursing or transition care

(3) An entity satisfies this subsection if:

(a) during the 3 years immediately preceding the date of the application, a health service standards assessment was conducted; and

(b) the assessment assessed the entity's ability to comply with the Australian Health Service Safety and Quality Accreditation Scheme requirements for:

(i) the National Safety and Quality Health Service Standards; and

(ii) the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time);

that are equivalent to the Aged Care Quality Standards that apply to the provider registration category personal and care support in the home or community, or nursing and transition care (as applicable); and

(c) the assessment covers the provider registration categories personal and care support in the home and community, or nursing or transition care, through which the entity delivers, or proposes to deliver funded aged care services as part of an integrated service arrangement; and

(d) the assessment found that the entity is able to comply with those Standards and that Module for all of the funded aged care services delivered, or proposed to be delivered, through those provider registration categories.

Note: The effect of this subsection is that an audit is not required for funded aged care services provided through the registration categories personal and care support in the home or community, or nursing and transition care, as part of an integrated service arrangement, for which a health service standards assessment has been conducted and has found that entity is able to comply with those Standards and that Module.

Meaning of health service standards assessment

(4) A ***health service standards assessment*** means an assessment conducted:

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(a) in accordance with Australian Health Service Safety and Quality Accreditation Scheme formulated and coordinated by the Australian Commission on Quality and Safety in Health Care; and

(b) by an accrediting agency approved by the Australian Commission on Quality and Safety in Health Care to assess health service organisations against the National Safety and Quality Health Service Standards and the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time).

109-15 Circumstances if audit finds nonconformance

For the purposes of subparagraph 109(2)(d)(ii) of the Act, circumstances for an application by an entity for registration or renewal of registration are that:

(a) an audit referred to in subparagraph 109(2)(d)(i) of the Act has found that the entity has not conformed with one or more of the Aged Care Quality Standards that apply to a provider registration category specified in the application; and

(b) the nonconformance:

(i) has been addressed; or

(ii) can be addressed through an update to a continuous improvement plan that outlines how the nonconformance will be addressed within a specified period; or

(iii) can be addressed by the imposition of a condition under section 143 of the Act.

109-25 Other requirements—delivery of funded aged care services in certain circumstances

(1) For the purposes of paragraph 109(2)(e) of the Act, this section prescribes other requirements for an application by an entity for registration, renewal of registration or variation of registration in a provider registration category other than residential care.

Delivery to certain individuals through the service group home support

(2) If the entity delivers, or intends to deliver, funded aged care services to an individual:

(a) who has an access approval in effect for the classification type ongoing for the service group home support; or

(b) who has the classification level SAH end-of-life pathway in effect for the classification type short-term for the service group home support;

another requirement is that the entity:

(c) also delivers, or intends to deliver, the service type care management to the individual; and

(d) has applied for, and satisfies the requirements for, registration in the provider registration category personal and care support in the home or community.

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Delivery of services in service type restorative care management

(3) If the entity delivers, or intends to deliver, funded aged care services in the service type restorative care management, another requirement is that the entity delivers, or intends to deliver, funded aged care services in the service type allied health and therapy.

Section does not apply to specialist aged care programs

(4) This section does not apply if the entity delivers, or intends to deliver, funded aged services only under a specialist aged care program.

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Division 2—Audit requirements

Subdivision A—Purpose of this Division

110-5 Purpose of this Division

For the purposes of subsection 110(1) of the Act, this Division prescribes requirements relating to conducting an audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category.

Subdivision B—How audits must be conducted—general

110-13 Audit must be conducted

(1) An audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category must be conducted by the Commissioner.

(2) The Commissioner must gather evidence relevant to the scope of the audit being conducted and may be assisted by persons with the technical knowledge or skill required to collect and interpret information relevant to the scope of the audit.

(3) Before the audit is undertaken, the Commissioner must give a notice to the entity that includes the following information:
  (a) a general description of the audit process;
  (b) that an audit is proposed to be conducted in accordance with the audit process;
  (c) the purpose of the audit, and the decision or decisions it will inform;
  (d) the scope of the audit, including the applicable Aged Care Quality Standards;
  (e) the period during which the audit is proposed to occur;
  (f) the applicable fees for the proposed audit;
  (g) advice on how individuals (if any) should be notified about opportunities to contribute to the audit;
  (h) a copy of the audit methodology;
  (i) any other information the Commissioner considers relevant.

Subdivision C—How audits must be conducted—assessments of approved residential care homes

110-26 Assessments—approved residential care homes

(1) This section applies if an audit of a registered provider's ability to conform with the Aged Care Quality Standards relates to an application for renewal of the registered provider's registration in the provider registration category residential care.

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Assessments of approved residential care homes

(2) The Commissioner must, for each of the approved residential care homes included in the registered provider's registration, either:
  (a) conduct a home assessment of the residential care home; or
  (b) if the residential care home is covered by an integrated service arrangement—be satisfied that a health standards assessment has found it complies with the National Safety and Quality Health Service Standards and the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time).

Scope of home assessment

(3) A home assessment of an approved residential care home must assess whether the registered provider delivering funded aged care services in the approved residential care home conforms with the applicable Aged Care Quality Standards.

(4) A home assessment of an approved residential care home must, to the extent possible, consider the following matters as part of the home assessment:
  (a) the experience of individuals to whom funded aged care services are delivered in the approved residential care home;
  (b) documents and records relevant to the home assessment;
  (c) feedback from the following:
    (i) aged care workers of the registered provider;
    (ii) responsible persons of the registered provider;
    (iii) the governing body of the registered provider;
    (iv) third parties with relevant knowledge or experience;
  (d) observations at the approved residential care home;
  (e) care outcomes relating to the approved residential care home.

Attendance at approved residential care homes

(5) A home assessment of an approved residential care home must include the following:
  (a) attendance by the Commissioner at the approved residential care home;
  (b) such other means of assessment as are appropriate.

Notice of home assessment

(6) Before a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must give written notice to the registered provider:
  (a) specifying each approved residential care home included in the registered provider's registration, and stating that a home assessment of each approved residential care home is to be conducted; and

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(b) requiring the registered provider to notify each individual to whom funded aged care services are delivered in each approved residential care home:
(i) that the home assessment is going to be conducted; and
(ii) that the person or persons conducting the home assessment will attend the approved residential care home as part of the home assessment, and the day or days on which this will occur; and
(iii) that the person or persons attending the approved residential care home will seek the individual's consent before engaging with the individual, or entering a part of the approved residential care home that comprises the individual's personal space (for example, the individual's room).

Rule if consent not obtained from individuals

(7) If an individual to whom funded aged care services are delivered at an approved residential care home does not give consent as mentioned in subparagraph (6)(b)(iii), the persons conducting the home assessment will not enter any part of the approved residential care home that comprises the individual's personal space.

Note: This means that if none of the individuals accessing funded aged care services in the approved residential care homes included in a registered provider's registration give consent, the person or persons conducting the home assessments will not enter any parts of the approved residential care homes that comprises the personal space of an individual.

110-28 Preliminary assessment report of home assessment

(1) If a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must prepare a preliminary assessment report setting out the findings of the home assessment.

(2) The preliminary assessment report must assign a grade for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home as outlined in the audit methodology mentioned in paragraph 110-13(3)(h).

(3) The Commissioner must:
(a) give a copy of the preliminary assessment report to the registered provider within 14 days from the attendance at the approved residential care home for the home assessment; and
(b) give the registered provider the opportunity to respond in writing to the report within 14 days from the day the Commissioner gave the preliminary assessment report to the registered provider.

110-30 Final assessment report of home assessment

(1) If a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must prepare a final assessment report setting out the findings of the home assessment.

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(2) The final assessment report must assign a grade for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home as outlined in the audit methodology mentioned in paragraph 110-13(3)(h).

(3) In preparing the final assessment report, the Commissioner must consider any response received from the registered provider as mentioned in paragraph 110-28(3)(b).

(4) The Commissioner must give a copy of the final assessment report to the registered provider within 28 days from:
   (a) if the registered provider responded in writing to the preliminary report within the period mentioned in paragraph 110-28(3)(b)—the day the Commissioner received the response; or
   (b) if the registered provider did not respond in writing to the preliminary report within the period mentioned in paragraph 110-28(3)(b)—the last day of that period.

(5) The registered provider must, within 14 days from receiving the final assessment report, notify the following of the findings of the home assessment (including the grade):
   (a) responsible persons and aged care workers of the registered provider who deliver funded aged care services in the approved residential care home;
   (b) individuals to whom funded aged care services are delivered in the approved residential care home.

Subdivision D—How audits must be conducted—attendance at a service delivery location for home or community setting

110-32 Attendance at a service delivery location—home or community setting

(1) This section applies if:
   (a) an audit of a registered provider's ability to conform with the Aged Care Quality Standards relates to an application for renewal of the registered provider's registration; and
   (b) the scope of the audit includes funded aged care services delivered by the registered provider in a home or community setting.

Notice of attendance at a service delivery location

(2) If the scope of the audit includes attendance at a service delivery location, the Commissioner must give written notice to the registered provider:
   (a) stating that attendance at the service delivery location is to be conducted; and
   (b) stating whether or not one or more persons propose to attend individuals' residences or the premises of a community setting in conducting the attendance at the service delivery location; and
   (c) if the Commissioner proposes to attend the residence of one of more individuals—requiring the registered provider to notify the individuals:

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(i) that attendance at the service delivery location is going to be conducted; and

(ii) that the Commissioner will attend individuals' residences as part of the attendance, and the day or days on which this will occur; and

(iii) that if the Commissioner proposes to attend the residence of a particular individual, the Commissioner will seek consent to enter the residence from the individual and any other person at their residence; and

(d) if the Commissioner proposes to attend the premises of a community setting—stating that the Commissioner will seek consent from the owner or occupier to enter the premises.

(3) If:

(a) an individual to whom funded aged care services are delivered at their residence does not give consent as mentioned in subparagraph (2)(c)(iii), attendance at the service delivery location must not include their residence; and

(b) if no such individuals give consent, attendance at the service delivery location must not be included in the scope of the audit.

(4) If it is not reasonably practicable to obtain consent from the owner or occupier of the premises where funded aged care services are delivered in a community setting, attendance at the service delivery location must not include those premises.

Subdivision E—How audits must be conducted—final audit report

110-38 Final audit reports

(1) If an audit of an entity's ability to conform with the Aged Care Quality Standards is conducted, the Commissioner must prepare a final audit report.

(2) The final audit report must include the following:

(a) the period to which the audit relates;

(b) the scope of the audit;

(c) the audit outcomes;

(d) an assessment of the entity's conformance, or ability to conform, with the Aged Care Quality Standards;

(e) if the final audit report identifies nonconformance with the Aged Care Quality Standards—whether the entity has the ability to conform and the things the entity must do, or has done, to conform;

(f) the outcomes of the following (if any):

(i) each home assessment of an approved residential care home conducted in accordance with section 110-26 for the purposes of the audit;

(ii) each attendance at a service delivery location of residences or other premises conducted in accordance with section 110-32 for the purposes of the audit.

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(3) The Commissioner must:
  (a) give a copy of the final audit report to the entity within 28 days of the completion of the audit; and
  (b) give the entity the opportunity to respond in writing to the final audit report within 14 days from the day the final audit report was given to the entity, or such longer period as the Commissioner agrees with the entity.

(4) An entity that is a registered provider must, within 28 days from receiving the final audit report, notify the following of the outcomes of the audit:
  (a) responsible persons and aged care workers of the registered provider;
  (b) if the audit relates to an approved residential care home—any individuals to whom funded aged care services are delivered in the approved residential care home.

Subdivision F—Type and scope of audits and other matters

110-40 Type and scope of audits for provider registration categories

Provider registration categories

(1) This section prescribes the types and scope of audits that can be conducted for the following provider registration categories:
  (a) personal and care support in the home or community;
  (b) nursing and transition care;
  (c) residential care.

Types of audit

(2) The types of audit that may be conducted in respect of the provider registration categories referred to in subsection (1) are as follows:
  (a) registration of an entity;
  (b) renewal of an entity's registration;
  (c) variation of an entity's registration.

Scope of audit

(3) The scope of an audit is to include (as applicable):
  (a) whether the audit relates to registration of an entity, or the renewal or variation of an entity's registration; and
  (b) the applicable Aged Care Quality Standards in respect of:
    (i) the provider registration category or categories for which the audit is being conducted; and
    (ii) service types to which the audit relates; and
  (c) whether or not the audit will include any home assessments or attendance at any service delivery locations.

Note 1: For the provider registration category residential care, a home assessment of all approved residential care homes must be conducted for renewal of registration (see subsection 110-26(2)), except in certain circumstances specified in

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subsection 109-10(2), where there has been a health service standards assessment in the previous 3 years.

Note 2: For the provider registration categories personal and care support in the home or community, and nursing and transition care, attendance at a service delivery location on renewal of registration may be conducted (see subsection 110-32(2)).

(4) The Commissioner must consider the following when determining the scope of the audit:

(a) matters or risks that are identified as requiring specific examination;

(b) in the case of renewal or variation of an entity's registration:

(i) the time that has elapsed since the most recent audit of the entity was conducted; and

(ii) the scope of any previous audits of the entity; and

(iii) the outcomes of previous audits of the entity; and

(iv) the history of compliance with the Act of the entity;

(c) any guidelines relating to audit matters made for the purposes of subsection 348(2) of the Act.

Note: In considering the scope of an audit, the Commissioner may consider an audit undertaken by another person or body, which the Commissioner recognises as equivalent to meeting the Quality Standards, despite the audit not having been undertaken by the Commissioner.

Subdivision G—Fees payable for an audit

110-45 Audit fee—audit in connection with registration

(1) This section applies to an audit, for one or more of the following provider registration categories, in connection with an entity applying to be registered as a registered provider under subsection 104(1) of the Act in the provider registration category or categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

(2) The fee payable by the entity for an audit for one or more of the provider registration categories is:

(a) unless subsection (3) applies to the entity—$14,870.00; or

(b) if subsection (3) applies to the entity—$0.

(3) This subsection applies to an entity if, at the time of the application:

(a) the entity intends to deliver funded aged care services under the MPSP or the TCP; or

(b) the entity intends that 85% of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 6 or MM7; or

(c) the entity is known as an Aboriginal Community Controlled Organisation.

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110-47 Audit fee—audit in connection with registration renewal

(1) This section applies to an audit, for one or more of the following provider registration categories, in connection with the renewal of the registration of a registered provider under subsection 107(1) of the Act in the provider registration category or categories:
  (a) personal and care support in the home or community;
  (b) nursing and transition care;
  (c) residential care.

(2) The fee payable by the registered provider for an audit for one or more of the provider registration categories is the sum of:
  (a) in any case:
    (i) unless subsection (3) applies to the registered provider—$7,890.00; or
    (ii) if subsection (3) applies to the registered provider—$0; and
  (b) for either or both of the provider registration categories personal and care support in the home or community and nursing and transition care:
    (i) unless subsection (3) applies to the registered provider—the amount that applies to the registered provider under subsection (5); or
    (ii) if subsection (3) applies to the registered provider—$0; and
  (c) for the provider registration category residential care:
    (i) unless subsection (4) applies to the registered provider—the sum of the amounts applicable under subsection (6) or (7) (as the case may be) for each of the approved residential care homes included in the registered provider's registration at the time of the application and for which home assessments must be conducted under subsection 110-26(2); or
    (ii) if subsection (4) applies to the registered provider—$0.

Circumstances in which a nil fee component is applicable

(3) For the purposes of paragraphs (2)(a) and (b), this subsection applies to a registered provider if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:
  (a) the entity is a registered provider delivering funded aged care services only under the MPSP or the TCP; or
  (b) the entity intends that all of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 5, MM6 or MM7; or
  (c) the Commissioner considers, based on the information held by the Commissioner as at that day, that the provider is in the smallest 10% of all registered providers based on the number of individuals to whom funded aged care services are delivered by the provider.

(4) For the purposes of paragraph (2)(c), this subsection applies to a registered provider if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:

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(a) the registered provider is delivering funded aged care services only under the MPSP or the TCP; or

(b) both of the following apply:

(i) an approved residential care home included in the provider's registration is located in an area in the 2023 MM category known as MM 4, MM 5, MM 6 or MM 7;

(ii) the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given was fewer than 25; or

(c) both of the following apply:

(i) an approved residential care home included in the provider's registration has specialised Aboriginal or Torres Strait Islander status or has specialised homeless status;

(ii) the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given was fewer than 25.

Personal and care support in the home or community and nursing and transition care

(5) For the purposes of paragraph (2)(b), the amount that applies to the registered provider is:

(a) if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration, the registered provider delivers funded aged care services only to fewer than 30 individuals in a single State or Territory—$9,800.00; or

(b) if, on that day, the registered provider delivers funded aged care services only to between 30 and 342 individuals in a single State or Territory—$15,550.00; or

(c) if, on that day, the registered provider delivers funded aged care services to:

(i) 343 or more individuals in a single State or Territory; or

(ii) any number of individuals in more than one State or Territory;

$17,950.00.

Residential care—standard amounts

(6) For an approved residential care home to which subsection (8) does not apply, the amount is:

(a) for an approved residential care home with not more than 150 beds—$16,340.00; or

(b) for an approved residential care home with more than 150 beds but not more than 250 beds—$17,510.00; or

(c) for an approved residential care home with more than 250 beds—$18,670.00.

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Residential care—reduced amounts

(7) For an approved residential care home to which subsection (8) applies, the amount is:

(a) for an approved residential care home with not more than 150 beds—$8,170.00; or

(b) for an approved residential care home with more than 150 beds but not more than 250 beds—$8,760.00; or

(c) for an approved residential care home with more than 250 beds—$9,340.00.

(8) This subsection applies to an approved residential care home included in a registered provider's registration if:

(a) on the day the Commissioner invites the provider under section 106 of the Act to renew the registration, funded aged care services are delivered in the approved residential care home:

(i) in any case—to fewer than 25 individuals; or

(ii) if the approved residential care home is located in an area in the 2023 MM category known as MM category 4—to at least 25, and fewer than 30, individuals; or

(iii) if the approved residential care home is located in an area in the 2023 MM category known as MM category 5—to at least 25, and fewer than 39, individuals; or

(iv) if the approved residential care home is located in an area in the 2023 MM category known as MM category 6 or 7—to at least 25 individuals; or

(b) on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:

(i) the approved residential care home has specialised Aboriginal and Torres Strait Islander status or specialised homeless status; and

(ii) funded aged care services are delivered in the approved residential care home to at least 25 individuals.

(9) For the purposes of paragraph (8)(b), the number of individuals is to be worked out by reference to the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given.

110-49 Audit fee—audit in connection with variation of registration

(1) This section applies to an audit, for one or more of the following provider registration categories, in connection with a registered provider applying to vary the provider's registration to register the provider in the provider registration category or categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

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(2) The fee payable by the registered provider for an audit for one or more of the provider registration categories is:

(a) unless subsection (3) applies to the registered provider—$18,530.00; or

(b) if subsection (3) applies to the registered provider—$0.

(3) This subsection applies to an entity if, at the time of the application:

(a) the entity intends to deliver funded aged care services under the MPSP or the TCP; or

(b) the entity intends that 85% of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 6 or MM7; or

(c) the entity is known as an Aboriginal Community Controlled Organisation.

110-51 Audit fee—refunds

(1) This section prescribes circumstances in which any of the following may be refunded to an entity:

(a) an audit fee prescribed in section 110-45 of this instrument in connection with an application under section 104 of the Act;

(b) an audit fee prescribed in section 110-47 of this instrument in connection with an application under section 107 of the Act;

(c) an audit fee prescribed in section 110-49 of this instrument in connection with an application under section 124 of the Act.

(2) The circumstances are that:

(a) the entity makes the application; and

(b) the entity pays, in connection with the application (whether before or after making the application), the audit fee; and

(c) an audit of the entity is not conducted under section 110 of the Act.

Subdivision H—Audit timeframes

110-53 Audit timeframes for provider registration categories

(1) Subsections (2) and (3) of this section prescribe the timeframes within which an audit must be conducted for the following provider registration categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

(2) An audit in relation to an initial application for registration must be conducted during the period beginning on the date of the application and ending when the Commissioner makes a decision on the application.

(3) An audit in relation to a renewal of registration must be conducted during the period beginning on the date of the invitation to renew under subsection 106(1)

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of the Act and ending when the Commissioner makes a decision on the application.

(4) The Commissioner must not make a decision to register an entity, or renew a registration, until the final audit report is completed.

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Division 3—Applications for approval of residential care homes

111-5 Application fee

For the purposes of paragraph 111(2)(b) of the Act, the application fee for an application by an entity for approval of a residential care home in relation to the entity is $3,800.00 for each residential care home specified in the application.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

111-10 Information for residential care homes

For the purposes of subparagraph 111(3)(b)(ii) of the Act, the other information for each residential care home specified in an application is as follows:

(a) the name of the residential care home;
(b) the street address of the residential care home;
(c) the name of the responsible person in charge of the residential care home;
(d) a copy of the certificate of occupancy or equivalent certificate (however described) for the residential care home, or any other document that specifies or relates to the number of beds in the residential care home or the total number of individuals that may occupy or reside in the residential care home;
(e) documentary evidence demonstrating that the building or buildings that comprise the residential care home are permanent and will not present a risk to the delivery of quality and safe residential care, including but not limited to:
  (i) floor plans and bed layout; and
  (ii) fixtures, furnishings and design; and
  (iii) an explanation of the design of the residential care home.

112-5 Period for making decision

For the purposes of subsection 112(2) of the Act, the period within which the Commissioner must make a decision on an application for approval of a residential care home in relation to an entity is:

(a) if the entity has made an application for registration under subsection 104(1) of the Act—the period that applies to that application under section 105-5 of this instrument; or
(b) if the entity is a registered provider—90 days from the day the Commissioner receives the application for approval of the residential care home.

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113-5 Approval of residential care homes

For the purposes of subparagraph 113(b)(ii) of the Act, other requirements of which the Commissioner must be satisfied before approving a residential care home in relation to an entity are as follows:

(a) either:
  (i) the entity owns the premises at which the residential care home is located; or
  (ii) if the entity does not own the premises at which the residential care home is located—the owner of the premises agrees to the entity using the premises as a residential care home;

(b) the building or buildings that comprise the residential care home are permanent; and

(c) the building or buildings that comprise the residential care home and its total number of beds will not present a risk to the delivery of quality and safe residential care.

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Division 4—Notice of decisions and other provisions

114-5 Other matters for notices of decisions to register or renew

For the purposes of paragraph 114(3)(f) of the Act, other matters that must be included in a notice of a decision given to an entity are the details of each residential care home (if any) that is approved in relation to the entity.

117-5 Deemed registration—classes of entity

For the purposes of subsection 117(1) of the Act, the following classes of entity are prescribed:

(a) hospitals (whether operated by government entities or non-government entities);

(b) entities that are not registered providers, but that:

(i) deliver services similar to funded aged care services that are delivered in an approved residential care home; or

(ii) deliver services similar to funded aged care services that are delivered in a home or community setting or in a similar sector;

(c) registered providers that are not registered in all of the provider registration categories.

117-10 Deemed registration—other matters for determinations of deemed registration

For the purposes of paragraph 117(2)(h) of the Act, other matters that must be specified in a determination that an entity is taken to be a registered provider are as follows:

(a) the ABN of the entity;

(b) each responsible person of the entity;

(c) the business location of the entity.

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Part 3—Variations, suspensions and revocations of registration

Division 1—Variations, suspensions and revocations

124-5 Application fee—variation to add provider registration categories

For the purposes of paragraph 124(2)(b) of the Act, the application fee for an application by a registered provider to vary the provider's registration to register the provider in a new provider registration category is the sum of the amounts specified in column 2 of the following table for each new provider registration category that the provider is applying to be registered in.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

Item	Column 1 Provider registration category	Column 2 Amount ($)
1	Home and community services	1,270.00
2	Assistive technology and home modifications	1,270.00
3	Advisory and support services	1,270.00
4	Personal and care support in the home or community	3,800.00
5	Nursing and transition care	3,800.00
6	Residential care	5,070.00

124-10 Application fee—variation to remove provider registration categories

(1) For the purposes of paragraph 124(2)(b) of the Act, this section prescribes the application fee for an application by a registered provider to vary the provider's registration by removing the provider from being registered in a provider registration category.

(2) For an application to remove the provider from being registered in one or more of the following provider registration categories, the application fee is $545.00:
  (a) home and community services;
  (b) assistive technology and home modifications;
  (c) advisory and support services.
  (d) any of the following provider registration categories under which the registered provider is not delivering funded aged care services at the time of the application:
    (i) personal and care support in the home or community;
    (ii) nursing and transition care;
    (iii) residential care.

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(3) For an application to remove the provider from being registered in one or more of the following provider registration categories under which the registered provider is delivering funded aged care services at the time of the application, the application fee is $4800.00 for each such category:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act

133-5 Classes of persons who must not be appointed as eligible advisers

For the purposes of paragraph 133(4)(a) of the Act, classes of persons who must not be appointed by a registered provider as an eligible adviser are as follows:

(a) persons who are not independent of the registered provider;

(b) persons who are unsuitable having regard to the matters specified in subsection 13(1) of the Act;

(c) persons who have, or may be perceived to have, a conflict of interest between their duties as an eligible adviser and any other interests or duties.

133-10 Matters to be taken into account in specifying period within which eligible adviser must be appointed

(1) For the purposes of paragraph 133(4)(b) of the Act, this section prescribes matters that the Commissioner must take into account in specifying a period in a notice given under subsection 133(2) of the Act for the purposes of paragraph 133(3)(a) of the Act (requiring a registered provider to appoint an eligible adviser).

(2) The matters are as follows:

(a) the location where funded aged care services are delivered by the registered provider;

(b) the nature of any contravention, or proposed contravention, of the Act by the registered provider that the Commissioner is satisfied has occurred, is occurring or may occur;

(c) whether, as a result of any such contravention or proposed contravention of the Act by the registered provider, there is an immediate and severe risk to the safety, health and well-being of individuals to whom the registered provider is delivering funded aged care services;

(d) the availability of persons who have appropriate qualifications, skills or experience to assist the registered provider to comply with the conditions and obligations that apply to the registered provider under Part 4 of Chapter 3 of the Act in relation to the matters specified in subparagraphs 133(3)(a)(i) and (ii) of the Act (which relate to funded aged care services and governance and business operations);

(e) any other relevant matters.

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Division 2—Variations, suspensions and revocations of approvals of residential care homes

136-5 Variation of approval on Commissioner's own initiative—bed availability

For the purposes of paragraph 136(2)(a) of the Act, the period for which the Commissioner must be satisfied that the number of beds available in a residential care home is likely to be reduced is a period of at least 2 years.

137-10 Variation of approval on application by registered provider—bed availability

For the purposes of paragraph 137(3)(a) of the Act, the period for which the Commissioner must be satisfied that the number of beds available in a residential care home is likely to be reduced is a period of at least 2 years.

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Division 3—Provider Register

141-10 Other matters that must be included in the Provider Register—registered providers

For the purposes of paragraph 141(3)(p) of the Act, other matters that the Provider Register must include in relation to the registration of a registered provider are as follows:

(a) the name of each parent or holding company forming part of the registered provider's business structure;

(b) the ACN of the registered provider's business entity (if relevant);

(c) whether the registered provider is known as an Aboriginal Community Controlled Organisation or Aboriginal Community Controlled Health Organisation;

(d) the name of each associated provider that delivers funded aged care services on behalf of the registered provider in any of the following provider registration categories:

(i) personal and care support in the home or community;

(ii) nursing and transition care;

(iii) residential care;

(e) if the registered provider's registration has been suspended:

(i) the date of suspension; and

(ii) the period of suspension, including the expiry date (if known); and

(iii) whether the suspension was at the request of the Commissioner or at the request of the registered provider; and

(iv) any specified condition to which the suspension relates;

(f) if the registered provider delivers funded aged care services in one or more approved residential care homes:

(i) the name of the responsible person of the registered provider who is in charge of each approved residential care home; and

(ii) the total number of beds at each approved residential care home, updated in accordance with any variations to the registered provider's registration and any notification under subsection 167(1) of the Act;

(g) if a compliance notice has been given to the registered provider under section 481 or 482 of the Act:

(i) the date of the notice; and

(ii) whether the notice was given by the Commissioner or the System Governor; and

(iii) the details of the non-compliance or possible non-compliance with the Act; and

(iv) whether the notice was given under subparagraph 481(a)(i) or 482(a)(i) of the Act (non-compliance), or subparagraph 481(a)(ii) or 482(a)(ii) of the Act (possible non-compliance); and

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(v) the action the provider must take or refrain from taking in response to the notice; and

(vi) whether the notice was varied or revoked;

(h) if a banning order against the registered provider is in force under section 497 of the Act:

(i) the date of the banning order; and

(ii) a linking electronic reference to the detail of the banning order in the banning orders register.

141-15 Other matters that may be included in the Provider Register—former registered providers

For the purposes of paragraph 141(4)(e) of the Act, other matters that the Provider Register may include in relation to an entity that was a registered provider are as follows:

(a) if the entity's registration lapsed—the date the registration lapsed;

(b) if the entity's registration was revoked:

(i) whether the registration was revoked at the request of the provider, or on the Commissioner's initiative; and

(ii) the date of the revocation.

141-20 Other matters that must be included in the Provider Register—responsible persons and aged care workers against whom banning orders are in force

For the purposes of paragraph 141(5)(d) of the Act, other matters that must be included in the Provider Register in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order is in force under section 498 are as follows:

(a) the date of the banning order;

(b) a linking electronic reference to the detail of the banning order in the banning orders register.

141-22 Other matters that may be included in the Provider Register—responsible persons and aged care workers against whom banning orders were in force

For the purposes of paragraph 141(6)(d) of the Act, other matters that may be included in the Provider Register in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order was in force under section 498 are as follows:

(a) the date of the banning order;

(b) a linking electronic reference to the detail of the banning order in the banning orders register.

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141-25 Corrections of the Provider Register

(1) For the purposes of paragraph 141(8)(a) of the Act:

(a) a person may request orally or in writing that the Commissioner make a correction to information relating to that person that is included in the Provider Register; and

(b) if the Commissioner considers information included in the Provider Register is inaccurate, incomplete, out-of-date, irrelevant or misleading, the Commissioner must correct the information (whether or not a person has made a request under paragraph (a) of this subsection).

(2) Despite subsection (1), the Commissioner must not make a correction to the Provider Register under this section if there is another process under the Act through which information included on the Provider Register can be updated or changed.

Note: For example, a change that can be made through a variation or change in circumstances notification is not a correction of the Provider Register.

141-30 Publication of the Provider Register

(1) For the purposes of paragraph 141(8)(b) of the Act, this section makes provision for and in relation to the publication of the Provider Register.

(2) In deciding whether to publish the Provider Register in whole or in part, or to publish specified information entered on the Provider Register on the Commission's website the Commissioner must have regard to:

(a) whether the Commissioner considers that publication would be contrary to the public interest; and

(b) whether the Commissioner considers that publication would be contrary to the interests of an individual accessing funded aged care services.

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Chapter 4—Conditions on provider registration

Part 1—Introduction

142-1 Simplified outline of this Chapter

This Chapter provides for matters relating to conditions on provider registration under Part 4 of Chapter 3 of the Act.

Part 3 of this Chapter relates to conditions relating to Rights, Principles and the Aged Care Code of Conduct.

Part 4 of this Chapter relates to the delivery of funded aged care services, and deals with conditions relating to:

(a) the Aged Care Quality Standards; and
(b) continuous improvement; and
(c) the delivery of funded aged care services; and
(d) requirements for starting and ceasing the provision of funded aged care services and continuity of those services.

Part 5 of this Chapter relates to conditions relating to financial matters.

Part 6 of this Chapter relates to aged care workers, and deals with conditions relating to:

(a) workforce and aged care worker requirements; and
(b) vaccinations.

Part 7 of this Chapter relates to information and access, and deals with conditions relating to:

(a) personal information and recordkeeping; and
(b) provision of information to individuals; and
(c) access by supporters.

Part 8 of this Chapter relates to governance, and deals with conditions relating to membership of governing bodies and advisory body requirements.

Part 9 of this Chapter relates to restrictive practices in approved residential care homes, and deals with conditions relating to:

(a) requirements relating to the use of restrictive practices; and
(b) requirements relating to behaviour support; and
(c) immunity from civil or criminal liability in relation to the use of restrictive practices in certain circumstances.

Part 10 of this Chapter relates to the management of incidents and complaints, and deals with conditions relating to:

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(a) implementing an incident management system and managing and preventing incidents; and
(b) implementing a complaints and feedback management system and managing complaints and feedback; and
(c) implementing a whistleblower system and maintaining a whistleblower policy.

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Part 3—Rights and principles

144-1 Kinds of providers to which the conditions apply

For the purposes of subsections 144(1) and (2) of the Act, every kind of registered provider is prescribed.

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Part 4—Delivery of funded aged care services

Division 1—Aged Care Quality Standards

146-5 Kinds of providers to which the condition applies

For the purposes of section 146 of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

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Division 2—Continuous improvement

147-5 Kinds of providers that must demonstrate capability and commitment

For the purposes of subsection 147(1) of the Act, every kind of registered provider is prescribed.

147-10 Kinds of providers that must have a continuous improvement plan

For the purposes of subsection 147(2) of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

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Division 3—Delivery of funded aged care services

Subdivision A—Kinds of provider to which the condition applies

148-5 Kinds of providers to which the condition applies

For the purposes of section 148 of the Act, every kind of registered provider is prescribed.

Subdivision B—Requirements for delivering funded aged care services

148-10 Purpose of this Subdivision

For the purposes of paragraph 148(a) of the Act, this Subdivision prescribes requirements for delivery of funded aged care services.

148-15 All registered providers—preventing damage to an individual's property

A registered provider must take reasonable steps to prevent damage being caused to an individual's property by the provider, or an aged care worker of the provider, in delivering funded aged care services to the individual.

148-20 Providers delivering services under provider registration category home and community services or personal and care support in the home and community—requirements for meals, snacks and drinks

(1) This section applies to a registered provider that:

(a) is registered in any of the following provider registration categories:

(i) home and community services;

(ii) personal and care support in the home and community; and

(b) delivers any of the following funded aged care services to an individual on a day through the service group home support under one of the registration categories mentioned in paragraph (a):

(i) the service meal delivery in the service type meals;

(ii) the service community and centre-based respite in the service type home or community general respite;

(iii) a service in the service type community cottage respite.

(2) The provider must ensure any meals, snacks and drinks delivered to an individual through the funded aged care services mentioned in paragraph (1)(b) are nutritious and appetising, having regard to the individual's needs and preferences.

Note: Providers have other statutory obligations in relation to food safety under the Australia New Zealand Food Standards Code.

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(3) The provider must, at least annually, have a dietitian assess the meals, snacks and drinks delivered by the provider through the funded aged care services mentioned in paragraph(1)(b) to ensure that any meals, snacks and drinks:
  (a) are appetising; and
  (b) are appropriate for the nutrition needs of individuals accessing funded aged care services, including individuals with specialised dietary needs; and
  (c) reflect evidence-based guidelines and practice.

Note Examples of specialised dietary needs include medical needs, or religious or cultural preferences.

(4) The provider must implement a quality assurance framework to continuously improve the meals, snacks and drinks delivered to individuals through the funded aged care services mentioned in paragraph (1)(b)by taking into account:
  (a) the satisfaction of individuals with the meals, snacks and drinks they are provided; and
  (b) the assessments undertaken and any recommendations made by a dietitian based on those assessments in accordance with subsection (3).

148-25 Providers delivering services under provider registration category home and community services, assistive technology and home modifications or advisory and support services—requirements for service delivery equipment

(1) This section applies to a registered provider that:
  (a) is registered in any of the following provider registration categories:
    (i) home and community services;
    (ii) assistive technology and home modifications;
    (iii) advisory and support services; and
  (b) is delivering funded aged care services to an individual on a day under any of the registration categories listed in paragraph (a); and
  (c) either:
    (i) uses equipment in delivering the service; or
    (ii) delivery of the service involves the sourcing, supply and provision of equipment to the individual.

(2) The provider must ensure that the equipment is safe and meets the needs of the individual at the time the service is delivered to the individual.

148-30 Providers delivering services under provider registration category home and community services, assistive technology and home modifications or advisory and support services—requirements for personal protective equipment, infection prevention and control

(1) This section applies to a registered provider that is registered in any of the following provider registration categories:
  (a) home and community services;
  (b) assistive technology and home modifications;

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(c) advisory and support services.

(2) When delivering funded aged care services to an individual on a day under any of the registration categories listed in subsection (1), the provider must ensure that:

(a) personal protective equipment is available to the individual, the aged care workers of the provider delivering the services and any other persons who need it; and

(b) the persons mentioned in paragraph (a) are supported to correctly use the equipment.

(3) The provider must:

(a) have an appropriate infection prevention and control system for delivery of funded aged care services; and

(b) ensure that aged care workers of the provider use hygienic practices and take appropriate infection prevention and control precautions when delivering funded aged care services.

148-33 Providers delivering services under provider registration category residential care—services that must be delivered

(1) This section applies to a registered provider that:

(a) is registered in the provider registration category residential care; and

(b) is delivering funded aged care services to an individual through the service group residential care.

(2) The services delivered to the individual by the provider must include the services listed and described in Division 8 (residential care service types) of Part 3 of Chapter 1.

148-35 Providers delivering services under the TCP—services that must be delivered

(1) This section applies to a registered provider that is delivering funded aged care services to an individual under the TCP.

(2) The services delivered to the individual by the provider must include the service transition care management in the service type assistance with transition care.

148-40 Providers delivering short-term funded aged care services through the service group home support—services that must be delivered

(1) This section applies to a registered provider that is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for the classification level SAH restorative care pathway for the classification type short-term through the service group home support.

(2) The services delivered to the individual by the provider must comprise a multidisciplinary package of early intervention care that is designed to optimise

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the functioning and independence of the individual, and reverse or slow the individual's functional decline, to help delay the individual's need to access ongoing funded aged care services.

(3) Without limiting subsection (2), the services delivered to the individual must include the following:
  (a) the service home support restorative care management in the service type restorative care management;
  (b) other services in accordance with the individual's access approval which may include:
    (i) a variety of services in the service type allied health and therapy; and
    (ii) services in the service type nursing care.

(4) The provider must ensure an aged care worker of the provider who holds relevant health qualifications (a ***restorative care partner***) delivers the service mentioned in paragraph (3)(a) to the individual.

148-45 Providers delivering certain funded aged care services through the service group home support—requirements for the service home support care management

(1) This section applies to a registered provider that:
  (a) is delivering ongoing funded aged care services to an individual (other than under a specialist aged care program) through the service group home support; or
  (b) is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for the classification level SAH end-of-life pathway through the service group home support.

(2) The provider must deliver the service home support care management in the service type care management to the individual at least once in each month where the provider also delivers other services to the individual.

Subdivision C—Requirements for service agreements

148-60 Purpose of this Subdivision

For the purposes of paragraph 148(c) of the Act, this Subdivision prescribes requirements for service agreements.

148-65 Requirements for service agreements—general

Entry into service agreement

(1) A registered provider must enter into a service agreement with an individual:
  (a) unless paragraph (b) applies—on or before the individual's start day; or
  (b) if the individual is accessing funded aged care services in any of the circumstances specified in subsection 71(4) of the Act, or the registered provider is delivering funded aged care services to the individual under the

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MPSP or the NATSIFACP—within 28 days after the day the registered provider commences delivery of the services to the individual.

(2) A registered provider must ensure the following:
  (a) the individual is involved in the development and negotiation of the service agreement;
  (b) if requested by the individual, a supporter, family member, carer or advocate of the individual, or any other person significant to the individual, is present during the development and negotiation of the service agreement;
  (c) the service agreement is expressed in plain language and is readily understandable by the individual;
  (d) the individual is helped to understand the terms of the service agreement.

Cooling-off period

(3) A service agreement must provide that, if the individual notifies (whether verbally or in writing) the registered provider that the individual wishes to withdraw from the service agreement:
  (a) within 14 days after the date of entry into the service agreement; and
  (b) before the individual's start day;

then
  (c) the service agreement has no effect; and
  (d) the registered provider must refund any amount paid by the individual under the service agreement.

(4) A service agreement for an individual to whom the registered provider is to deliver funded aged care services under the classification type ongoing through the service group residential care must provide that, if the individual notifies (whether verbally or in writing) the registered provider that the individual wishes to withdraw from the service agreement within 28 days after the date of entry into the service agreement, the registered provider must refund any amount paid by the individual under the service agreement in relation to services that had not been delivered by the termination date.

Variation of service agreement

(5) A service agreement must provide that the agreement may be varied:
  (a) by the registered provider if:
    (i) the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999*; and
    (ii) the provider has given reasonable notice in writing about the variation to the individual; and
    (iii) the variation is not inconsistent with the *A New Tax System (Goods and Services Tax) Act 1999* or the Act; or
  (b) by mutual consent of the individual and the registered provider if:
    (i) there has been adequate consultation about the variation between the individual and the provider; and

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(ii) the provider has obtained consent from the individual to make the variation; and

(iii) the variation is not inconsistent with the *A New Tax System (Goods and Services Tax) Act 1999* or the Act.

Review of service agreement

(6) A service agreement between a registered provider and an individual accessing ongoing funded aged care services must provide that the provider will review the service agreement:

(a) at least once every 12 months; and

(b) upon request from the individual.

(7) Without limiting the nature of the review, the provider must:

(a) give the individual an opportunity to participate in the review; and

(b) consider whether any updates need to be made to the service agreement; and

(c) if necessary, vary the service agreement in accordance with subsection (5).

148-70 Requirements for service agreements—contents

All registered providers

(1) A service agreement must not contain any provision that would have the effect of the individual being treated less favourably in relation to any matter than the individual would otherwise be treated, under any law of the Commonwealth, in relation to that matter.

(2) A service agreement entered into between a registered provider and an individual must contain the following:

(a) a statement setting out the parties to the agreement, including the following:

(i) the name of the individual;

(ii) the contact details of the individual;

(iii) the name of the provider;

(iv) the contact details of the provider;

(b) the contact details of the supporters of the individual (if any);

(c) a copy of the individual's access approval;

(d) the approved residential care home (if any) in or from which the provider will deliver funded aged care services to the individual;

(e) the date when the service agreement commences;

(f) the start day for the individual;

(g) if the individual is accessing short-term or hospital transition funded aged care services:

(i) when the provider will cease delivering short-term or hospital transition funded aged care services to the individual; and

(ii) the date when the service agreement ends;

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(h) if the individual is accessing ongoing funded aged care services, the date the service agreement is to be reviewed in accordance with subsection 148-65(6);

(i) how the individual will be involved in decisions relating to how, when and by whom funded aged care services are delivered to the individual.

(3) Despite subsection (2), a service agreement entered into between a registered provider and an individual does not have to contain the matters specified in paragraph (2)(i) if the provider is delivering funded aged care services to the individual under the TCP.

Certain registered providers delivering services through the service groups home support, assistive technology or home modifications (other than under a specialist aged care program)

(4) A service agreement entered into between a registered provider (to whom subsection (5) applies) and an individual must also contain the following:

(a) the funded aged care services the provider will deliver to the individual, including the following:

(i) the name of each service as provided in the service list under section 8-5 of this instrument;

(ii) if the provider intends for an associated provider to deliver any services to the individual, which services will be delivered by the associated provider;

(b) the prices the provider will charge the individual for each of the funded aged care services the provider will deliver to the individual;

(c) if the individual is to be charged a price for delivery of a funded aged care service that is higher than the price published on the provider's website or the department's website—the reason for the higher price;

(d) a statement that the prices mentioned in paragraphs (b) and (c) may be subject to regular price increases to account for indexation and the details of such increases, including:

(i) the date the prices will increase; and

(ii) the method for working out the increase; and

(iii) the reason for the matters specified at subparagraphs (i) and (ii);

(da) a statement that the individual agrees to pay any applicable fees or contributions referred to in Division 1 of Part 3 of Chapter 4 of the Act;

(e) a statement that the provider may only cease delivery of funded aged care services to the individual in the circumstances specified in subsection 149-35(2);

(f) if either of the circumstances in paragraphs 149-35(2)(e) or (f) arise, any other requirements for notifying the provider;

(g) how and when the service agreement may be terminated;

(h) a statement that the registered provider will not charge an individual contribution to the individual if the individual has made an application for a fee reduction supplement determination under subsection 197-20(1) and the System Governor has not decided on that application;

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(i) a statement that where, in relation to an application mentioned in paragraph (h), the System Governor makes a determination that the fee reduction supplement should not apply to the individual, the registered provider can collect the unpaid individual contributions for the period beginning on the day the application was made.

(5) This subsection applies to a registered provider that is delivering funded aged care services to an individual through the service groups home support, assistive technology or home modifications (other than under a specialist aged care program).

Registered providers delivering services under the CHSP, MPSP or NATSIFACP

(6) A service agreement entered into between a registered provider (to whom subsection (9)) applies and an individual must also contain:
(a) the matters mentioned in paragraphs (4)(a), (e), (f) and (g); and
(b) the fees and contribution that the registered provider will charge the individual for each of the funded aged care services the provider will deliver to the individual.

(7) A service agreement entered into between a registered provider (to whom subsection (10) applies) and an individual must also contain the matters mentioned in paragraphs (4)(a), (e), (f) and (g).

(8) A service agreement entered into between a registered provider (to whom subsection (9) or (10) of this section applies) and an individual must also contain a statement that the individual agrees to pay any applicable fees referred to in Division 3 of Part 3 of Chapter 4 of the Act.

(9) This subsection applies to a registered provider that is delivering funded aged care services to an individual under the CHSP.

(10) This subsection applies to a registered provider that is delivering funded aged care services to an individual under the MPSP or NATSIFACP.

Registered providers delivering services through the service group residential care

(11) A service agreement entered into between a registered provider (to whom subsection (13) or (14) of this section applies) and an individual must also contain which fees or contributions (if any), referred to in Division 2, 2A or 3 of Part 3 of Chapter 4 of the Act, the provider will charge the individual.

(12) A service agreement entered into between a registered provider (to whom subsection (13) of this section applies) and an individual must also contain the following:
(a) that the provider may only ask the individual to leave the approved residential care home in the circumstances specified in subsection 149-60(1);

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(b) the assistance the provider will provide to the individual to obtain suitable alternative accommodation if the individual is asked to leave the approved residential care home;
(c) how and when the service agreement may be terminated;
(d) for any fees or contributions that the provider will charge the individual (as set out in the agreement under subsection (11))—the policies and practices the provider will follow in setting and updating the amounts of those fees and contributions.

(13) This subsection applies to a registered provider that is delivering ongoing funded aged care services to an individual through the service group residential care.

(14) This subsection applies to a registered provider that:
(a) is delivering short-term funded aged care services to an individual through the service group residential care; or
(b) is delivering funded aged care services to an individual through the service group residential care under the TCP.

Subdivision D—Requirements for care and services plans

148-75 Purpose of this Subdivision

For the purposes of paragraph 148(e) of the Act, this Subdivision prescribes requirements for care and services plans.

148-80 Requirements for care and services plans—general

When a care and services plan must be developed

(1) A registered provider must develop a care and services plan for an individual:
(a) unless paragraph (b) applies—on or before the individual's start day; or
(b) if the individual is accessing funded aged care services in any of the circumstances specified in subsection 71(4) of the Act, or the registered provider is delivering funded aged care services to the individual under the MPSP or the NATSIFACP—within 28 days after the day the registered provider commences delivery of the services to the individual.

How a care and services plan is developed

(2) A registered provider to whom subsection (5) applies must actively engage with:
(a) the individual; and
(b) supporters of the individual (if any); and
(c) any other persons involved in the care of the individual;
in developing and reviewing the individual's care and services plan through ongoing communication.

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Care and services plan to be in line with the individual's needs

(3) A registered provider to whom subsection (5) applies must ensure an individual's care and services plan:
  (a) describes the current care needs, goals and preferences of the individual; and
  (b) includes strategies for risk management and preventative care; and
  (c) where an individual is accessing ongoing funded aged care services, is reviewed at least once every 12 months.

Care and services plan to be accessible to individual

(4) A registered provider must provide a copy of an individual's care and services plan to the individual at the following times:
  (a) once the plan is developed;
  (b) any time the plan is updated;
  (c) upon request from the individual.

(5) This subsection applies to a registered provider that is delivering funded aged care services to an individual under any of the following registration categories:
  (a) home and community services;
  (b) assistive technology and home modifications;
  (c) advisory and support services.

Note 1: See subsections 15-20(1) to (3) for the Aged Care Quality Standards relating to care and services plans which apply to providers registered in provider registration categories personal and care support in the home and community, nursing and transition care, and residential care.

Note 2: For funded aged care services relating to care and services plans, see item 1 of the table in section 8-20 and items 1 and 4 in the table in section 8-155.

148-81 Requirements for care and services plans—restorative care partner to be responsible for care and services plans in certain circumstances

(1) This section applies to a registered provider that is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for the classification level SAH restorative care pathway through the service group home support.

(2) The provider must ensure the restorative care partner who will deliver the service mentioned in paragraph 148-40(3)(a) to the individual develops a care and services plan for the individual in accordance with any applicable requirements set out in this Subdivision.

(3) The provider must consider exit planning as part of the care and services plan and must ensure the plan complements any ongoing services the individual is also accessing.

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148-85 Requirements for care and services plans—contents for all individuals (other than individuals accessing services through the service group residential care)

Application of this section

(1) This section applies to a registered provider that is delivering funded aged care services to an individual under any of the following registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care.

Contents

(2) A care and services plan for an individual must include the following:

(a) the funded aged care services that the provider will deliver to the individual, including:

(i) the frequency of the services; and

(ii) the volume or duration of the services;

(b) when the care and services plan will be reviewed;

(c) if the individual is accessing ongoing funded aged care services, the date the individual's service agreement is to be reviewed in accordance with subsection 148-65(6).

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Division 4—Starting and ceasing the provision of funded aged care services and continuity of those services

Subdivision A—Preliminary

149-5 Requirements relating to starting and ceasing the provision of funded aged care services and continuity of those services

For the purposes of section 149 of the Act, this Division prescribes requirements for the following:

(a) providing a start notification to the System Governor and the Commissioner;
(b) ceasing the delivery of funded aged care services to an individual;
(c) providing a cessation notification to the System Governor and the Commissioner;
(d) ceasing to deliver any funded aged care services;
(e) if the provider delivers funded aged care services in an approved residential care home—security of tenure for individuals accessing those services;
(f) continuity of funded aged care services for individuals.

Note: For requirements relating to a service agreement between an individual and a registered provider, see section 148-70 of this instrument.

Subdivision B—Start notifications

149-10 Requirements for start notifications—general

(1) A registered provider must prepare a start notification for delivering funded aged care services to an individual in accordance with this section.

(2) Despite subsection (1), a registered provider does not have to prepare a start notification for an individual where the individual will access funded aged care services under a specialist aged care program other than the TCP.

(3) A start notification must be in an approved form.

Start notification for an individual accessing funded aged care services through the service groups home support, assistive technology or home modifications

(4) A start notification for an individual accessing funded aged care services through the service groups home support, assistive technology or home modifications must specify the following:

(a) the name of the individual;
(b) the start day for the individual;
(c) the service delivery branch through which funded aged care services will be delivered to the individual.

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Start notification for an individual accessing funded aged care services through the classification type ongoing for the service group residential care

(5) A start notification for an individual accessing funded aged care services through the classification type ongoing for the service group residential care must specify the following:

(a) the name of the individual;

(b) the start day for the individual;

(c) the approved residential care home at which funded aged care services will be delivered to the individual.

Start notification for an individual accessing funded aged care services through the classification type short-term or hospital transition for the service group residential care

(6) A start notification for an individual accessing funded aged care services through the classification type short-term or hospital transition for the service group residential care must specify the following:

(a) the name of the individual;

(b) the start day for the individual;

(c) the approved residential care home at which funded aged care services will be delivered to the individual.

149-15 Requirements for start notifications—provision to System Governor and Commissioner

A registered provider must give a start notification for an individual to the System Governor and the Commissioner:

(a) for an individual mentioned in subsections 149-10(4) and (5)—within 28 days after the individual's start day; or

(b) for an individual mentioned in subsection 149-10(6)—within 14 days after the individual's start day.

Subdivision C—Cessation notifications

149-20 Requirements for cessation notifications—general

(1) A registered provider must prepare a cessation notification for ceasing the delivery of funded aged care services to an individual in accordance with this section.

(2) Despite subsection (1), a registered provider does not have to prepare a cessation notification for an individual where the individual is accessing funded aged care services under a specialist aged care program other than the TCP.

(3) A cessation notification must be in an approved form.

(4) A cessation notification for an individual must specify the following:

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(a) the name of the individual;
(b) the day the provider ceased to deliver funded aged care services to the individual;
(c) the reason for ceasing the delivery of funded aged care services to the individual.

149-25 Requirements for cessation notifications—provision to System Governor and Commissioner

A registered provider must give a cessation notification for an individual to the System Governor and the Commissioner:

(a) for an individual accessing funded aged care services through the classification type short-term for the service group residential care—within 14 days after the cessation of delivery of services through the approved residential care home of the provider; or
(b) for all other individuals—within 28 days after the cessation of delivery of services through the approved residential care home or service delivery branch of the provider.

Subdivision D—Ceasing delivery of funded aged care services (other than services delivered in an approved residential care home)

149-30 Application of this Subdivision

This Subdivision applies to a registered provider who is delivering funded aged care services to an individual for a classification type for the service groups home support, assistive technology or home modifications.

149-35 Requirements for ceasing delivery of funded aged care services - general

(1) A registered provider must not cease to deliver funded aged care services to an individual unless:
(a) one of the circumstances in subsection (2) applies; and
(b) the provider has given notice to the individual in accordance with section 149-40.

Circumstances where registered provider may cease delivery of funded aged care services to an individual

(2) The circumstances in which a registered provider may cease to deliver funded aged care services to an individual are:
(a) the individual cannot be cared for in the home or community with the resources available to the provider; or
(b) the individual's condition changes to the extent that:
(i) the individual no longer needs the funded aged care services delivered by the provider; or

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(ii) the individual's needs, as assessed by an approved needs assessor, can be more appropriately met by other types of funded aged care services; or

(c) the individual has:

(i) intentionally caused serious injury to an aged care worker of the provider; or

(ii) intentionally infringed the right of an aged care worker of the provider to work in a safe environment; or

(d) the individual:

(i) has not paid to the provider, for a reason within the individual's control, any applicable fee or contribution referred to in Division 1 of Part 3 of Chapter 4 of the Act as agreed in the service agreement between the individual and the provider; and

(ii) has not negotiated an alternative arrangement with the provider for payment of the fee or contribution; and

(iii) if the individual is accessing the services other than under a specialist aged care program—has no application for the fee reduction supplement in place; or

(e) the individual notifies the provider, in writing, that the individual wishes to move to a location where funded aged care services are not delivered by the provider; or

(f) the individual notifies the provider, in writing, that the individual no longer wishes to receive funded aged care services from the provider.

Note: The circumstances in which a registered provider may cease delivering funded aged care services to an individual must be specified in a service agreement between the individual and the registered provider made under section 148-70.

149-40 Requirements for ceasing delivery of funded aged care services—notice to individual about cessation of services

Notice to be given if registered provider intends to cease delivery of funded aged care services

(1) If a registered provider intends to cease delivery of funded aged care services to an individual, the provider must give the individual a written notice which includes the following:

(a) the decision;

(b) the reasons for the decision;

(c) the date the provider intends to cease delivery of funded aged care services to the individual;

(d) the individual's rights in relation to cessation of the delivery of funded aged care services, including the right to access:

(i) the provider's complaints and feedback management system; and

(ii) any other mechanisms available to address complaints; and

(iii) independent aged care advocates.

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Note: For complaints and feedback management systems, see section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument.

(2) The registered provider must give the notice to the individual at least 14 days before the date the provider ceases delivery of funded aged care services to the individual.

Notice to be given if registered provider no longer intends to cease delivery of funded aged care services

(3) If:

(a) the decision to cease the delivery of funded aged care services was based on the individual's behaviour; and

(b) the registered provider has given the individual a notice under subsection (1); and

(c) after giving the notice, the provider has agreed with the individual that, because of a change in the behaviour, the delivery of funded aged care services will not cease;

the provider must give the individual a written notice stating that the provider no longer intends to cease delivery of funded aged care services to the individual.

149-45 Requirements for ceasing delivery of funded aged care services—notice to individual about unspent portions

(1) This section applies if:

(a) a registered provider holds an unspent Commonwealth portion or unspent care recipient portion for an individual to whom the provider is delivering funded aged care services; and

(b) section 226C or 226D of the Act apply.

(2) The registered provider must give a notice relating to the individual's unspent Commonwealth portion or unspent care recipient portion in accordance with this section.

Note: See paragraphs 226C(2)(a) and 226D(2)(a) of the Act for requirements to give written notice to the System Governor about the unspent Commonwealth portion.

(3) The notice must:

(a) specify the following:

(i) the day the provider ceased to deliver funded aged care services to the individual;

(ii) the available balance (including a nil amount) of the unspent Commonwealth portion for the individual;

(iii) the balance (including a nil amount) of the unspent care recipient portion for the individual;

(iv) if the amount of the unspent care recipient portion for the individual was reduced by the individual contributions charged to the individual by the provider under paragraph 273A-20(a) of this instrument—the amount of those individual contributions; and

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(b) explain:
(i) the effect of paragraphs 226C(2)(b) and 226D(2)(b) of the Act; and
(ii) the effect of subsections 226A(7) to (9) and 226E(5) and (6) of the Act; and
(iii) the effect of paragraph 273A-20(b) of this instrument.

When notice must be given

(4) The notice must be given within 28 days after the cessation of delivery of services.

Who notice is given to

(5) The notice must be given to:
(a) the individual; or
(b) if the individual has died:
(i) the individual's legal representative; or
(ii) the individual's estate.

Note: A copy of the notice may also need to be given to another registered provider under section 149-80 of this instrument or a supporter of the individual under section 29 of the Act.

149-46 Requirements for ceasing delivery of funded aged care services—notice to new registered provider about account balances

(1) This section applies if:
(a) a registered provider has ceased the delivery of funded aged care services to an individual through a service delivery branch of the provider; and
(b) within 60 days after the day the registered provider ceased to deliver funded aged care services to the individual, the provider is notified that the individual has entered into a service agreement with a new registered provider; and
(c) the new registered provider will deliver funded aged care services to the individual for a classification type for the service groups home support, assistive technology or home modifications through a service delivery branch of the new registered provider.

(2) The registered provider must give a notice to the individual's new registered provider specifying what the provider estimates will be the available balance of the individual's:
(a) notional ongoing home support account (if any); and
(b) notional short-term home support account (if any); and
(c) notional assistive technology account (if any); and
(d) notional home modifications account (if any); and
(e) notional home care account (if any);
after the provider gives a claim in accordance with section 251 of the Act for payment of subsidy for the delivery of funded aged care services to the

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individual for the relevant period where the provider ceased delivering services to the individual.

(3) The notice must be given within 28 days after the registered provider is notified that the individual has entered into a service agreement with the new registered provider.

Subdivision E—Security of tenure for individuals accessing funded aged care services in an approved residential care home

149-50 Application of this Subdivision

This Subdivision applies to a registered provider who is delivering funded aged care services to an individual for a classification type ongoing for the service group residential care in an approved residential care home of the registered provider.

149-55 Security of tenure—general

A registered provider must not take action to make an individual accessing funded aged care services in an approved residential care home of the approved provider leave the home, or imply that the individual must leave the home, unless:

(a) one of the circumstances in subsection 149-60(1) apply; and
(b) suitable alternative accommodation is available for the individual that meets the requirements in subsection 149-60(2); and
(c) the provider has given notice to the individual in accordance with section 149-65.

149-60 Security of tenure—circumstances where registered provider may ask an individual to leave an approved residential care home

(1) A registered provider may only ask an individual accessing funded aged care services in an approved residential care home of the approved provider to leave the residential care home if:

(a) the approved residential care home is closing; or
(b) the provider can no longer provide accommodation and funded aged care services through the approved residential care home which are suitable for the individual, having regard to the individual's needs as assessed in accordance with subsection (4) and the provider has not agreed to deliver funded aged care services of the kind that the individual presently needs; or
(c) the individual no longer needs the funded aged care services delivered through the approved residential care home, as assessed by an approved needs assessor in accordance with subsection 64(2) of the Act; or
(d) the individual has been accessing funded aged care services under a specialist dementia care agreement and a clinical advisory committee

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constituted in accordance with the agreement has determined that the individual is not suitable to continue accessing those services; or

(e) the individual has not paid any agreed fee or contribution to the provider within 42 days after the day when it is payable, for a reason within the individual's control; or

(f) the individual has intentionally caused:

(i) serious damage to the approved residential care home; or

(ii) serious injury to an aged care worker of the provider, or to another individual accessing funded aged care services at the approved residential care home; or

(g) the individual is away from the approved residential care home for a continuous period of at least 7 days for a reason other than:

(i) emergency leave; or

(ii) hospital leave; or

(iii) hospital transition leave; or

(iv) extended hospital leave; or

(v) social leave.

Note: For when an individual is on leave, see section 244 of the Act.

Suitable accommodation to be available before individual can be required to leave approved residential care home

(2) If a registered provider intends to ask an individual to leave the approved residential care home, the provider must ensure suitable alternative accommodation is available:

(a) with an alternative registered provider that meets the individual's needs and is affordable by the individual; or

(b) in a place more suited to the individual's long term needs.

(3) Without limiting subsection (2), suitable alternative accommodation with an alternative registered provider will be available if the alternative registered provider has offered to enter into a service agreement with the individual under section 148-70 of this instrument for the delivery of funded aged care services to the individual.

Note: A registered provider is required to detail the steps taken to ensure any alternative accommodation meets the needs of the individual in a continuity of care plan for the individual prepared under section 149-75 of this instrument.

Assessing the individual's needs

(4) For the purposes of paragraph (1)(b), the needs of the individual must be assessed by:

(a) an approved needs assessor; or

(b) at least 2 medical or other health practitioners who meet the following criteria:

(i) one must be independent of the registered provider and the approved residential care home, and must be chosen by the individual;

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(ii) both must be competent to assess the aged care needs of the individual.

149-65 Security of tenure—notice requirements

Notice to be given if individual asked to leave residential care service

(1) If a registered provider of an approved residential care home decides to ask an individual to leave the approved residential care home, the provider must give the individual a written notice which includes the following:

(a) the decision;

(b) the reasons for the decision;

(c) the date the individual is to leave;

(d) the individual's rights in relation to being asked to leave the approved residential care home, including the right to access:

(i) the provider's complaints and feedback management system; and

(ii) any other mechanisms available to address complaints; and

(iii) independent aged care advocates;

(e) a copy of the continuity of care plan for the individual.

Note: For complaints and feedback management systems, see section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this instrument.

(2) The registered provider must give the notice to the individual at least 14 days before the individual is to leave.

Notice to be given if individual no longer required to leave approved residential care home

(3) If:

(a) the decision to require the individual to leave the approved residential care home was based on the individual's behaviour; and

(b) the registered provider has given the individual a notice under subsection (1); and

(c) after giving the notice, the provider has agreed with the individual that, because of a change in the behaviour, the individual should not be required to leave the residential care home;

the provider must give the individual a written notice stating that the individual is no longer required to leave the residential care home.

149-70 Security of tenure—movement of individuals

(1) A registered provider must not move an individual from a room, or part of a room, in the approved residential care home to another room, or part of a room, in the home unless:

(a) the move is at the individual's request; or

(b) the individual agrees to the move after being fully consulted and without being subjected to any pressure; or

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(c) the move is necessary on genuine medical grounds as assessed by one of the following:
  (i) an approved needs assessor;
  (ii) at least 2 medical or other health practitioners who meet the criteria in subparagraphs 149-60(4)(b)(i) and (ii) of this instrument; or
(d) the individual has been accessing funded aged care services under a specialist dementia care agreement and a clinical advisory committee constituted in accordance with the agreement has determined that the individual is not suitable to continue accessing those services in the individual's current room, or part of a room; or
(e) the move is necessary to carry out repairs or improvements to the home and the individual has the right to return to the room, or the part of the room, if it continues to exist as a room, or part of a room, for individuals when the repairs or improvements are finished; or
(f) the move is necessary due to an emergency, including (but not limited to) the following:
  (i) during serious medical situations such as disease outbreak, viral pandemic and epidemic;
  (ii) in circumstances in which the safety of the individual is compromised such as during a fire, natural disaster or flood;
  (iii) the individual has been repeatedly violent towards another person in the same room or in close proximity to the individual.

Subdivision F—Continuity of funded aged care services

149-75 Continuity of care plan

(1) A registered provider must prepare a plan for ensuring the continuity of funded aged care services for an individual (a ***continuity of care plan***) in accordance with this section if the provider intends to ask an individual to leave an approved residential care home of the provider in any of the circumstances prescribed in subsection 149-60(1) of this instrument.

Continuity of care plan for individuals accessing funded aged care services in an approved residential care home

(2) A continuity of care plan for an individual accessing funded aged care services through the classification type ongoing for the service group residential care in an approved residential care home of a registered provider must specify the following:
  (a) details of any suitable alternative accommodation that is available that meet the requirements in subsection 149-60(2);
  (b) the steps the registered provider has taken to ensure that any alternative accommodation meets the individual's needs;
  (c) how any records relating to ensuring the continuity of funded aged care services for the individual will be transferred to a suitable alternative registered provider if required under section 149-80;

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(d) the intended start date (if any) for the individual with a suitable alternative registered provider;
(e) where an individual will not continue accessing funded aged care services with an alternative registered provider, the reason for this;
(f) the way in which the registered provider proposes to help the individual move (with their personal possessions);
(g) the measures that the registered provider proposes to take to refund any fees or contributions to the individual as required by Part 3 of Chapter 4 of the Act;
(h) the measures that the registered provider proposes to take to deal with any refundable deposit balance paid by the individual as required by Division 7 of Part 4 of Chapter 4 of the Act.

149-80 Transfer of records between registered providers

(1) This section applies if:
(a) a registered provider (the ***outgoing provider***) ceases to deliver funded aged care services to an individual; and
(b) another registered provider (the ***incoming provider***) starts the delivery of funded aged care services to the individual.

Records to be given to incoming provider on request

(2) The incoming provider may request the outgoing provider give records relating to the individual which are necessary to ensure the continuity of funded aged care services for the individual.

(3) If a request for records is made under subsection (2), the outgoing provider must give the incoming provider the records, or copies of such records, within 28 days after the request is made.

(4) Without limiting subsections (2) and (3), the outgoing provider must give the following records:
(a) any records relating to the individual the provider is required to keep under section 7 of the *Records Principles 2014*;
(b) any records relating to the individual the provider is required to keep under section 154-1000 of this instrument.

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Part 5—Conditions relating to financial matters

150A-1 Requirements for refundable deposit register

For the purposes of section 150A of the Act, a registered provider's refundable deposit register must:

(a) be able to produce the information prescribed under this Division (as applicable) in a single, itemised document; and

(b) require the collection of information prescribed under this Division that will enable the provider to provide information to the Commissioner, if required or requested to do so by the Commissioner.

150A-3 Kinds of providers to which the condition applies

For the purposes of section 150A of the Act, a registered provider registered in the category residential care that receives or has received payment of any of the following from an individual, wholly or partly as a lump sum:

(a) a refundable deposit;

(b) an accommodation bond;

(c) an entry contribution;

is prescribed.

150A-5 Refundable deposit register to include information about refundable deposit paid and refundable deposit balances held

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register for each individual from whom a refundable deposit is paid to the provider, or in respect of whom the registered provider holds a refundable deposit balance:

(a) the name of the individual;

(b) the Aged Care Management Payment System number for the individual;

(c) the date on which the individual entered the approved residential care home through which the individual is provided with funded aged care services by the registered provider;

(d) the date on which the whole or each part of the refundable deposit paid by lump sum was paid to the registered provider for entry to the approved residential care home referred to in paragraph (c);

(e) the amount of each payment referred to in paragraph (d);

(f) the amount of each deduction made from the refundable deposit authorised under section 307 or section 308 of the Act;

(g) the date when each of the deduction referred to in paragraph (f) was made;

(h) for each deduction made under paragraph (f)—the provision that the deduction was authorised under and the reason for the deduction;

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(i) the refundable deposit balance as at the end of each calendar month in relation to the individual during which the registered provider held a refundable deposit balance;

(j) any amount refunded to the individual under subsection 304-5(1) of this instrument;

(k) the date when any amount was refunded to the individual under subsection 304-5(1) of this instrument;

(l) where the registered provider began delivering funded aged care services to the individual and the amount of accommodation payment charged to the individual is higher than the maximum accommodation payment amount prescribed by rules made for the purposes of section 289 of the Act—the Independent Health and Aged Care Pricing Authority approval number;

(m) any transfer of the refundable deposit made under section 312 of the Act, including any amount, the date of that transfer and the amount of retention period remaining.

150A-15 Refundable deposit register to include information about refundable deposit balances refunded

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register for each individual from whom a refundable deposit is paid to the provider, or in respect of whom the registered provider holds a refundable deposit balance:

(a) if the refundable deposit balance was refunded because the individual died;

(i) the date on which the individual died; and

(ii) if applicable, the date on which the registered provider is shown the probate, the will of the individual, letters of administration of the estate of the individual or other evidence that satisfied the provider that the refundable deposit is to be refunded to a person;

(b) if the refundable deposit balance was refunded because the individual ceased to be provided with ongoing funded aged care services in the service group residential care at the approved residential care home—the date on which the individual ceased to be provided with those ongoing funded aged care services;

(c) if paragraph (b) applies and the individual notified the registered provider, before the date referred to in that paragraph, that the individual intended to enter another approved residential care home to receive ongoing funded aged care services in the service group residential care—the date of notification by the individual;

(d) if the refundable deposit was refunded because of changes to the nature of delivery of funded aged care services to the individual whilst in the care of the registered provider, and those changes result in excess deposit being held by the registered provider—a description of those changes;

(e) if the refundable accommodation contribution amount is reduced because of changes to the daily means tested amount or the accommodation supplement applicable to the individual and that reduction results in excess deposit being held by the registered provider—the date the new daily

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means tested amount or new accommodation supplement applied and the date the provider refunded the excess refundable deposit.

(f) the date on which, or by which, the registered provider was required to refund the refundable deposit to the individual as worked out in accordance with section 311 of the Act;

(g) the date on which the refundable deposit was refunded to the individual or another person;

(h) the amount of the refundable deposit refunded;

(i) the amounts (if any) of interest paid, as required by section 313-5 of this instrument and worked out under section 313-10 of this instrument, broken down into amounts worked out using the base interest rate and amounts worked out using the maximum permissible interest rate, and the date or dates on which the amounts were paid.

150A-20 Refundable deposit register to include information about accommodation bond balances held by the registered provider

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register in relation to an individual in respect of whom an accommodation bond was paid to the registered provider on or after 1 July 2006, or in respect of whom the registered provider holds an accommodation bond balance on or after that date:

(a) the name of the individual;

(b) the Residential Identification Number allocated by the Department in respect of the individual;

(c) the date on which the individual entered the approved residential care home in which the individual is provided with funded aged care services by the registered provider on or after 1 July 2006;

(d) if, immediately before entering the approved residential care home referred to in paragraph (c), the individual was provided with care through an approved residential care home (the ***original approved residential care home***), and an accommodation bond was paid for the individual's entry to the original approved residential care home—the date on which the individual entered the original approved residential care home;

(e) the date on which the whole or each part of an accommodation bond paid by lump sum was paid for entry to the registered provider referred to in paragraph (c);

(f) the amount of each payment referred to in paragraph (e);

(g) the amount of each deduction made from the accommodation bond on or after 1 July 2006;

(h) the date of each deduction referred to in paragraph (g);

(i) the reason for each deduction referred to in paragraph (g);

(j) the accommodation bond balance as at 1 July 2006 (if applicable);

(k) the accommodation bond balance at the end of each calendar month commencing on or after 1 July 2006 during which the registered provider held the accommodation bond balance in respect of the individual.

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150A-25 Refundable deposit register to include information about accommodation bond balances refunded

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register in relation to an individual in respect of whom an accommodation bond balance is refunded on or after 1 July 2006:

(a) if accommodation bond balance was refunded because the individual died;
  (i) the date on which the individual died; and
  (ii) if applicable, the date on which the registered provider is shown the probate, the will of the individual, letters of administration of the estate of the individual or other evidence that satisfied the provider that the refundable deposit is to be refunded to a person;

(b) if the accommodation bond balance was refunded because the individual ceased to be provided with ongoing services in the services group residential care at the approved residential care home—the date on which the individual ceased to be provided with that care;

(c) if paragraph (b) applies and the individual notified the registered provider, before the date referred to in that paragraph, that the individual intended to enter another approved residential care home to receive residential care—the date of notification;

(d) the date on which, or by which, the registered provider was required to refund the accommodation bond balance to the individual, worked out in accordance with section 287-102 of this instrument;

(e) the date on which the accommodation bond payment balance was refunded;

(f) the amount of the accommodation bond balance refunded;

(g) the amounts (if any) of interest paid, as required by and worked out under section 287-103A of this instrument, broken down into amounts worked out using the base interest rate and amounts worked out using the pre-2014 maximum permissible interest rate, and the date or dates on which the amounts were paid.

150A-30 Refundable deposit register to include information about entry contributions paid and entry contribution balances held

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register in relation to an individual who holds an entry contribution balance on or after 1 July 2006:

(a) the name of the individual;

(b) the Resident Identification Number allocated by the Department in respect of the individual;

(c) the date on which the entry contribution was paid;

(d) the amount of the entry contribution;

(e) the entry contribution balance at the end of each calendar month commencing on or after 1 July 2006 during which the registered provider held an entry contribution balance in respect of the individual.

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150A-35 Refundable deposit register to include information about entry contributions balances refunded

For the purposes of section 150A of the Act, a registered provider must include the following information in the refundable deposit register in relation to an individual of whom an entry contribution balance is refunded on or after 1 July 2006:

(a) the date on which the individual ceased to be provided with care;

(b) the date on which the registered provider was required to refund the entry contribution balance to the individual worked out in accordance with the formal agreement applying in respect of the entry contribution balance;

(c) the date on which the entry contribution balance was refunded;

(d) the amount of the entry contribution balance refunded;

(e) the amount (if any) of interest paid and the date when the interest was paid.

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Part 6—Aged care workers

Division 1—Workforce and aged care worker requirements

Subdivision A—Kinds of provider to which the condition applies

152-5 Kinds of provider to which the condition applies

For the purposes of subsection 152(1) of the Act, every kind of registered provider is prescribed.

Subdivision B—Worker screening requirements

152-10 Purpose of this Subdivision

For the purposes of paragraphs 152(1)(a) and (b) of the Act, this Subdivision prescribes worker screening requirements.

152-15 Responsible persons of registered providers delivering services other than under CHSP or NATSIFACP

Clearance requirements

(1) A registered provider (other than a registered provider to whom subsection (5) or (6) applies) must ensure that each responsible person of the provider is:
  (a) a person to whom subsection 152-25(1) (police certificates) applies; or
  (b) a person to whom subsection (2) of this section applies; or
  (c) a person in respect of whom an NDIS clearance decision is in force.

(2) This subsection applies to a person:
  (a) in respect of whom an NDIS screening application or a police certificate is pending; and
  (b) who is subject to appropriate supervision while that application or certificate is pending; and
  (c) who has made, and given to the registered provider, a statutory declaration stating the person:
    (i) has never been convicted of murder or sexual assault; and
    (ii) has never been convicted of, and sentenced to imprisonment for, any other form of assault.

Notification requirements

(3) A registered provider (other than a registered provider to whom subsection (5) or (6) applies) must take reasonable measures to require each responsible person of the provider to notify the provider if:
  (a) an NDIS exclusion decision is in force in respect of the person; or

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(b) an NDIS clearance decision in respect of the person is suspended; or
(c) the person has been:
(i) convicted of murder or sexual assault; or
(ii) convicted of, and sentenced to imprisonment for, any other form of assault.

Continuation requirements

(4) A registered provider (other than a registered provider to whom subsection (5) or (6) applies) must ensure that a responsible person of the provider is not allowed to continue as a responsible person if the provider is satisfied on reasonable grounds that the person has been:
(a) convicted of murder or sexual assault; or
(b) convicted of, and sentenced to imprisonment for, any other form of assault.

Registered providers in relation to whom this section does not apply

(5) This subsection applies to a registered provider that:
(a) delivers funded aged care services under CHSP; and
(b) is registered in any of the following provider registration categories:
(i) home and community services;
(ii) assistive technology and home modifications;
(iii) advisory and support services;
(iv) personal and care support in the home or community;
(v) nursing and transition care.

(6) This subsection applies to a registered provider that delivers funded aged care services under NATSIFACP.

152-16 Responsible persons of registered providers delivering services only under CHSP, NATSIFACP, or CHSP and NATSIFACP

Clearance requirements

(1) A registered provider to whom subsection (6), (7) or (8) applies must ensure that each responsible person of the provider is:
(a) a person to whom subsection 152-25(2), (3) or (5) (police certificates) applies; or
(b) a person to whom subsection (2) of this section applies; or
(c) a person in respect of whom an NDIS clearance decision is in force.

(2) This subsection applies to a person:
(a) in respect of whom an NDIS screening application or a police certificate is pending; and
(b) who is subject to appropriate supervision while that application or certificate is pending; and

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(c) who has made, and given to the registered provider, a statutory declaration stating the person:
(i) has never been convicted of an offence involving the death of a person; and
(ii) has never been convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection (3).

(3) For the purposes of subparagraph (2)(c)(ii), the offences are the following:
(a) a sex related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child;
(b) an offence involving dishonesty.

Notification requirements

(4) A registered provider to whom subsection (6), (7) or (8) applies must take reasonable measures to require each responsible person of the provider to notify the provider if:
(a) an NDIS exclusion decision is in force in respect of the person; or
(b) an NDIS clearance decision in respect of the person is suspended; or
(c) the person is, after the commencement of this section:
(i) convicted of an offence involving the death of a person; or
(ii) convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection (3).

Continuation requirements

(5) A registered provider to whom subsection (6), (7) or (8) applies must ensure that a responsible person of the provider is not allowed to continue as a responsible person if the provider is satisfied on reasonable grounds that the responsible person is, after the commencement of this section:
(a) convicted of an offence involving the death of a person; or
(b) convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection (3).

Registered providers in relation to whom this section applies

(6) This subsection applies to a registered provider that:
(a) delivers funded aged care services only under CHSP; and
(b) is registered in any of the following provider registration categories:
(i) home and community services;
(ii) assistive technology and home modifications;
(iii) advisory and support services;
(iv) personal and care support in the home or community;
(v) nursing and transition care.

(7) This subsection applies to a registered provider that delivers funded aged care services only under NATSIFACP.

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(8) This subsection applies to a registered provider that delivers funded aged care services only under CHSP and NATSIFACP.

152-17 Responsible persons of other registered providers

(1) A registered provider:
  (a) to whom either or both subsection (2) or (3) applies; and
  (b) to whom subsection (4) applies;
must comply with each of the requirements mentioned in section 152-16.

(2) This subsection applies to a registered provider that:
  (a) delivers funded aged care services under CHSP; and
  (b) is registered in any of the following provider registration categories:
    (i) home and community services;
    (ii) assistive technology and home modifications;
    (iii) advisory and support services;
    (iv) personal and care support in the home or community;
    (v) nursing and transition care.

(3) This subsection applies to a registered provider that delivers funded aged care services under NATSIFACP.

(4) This subsection applies to a registered provider that delivers funded aged care services other than under CHSP or NATSIFACP.

152-20 Aged care workers delivering services other than under CHSP or NATSIFACP

Clearance requirements

(1) A registered provider must ensure that each aged care worker of the provider, other than a worker to whom subsection (5) or (6) applies, is:
  (a) a person to whom subsection 152-25(1) (police certificates) applies; or
  (b) a person to whom subsection (2) of this section applies; or
  (c) a person in respect of whom an NDIS clearance decision is in force; or
  (d) a secondary school student on a formal work experience placement with the provider and the worker is directly supervised by a person to whom paragraph (a) or (c) applies.

(2) This subsection applies to a person:
  (a) in respect of whom an NDIS screening application or a police certificate is pending; and
  (b) who is subject to appropriate supervision while that application or certificate is pending; and
  (c) who has made, and given to the registered provider, a statutory declaration stating the person:
    (i) has never been convicted of murder or sexual assault; and

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(ii) has never been convicted of, and sentenced to imprisonment for, any other form of assault.

Notification requirements

(3) A registered provider must take reasonable measures to require each aged care worker of the provider, other than a worker to whom subsection (5) or (6) applies, to notify the provider if:
  (a) an NDIS exclusion decision is in force in respect of the worker; or
  (b) an NDIS clearance decision in respect of the worker is suspended; or
  (c) the worker has been:
    (i) convicted of murder or sexual assault; or
    (ii) convicted of, and sentenced to imprisonment for, any other form of assault.

Continuation requirements

(4) A registered provider must ensure that an aged care worker of the provider, other than a worker to whom subsection (5) or (6) applies, is not allowed to continue as an aged care worker if the provider is satisfied on reasonable grounds that the worker has been:
  (a) convicted of murder or sexual assault; or
  (b) convicted of, and sentenced to imprisonment for, any other form of assault.

Aged care workers in relation to whom this section does not apply

(5) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services under CHSP.

(6) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services under NATSIFACP.

152-21 Aged care workers delivering services only under CHSP, NATSIFACP, or CHSP and NATSIFACP

Clearance requirements

(1) A registered provider must ensure that each aged care worker of the provider to whom subsection (5), (6) or (7) applies is:
  (a) a person to whom subsection 152-25(2), (3) or (5) (police certificates) applies; or
  (b) a person to whom subsection (2) of this section applies; or
  (c) a person in respect of whom an NDIS clearance decision is in force; or
  (d) a secondary school student on a formal work experience placement with the provider and the worker is directly supervised by a person to whom paragraph (a) or (c) applies.

(2) This subsection applies to a person:

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(a) in respect of whom an NDIS screening application or a police certificate is pending; and
(b) who is subject to appropriate supervision while that application or certificate is pending; and
(c) who has made, and given to the registered provider, a statutory declaration stating the person:
(i) has never been convicted of an offence involving the death of a person; and
(ii) has never been convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Notification requirements

(3) A registered provider must take reasonable measures to require each aged care worker of the provider to whom subsection (5), (6) or (7) applies to notify the provider if:
(a) an NDIS exclusion decision is in force in respect of the worker; or
(b) an NDIS clearance decision in respect of the worker is suspended; or
(c) the worker is, after the commencement of this section:
(i) convicted of an offence involving the death of a person; or
(ii) convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Continuation requirements

(4) A registered provider must ensure that an aged care worker of the provider to whom subsection (5), (6) or (7) applies is not allowed to continue as an aged care worker if the provider is satisfied on reasonable grounds that the worker is, after the commencement of this section:
(a) convicted of an offence involving the death of a person; or
(b) convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Aged care workers in relation to whom this section applies

(5) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services only under CHSP.

(6) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services only under NATSIFACP.

(7) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services only under CHSP and NATSIFACP.

152-22 Other aged care workers

(1) A registered provider in respect of an aged care worker of the provider:
(a) to whom either or both subsection (2) or (3) applies; and
(b) to whom subsection (4) applies;

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must comply with each of the requirements mentioned in section 152-21.

(2) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services under CHSP.

(3) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services under NATSIFACP.

(4) This subsection applies to an aged care worker of a registered provider if the worker delivers funded aged care services other than under CHSP or NATSIFACP.

152-25 Police certificates

Responsible persons or aged care workers of registered providers delivering services other than under CHSP or NATSIFACP

(1) This subsection applies to a person if:
  (a) there is for the person a police certificate that is not more than 3 years old; and
  (b) the police certificate does not record that the person has been:
    (i) convicted of murder or sexual assault; or
    (ii) convicted of, and sentenced to imprisonment for, any other form of assault; and
  (c) for a person who has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been:
    (i) convicted of murder or sexual assault; or
    (ii) convicted of, and sentenced to imprisonment for, any other form of assault.

Responsible persons or aged care workers of registered providers delivering services under CHSP

(2) This subsection applies to a person who is a responsible person or aged care worker of a registered provider to which subsection (4) applies if:
  (a) there is for the person a police certificate that is not more than 3 years old; and
  (b) either:
    (i) the person was engaged as a responsible person or aged care worker of the registered provider on or after the commencement of this section; or
    (ii) the police certificate was issued after the commencement of this section; and
  (c) the police certificate does not record that the person has been convicted of an offence involving the death of a person; and

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(d) the police certificate does not record that in the 5 years before the date of the certificate, the person has been convicted of, and sentenced to imprisonment for at least one year for, any of the following offences:
(i) a sex-related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child;
(ii) an offence involving dishonesty; and

(e) for a person who has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been:
(i) convicted of an offence involving the death of a person; or
(ii) convicted of, and sentenced to imprisonment for at least one year for, a sex-related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child; or
(iii) convicted of, and sentenced to imprisonment for at least one year for, an offence involving dishonesty.

(3) This subsection applies to a person who is a responsible person or aged care worker of a registered provider to which subsection (4) applies if:
(a) the person was engaged as a responsible person or aged care worker of the registered provider before the commencement of this section; and
(b) there is for the person a police certificate that:
(i) was issued before the commencement of this section; and
(ii) is not more than 3 years old.

(4) This subsection applies to a registered provider that:
(a) delivers funded aged care services under CHSP; and
(b) is registered in any of the following provider registration categories:
(i) home and community services;
(ii) assistive technology and home modifications;
(iii) advisory and support services;
(iv) personal and care support in the home or community;
(v) nursing and transition care.

Responsible persons or aged care workers of registered providers delivering services under NATSIFACP

(5) This subsection applies to a person who is a responsible person or aged care worker of a registered provider to which subsection (6) applies if:
(a) there is for the person a police certificate that is not more than 3 years old; and
(b) the police certificate does not record that the person has been convicted of an offence involving the death of a person; and
(c) the police certificate does not record that in the 5 years before the date of the certificate, the person has been convicted of, and sentenced to imprisonment for at least one year for, any of the following offences:

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(i) a sex-related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child;

(ii) an offence involving dishonesty; and

(d) for a person who has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been:

(i) convicted of an offence involving the death of a person; or

(ii) convicted of, and sentenced to imprisonment for at least one year for, a sex-related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child; or

(iii) convicted of, and sentenced to imprisonment for at least one year for, an offence involving dishonesty.

(6) This subsection applies to a registered provider that:

(a) delivers funded aged care services under NATSIFACP; and

(b) is registered in any of the following provider registration categories:

(i) home and community services;

(ii) assistive technology and home modifications;

(iii) advisory and support services;

(iv) personal and care support in the home or community;

(v) nursing and transition care;

(vi) residential care.

Subdivision C—Qualifications and training requirements

152-35 Qualifications and training requirements

For the purposes of paragraph 152(c) of the Act, the requirements are that aged care workers of a registered provider must have appropriate qualifications, skills or experience to provide the funded aged care services that the provider delivers to individuals.

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Division 2—Vaccination

153-5 Kinds of provider to which the condition applies

For the purposes of subsection 153(1) of the Act, a registered provider registered in the registration category residential care is prescribed.

153-10 Requirements for providing access to vaccinations to individuals

For the purposes of subsection 153(1) of the Act, the requirement in accordance with which a registered provider must provide access to the vaccinations mentioned in subsection 153(2) of the Act for free to individuals to whom the provider is delivering funded aged care services is that the provider must do so in accordance with the National Immunisation Program Schedule, published by the Department, as existing from time to time.

Note: The National Immunisation Program Schedule could in 2026 be viewed on the Department's website (https://www.health.gov.au).

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Part 7—Information and access

Division 1—Personal information and record keeping

Subdivision A—Purpose of this Division

154-1 Purpose of this Division

For the purposes of paragraph 154(a) of the Act, this Division prescribes:

(a) the kinds of records that registered providers must keep and retain; and

(b) requirements for keeping and retaining those records.

Subdivision B—Information provided to an individual

154-2 Requirement to keep and retain information provided to an individual

(1) A registered provider must keep records demonstrating their compliance with their obligations and conditions of registration under Chapter 3.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

154-3 Requirement to correct personal information

(1) This section applies to a registered provider that is not any of the following:

(a) an APP entity within the meaning of the *Privacy Act 1988*;

(b) a State or Territory; or

(c) a body established for a public purpose by or under a law of the State or Territory (other than a local government authority).

(2) It is a requirement that when a registered provider keeps and retains records, the registered provider must comply with Australian Privacy Principle 13 as set out in Schedule 1 of the *Privacy Act 1988*, as if it were an organisation for the purposes of that Act.

Note: A registered provider that is an APP entity remains subject to the *Privacy Act 1988*, including APP 13.

Subdivision C—Vaccination

154-5 Application of this Subdivision to certain registered providers

This Subdivision applies to a registered provider registered in the provider registration category residential care.

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154-10 Records about service staff—influenza vaccinations

(1) A registered provider must keep records, for each calendar year, of the following information:

(a) the total number of service staff in relation to the approved residential care home;

(b) the number of those service staff who have informed the registered provider, whether voluntarily or as required under a law of a State or Territory, that they have received the annual seasonal influenza vaccination for that year (whether or not under the registered provider's influenza vaccination scheme (if any)).

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

154-15 Records about service staff—COVID-19 vaccinations

(1) A registered provider must keep records, for each calendar year, of the following information:

(a) the total number of service staff in relation to the approved residential care home;

(b) the number of those service staff who have voluntarily informed the registered provider that they have received a COVID-19 vaccination in that year.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

154-20 Records about individuals receiving residential care—influenza vaccinations

(1) A registered provider must keep records, for each calendar year, of the following information:

(a) the total number of individuals accessing funded aged care services in the approved residential care home;

(b) the number of those individuals who have voluntarily informed the registered provider that they have received the annual seasonal influenza vaccination for that year.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

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Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

154-25 Records about individuals receiving residential care—COVID-19 vaccinations

(1) A registered provider must keep records, for each calendar year, of the following information:

(a) the total number of individuals accessing funded aged care services in the approved residential care home;

(b) the number of those individuals who have voluntarily informed the registered provider that they had received one or more COVID-19 vaccinations in that year;

(c) the number of individuals covered by paragraph (b) who have informed the registered provider that they had received only one COVID-19 vaccination;

(d) the number of individuals covered by paragraph (b) who have informed the registered provider that they had received 2 COVID-19 vaccinations.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision D—Quality indicators

154-105 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider that is required to give a quality indicators report under section 166-110.

154-110 Requirements for records on quality indicators

(1) Each of the following kinds of records are prescribed kinds of records that a registered provider must keep and retain:

(a) a quality indicators report;

(b) records relating to the collection and measurements of quality indicators.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

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Subdivision E—Incidents

154-150 Records about details of incidents

A registered provider must keep and retain the details recorded in relation to an incident under section 164-25(1) of this instrument in written or electronic form for 7 years starting on the day the record is made or received.

Subdivision F—Complaints and feedback

154-200 Application of Subdivision to feedback received

This Subdivision applies to feedback received by a registered provider:

(a) that is managed in accordance with section 165-30; and

(b) raises an issue as referred to in subsection 165-30(2).

154-205 Requirements for records of complaints and feedback

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:

(a) complaints and feedback received each year;

(b) the nature of complaints and feedback;

(c) the action taken to resolve complaints and feedback;

(d) responses provided to individuals about their complaints and feedback;

(e) any improvements made by the registered provider in relation to complaints and feedback;

(f) an evaluation of the effectiveness of the actions taken by the registered provider and their related outcome in relation to each complaint and feedback;

(g) a record of the number of days taken to resolve each complaint and feedback;

(h) the education and training that has been delivered to the aged care workers and responsible persons of the registered provider in relation to each complaint and feedback.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision G—Prudential and financial

154-300 Requirement to keep and retain financial and prudential reports

(1) Each of the following kinds of records are prescribed kinds of records that a registered provider must keep and retain:

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(a) an aged care financial report;
(b) a quarterly financial report;
(c) a general purpose financial report;
(d) an annual prudential compliance statement.

Note: See Subdivision E of Division 3 of Part 2 of Chapter 5 of this instrument for requirements relating to each record prescribed.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision H—CHSP

154-400 Application of Subdivision

This Subdivision applies to a registered provider of a kind who is registered in one or more of the following provider registration categories:

(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care;

and delivers funded aged care services under the CHSP.

154-405 Requirements for records

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:

(a) the amount of financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider within a particular financial year;
(b) any individual fees and contributions collected over the financial year;
(c) expenditure for the delivery of funded aged care services by the provider under the funding agreement;
(d) any surplus and uncommitted funds from the previous financial year;
(e) service types, and the duration of services, delivered to each individual;
(f) activity and performance data.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years, starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

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Subdivision J—NATSIFACP

154-500 Application of Subdivision

This Subdivision applies to a registered provider of a kind who is registered in one or more of the following provider registration categories:

(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care;
(f) residential care;

and delivers funded aged care services under the NATSIFACP.

154-505 Requirements for records

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:

(a) the amount of financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider under subsection 264(2) of the Act within a particular financial year;
(b) any individual fees and contributions collected over the financial year;
(c) expenditure for the delivery of funded aged care services by the provider under the funding agreement;
(d) any surplus and uncommitted funds from the previous financial year;
(e) service types, and the duration of services, delivered to each individual;
(f) individual care and services plans;
(g) progress in embedding a wellness and reablement approach to service delivery;
(h) individual service agreements;
(i) a summary of the activities undertaken to prevent disease outbreaks;
(j) the number of individuals who are waiting to access funded aged care services for the financial year and the reason for the waitlist.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision K—Multi-Purpose Service Program

154-605 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under the MPSP.

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154-610 Requirements for records

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:

(a) records of the amount of subsidy received under Division 5 of Part 2 of Chapter 4 of the Act to deliver funded aged care services at each approved residential care home;

(b) records of any individual fees or contributions paid to the provider under Part 3 of Chapter 4 of the Act by individuals accessing funded aged care services, in or from, each approved residential care home;

(c) records of expenditure by the provider for the delivery of funded aged care services at each approved residential care home for the financial year;

(d) records of the service types delivered for the financial year;

(e) records of the number of individuals who have accessed funded aged care services, or are waiting to access services, in, or from, the approved residential care home for the financial year, including:

(i) whether the individual had an access approval when they commenced accessing services; and

(ii) the service types the individual accessed, including the services where specified in the individual's access approval; and

(iii) the individual's classification type for a service group; and

(iv) when the individual commenced and ceased accessing services; and

(v) the reason the individual ceased accessing services;

(f) records of the demographic information about each individual who have accessed funded aged care services, or are waiting to access services for the financial year, including:

(i) the name of the individual; and

(ii) the gender of the individual; and

(iii) the date of birth of the individual; and

(iv) whether the individual is an Aboriginal or Torres Strait Islander person; and

(v) whether the individual has dementia or dementia symptoms;

(f) records of a summary of the activities undertaken to prevent disease outbreaks.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision L—Transition Care Program

154-650 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under the TCP.

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154-665 Requirements for records

(1) Each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:
  (a) records of claims for payment of subsidy made by the provider under section 260 of the Act;
  (b) records of the amount of subsidy the Commonwealth has paid to the provider for the financial year;
  (c) records of any individual fees or contributions paid to the provider under Part 3 of Chapter 4 of the Act by individuals accessing funded aged care services for the financial year;
  (d) records of expenditure by the provider for the delivery of funded aged care services for the financial year;
  (e) records of any System Governor approved unspent funds from previous financial years.

(2) It is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision M—Governing bodies

154-700 Records about independent non-executive members of a governing body

(1) If, because of paragraph 157(2)(a) of the Act and section 157-5 of this instrument, a registered provider is required to ensure that a majority of the members of its governing body are independent non-executive members, the registered provider must keep and retain records of:
  (a) the names of the members of its governing body; and
  (b) which of those members are independent non-executive members.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

(3) Despite subsection (2), if a record prescribed under subsection (1) relates to a specific member of the governing body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the governing body.

154-705 Records about members of a governing body with clinical care provision experience

(1) If, because of paragraph 157(2)(b) of the Act and section 157-10 of this instrument, a registered provider is required to ensure that at least one member of its governing body has experience in the provision of clinical care, the registered provider must keep and retain records of:

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(a) the names of the members of its governing body who have experience in the provision of clinical care; and
(b) the details of those members' experience.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

(3) Despite subsection (2), if a record prescribed under subsection (1) relates to a specific member of the governing body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the governing body.

Subdivision N—Advisory bodies

154-800 Records about the quality care advisory body

(1) If, because of paragraph 158(2)(a) of the Act and section 158-5 of this instrument, a registered provider is required to establish, and continue in existence, a quality care advisory body, the registered provider must keep and retain the following:
(a) records of the names of the members of the quality care advisory body and details of:
(i) the date each member was appointed to the quality care advisory body; and
(ii) the date (if any) a member resigned from the quality care advisory body;
(b) records of how the quality care advisory body satisfies the requirements of section 158-15 of this instrument (requirements for reports of quality care advisory bodies);
(c) a copy of the minutes of any meeting held by the quality care advisory body and the date on which the meeting was held;
(d) a copy of each written report given to the governing body of the provider by the quality care advisory body under subparagraph 158(2)(a)(ii) of the Act;
(e) records of any feedback given to the governing body of the provider by the quality care advisory body under subparagraph 158(2)(a)(iii) of the Act;
(f) a copy of any written advice given to the quality care advisory body by the governing body of the provider under subparagraph 158(2)(b)(ii) of the Act advising how the governing body has considered the report and feedback mentioned in paragraphs (d) and (e) of this subsection.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

(3) Despite subsection (2), if a record prescribed under subsection (1) relates to a specific member of the quality care advisory body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the quality care advisory body.

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154-805 Records about the consumer advisory body

(1) If, because of paragraph 158(4)(a) of the Act and section 158-20 of this instrument, a registered provider is required to offer the opportunity to establish one or more consumer advisory bodies, the registered provider must keep and retain the following:
  (a) a copy of each written offer made to individuals to whom the provider delivers funded aged care services and the supporters of those individuals giving them the opportunity to establish a consumer advisory body;
  (b) records of the date on which each offer was given to those individuals and supporters.

(2) If one or more consumer advisory bodies are established, the registered provider must also keep and retain the following in relation to each body:
  (a) a copy of the minutes of each meeting of the consumer advisory body;
  (b) records of any feedback given to the governing body of the provider by the consumer advisory body;
  (c) a copy of any written advice given to the consumer advisory body by the governing body under subparagraph 158(4)(b)(ii) of the Act advising how the governing body has considered any such feedback.

(3) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

Subdivision P—Worker screening

154-900 Records of responsible persons

(1) A registered provider must keep, and keep up-to-date, a record for each responsible person of the provider that includes the following information and documents:
  (a) the person's full name, date of birth and address;
  (b) if paragraph 152-15(1)(a) or 152-16(1)(a) applies to the person—a record of the person's police certificate;
  (c) if paragraph 152-15(1)(b) or 152-16(1)(b) applies to the person—a record of the person's statutory declaration;
  (d) if paragraph 152-15(1)(c) or 152-16(1)(c) applies to the person—a record of the person's NDIS clearance decision.

(2) Subject to subsection (3), the registered provider must also keep a record of:
  (a) the name of the person who ensured that the responsible person has a police certificate, statutory declaration or NDIS clearance decision; and
  (b) the date the person did so.

(3) Subsection (2) applies if the responsible person's police certificate, statutory declaration or NDIS clearance is received by the registered provider on or after the commencement of this section.

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154-905 Records of aged care workers

(1) A registered provider must keep, and keep up-to-date, a record for each aged care worker of the provider that includes the following information and documents:
  (a) the worker's full name, date of birth and address;
  (b) how the provider has ensured that the worker:
    (i) has appropriate qualifications, skills or experience to provide the funded aged care services that the registered provider delivers to individuals (see section 152-35 of this instrument); and
    (ii) is given opportunities to develop their capability to provide those services (see paragraph 152(d) of the Act);
  (c) if paragraph 152-20(1)(a) or 152-21(1)(a) of this instrument applies to the worker—a record of the worker's police certificate;
  (d) if paragraph 152-20(1)(b) or 152-21(1)(b) of this instrument applies to the worker—a record of the worker's statutory declaration;
  (e) if paragraph 152-20(1)(c) or 152-21(1)(c) of this instrument applies to the worker—a record of the worker's NDIS clearance decision.

(2) Subject to subsection (3), the registered provider must also keep a record of:
  (a) the name of the person who ensured that the worker has a police certificate, statutory declaration or NDIS clearance decision; and
  (b) the date the person did so.

(3) Subsection (2) applies if the worker's police certificate, statutory declaration or NDIS clearance is received by the registered provider on or after the commencement of this section.

154-910 How long records required by sections 154-900 and 154-905 to be kept

A registered provider must keep a record required by section 154-900 or 154-905 for 7 years starting on the later of the following:
  (a) the day the record is first made;
  (b) the day the latest update to the record is made.

154-915 Copies of records relating to allegations of misconduct

(1) This section applies if a registered provider has a copy of a record relating to:
  (a) an allegation of misconduct against a responsible person or aged care worker of the provider; or
  (b) any action taken, including any investigation, in response to such an allegation.

(2) The provider must keep the copy for 7 years starting on the first day the provider has the copy.

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Subdivision Q—Delivery and continuity of funded aged care services

154-1000 Requirement to keep and retain records relating to continuity of funded aged care services

(1) A registered provider must keep the following kinds of records, or copies of such records, for an individual to whom the provider is delivering funded aged care services:

(a) any assessment and classification records of the individual that are not provided to the System Governor in electronic form;

(b) the service agreement between the provider and the individual;

(c) the care and services plan for the individual;

(d) the medical records, progress notes and other clinical records of the individual;

(e) where the provider is delivering funded aged care services to the individual through the service group residential care, the accounts of the individual, including:

(i) the entry (if any) in the refundable deposit register of the provider that relates to the individual; and

(ii) amounts (if any) of daily accommodation payments, daily accommodation contributions or accommodation charge paid by the individual; and

(iii) entry and leave arrangements for the individual; and

(iv) the accommodation agreement between the provider and the individual; and

(f) where the provider is delivering funded aged care services to the individual through the service groups home support, assistive technology or home modifications, the accounts of the individual, including any notices provided to the individual in accordance with section 149-45;

(g) applicability of any fee reduction supplements to the individual under sections 197-5, 231-15 or 231-20;

(h) the name and contact details of any supporter registered in relation to the individual;

(i) measurements, assessments and information about the individual obtained in accordance with sections 154-110, 166-110 and 166-112 of this instrument;

(j) monthly statements prepared in accordance with section 155-40 of this instrument.

(2) It is a requirement that a registered provider keep a record made under this section for 7 years starting on the day the record is made.

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Subdivision R—Status of service delivery branches

154-1100 Requirement to keep and retain records about service delivery branches

(1) A registered provider must keep records of their compliance with the reporting requirements under Subdivision M of Division 3 of Part 2 of Chapter 5, including records of the following:
  (a) any reports given under section 166-910;
  (b) any reports given under section 166-915;
  (c) any reports given under section 166-920;
  (d) any reports given under section 166-925;
  (e) any reports given under section 166-930.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

Subdivision S—Claims for subsidy

154-1200 Application of this Subdivision

(1) This Subdivision applies to a registered provider registered in any registration category.

(2) Despite subsection (1), this Subdivision does not apply to a registered provider only delivering funded aged care services under one of the following specialist aged care programs:
  (a) CHSP;
  (b) MPSP;
  (c) NATSIFACP.

154-1205 Requirement to keep and retain records which enable claims for payment of subsidy to be verified

(1) A kind of record that a registered provider must keep and retain under paragraph 154(a) of the Act is any record that enables claims for payments of subsidy to be properly verified.

(2) Without limiting subsection (1), a kind of record that enables claims for payments of subsidy to be properly verified includes the following:
  (a) the service agreement between the registered provider and the individual to whom the provider is delivering funded aged care services;
  (b) the medical records, progress notes and other clinical records of the individual to whom the provider is delivering funded aged care services;
  (c) invoices for the delivery of funded aged care services to an individual;
  (d) attendance records for an aged care worker of the provider.

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(3) It is a requirement that a registered provider keep a record prescribed under subsection (1) for 7 years starting on the day the record is made.

Subdivision T—Compliance

154-1300 Requirement to keep and retain records relating to compliance

(1) A kind of record that a registered provider must keep and retain under section 154 of the Act is any record that enables proper assessments to be made of whether a provider has complied, or is complying, with its obligations under Chapter 3 of the Act.

(2) It is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

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Division 2—Provision of information to individuals

155-1 Purpose of this Division

For the purposes of section 155 of the Act, this Division prescribes the requirements for the following:

(a) the records and information that a registered provider must provide and explain to individuals accessing, or seeking to access, funded aged care services;

(b) the records and information (including personal information) held by the registered provider about the individual to whom the registered provider delivers funded aged care services that a registered provider must allow and facilitate access by an individual.

155-5 Kind of information to be provided and explained

For the purposes of subsection 155(1) of the Act, this Division prescribes requirements for the provision and explanation of the following kinds of information to individuals:

(a) the Statement of Rights;

(b) information to assist individuals to choose, in accordance with the individual's access approval, funded aged care services that best meet their needs;

(c) clear and understandable invoices;

(d) information about a registered provider's management and use of refundable deposits;

(e) information for prospective individuals;

(f) monthly statements;

(g) individualised budget;

(h) general information for individuals accessing any funded aged care services;

(i) general information for individuals accessing funded aged care services in a home or community setting;

(j) general information for individuals accessing funded aged care services in an approved residential care home;

(k) information about the financial position of the registered provider in a provider registration category other than residential care;

(l) pricing information.

155-15 Information to be provided and explained—Statement of Rights

(1) For the purposes of subsection 155(1) of the Act, a registered provider must provide an individual accessing or seeking to access funded aged care services the following:

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(a) information about the individual's rights under the Statement of Rights set out in section 23 of the Act, in relation to the funded aged care services the individual accesses;

(b) a copy of the Statement of Rights.

Note: The registered provider must retain records relating to the Statement of Rights given under paragraph (1)(b) (see section 154-2).

(2) A registered provider must assist the individual to understand the information and the Statement of Rights given under subsection (1).

(3) A registered provider must comply with subsections (1) and (2) before, or when, the registered provider commences delivery of funded aged care services to that individual.

155-20 Information to be provided—information to assist individuals to choose funded aged care services that best meet their needs

(1) This section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care.

(2) A registered provider must provide such information as is reasonably necessary to assist an individual to choose, in accordance with the individual's access approval, the funded aged care services that best meet the individual's goals and assessed needs and preferences within the limits of the resources available.

155-25 Information to be provided—clear and understandable invoices

For the purposes of subsection 155(1) of the Act, a registered provider must provide an individual with invoices that are clear and in a format that is understandable.

155-30 Information to be provided—information about a registered provider's management and use of refundable deposits

(1) This section applies to a registered provider if the registered provider is prescribed under section 150A-3 of this instrument.

Notification by registered provider

(2) Within 7 days after an accommodation agreement is entered into between a registered provider and an individual, the registered provider must notify the individual, in writing, that the registered provider will give the individual, within 7 days of a request by the individual, the following information and documents:

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(a) a summary of the permitted uses for which refundable deposits and accommodation bonds have been used by the registered provider during the previous financial year;

(b) if, during the 2 years prior to the request, the registered provider has given the System Governor an aged care financial report for the registered provider that included a permitted uses reconciliation—a copy of the permitted uses reconciliation included in the most recent such report;

(c) information about whether the registered provider has, during the previous financial year, complied with:

(i) section 310 of the Act; and

(ii) the Financial and Prudential Standards;

(d) information about:

(i) the number (if any) of refundable deposit balances or accommodation bond balances that, in the previous financial year, were not refunded in accordance with section 311 of the Act or section 287-102 of this instrument; and

(ii) the number (if any) of entry contribution balances that, in the previous financial year, were not refunded in accordance with a formal agreement;

(e) if the registered provider is required to implement and maintain a written investment management strategy under the Financial and Prudential Standards—the registered provider's investment objectives as recorded in the registered provider's investment management strategy;

(f) a copy of the audit opinion referred to in paragraph 166-380(g) of this instrument for the previous financial year;

(g) a copy of either:

(i) the most recent statement of the audited accounts in relation to the registered provider; or

(ii) if the registered provider is operated as part of a broader organisation—the most recent statement of the audited accounts of the organisation's aged care component;

(h) a copy of the refundable deposit register entry that relates to the individual, as at the time of the request.

(3) A registered provider that is not required to prepare annual financial reports under Part 2M.3 of Chapter 2M of the *Corporations Act 2001* is not required to comply with paragraph (2)(g) of this section.

Disclosure of refundable deposit register entry relating to an individual

(4) A copy of the refundable deposit register entry that relates to the individual must be provided to the individual or another person in the following circumstances:

(a) when the individual ceases to access funded aged care services through the registered provider's approved residential care home, the record must be provided to the individual, or if the individual has died, the individual's legal representative or estate;

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(b) when the individual moves to another approved residential care home of another approved provider, the record must be provided to the individual.

Disclosure on request

(5) If an individual requests the registered provider of an approved residential care home in which the individual is accessing funded aged care services to give the individual the information and documents referred to in subsection (2) or (4), the registered provider must give the individual the information and documents requested within 7 days after receiving the request.

(6) Subsection (5) applies in relation to an individual who is accessing funded aged care services in an approved residential care home:
(a) whether or not the individual entered into an accommodation agreement with the registered provider of the approved residential care home; and
(b) whether or not the individual has paid a refundable deposit; an accommodation bond or an entry contribution to that registered provider.

(7) If:
(a) as a result of a request by an individual, a registered provider is required under subsection (5) to give the individual the summary referred to in paragraph (2)(a); and
(b) the registered provider has given the System Governor an aged care financial report for the registered provider for the previous financial year, and that report included a permitted uses reconciliation;
the registered provider may satisfy the requirement to give the individual the summary by giving the individual a copy of that permitted uses reconciliation.

Disclosure after end of financial year for registered provider

(8) Within 4 months after the end of each financial year for a registered provider, the registered provider must give each individual who has paid a refundable deposit, an accommodation bond or an entry contribution to the registered provider for entry to the approved residential care home operated by the registered provider:
(a) a copy of the refundable deposit record that relates to the individual as at the end of the financial year; and
(b) a written statement that the registered provider will provide, within 7 days of a request by the individual, the information and documents referred to in subsection (2).

155-35 Information to be provided—to prospective individuals

(1) This section applies to a registered provider if the registered provider is prescribed under section 150A-3 of this instrument.

(2) Within 7 days of a request from a prospective individual, a registered provider must give the prospective individual the information and documents referred to in paragraphs 155-30(2)(a) to (g).

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155-36 Information to be provided—statement of audited accounts

(1) Subject to subsection (2), if section 155-30 of this instrument does not apply to the registered provider that is registered in the provider registration category residential care, the provider must, if asked by an individual to whom the provider is delivering funded aged care services, give the individual, within 7 days of the request, a copy of either:
   (a) the most recent statement of the audited accounts in relation to the registered provider; or
   (b) if the registered provider is operated as part of a broader organisation—the most recent statement of the audited accounts of the organisation's aged care component; or
   (c) the most recent audited general purpose financial report prepared under Subdivision E of Division 3 of Part 2 of Chapter 5 of this instrument.

(2) Despite subsection (1) of this section, a registered provider is not required to comply with this requirement if the registered provider:
   (a) is not required to prepare annual financial reports under Part 2M.3 of the Chapter 2M of the *Corporations Act 2001*; and
   (b) is not required to prepare a general purpose financial report under section 166-345 of this instrument.

155-40 Information to be provided—monthly statement

(1) This section applies to a registered provider registered in any of the following provider registration categories:
   (a) home and community services;
   (b) assistive technology and home modifications;
   (c) advisory and support services;
   (d) personal and care support in the home or community;
   (e) nursing and transition care.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services under a specialist aged care program.

(3) A registered provider that delivers funded aged care services to an individual through a service delivery branch in a calendar month must give the individual a written statement relating to the services delivered in that calendar month no later than the last day of the following month.

Monthly statement for an individual accessing care through the service group home support

(4) The monthly statement must contain the following:
   (a) the amount of person-centred subsidy for the individual for the quarter in their ongoing home support account or the amount of person-centred subsidy for the individual for the episode in their short-term home support account;

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(b) the amount of person-centred subsidy that was available for the individual in their ongoing or short-term home support account at the beginning of the calendar month;

(c) the amount of person-centred subsidy for the individual remaining in their ongoing or short-term home support account at the end of the calendar month;

(d) the name and amount of the primary-centred supplements (if any) for the individual in their ongoing home support account for the quarter and the name and amount of the primary-centred supplements (if any) for the individual in their short-term home support account for the episode;

(e) rollover credits received in respect of the quarter;

(g) an itemised list of:

(i) each episode of services or items delivered to the individual during the calendar month; and

(ii) any adjustments, variations or refunds from previous calendar months, including the service name and delivery date if relating to a service; and

(iii) any adjustments, variations or refunds from previous calendar months, including the service name and delivery date if relating to individual contribution amounts;

(h) for each service or item delivered under the classification type ongoing or the classification type short-term:

(i) the name of the service or item as described in the service list under section 8-5 of this instrument; and

(ii) the price or cost that the registered provider charged the individual in respect of the calendar month; and

(iii) the date on which the service or item was delivered in respect of the calendar month; and

(iv) the contribution amount for the individual in respect of each service or item delivered in the calendar month; and

(v) the total amount of contribution paid by the individual for the calendar month; and

(vi) the amount of subsidy claimed by the registered provider in respect of each service or item delivered in the calendar month; and

(vii) the number of units or hours delivered in respect of the calendar month; and

(viii) if the service or item was delivered by an associated provider of the registered provider or by a third party, that fact;

(i) for each service delivered under the classification type ongoing or short-term:

(i) identify the individual contribution rate, which must be provided each time there is a change to the contribution rate arising from a new determination made under section 314 of the Act; and

(ii) the corresponding amount for which the individual is responsible to contribute for delivery of that service;

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(j) for individuals with the classification type ongoing, information relating to the total number of units or hours delivered for the service type care management delivered in the relevant calendar month;

(k) for individuals with the classification level SAH end-of-life pathway for the classification type short-term, information relating to:

(i) the total number of units or hours delivered for the service type care management; and

(ii) the price and cost of the service and amount of subsidy claimed by the provider in respect of that service;

(l) for individuals with the classification level SAH restorative care pathway for the classification type short-term, information relating to:

(i) the total number of units or hours delivered for the service type restorative care management; and

(ii) the price and cost of the service and amount of subsidy claim by the provider in respect of that service;

(m) for each service taken to be delivered in accordance with subsection 11A(2) of the Act:

(i) the name of the service as provided in the list referred to in subsection 8(1) of the Act; and

(ii) the amount that the registered provider charged the individual for the service; and

(iii) the date on which the service was taken to be delivered; and

(iv) if the registered provider charged an individual contribution for the service, the individual contribution rate used to work out the individual contribution; and

(v) the amount of subsidy claimed by the registered provider for the service.

Monthly statement for an individual accessing care through the service groups assistive technology or home modifications

(5) The monthly statement must contain the following:

(a) the amount of person-centred subsidy for the individual for the account period;

(b) the available balance of the individual's notional assistive technology or home modifications account (if any) at the beginning of the calendar month;

(c) the available balance of the individual's notional assistive technology account or home modifications account at the end of the calendar month;

(d) the available balance of the individual's notional assistive technology account or notional home modifications account after taking into account any committed funds;

(e) any amount of the available balance that is no longer available to the individual due to the ceasing of the individual's notional assistive technology account or notional home modifications account in respect of the calendar month;

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(f) the end date of the account period for the individual's notional assistive technology account or notional home modifications account in the following calendar month;

(g) the name and amount of primary person-centred supplements (if any) for the individual for the account period;

(h) any additional approved amounts as specified in the determination made under subsection 211-20(5) of this instrument;

(i) an itemised list of:

(i) assistive technology or home modification items and services (if any), including administration or coordination, delivered to the individual during the calendar month; and

(ii) any adjustments, variations or refunds from previous calendar months;

(j) for each item or service delivered:

(i) the name of the item or service; and

(ii) the price that the registered provider charged the individual for the item or service in respect of the calendar month; and

(iii) the date on which the item or service was delivered in respect of the calendar month; and

(iv) the amount of contribution (if any) paid by the individual in respect of each item or service delivered in the calendar month; and

(v) the total amount of contribution paid by the individual for the calendar month; and

(vi) the amount of subsidy claimed by the registered provider in respect of each service or item delivered in the calendar month; and

(vii) the rate and number of item units or service hours delivered in respect of the calendar month; and

(viii) if the service or item was delivered by an associated provider of the registered provider or by a third party, that fact;

(k) any commitments to assistive technology or home modifications made during the calendar month, including those items, modifications or related services which are agreed to with the individual, but which have not yet been delivered within the calendar month;

(l) for each item or service committed to but not yet delivered:

(i) the name and price for each item or service agreed to; and

(ii) the amount of contribution in respect of each item or service that remains to be paid; and

(iii) the total amount of committed funds, including a breakdown of the total amount of subsidy to be claimed and the total amount of contribution to be paid;

(m) any assistive technology or home modification items charged through the assistive technology or home modifications account or through unspent Commonwealth portion;

(n) for each service taken to be delivered in accordance with subsection 11A(2) of the Act:

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(i) the name of the service as provided in the service list under section 8-5 of this instrument; and
(ii) the amount that the registered provider charged the individual for the service; and
(iii) the date on which service was taken to be delivered; and
(iv) if the registered provider charged an individual contribution for the service, the individual contribution rate used to work out the individual contribution; and
(v) the amount of subsidy claimed by the registered provider for the service.

Unspent portions and notional home care accounts

(6) If an individual has a notional home care account; or the registered provider holds an unspent Commonwealth portion or an unspent care recipient portion for the individual, the monthly statement must contain the following:
(a) the available balance of the individual's notional home care account at the beginning and end of the calendar month;
(b) the available balance of the individual's unspent Commonwealth portion at the beginning and end of the calendar month;
(c) the amount of the individual's unspent care recipient portion at the beginning and end of the calendar month.

Monthly statement for established account types

(7) The monthly statement must only contain information regarding the notional accounts established for the individual.

Monthly statement for a period in which no services are delivered

(8) If no service or item was delivered by registered provider to the individual during the calendar month, a statement must still be provided no later than the last day of the following calendar month.

When statement must be given

(9) A registered provider must give the statement to the individual no later than the last day of the following calendar month.

Informing the individual of, and helping the individual to understand, statement

(10) A registered provider must inform the individual of and help the individual to understand the monthly statement.

155-45 Information to be given—final monthly statement

(1) This section applies to a registered provider registered in any of the following provider registration categories:
(a) home and community services;

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(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services under a specialist aged care program.

(3) If a registered provider ceases to deliver funded aged care services to the individual, the registered provider must give the individual or their supporter, after the final claim is made for the individual, a final monthly statement.

(4) The final monthly statement must be prepared in accordance with subsection 155-40(4) or (5).

(6) A registered provider must give the final monthly statement to the individual or their supporter no later than the last day of the calendar month after the last claim is made.

155-50 Information to be provided—individualised budget

(1) This section applies to a registered provider registered in any of the following provider registration categories:
(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services under a specialist aged care program.

(3) A registered provider that delivers funded aged care services to an individual through one or more of the service groups home support, assistive technology and home modifications must give the individual a written individualised budget.

(4) The individualised budget for the individual must:
(a) be prepared in partnership with the individual; and
(b) cover a period agreed with the individual (the ***budget period***); and
(c) be prepared having regard to the individual's preferences, goals and assessed needs, the resources available and the funded aged care services selected by the individual for the budget period; and
(d) set out an itemised budget for the funded aged care services to be delivered to the individual in the budget period, as set out in the individual's care and services plan, including, for each service to be delivered to the individual on a day:
(i) if an individual contribution rate determination for the individual is in effect—the individual contribution rate for the service for the individual; and

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(ii) if an individual contribution rate determination for the individual is not in effect—the maximum individual contribution rate that could apply to the service for the individual (when determined for each means testing category for the individual under section 314 of the Act); and

(iii) if known—the cost for the delivery of the service; and

(iv) if known—the amount that will be the individual contribution for the delivery of the service to the individual on the day; and

(v) if known—the amount of subsidy for which the provider will be eligible for the delivery of the service to the individual on the day; and

(e) for the service group assistive technology, the itemised budget must also specify the following (if known):

(i) the description and cost for assistive technology products and equipment;

(ii) the description and cost for assistive technology product and equipment repair or maintenance;

(iii) the prescription cost (if applicable) for assistive technology;

(iv) the description and cost of wraparound activities for assistive technology;

(v) administrative costs charged by the registered provider for assistive technology; and

(f) for the service group home modifications, the itemised budget must also specify the following:

(i) the description and cost of home modification supplies and services;

(ii) the prescription cost (if applicable) for home modifications;

(iii) the description and cost of wraparound activities for home modifications;

(iv) coordination costs charged by the registered provider for home modifications; and

(g) if known—set out the amount of subsidy payable to the registered provider for the individual in respect of the period agreed between the individual and the registered provider.

(5) A registered provider must give the individualised budget to the individual as soon as practicable after the registered provider has all the necessary information to complete it.

(6) A registered provider must review and, if necessary, revise the individualised budget for the individual if:

(a) a change to the funded aged care services mentioned in paragraph (4)(d) is proposed; or

(b) there is a change to the costs for delivering those services; or

(c) the individual contribution rate for the individual changes; or

(d) the individual requests the registered provider to do so.

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(7) If a registered provider reviews and revises the individualised budget for an individual, the registered provider must give the individual a copy of the revised individualised budget:
  (a) if the review and revision was for a reason referred to in paragraph (6)(a), (b) or (c)—as soon as practicable after the registered provider has all the necessary information to complete it; or
  (b) if the review and revision was in response to a request referred to in paragraph (6)(d)—within 14 days of the request being made.

(8) The registered provider must inform the individual of, and help the individual to understand, the individualised budget for the individual.

155-55 Information to be provided—general information for individuals accessing any funded aged care services

(1) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing, or seeking to access, funded aged care services the following:
  (a) a copy of the document mentioned in paragraph 165-20(1)(f) of this instrument, relating to giving complaints and feedback;
  (b) an explanation of the effect of section 168 of the Act (which deals with the protection of personal information);
  (c) a copy of the Aged Care Code of Conduct.

(2) A registered provider must assist the individual to understand the information given under subsection (1) of this section.

(3) A registered provider must comply with subsections (1) and (2) before, or when, the registered provider commences delivery of funded aged care services to that individual.

155-60 Information to be provided—general information for individuals accessing funded aged care services in a home or community setting

(1) This section applies to a registered provider registered in any of the following provider registration categories:
  (a) home and community services;
  (b) assistive technology and home modifications;
  (c) advisory and support services;
  (d) personal and care support in the home or community;
  (e) nursing and transition care.

(2) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing, or seeking to access, funded aged care services in a home or community setting the following:
  (a) an explanation of the effect of Division 1 of Part 5 of Chapter 4 of the Act and Division 1 of Part 2 of Chapter 10 of this instrument (which deals with means testing in a home or community setting);

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(b) information about the circumstances in which the provider may cease delivery of funded aged care services to the individual as specified in subsection 149-35(2) of this instrument, including an explanation of the effect of section 149-40 (which deals with notice requirements applicable to the provider);

(c) an explanation of the effect of subsection 148-80(1) of this instrument (which deals with the development of a care and services plan for the individual);

(d) information that the provider will give the individual a monthly statement in accordance with sections 155-40 and 155-45 of this instrument;

(e) for individuals accessing funded aged care services through the service group home support, other than under a specialist aged care program—a copy of the most recent version of the Support at Home Service List published by the Department.

Note: The Support at Home Service List could in 2026 be viewed on the Department's website (https://www.health.gov.au).

(3) A registered provider must assist the individual to understand the information given under subsection (2) of this section.

(4) A registered provider must comply with subsections (2) and (3) before, or when, the registered provider commences delivery of funded aged care services to that individual.

(5) Despite subsection (2) of this section, the requirements of paragraphs (2)(a) and (2)(d) of this section do not apply in respect of the delivery of funded aged care services delivered under any specialist aged care program.

155-65 Information to be provided—general information for individuals accessing funded aged care services in an approved residential care home

(1) This section applies to a registered provider registered in the provider registration category residential care.

(2) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing, or seeking to access, funded aged care services in an approved residential care home the following:

(a) information about the circumstances in which the individual may be asked to leave the approved residential care home as specified in subsection 149-60(1) of this instrument, including an explanation of the effect of section 149-65 (which deals with notice requirements applicable to the provider);

(b) information about any policies or protocols of the approved residential care home that are relevant to the individual.

(3) A registered provider must assist the individual to understand the information given under subsection (2) of this section.

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(4) A registered provider must comply with subsections (2) and (3) before, or when, the registered provider commences delivery of funded aged care services to that individual.

155-70 Information to be provided—information about the financial position of a registered provider registered in a provider registration category other than residential care

(1) Subject to subsection (2), this section applies to a registered provider registered in any of the following provider registration categories:
  (a) home and community services;
  (b) assistive technology and home modifications;
  (c) advisory and support services;
  (d) personal and care support in the home or community;
  (e) nursing and transition care.

(2) This section does not apply to registered providers of services in the registration categories listed in subsection (1) which are government entities.

(3) For the purposes of subsection 155(1) of the Act, before or when a registered provider starts delivering funded aged care services to an individual the registered provider must notify the individual, in writing, that the registered provider will give the individual, within 7 days of a request by the individual, the following information and documents:
  (a) a clear and simple presentation of the financial position of the registered provider;
  (b) a copy of the most recent statement of the audited accounts of the service delivery branch or, if the service delivery branch is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the service delivery branch).

(4) If an individual requests the registered provider to give the individual the information and documents referred to in subsection (3), the registered provider must give the individual the information and documents requested within 7 days after receiving the request.

(5) A registered provider that is not required to prepare annual financial reports under Part 2M.3 of Chapter 2M of the *Corporations Act 2001* is not required to comply with paragraph (3)(b) of this section.

155-80 Information to be provided—pricing information (by way of publication)

(1) This section applies to a registered provider registered in any of the following provider registration categories:
  (a) home and community services;
  (b) assistive technology and home modifications;
  (c) advisory and support services;

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(d) personal and care support in the home or community;
(e) nursing and transition care.

Service group home support

(2) A registered provider delivering funded aged care services through the service group home support must publish on the registered provider's website the most common price that the registered provider charges individuals for each service in the following service types:
(a) allied health and therapy;
(b) care management;
(c) domestic assistance;
(d) home maintenance and repairs;
(e) home or community general respite;
(f) meals;
(g) nursing care;
(h) personal care;
(i) restorative care management;
(j) social support and community engagement;
(k) therapeutic services for independent living;
(l) transport.

(3) The pricing information published for the purposes of subsection (2) of this section must:
(a) specify the most common price for delivery of the service during standard business hours; and
(b) specify the most common price for delivery of the service on weekdays outside standard business hours; and
(c) specify the most common price for delivery of the service on Saturdays; and
(d) specify the most common price for delivery of the service on Sundays; and
(e) specify the most common price for delivery of the service on public holidays.

(4) In this section:

most common price means the price for a service that the registered provider has most frequently charged during the previous 2 calendar months, calculated at the end of the following:
(a) August;
(b) October;
(c) December;
(d) February;
(e) April;
(f) June.

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(5) A registered provider must update the pricing information on the registered provider's website for a service where the most common price for the service changes, within 30 days of the end of the calculation period mentioned in subsection (4).

(6) A registered provider is not required to publish a price for a service under subsection (2) if the registered provider is not currently delivering the service and has not delivered the service in the last 12 months.

(7) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under a specialist aged care program.

Service group assistive technology

(8) A registered provider registered in the provider registration category assistive technology and home modifications delivering funded aged care services through the service group assistive technology must publish on the registered provider's website:

(a) whether the registered provider charges a provider administration fee for the provision of funded aged care services; and

(b) if the registered provider charges a provider administration fee, the amount of the provider administration fee as a percentage of the price for the provision of services.

(9) A registered provider must update the pricing information on the registered provider's website where the information published under subsection (8) changes, within 30 days of the change.

Service group home modifications

(10) A registered provider registered in the provider registration category assistive technology and home modifications delivering funded aged care services through the service group home modifications must publish on the registered provider's website:

(a) whether the registered provider charges a provider coordination fee for the provision of funded aged care; and

(b) if the registered provider charges a provider coordination fee, the amount of the provider coordination fee as a percentage of the price for the provision of services.

(11) A registered provider must update the pricing information on the registered provider's website where the information published under subsection (10) changes, within 30 days of the change.

155-85 Requirements for allowing and facilitating access to information held about an individual

(1) For the purposes of subsection 155(2) of the Act, a registered provider that is not any of the following is prescribed:

(a) an APP entity within the meaning of the *Privacy Act 1988*;

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(b) a State or Territory;

(c) body established for a public purpose by or under a law of the State or Territory (other than a local government authority).

(2) For the purposes of paragraph 155(2)(b) of the Act, it is a requirement when a registered provider is allowing and facilitating access by an individual to whom the registered provider delivers funded aged care services to records and information (including personal information) held by the registered provider about the individual, that the registered provider must comply with Australian Privacy Principle 12 as set out in Schedule 1 of the *Privacy Act 1988*, as if it were an organisation for the purposes of that Act.

Note: A registered provider that is an APP entity remains subject to the *Privacy Act 1988*, including APP 12.

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Division 3—Access by supporters etc.

156-5 Access to individuals

(1) For the purposes of subsection 156(1) of the Act, every kind of registered provider is prescribed.

Supporters

(2) For the purposes of subsection 156(1) of the Act, it is a requirement that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) by a supporter of an individual to whom the provider delivers funded aged care services to the individual at any time requested, or consented to, by the individual.

Note: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

Legal advisors etc.

(3) For the purposes of subsection 156(1) of the Act, it is a requirement that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) to an individual to whom the provider delivers funded aged care services by a relevantly qualified person providing legal advice or another legal service to the individual at any time requested, or consented to, by the individual.

Note: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

Independent aged care advocates

(4) For the purposes of subsection 156(1) of the Act, it is a requirement that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) by an independent aged care advocate to an individual to whom the provider delivers funded aged care services:

(a) unless paragraph (b) applies—at any time requested, or consented to, by the individual; or

(b) if the individual is unable to request or consent to the access—at any time.

Note: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

Aged care volunteer visitor

(5) For the purposes of subsection 156(1) of the Act, it is a requirement that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) by an aged

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care volunteer visitor to an individual to whom the provider delivers funded aged care services at any time requested, or consented to, by the individual.

Note: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

156-10 Access to settings

(1) For the purposes of subsection 156(2) of the Act:

(a) every kind of registered provider is prescribed; and

(b) it is a prescribed requirement that, if:

(i) a registered provider delivers funded aged care services to an individual in a setting; and

(ii) the individual requests, or consents to, access by an independent aged care advocate; and

(iii) the purpose of the access by the advocate is to provide information and education to the individual;

the registered provider must allow and facilitate the access to the individual, and any other individual who requests or consents to the access, in the setting.

Note 1: See also subsection 156(4) of the Act, which relates to providers delivering services to an individual in a home or community setting, and access requirements only applying in relation to times during which those services are being delivered.

Note 2: See also subsections 156(6) and (7) of the Act, which relate to access to settings.

(2) Without limiting paragraph (1)(b), a setting may include the following:

(a) a residential care home;

(b) a home or community setting.

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Part 8—Governance

Division 1—Membership of governing bodies

157-5 Kinds of provider to which the independent non-executive members requirement applies

(1) For the purposes of paragraph 157(2)(a) of the Act, a registered provider registered in any of the following provider registration categories is prescribed, unless the provider is covered by subsection (2):
  (a) nursing and transition care;
  (b) residential care.

(2) This subsection covers a registered provider that is:
  (a) a kind of body known as an Aboriginal Community Controlled Organisation; or
  (b) a body that is registered under the Co-operatives National Law or the *Co-operatives Act 2009* (WA) as a co-operative and has clauses in its rules to the effect that:
    (i) an objective or primary activity of the registered provider is delivering quality funded aged care services to individuals in accordance with the Aged Care Quality Standards; and
    (ii) distribution of assets to members upon winding-up are limited to the nominal value of the member's contribution to the co-operative, provided that such a limitation complies with the legislation under which the co-operative is registered.

157-10 Kinds of provider to which the clinical care provision experience requirement applies

For the purposes of paragraph 157(2)(b) of the Act, a registered provider is prescribed if the provider:
  (a) is registered in any of the following provider registration categories:
    (i) nursing and transition care;
    (ii) residential care; and
  (b) is not a kind of body known as an Aboriginal Community Controlled Organisation.

157-15 Kinds of providers to which other governing body requirements apply

For the purposes of subsection 157(5) of the Act, a registered provider that is covered by paragraph 157-5(2)(b) of this instrument must ensure that the members of the provider's governing body undertake training on governance focused on co-operatives or includes course material on co-operatives within 6 months of the member's appointment as a member of the governing body.

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157-20 Application for determination that certain conditions do not apply—other matters that the Commissioner may take into account

For the purposes of paragraph 159(4)(h) of the Act, the matters are the following:

(a) subject to paragraph (b) of this section, the registered provider's history of compliance with the governance conditions set out in paragraphs 157(2)(a) and 157(2)(b) of the Act;

(b) any circumstances surrounding the registered provider's history of non-compliance with the governance conditions set out in paragraphs 157(2)(a) and 157(2)(b) of the Act, including steps (if any) that the provider has taken to become compliant;

(c) any other matter the Commissioner considers relevant.

Note: For paragraph (b), examples of circumstances include the following:

(a) where a member of a governing body has unexpectedly resigned, and recruitment of a new member is ongoing, which renders a provider non-compliant with a governance condition;

(b) where a person has accepted a role as a member of the governing body but is yet to commence in that role.

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Division 2—Advisory body requirements

158-5 Kinds of provider to which the quality care advisory body condition applies

For the purposes of subsection 158(2) of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

(a) nursing and transition care;

(b) residential care.

158-10 Requirements for membership of quality care advisory body

For the purposes of subparagraph 158(2)(a)(i) of the Act, the requirements are that the membership of the quality care advisory body of a registered provider must include the following:

(a) a responsible person of the registered provider who has appropriate experience in the delivery of funded aged care services;

(b) if the registered provider is registered in the provider registration category residential care—a person who is directly involved in the provider's delivery of funded aged care services;

(c) if the registered provider is registered in the provider registration category nursing and transition care and delivers funded aged care services in the service type nursing care—a person who is directly involved in the delivery of those services;

(d) a person who represents the interests of individuals to whom the provider delivers funded aged care services.

Note: For paragraph (d), examples of such persons include the following:

(a) an individual to whom the provider is delivering funded aged care services;

(b) a member of a consumer advisory body (if established);

(c) a member of an organised consumer advisory service.

158-15 Requirements for reports of quality care advisory body

For the purposes of subparagraph 158(2)(a)(ii) of the Act, the requirements for a written report given by the quality care advisory body of a registered provider to the governing body of the provider are that the report must include any concerns that the body has about the quality of funded aged care services delivered by the provider in the period covered by the report (the ***report period***), taking into account the following:

(a) feedback provided (if any) about the quality of funded aged care services delivered by the provider in the report period by:

(i) individuals to whom the provider delivered funded aged care services; and

(ii) responsible persons and aged care workers of the provider;

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(b) complaints received (if any) in the report period by the provider about the quality of funded aged care services delivered by the provider and action taken by the provider to address the complaints;

(c) the use of regulatory mechanisms (if any) under Chapter 6 of the Act by the Commissioner in relation to the quality of funded aged care services delivered by the provider;

(d) progress made in the report period in relation to the provider's continuous improvement plan, particularly improvements made in the delivery of funded aged care services by the provider;

(e) the results of any audits performed by the Commissioner under section 110-38;

(f) staffing arrangements of the provider during the report period, including details of the following, as applicable:

(i) the availability of allied health professionals or registered health practitioners;

(ii) the availability of registered nurses;

(iii) turnover of the aged care workers of the provider;

(g) reportable incidents (if any) in connection with the delivery of funded aged care services to an individual by the provider that occurred in the report period and any action taken by the provider in response to the reportable incidents;

(h) if the provider delivers funded aged care services in an approved residential care home:

(i) feedback received (if any) in the report period from individuals to whom the provider delivers funded aged care services about the quality of food provided by the provider; and

(ii) changes (if any) in the report period in the quality of food provided, and the food preparation model used, by the provider; and

(iii) menu assessments (if any) conducted by an accredited practising dietitian in the report period in relation to food and nutrition provided by the provider; and

(iv) information compiled or derived from a measurement or other assessment made by the provider in the report period in relation to the Quality Indicators in Subdivision B of Division 3 of Part 2 of Chapter 5 of this instrument.

158-20 Kinds of provider to which the consumer advisory bodies condition applies

For the purposes of subsection 158(4) of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

(a) nursing and transition care;

(b) residential care.

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Part 9—Restrictive practices—approved residential care homes

Division 1—Preliminary

162-5 Kinds of provider to which the condition applies

For the purposes of section 162 of the Act, a registered provider registered in the provider registration category residential care is prescribed.

162-10 Requirements relating to the use of restrictive practices

For the purposes of section 162 of the Act, this Part prescribes requirements relating to the use of restrictive practices in relation to an individual to whom a registered provider is delivering funded aged care services in an approved residential care home.

Note: See also sections 17 and 18 of the Act and Division 2 of Part 7 of Chapter 1 of this instrument.

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Division 2—Requirements relating to the use of restrictive practices

162-15 Requirements for the use of any restrictive practice

(1) The following requirements apply to the use of any restrictive practice in relation to an individual:

(a) the restrictive practice is used only:

(i) as a last resort to prevent harm to the individual or other persons; and

(ii) after consideration of the likely impact of the use of the restrictive practice on the individual;

(b) to the extent possible, best practice alternative strategies are used before the restrictive practice is used;

(c) the alternative strategies that have been considered or used have been documented in the behaviour support plan for the individual;

(d) the restrictive practice is used only to the extent that it is necessary and in proportion to the risk of harm to the individual or other persons;

(e) the restrictive practice is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the individual or other persons;

(f) informed consent to the use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), has been given by:

(i) the individual; or

(ii) if the individual lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice;

(g) the use of the restrictive practice is in accordance with the informed consent mentioned in paragraph (f);

(h) the use of the restrictive practice complies with any provisions of the behaviour support plan for the individual that relate to the use of the restrictive practice;

(i) the use of the restrictive practice complies with the Aged Care Quality Standards and the Aged Care Code of Conduct;

(j) the use of the restrictive practice is not inconsistent with the Statement of Rights;

(k) the use of the restrictive practice meets the requirements (if any) of the law of the State or Territory in which the restrictive practice is used.

(2) However, the requirements set out in paragraphs (1)(a), (b), (c), (f), (g) and (h) do not apply to the use of a restrictive practice in relation to an individual if the use of the restrictive practice in relation to the individual is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 162-35 for other responsibilities of registered providers that apply if the use of a restrictive practice in relation to an individual is necessary in an emergency.

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162-20 Additional requirements for the use of restrictive practices other than chemical restraint

(1) The following requirements apply to the use of a restrictive practice in relation to an individual that is not chemical restraint:

(a) an approved health practitioner who has day-to-day knowledge of the individual has:

(i) assessed the individual as posing a risk of harm to the individual or any other person; and

(ii) assessed that the use of the restrictive practice is necessary;

(b) the following matters have been documented in the behaviour support plan for the individual:

(i) the assessments;

(ii) a description of any engagement with persons other than the approved health practitioner in relation to the assessments;

(iii) a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments.

(2) However, the requirement set out in paragraph (1)(b) does not apply to the use of a restrictive practice in relation to an individual if the use of the restrictive practice in relation to the individual is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 162-35 for other responsibilities of registered providers that apply if the use of a restrictive practice in relation to an individual is necessary in an emergency.

162-25 Additional requirements for the use of restrictive practices that are chemical restraint

(1) The following requirements apply to the use of a restrictive practice in relation to an individual that is chemical restraint:

(a) the registered provider is satisfied that a medical practitioner or nurse practitioner has:

(i) assessed the individual as posing a risk of harm to the individual or any other person; and

(ii) assessed that the use of the chemical restraint is necessary; and

(iii) prescribed medication for the purpose of using the chemical restraint; and

(iv) obtained informed consent to the prescribing of the medication for the purpose of using the chemical restraint;

(b) the following matters have been documented in the behaviour support plan for the individual:

(i) the assessments;

(ii) the practitioner's decision to use the chemical restraint;

(iii) the individual's behaviours that are relevant to the need for the chemical restraint;

(iv) the reasons the chemical restraint is necessary;

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(v) the information (if any) provided by the registered provider to the practitioner that informed the decision to prescribe the medication for the purpose of using the chemical restraint;

(vi) that the registered provider is satisfied that the practitioner obtained informed consent to the prescribing of the medication;

(vii) the details of the prescription for the prescribed medication, including its name, dosage and when it may be used;

(viii) a description of any engagement with persons other than the practitioner in relation to the use of the chemical restraint;

(ix) a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments;

(c) the use of the medication for the purpose of using the chemical restraint is in accordance with the prescription mentioned in subparagraph (b)(vii).

Note: Codes of appropriate professional practice for medical practitioners and nurse practitioners provide for the practitioners to obtain informed consent before prescribing medications. Those codes are approved under the National Law and are:

(a) for medical practitioners—*Good medical practice: a code of conduct for doctors in Australia* (which in 2025 could be viewed on the website of the Medical Board of Australia (www.medicalboard.gov.au)); and

(b) for nurse practitioners—*Code of conduct for nurses* (which in 2025 could be viewed on the website of the Nursing and Midwifery Board of Australia (www.nursingmidwiferyboard.gov.au)).

(2) However, the requirements set out in subparagraph (1)(a)(iv) and paragraph (1)(b) do not apply to the use of a restrictive practice in relation to an individual if the use of the restrictive practice in relation to the individual is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 162-35 for other responsibilities of registered providers that apply if the use of a restrictive practice in relation to an individual is necessary in an emergency.

162-30 Requirements while restrictive practice being used

If a registered provider uses a restrictive practice in relation to an individual, the registered provider must ensure that while the restrictive practice is being used:

(a) the individual is monitored for the following:

(i) signs of distress or harm;

(ii) side effects and adverse events;

(iii) changes in mood or behaviour;

(iv) changes in well-being, including the individual's ability to engage in activities that enhance quality of life and are meaningful and pleasurable;

(v) changes in the individual's ability to maintain independent function (to the extent possible);

(vi) changes in the individual's ability to engage in activities of daily living (to the extent possible); and

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(b) the necessity for the use of the restrictive practice is regularly monitored, reviewed and documented; and

(c) the effectiveness of the use of the restrictive practice, and the effect of changes in the use of the restrictive practice, are monitored; and

(d) to the extent possible, changes are made to the individual's environment to reduce or remove the need for the use of the restrictive practice; and

(e) if the restrictive practice is chemical restraint—information about the effects and use of the chemical restraint is provided to the medical practitioner or nurse practitioner who prescribed the medication for the purpose of using the chemical restraint as mentioned in paragraph 162-25(1)(a).

162-35 Requirements following emergency use of restrictive practice

If a registered provider uses a restrictive practice in relation to an individual and the use of the restrictive practice in relation to the individual is necessary in an emergency, the registered provider must, as soon as practicable after the restrictive practice starts to be used:

(a) if the individual lacked capacity to consent to the use of the restrictive practice—inform the restrictive practices substitute decision-maker for the restrictive practice about the use of the restrictive practice; and

(b) ensure that the following matters are documented in the behaviour support plan for the individual:

(i) the individual's behaviours that were relevant to the need for the use of the restrictive practice;

(ii) the alternative strategies that were considered or used (if any) before the use of the restrictive practice;

(iii) the reasons the use of the restrictive practice was necessary;

(iv) the care to be provided to the individual in relation to the individual's behaviour;

(v) if the restrictive practices substitute decision-maker for the restrictive practice was informed about the use of the restrictive practice under paragraph (a)—a record of the restrictive practices substitute decision-maker being so informed; and

(c) if the restrictive practice is not chemical restraint—ensure that the assessments mentioned in paragraph 162-20(1)(a) are documented in the behaviour support plan for the individual; and

(d) if the restrictive practice is chemical restraint—ensure that the matters mentioned in subparagraphs 162-25(1)(b)(i) to (v) and (vii) to (ix) are documented in the behaviour support plan for the individual.

162-40 Requirements relating to nominations of restrictive practices nominees

Preventing coercion and duress

(1) A registered provider must take reasonable steps to ensure that:

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(a) an individual to whom the registered provider delivers funded aged care services is not subject to coercion or duress in making, varying or revoking a nomination under section 6-15; and

(b) an individual nominated under section 6-15 (whether as an individual or as a member of a group) is not subject to coercion or duress in agreeing as mentioned in paragraph 6-15(2)(b) or (3)(b), or in withdrawing that agreement.

Assisting care individuals

(2) If an individual nominates an individual under section 6-15 (whether as an individual or as a member of a group), the registered provider delivering funded aged care services to the individual must assist the individual to:

(a) notify the individual of the nomination; and

(b) give the individual a copy of the nomination; and

(c) seek the individual's agreement as mentioned in paragraph 6-15(2)(b) or (3)(b).

Keeping records

(3) If an individual nominates an individual under section 6-15 (whether as an individual or as a member of a group), the registered provider delivering funded aged care services to the individual must keep a record of:

(a) the nomination; and

(b) whether the individual has agreed as mentioned in paragraph 6-15(2)(b) or (3)(b); and

(c) if the individual has agreed as mentioned in paragraph 6-15(2)(b) or (3)(b)—whether the individual has withdrawn that agreement.

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Division 3—Requirements relating to behaviour support

162-45 Requirement for behaviour support plans

(1) If:

(a) a registered provider delivers funded aged care services to an individual; and

(b) behaviour support is needed for the individual;

the registered provider must ensure that a behaviour support plan for the individual is included in the care and services plan for the individual.

(2) The registered provider must ensure that the behaviour support plan:

(a) is prepared, reviewed and revised in accordance with this Division; and

(b) sets out the matters required by this Division and Division 2.

(3) In preparing the behaviour support plan, the registered provider must take into account any previous assessment relating to the individual that is available to the registered provider.

162-50 Requirements for behaviour support plans—alternative strategies for addressing behaviours of concern

A behaviour support plan for an individual must set out the following matters:

(a) information about the individual that helps the registered provider to understand the individual and the individual's behaviour (such as information about the individual's past experience and background);

(b) any assessment of the individual that is relevant to understanding the individual's behaviour;

(c) information about behaviours of concern for which the individual may need support;

(d) the following information about each occurrence of behaviours of concern for which the individual has needed support:

(i) the date, time and duration of the occurrence;

(ii) any adverse consequences for the individual or other persons;

(iii) any related incidents;

(iv) any warning signs for, or triggers or causes of, the occurrence (including trauma, injury, illness or unmet needs such as pain, boredom or loneliness);

(e) alternative strategies for addressing the behaviours of concern that:

(i) are best practice alternatives to the use of restrictive practices in relation to the individual; and

(ii) take into account the individual's preferences (including preferences in relation to care delivery) and matters that might be meaningful or of interest to the individual; and

(iii) aim to improve the individual's quality of life and engagement;

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(f) any alternative strategies that have been considered for use, or have been used, in relation to the individual;

(g) for any alternative strategy that has been used in relation to the individual:

(i) the effectiveness of the strategy in addressing the behaviours of concern; and

(ii) records of the monitoring and evaluation of the strategies;

(h) a description of the registered provider's consultation about the use of alternative strategies in relation to the individual with the individual or a supporter of the individual (if any).

162-55 Requirements for behaviour support plans—if use of restrictive practice assessed as necessary

If the use of a restrictive practice in relation to an individual is assessed as necessary as mentioned in section 162-20 or 162-25, the behaviour support plan for the individual must set out the following matters:

(a) the individual's behaviours of concern that are relevant to the need for the use of the restrictive practice;

(b) the restrictive practice and how it is to be used, including its duration, frequency and intended outcome;

(c) the best practice alternative strategies that must be used (to the extent possible) before using the restrictive practice;

(d) how the use of the restrictive practice is to be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that arise from the use of the restrictive practice;

(e) how the use of the restrictive practice is to be reviewed, including consideration of the following:

(i) the outcome of its use and whether the intended outcome was achieved;

(ii) whether an alternative strategy could be used to address the individual's behaviours of concern;

(iii) whether a less restrictive form of the restrictive practice could be used to address the individual's behaviours of concern;

(iv) whether there is an ongoing need for its use;

(v) if the restrictive practice is chemical restraint—whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;

(f) if the individual lacks the capacity to give informed consent to the use of the restrictive practice:

(i) whether subsection 6-20(1), or an item of the table in subsection 6-20(2), applies for the restrictive practice in relation to the individual, and why that subsection or item applies; and

(ii) the name of the restrictive practices substitute decision-maker for the restrictive practice in relation to the individual;

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(g) a description of the registered provider's consultation about the use of the restrictive practice with:
  (i) the individual; or
  (ii) if the individual lacks the capacity to give informed consent to the use of the restrictive practice—the restrictive practices substitute decision-maker for the restrictive practice;

(h) a record of the giving of informed consent to the use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), by:
  (i) the individual; or
  (ii) if the individual lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.

Note: Sections 162-20 and 162-25 also require other matters to be documented in the behaviour support plan.

162-60 Requirements for behaviour support plans—if restrictive practice used

If a restrictive practice is used in relation to an individual, the behaviour support plan for the individual must set out the following matters:

(a) the restrictive practice and how it was used, including the following:
  (i) when it began to be used;
  (ii) the duration of each use;
  (iii) the frequency of its use;
  (iv) the outcome of its use and whether the intended outcome was achieved;
  (v) whether its use was in accordance with the informed consent set out under paragraph 162-55(h);

(b) if, under the plan, the restrictive practice is to be used only on an as-needed basis in response to particular behaviour, or in particular circumstances:
  (i) the individual's behaviours of concern that led to the use of the restrictive practice; and
  (ii) the actions (if any) taken leading up to the use of the restrictive practice, including any alternative strategies that were used before the restrictive practice was used;

(c) the details of the persons involved in the use of the restrictive practice;

(d) a description of any engagement with external support services (for example, dementia support specialists) in relation to the use of the restrictive practice;

(e) details of the monitoring of the use of the restrictive practice as required by the plan;

(f) the outcome of the review of the use of the restrictive practice as required by the plan.

Note 1: For paragraphs (e) and (f), see paragraphs 162-55(d) and (e) for the requirements for a behaviour support plan for an individual to require monitoring and review of the use of a restrictive practice in relation to the individual.

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Note 2: If the use of a restrictive practice in relation to an individual is necessary in an emergency, other matters must also be documented in the behaviour support plan for the individual (see section 162-35).

162-65 Requirements for behaviour support plans—if need for ongoing use of restrictive practice indicated

If a review of the use of a restrictive practice in relation to an individual (as required by the behaviour support plan for the individual) indicates a need for the ongoing use of the restrictive practice, the behaviour support plan for the individual must set out the following matters:

(a) the restrictive practice and how it is to be used, including its duration, frequency and intended outcome;

(b) how the ongoing use of the restrictive practice is to be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that arise from the use of the restrictive practice;

(c) how the ongoing use of the restrictive practice is to be reviewed, including consideration of the following:

(i) the outcome of the ongoing use of the restrictive practice and whether the intended outcome is being achieved;

(ii) whether an alternative strategy could be used to address the individual's behaviours of concern;

(iii) whether a less restrictive form of the restrictive practice could be used to address the individual's behaviours of concern;

(iv) whether there continues to be need for the ongoing use of the restrictive practice;

(v) if the restrictive practice is chemical restraint—whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;

(d) a description of the registered provider's consultation about the ongoing use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), with:

(i) the individual; or

(ii) if the individual lacks the capacity to give informed consent to the ongoing use of the restrictive practice—the restrictive practices substitute decision-maker for the restrictive practice;

(e) a record of the giving of informed consent to the ongoing use of the restrictive practice by:

(i) the individual; or

(ii) if the individual lacks capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.

162-70 Requirement to review and revise behaviour support plans

A registered provider must review a behaviour support plan for an individual and make any necessary revisions:

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(a) on a regular basis; and
(b) as soon as practicable after any change in the individual's circumstances.

162-75 Requirement to consult on behaviour support plans

(1) In preparing, reviewing or revising a behaviour support plan for an individual, a registered provider must consult the following:
   (a) if the individual has the capacity to be consulted—the individual and a supporter of the individual (if any);
   (b) if the individual lacks the capacity to be consulted—a person or body who, under the law of the State or Territory in which the individual accesses funded aged care services, can make decisions about that care;
   (c) health practitioners with expertise relevant to the individual's behaviours of concern.

(2) If the use of a restrictive practice in relation to the individual is assessed as necessary as mentioned in section 162-20 or 162-25, the registered provider must also consult the following in preparing, reviewing or revising the behaviour support plan:
   (a) the approved health practitioner who made the assessment;
   (b) if the individual lacks the capacity to be consulted—the restrictive practices substitute decision-maker for the restrictive practice.

(3) In consulting under this section, the registered provider must provide the plan or revised plan, and any associated information, in an appropriately accessible format.

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Division 4—Immunity from civil or criminal liability in relation to the use of a restrictive practice in certain circumstances

163-5 Giving of informed consent by certain persons or bodies

For the purposes of paragraph 163(2)(a) of the Act (which refers to the giving of informed consent to the use of a restrictive practice in relation to an individual), a person or body that is a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual is prescribed.

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Part 10—Management of incidents and complaints

Division 1—Incident management

Subdivision A—Preliminary

164-1 Kinds of provider to which the condition applies

For the purposes of section 164 of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

(a) home and community services;
(b) advisory and support services;
(c) personal and care support in the home or community;
(d) nursing and transition care;
(e) residential care.

164-5 Requirements relating to incident management

For the purposes of section 164 of the Act, this Division prescribes:

(a) requirements for implementing and maintaining an incident management system; and
(b) requirements for managing, and taking reasonable steps to prevent, incidents.

Note: For requirements for reporting reportable incidents to the Commissioner, see Division 2 of Part 2 of Chapter 5 of this instrument.

164-10 Incidents to which this Division applies

(1) This Division applies to incidents that consist of acts, omissions, events or circumstances that:

(a) occur, are alleged to have occurred, or are suspected of having occurred, in connection with the delivery of funded aged care services to an individual by a registered provider; and
(b) either:
(i) have caused harm to the individual or another person; or
(ii) could reasonably have been expected to have caused harm to an individual or another person.

(2) This Division also applies to incidents not covered by subsection (1) that consist of acts, omissions, events or circumstances that:

(a) a registered provider becomes aware of in connection with the delivery of funded aged care services to an individual in a residential care home of the registered provider; and
(b) have caused harm to the individual.

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Subdivision B—Implementing and maintaining an incident management system

164-15 Requirements for system—objects

The objects of a registered provider's incident management system must include the following:

(a) to promote the safety, health, well-being and quality of life of individuals to whom the provider delivers funded aged care services by:
  (i) detecting, addressing and remediating incidents; and
  (ii) preventing incidents; and
  (iii) ensuring the provider's incident management system facilitates the open disclosure and resolution of incidents between individuals and the provider;

(b) to promote continuous improvement of:
  (i) the provider's management and prevention of incidents; and
  (ii) the provider's delivery of funded aged care services.

164-20 Requirements for system—general

A registered provider's incident management system must:

(a) be able to identify, record, assess, respond to and report on incidents; and

(b) specify procedures for identifying, recording, assessing, responding to and reporting on incidents; and

(c) require that appropriate support and assistance (including access to advocates and language services) is provided to persons affected by an incident to ensure their safety, health, well-being and quality of life; and

(d) specify how persons affected by an incident will be appropriately involved in the management and resolution of the incident; and

(e) specify the roles and responsibilities of aged care workers and responsible persons of the provider in managing and responding to incidents; and

(f) specify the roles and responsibilities of aged care workers and responsible persons of the provider in notifying reportable incidents to the Commissioner; and

(g) require an aged care worker of the provider who becomes aware of a reportable incident to notify one of the following of that fact as soon as possible:
  (i) a responsible person of the provider;
  (ii) a supervisor or manager of the aged care worker;
  (iii) a person specified for the purposes of paragraph (e) or (f); and

(h) require reportable incidents to be reported to the Commissioner in accordance with Division 2 of Part 2 of Chapter 5 of this instrument; and

(i) specify when an investigation by the provider is required to establish:
  (i) the causes of a particular incident; and
  (ii) the harm caused by the incident; and

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(iii) any operational issues that may have contributed to the incident occurring; and

(j) specify the nature of investigations mentioned in paragraph (i); and

(k) specify when remedial action is required and the nature of that action; and

(l) set out procedures for ensuring that the requirements of sections 164-40 and 164-45 are complied with.

164-25 Requirements for system—recording details of incidents

(1) A registered provider's incident management system must require the following details, as a minimum, to be recorded in relation to each incident:

(a) a description of the incident, including:

(i) the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the incident; and

(ii) if known—the consequences of that harm;

(b) whether the incident is a reportable incident;

(c) if known—the time, date and place at which the incident occurred or was alleged or suspected to have occurred;

(d) the time and date the incident was identified;

(e) the names and contact details of the persons directly involved in the incident;

(f) the names and contact details of any witnesses to the incident;

(g) details of the assessments undertaken in accordance with subparagraph 164-40(1)(b)(i) and subsection 164-45(1);

(h) the actions taken in response to the incident, including actions taken under sections 164-40 or 164-45;

(i) any consultations undertaken with the persons affected by the incident;

(j) whether persons affected by the incident have been provided with any reports or findings regarding the incident;

(k) if an investigation is undertaken by the provider in relation to the incident—the details and outcomes of the investigation;

(l) the name and contact details of the person recording the details of the incident;

(m) if the incident has been reported to the police—the details included in that report.

(2) A registered provider's incident management system must require details recorded in relation to an incident to be retained for 7 years after the date the record was made or received, in accordance with section 154-150 of this instrument.

164-30 Requirements for system—data collection and analysis

A registered provider's incident management system must:

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(a) require the collection of data relating to incidents that will enable the provider to:
  (i) identify occurrences, or alleged or suspected occurrences, of similar incidents; and
  (ii) identify and address systemic issues in the quality of funded aged care services delivered by the provider; and
  (iii) provide feedback and training to the provider's aged care workers and responsible persons about managing and preventing incidents; and
  (iv) provide information to the Commissioner, if required or requested to do so by the Commissioner; and
  (v) provide information to the provider's quality care advisory body (if any) and consumer advisory bodies (if any) to assist the body or bodies to prepare reports or feedback about the quality of the funded aged care services delivered by the provider; and
  (vi) continuously improve the provider's management and prevention of incidents; and
(b) require the regular analysis and review of data mentioned in paragraph (a) to assess:
  (i) the effectiveness of the provider's management and prevention of incidents; and
  (ii) what (if any) actions could be taken to improve the provider's management and prevention of incidents.

164-35 Requirements for registered providers

(1) A registered provider must:
(a) prepare and keep up to date documents detailing:
  (i) the provider's incident management system, including the objects mentioned in section 164-15 and the requirements mentioned in sections 164-20 to 164-30; and
  (ii) the roles and responsibilities in the system of the provider's aged care workers and responsible persons in identifying, managing and resolving incidents and in preventing incidents from occurring; and
(b) give the documents to:
  (i) the provider's aged care workers and responsible persons; and
  (ii) to the Commissioner, if required or requested to do so by the Commissioner; and
(c) ensure that the provider's aged care workers and responsible persons are aware of, and understand, their roles and responsibilities in the system; and
(d) require the provider's aged care workers and responsible persons to comply with the system; and
(e) provide appropriate training to the provider's aged care workers and responsible persons on how the system works, including:
  (i) how to recognise, respond to and report incidents; and
  (ii) their roles and responsibilities in the system; and

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(f) make the documents mentioned in paragraph (a) available, in an accessible form, to the following persons:
(i) the individuals to whom the provider is delivering funded aged care services;
(ii) supporters, family members, carers and advocates of the individuals to whom the provider is delivering funded aged care services, and any other person significant to those individuals; and
(g) assist persons referred to in paragraph (f) to understand how the system works.

(2) Without limiting paragraph (1)(e), a provider provides appropriate training to a person who is an aged care worker or responsible person of the provider if the training is provided:
(a) at least annually; and
(b) at the following times:
(i) when the person becomes an aged care worker or responsible person of the provider;
(ii) when there is a change to how the system works that affects the person's roles and responsibilities in the system;
(iii) when there is a change to the person's role that affects the person's roles and responsibilities in the system.

Subdivision C—Managing and preventing incidents

164-40 Requirements for managing incidents

General

(1) A registered provider must manage an incident:
(a) in accordance with the provider's incident management system; and
(b) by doing the following:
(i) assessing the support and assistance required to ensure the safety, health, well-being and quality of life of persons affected by the incident;
(ii) providing that support and assistance to those persons;
(iii) assessing how to appropriately involve each person affected by the incident, or a supporter or advocate of the person, in the management and resolution of the incident;
(iv) involving each person or supporter or advocate in that way;
(v) using an open disclosure process.

Notifying police of incident where reasonable grounds to do so

(2) If there are reasonable grounds to report the incident to police, the provider must notify a police officer of the incident within 24 hours of becoming aware of the incident.

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(3) If the provider later becomes aware of reasonable grounds to report the incident to police, the provider must notify a police officer of the incident within 24 hours of becoming aware of those grounds.

164-45 Requirements for improving management of incidents and taking reasonable steps to prevent incidents

(1) The provider must assess the incident in relation to the following, taking into account the views of persons affected by the incident:

(a) whether the incident could have been prevented;

(b) what (if any) remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their harm;

(c) how well the incident was managed and resolved;

(d) what (if any) actions could be taken to improve the provider's management and resolution of similar incidents;

(e) whether other persons or bodies should be notified of the incident.

(2) The provider must notify the persons and bodies determined under paragraph (1)(e).

(3) The provider must:

(a) take any actions determined under paragraph (1)(b); and

(b) take any actions determined under paragraph (1)(d) of this section or subparagraph 164-30(b)(ii) that are reasonable in the circumstances.

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Division 2—Complaints, feedback and whistleblowers

Subdivision A—Preliminary

165-5 Purpose of this Part

For the purposes of section 165 of the Act, this Part prescribes requirements for the following:

(a) implementing and maintaining a complaints and feedback management system;

(b) managing complaints and feedback;

(c) implementing and maintaining a whistleblower system and maintaining a whistleblower policy;

(d) managing disclosures that qualify for protection under section 547 of the Act (whistleblower protections).

Subdivision B—Implementing and maintaining a complaints and feedback management system

165-10 Objects of this Subdivision

The objects of this Subdivision are:

(a) to promote quality care and the safety of individuals to whom a registered provider delivers funded aged care services by ensuring the provider's complaints and feedback management system facilitates the open disclosure and resolution of complaints between individuals and the provider; and

(b) to ensure that the provider's complaints and feedback management system acknowledges, assesses, manages and resolves matters relating to the provider's delivery of funded aged care services in a fair, transparent, accessible, safe, culturally safe and timely manner; and

(c) to ensure that:

(i) individuals to whom the provider delivers funded aged care services; and

(ii) supporters of those individuals, and other persons supporting those individuals; and

(iii) the provider's aged care workers; and

(iv) any other persons;

are encouraged and supported to make complaints and give feedback about the provider's delivery of funded aged care services; and

(d) to ensure that complaints and feedback contribute to the continuous improvement of the provider's delivery of funded aged care services.

165-15 Requirements for system—general

(1) A registered provider's complaints and feedback management system must:

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(a) be able to:
  (i) receive, record, assess, acknowledge, respond to and report on complaints and feedback; and
  (ii) securely store information relating to complaints and feedback; and
(b) enable any person to:
  (i) make a complaint or give feedback; and
  (ii) withdraw a complaint or feedback that the person has made or given; and
(c) enable complaints to be made and withdrawn, and feedback to be given and withdrawn, orally and in writing; and
(d) enable complaints to be made, and feedback to be given, anonymously; and
(e) require that there are to be no costs charged by the provider for making, withdrawing or managing a complaint or giving, withdrawing or managing feedback; and
(f) require that the process for making and resolving complaints and giving and responding to feedback is accessible to any person who wishes to make or give, or has made or given, a complaint or feedback; and
(g) require that appropriate support and assistance (including access to advocates and language services) is provided to:
  (i) any person who wishes to make or give, or has made or given, a complaint or feedback; and
  (ii) each individual to whom the provider delivers funded aged care services who is directly affected by an issue raised in a complaint or feedback; and
(h) require that the role of the independent aged care advocate is acknowledged and supported; and
(i) enable cooperation with, and facilitate arrangements for, the independent aged care advocate to support the following persons in making a complaint, giving feedback, or otherwise in relation to a complaint made or feedback given:
  (i) individuals to whom the provider delivers funded aged care services;
  (ii) supporters of those individuals, and other persons supporting those individuals; and
(j) require that, if a person who has made a complaint (other than anonymously), or an individual to whom the provider delivers funded aged care services who is directly affected by an issue raised in the complaint, wishes to be involved in the resolution of the complaint, the person or individual is:
  (i) involved in an appropriate way in the resolution of the complaint; and
  (ii) kept informed in an appropriate way of the progress and outcome of the complaint; and
(k) require that there are no reprisals for a person who makes a complaint or gives feedback; and
(l) require that information provided in a complaint or feedback is kept confidential and only disclosed if required by law or if the disclosure is otherwise appropriate in the circumstances; and

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(m) require that the provider must, in responding to a complaint or feedback, afford procedural fairness to:
  (i) the person who made the complaint or gave the feedback (other than anonymously); and
  (ii) the person (if any) against whom the complaint is made or who is the subject of the feedback; and
(n) require that the provider practise open disclosure and prioritise restorative practices; and
(o) ensure that any requirements for the referral or notification of complaints under Commonwealth, State or Territory laws (as applicable) are met; and
(p) provide for the system to be reviewed as required, and at least annually, to ensure that it is meeting the requirements mentioned in paragraphs (a) to (o).

(2) Without limiting paragraph (1)(l), a disclosure is appropriate if the person about whom the information relates has consented to the disclosure.

165-20 Requirements for registered providers

(1) A registered provider must:
(a) prepare and keep up to date documents detailing:
  (i) the provider's complaints and feedback management system, including the requirements mentioned in section 165-15; and
  (ii) the roles and responsibilities in the system of the provider's aged care workers and responsible persons in relation to complaints and feedback; and
(b) give the documents to the provider's aged care workers and responsible persons; and
(c) ensure that the provider's aged care workers and responsible persons are aware of, and understand, their roles and responsibilities in the system; and
(d) require the provider's aged care workers and responsible persons to comply with the system; and
(e) provide appropriate training to the provider's aged care workers and responsible persons on how the system works, including:
  (i) how to handle personal information and data; and
  (ii) how to recognise and respond to complaints and feedback; and
  (iii) managing relationships and clearly communicating with persons making complaints or giving feedback; and
  (iv) when and how to escalate complaints and feedback in the system; and
  (v) their roles and responsibilities in the system; and
  (vi) the roles and functions of independent aged care advocates in the system; and
(f) publish an accessible document that:
  (i) describes how a complaint can be made, or feedback can be given, to the provider; and

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(ii) describes what a person who makes a complaint or gives feedback to the provider can expect in relation to the provider's management of the complaint or feedback; and

(iii) includes information about how a complaint can be made, or feedback can be given, to the Complaints Commissioner; and

(iv) explains that the provider will not victimise or discriminate against anyone for making a complaint or giving feedback to the provider or the Complaints Commissioner; and

(v) includes information about how to contact an independent aged care advocate; and

(g) give the document mentioned in paragraph (f) to the following:

(i) individuals to whom the provider delivers funded aged care services;

(ii) any other person who requests the document; and

(h) if it is necessary, to enable a person to whom the document mentioned in paragraph (f) must be given under subparagraph (g)(i) to understand the document, to translate the document into another language or present the document in an alternative appropriate format—translate the document into that language, or present the document in that format, and give the translation or reformatted document to the person; and

(i) help the persons mentioned in subparagraph (g)(i) to understand how the provider's complaints and feedback management system works; and

(j) communicate regularly, and at least monthly, to the persons mentioned in paragraph (b) and subparagraph (g)(i) that complaints and feedback are welcome; and

(k) review the system as mentioned in paragraph 165-15(p).

(2) Without limiting paragraph (1)(e), the provider provides appropriate training to a person who is an aged care worker or responsible person of the provider if the training is provided:

(a) at regular intervals, which must be at least annually; and

(b) at the following times:

(i) when the person becomes an aged care worker or responsible person of the provider;

(ii) when there is a change to how the system works that affects the person's roles and responsibilities in the system;

(iii) when there is a change to the person's role that affects the person's roles and responsibilities in the system.

Subdivision C—Managing complaints and feedback

165-25 Requirements for complaints management and resolution

If a registered provider receives a complaint, the provider must:

(a) manage the complaint in accordance with the provider's complaints and feedback management system; and

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(b) as soon as practicable after receiving the complaint, resolve each issue raised in the complaint by taking appropriate action in relation to the issue; and

(c) in resolving each issue raised in the complaint, use a resolution approach that:

(i) is consistent with the Statement of Rights; and

(ii) is appropriate given the nature of the issue; and

(iii) is centred around each individual to whom the provider delivers funded aged care services who is directly affected by the issue; and

(iv) seeks to address the issue as raised in the complaint; and

(v) will contribute to the continuous improvement of the provider's delivery of funded aged care services; and

(d) unless the complaint was made anonymously—take reasonable steps to notify the following persons of the outcome of the complaint, and the reasons for the outcome:

(i) the person who made the complaint;

(ii) if the complaint was made on behalf of an individual to whom the provider is delivering funded aged care services—the individual; and

(e) unless the complaint was made anonymously—take reasonable steps to tell the following persons how the complaint (the ***initial complaint***) can also be made to the Complaints Commissioner:

(i) the person who made the complaint;

(ii) if the complaint was made on behalf of an individual to whom the provider is delivering funded aged care services—the individual; and

(f) take reasonable steps to tell any other person involved in the resolution of the initial complaint how the complaint can also be made to the Complaints Commissioner; and

(g) take reasonable steps to tell the persons mentioned in paragraphs (d) and (e):

(i) how a new complaint about the resolution of the initial complaint can be made to the Complaints Commissioner;

(ii) information about the availability of independent aged care advocates to assist with making a new complaint to the Complaints Commissioner.

Note: See section 29 of the Act for provisions relating to giving information and documents to supporters.

165-30 Requirements for feedback management and resolution

(1) If a registered provider receives feedback, the provider must manage the feedback in accordance with the provider's complaints and feedback management system.

(2) In resolving any issues raised in the feedback, the provider must:

(a) use a resolution approach that will contribute to the continuous improvement of the provider's delivery of funded aged care services; and

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(b) unless the feedback was given anonymously—consult with:
(i) the person who gave the feedback; and
(ii) if the feedback was given on behalf of an individual to whom the provider is delivering funded aged care services—the individual; and
(iii) if the person who gave the feedback is an individual to whom the provider is delivering funded aged care services and the individual has consented to the consultation—the individual's supporter (if any); and
(iv) if the feedback was given on behalf of an individual to whom the provider is delivering funded aged care services and the individual has consented to the consultation—the individual's supporter (if any).

(3) The provider must:
(a) unless the feedback was given anonymously—take reasonable steps to tell the persons mentioned in paragraph (2)(b) how the feedback (the ***initial feedback***) can also be given to the Complaints Commissioner; and
(b) take reasonable steps to tell any other person involved in the resolution of any issue raised by the initial feedback how the feedback can also be given to the Complaints Commissioner; and
(c) take reasonable steps to tell the persons mentioned in paragraph (2)(b) and paragraph (b) of this subsection how a complaint or new feedback about the resolution of any issue raised by the initial feedback can be made or given to the Complaints Commissioner.

165-35 Other requirements relating to complaints and feedback

(1) If a registered provider receives a complaint or feedback, the provider must:
(a) provide appropriate support and assistance (including access to advocates and language services), in relation to contacting the Complaints Commissioner, to the following persons:
(i) the person who made the complaint or gave the feedback (other than anonymously);
(ii) each individual to whom the provider delivers funded aged care services who is directly affected by an issue raised in the complaint or feedback; and
(b) take reasonable steps to ensure that:
(i) the person who made the complaint or gave the feedback, or on whose behalf the complaint was made or the feedback was given, is not adversely affected as a result of the making of the complaint or the giving of the feedback; and
(ii) no individual to whom the provider delivers funded aged care services who is affected by an issue raised in the complaint or feedback suffers any detriment, victimisation or reprisal as a result of the making of the complaint or the giving of the feedback.

(2) A registered provider must use an open disclosure process:
(a) in relation to a matter that is the subject of a complaint or feedback; and

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(b) if things go wrong in managing a complaint or feedback or resolving an issue raised in a complaint or feedback.

Handling whistleblower disclosures as complaints or feedback

(3) An individual who discloses information that qualifies for protection under section 547 of the Act (whistleblower protections) to a provider may elect to have the disclosure managed as a complaint or feedback under paragraph 165(1)(b) of the Act and this Division of this instrument.

(4) If an individual makes an election under subsection (3), the provider must manage the disclosure as a complaint or feedback in accordance with this Subdivision rather than in accordance with Subdivision E.

Subdivision D—Implementing and maintaining a whistleblower system and maintaining a whistleblower policy

165-40 Objects of this Subdivision

The objects of this Subdivision are:

(a) to promote quality care and the safety of individuals to whom a registered provider delivers funded aged care services by ensuring the provider's whistleblower system facilitates certain disclosures of information by individuals without fear of persecution, retribution or personal detriment; and

(b) to ensure that the confidentiality of such disclosures is maintained and, where relevant, the anonymity of the individual making the disclosure, and any other specified individual, is protected; and

(c) to ensure that the provider's whistleblower system acknowledges, assesses, manages and responds to concerns raised in such disclosures in a fair, transparent, accessible, safe, culturally safe and timely manner; and

(d) to ensure that such disclosures contribute to the continuous improvement of the provider's delivery of funded aged care services; and

(e) to ensure that aged care workers and any other persons are encouraged and supported to raise concerns about the provider's delivery of funded aged care services.

165-45 Requirements for system—general

A registered provider's whistleblower system must:

(a) support the operation of Part 5 of Chapter 7 of the Act (whistleblower protections); and

(b) enable individuals to disclose information to the following:

(i) the provider;

(ii) a responsible person of the provider;

(iii) an aged care worker of the provider; and

(c) enable disclosures of information mentioned in paragraph (b) to be made:

(i) orally and in writing; and

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(ii) anonymously; and

(d) provide for the system to be reviewed as required, and at least annually, to ensure that it is meeting the requirements mentioned in paragraphs (a) to (c).

165-50 Requirements for registered providers—general

(1) A registered provider must:

(a) prepare and keep up to date documents detailing:

(i) the provider's whistleblower system, including the requirements mentioned in section 165-45; and

(ii) the roles and responsibilities in the system of the provider's aged care workers and responsible persons; and

(b) give the documents to the provider's aged care workers and responsible persons; and

(c) ensure that the provider's aged care workers and responsible persons are aware of, and understand, their roles and responsibilities in the system; and

(d) require the provider's aged care workers and responsible persons to comply with the system; and

(e) provide appropriate training to the provider's aged care workers and responsible persons on how the system works, including:

(i) how to handle personal information and data; and

(ii) how to recognise and respond to disclosures that qualify for protection under section 547 of the Act; and

(iii) managing relationships and communicating with disclosers; and

(iv) when and how to escalate disclosures in the system; and

(v) their roles and responsibilities in the system; and

(vi) the penalties for contravening subsection 550(1) of the Act (confidentiality of identity of disclosers); and

(f) communicate regularly, and at least monthly, to the provider's aged care workers and responsible persons that disclosures that qualify for protection under section 547 of the Act are welcome; and

(g) review the system as mentioned in paragraph 165-45(d).

(2) Without limiting paragraph (1)(e), the provider provides appropriate training to a person who is an aged care worker or responsible person of the provider if the training is provided:

(a) at regular intervals, which must be at least annually; and

(b) at the following times:

(i) when the person becomes an aged care worker or responsible person of the provider;

(ii) when there is a change to how the system works that affects the person's roles and responsibilities in the system;

(iii) when there is a change to the person's role that affects the person's roles and responsibilities in the system.

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165-55 Requirements for registered providers—whistleblower policy

A registered provider must:

(a) prepare and keep up to date a whistleblower policy that sets out the following:
  (i) the effect of Part 5 of Chapter 7 of the Act;
  (ii) that individuals may disclose information to the provider or another person mentioned in section 547 of the Act, and how such disclosures may be made;
  (iii) how the provider will manage disclosures that qualify for protection under section 547 of the Act that are made to the provider or a responsible person or aged care worker of the provider;
  (iv) that individuals may also disclose information to the entities mentioned in subparagraphs 547(a)(i), (ii), (vi) and (vii) of the Act, and how such disclosures may be made;
  (v) how the provider will investigate disclosures;
  (vi) how the provider will comply with the requirements mentioned in paragraphs 165-60(c) and (d) of this instrument;
  (vii) how the provider will comply with the obligations in section 553 of the Act;
  (viii) what an individual who has made a disclosure that qualifies for protection under section 547 of the Act can do if they suspect that there has been a contravention of a provision of Part 5 of Chapter 7 of the Act; and
(b) publish the policy in an accessible document; and
(c) give the policy to the provider's aged care workers and responsible persons; and
(d) give the policy to the following:
  (i) individuals to whom the provider delivers funded aged care services;
  (ii) a person who requests the policy and is a supporter of an individual to whom the provider delivers funded aged care services;
  (iii) any other person who requests the policy; and
(e) if it is necessary, to enable a person to whom the policy must be given under subparagraph (d)(i) or (ii) to understand the policy, to translate the policy into another language or present the policy in an alternative appropriate format—translate the policy into that language, or present the policy in that format, and give the translation or reformatted policy to the person; and
(f) help the persons mentioned in subparagraphs (d)(i) and (ii) to understand how the whistleblower system works; and
(g) communicate regularly, and at least monthly, to the persons mentioned in paragraph (c) and subparagraphs (d)(i) and (ii) that disclosures that qualify for protection under section 547 of the Act are welcome.

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Subdivision E—Managing disclosures that qualify for protection under section 547 of the Act

165-60 Requirements for managing disclosures

If an individual makes a disclosure that qualifies for protection under section 547 of the Act to a registered provider or a responsible person or aged care worker of the provider, the provider must:

(a) manage the disclosure in accordance with the provider's whistleblower system; and

(b) as soon as practicable after the disclosure is made, take appropriate action in relation to the disclosure; and

(c) support:

(i) the individual (the ***first individual***) who made the disclosure; and

(ii) any other individual, or an entity, that employs or is otherwise associated with the first individual, and to which detriment might be caused, or a threat of detriment might be made, because of the disclosure; and

(d) ensure fair treatment of any responsible person or aged care worker of the provider who is mentioned in the disclosure or to whom the disclosure relates.

Note: See section 551 of the Act for civil penalties for victimisation relating to a disclosure that qualifies for protection under section 547 of the Act.

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Chapter 5—Registered provider, responsible person and aged care worker obligations

Part 1—Introduction

165A-1 Simplified outline of this Chapter

This Chapter provides for matters relating to registered provider, responsible person and aged care worker obligations under Part 4 of Chapter 3 of the Act.

Part 2 of this Chapter relates to obligations relating to reporting, notifications and information, and deals with requirements for reporting by certain registered providers to particular persons specified in subsection 166(2) of the Act on:

(a) vaccinations; and
(b) quality indicators; and
(c) complaints and feedback management; and
(d) complaints and feedback information on request; and
(e) prudential and financial matters; and
(f) reportable incidents; and
(g) the specialist aged care program CHSP; and
(h) the specialist aged care program NATSIFACP; and
(i) governing bodies; and
(j) registered nurses; and
(k) the status of service delivery branches; and
(l) the Multi-Purpose Service Program; and
(m) the transition care program; and
(n) pricing information.

Part 3 of this Chapter relates to provider obligations in relation to notifying of changes in circumstances, and deals with:

(a) certain kinds of changes in relation to which certain kinds of registered providers must give notice to the Commissioner; and
(b) circumstances in relation to which a notice must also be given to the System Governor; and
(c) information that must be included in a notice given to the Commissioner or the System Governor.

Part 4 of this Chapter deals with the kinds of registered providers to which the obligation to notify of changes of circumstances relating to suitability applies.

Part 5 of this Chapter relates to obligations relating to suitability of responsible persons, and deals with the kind of registered providers to which the obligations apply and requirements for records of suitability matters.

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Part 6 of this Chapter relates to obligations relating to aged care workers, and deals with registered nurses and the delivery of direct care.

Part 7 of this Chapter relates to other obligations, and deals with requirements relating to cooperation by registered providers with the Pricing Authority.

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Part 2—Obligations relating to reporting, notifications and information

Division 1—Preliminary

165A-2 No limitation on other requests

Nothing in this Part limits or affects the System Governor, the Commissioner or the Complaints Commissioner from requesting information from a registered provider under any other provision of the Rules or the Act.

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Division 2—Reportable incidents

165A-5 Purpose of this Subdivision

For the purposes of paragraph 165A(2)(b) of the Act, this Subdivision prescribes requirements for reporting reportable incidents to the Commissioner.

165A-10 Application of Subdivision to registered providers

For the purposes of subsection 165A(1) of the Act, every kind of registered provider is prescribed.

165A-15 Registered provider must notify reportable incidents in accordance with this Subdivision

A registered provider must take all reasonable steps to ensure that reportable incidents are notified to the Commissioner in accordance with this Subdivision.

165A-20 Registered provider must ensure that aged care workers notify reportable incidents

A registered provider must ensure that an aged care worker of the provider who becomes aware of a reportable incident notifies one of the following of that fact as soon as possible:

(a) one of the provider's responsible persons;
(b) a supervisor or manager of the aged care worker;
(c) a person specified for the purposes of paragraph 164-20(e).

165A-25 Priority 1 notice must be given within 24 hours

(1) If:

(a) a registered provider becomes aware of a reportable incident; and
(b) the provider has reasonable grounds to believe that the incident is a priority 1 reportable incident;

the provider must give the Commissioner a notice (a ***priority 1 notice***) in accordance with subsection (4) within 24 hours of becoming aware of the reportable incident.

Note: Notice about certain reportable incidents is not required to be given: see section 165A-35.

(2) A ***priority 1 reportable incident*** is a reportable incident:

(a) that has caused an individual physical or psychological injury or discomfort that requires medical or psychological treatment; or
(b) where there are reasonable grounds to report the incident to police; or
(c) of the kind covered by paragraph 16(1)(b) of the Act (about unlawful sexual contact or inappropriate sexual conduct, inflicted on an individual); or

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(d) of the kind covered by paragraph 16(1)(d) or (h) of the Act (about unexpected death or unexplained absence).

(3) For the purposes of paragraph (2)(a), in considering whether a reportable incident has caused an individual who has an impairment that directly affects their ability to recognise or communicate physical or psychological injury or discomfort (an ***impairment***), physical or psychological injury or discomfort that requires medical or psychological treatment, a registered provider:

(a) must not consider the impairment as:

(i) preventing the individual from being caused physical or psychological injury or discomfort; or

(ii) reducing the degree of physical or psychological injury or discomfort caused; and

(b) must recognise and consider that each individual's experience of an incident will be unique and that an impairment may contribute to causing the individual physical or psychological injury or discomfort.

Information to be included in notice

(4) Subject to subsection (5), the priority 1 notice must include the following information about the reportable incident:

(a) the name and contact details of the registered provider;

(b) a description of the reportable incident including:

(i) the kind of reportable incident; and

(ii) the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the incident; and

(iii) if known—the consequences of that harm;

(c) the immediate actions taken in response to the reportable incident, including:

(i) actions taken to ensure the safety, health and well-being of each individual affected by the incident or the supporter of the individual; and

(ii) whether the incident has been reported to police or any other body;

(d) any further actions proposed to be taken in response to the reportable incident;

(e) the name, position and contact details of the person giving the notice;

(f) if known—the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;

(g) the names of the persons directly involved in the reportable incident;

(h) if known—the level of cognition of the affected individuals directly involved in the reportable incident.

(5) The registered provider is not required to include information in the priority 1 notice if that information is not available within the 24 hours.

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Additional information

(6) The registered provider must give the Commissioner a notice including the following information about the reportable incident within 5 days after the start of the 24 hours, or within such other period as the Commissioner determines:
  (a) any information required by subsection (4) not provided in the priority 1 notice;
  (b) any further information specified by the Commissioner that is required to deal with the reportable incident.

(7) However, the registered provider is not required to give a notice under subsection (6) if the Commissioner decides otherwise.

Form of notices

(8) A notice given under this section must:
  (a) be in writing; and
  (b) be in the approved form.

Note: The Commissioner may approve forms for the purposes of this Division: see section 585 of the Act.

165A-30 Priority 2 notice must be given within 30 days

(1) If:
  (a) a registered provider becomes aware of a reportable incident; and
  (b) the provider has not given a notice under section 165A-25 about the incident;

the provider must give the Commissioner a notice (a ***priority 2 notice***) in accordance with subsection (2) within 30 days of becoming aware of the incident.

Note: Notice about certain reportable incidents is not required to be given: see section 165A-35.

(2) The priority 2 notice must include the following information about the reportable incident:
  (a) the name and contact details of the registered provider;
  (b) a description of the reportable incident including:
    (i) the kind of reportable incident; and
    (ii) the harm that was caused, or that could reasonably have been expected to have been caused to each person affected by the incident; and
    (iii) if known—the consequences of that harm;
  (c) the actions taken in response to the reportable incident, including:
    (i) actions taken to ensure the safety, health and well-being of each individual affected by the incident or the supporter of the individual; and
    (ii) whether the incident has been reported to police or any other body;

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(d) any further actions proposed to be taken in response to the reportable incident;
(e) the name, position and contact details of the person giving the notice;
(f) if known—the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;
(g) the names of the persons directly involved in the reportable incident;
(h) if known—the level of cognition of the affected individuals directly involved in the reportable incident.

Additional information

(3) If the Commissioner requires the registered provider to give a notice including specified further information about the reportable incident within a specified period, the provider must give the Commissioner a notice including that information with the specified period.

Form of notices

(4) A notice given under this section must:
(a) be in writing; and
(b) be in the approved form.

Note: The Commissioner may approve forms for the purposes of this Division: see section 585 of the Act.

165A-35 Reporting not required in certain circumstances

The Commissioner may decide that a registered provider is not required to give a notice under section 165A-25 or 165A-30 about a reportable incident if the Commissioner is satisfied that:
(a) the same incident has been repeatedly alleged by an individual accessing funded aged care services to have occurred; and
(b) the allegation is the result of a delusion of the individual.

165A-40 Significant new information must be notified

(1) A registered provider must notify the Commissioner of significant new information relating to a reportable incident as soon as reasonably practicable after becoming aware of the information if:
(a) the provider notifies the Commissioner of the reportable incident under section 165A-25 or 165A-30; and
(b) the provider later becomes aware of the significant new information.

(2) The notification must:
(a) be in writing; and
(b) be in the approved form.

Note: The Commissioner may approve forms for the purposes of this Division: see section 585 of the Act.

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165A-45 Final report about reportable incident must be given if required

(1) If required by the Commissioner, a registered provider must give the Commissioner a final report that includes specified information about a reportable incident.

(2) The final report must be given:
  (a) within 84 days of the day a notice about the incident was first given to the Commissioner under section 165A-25 or 165A-30; or
  (b) within such other period as is specified by the Commissioner.

(3) The final report must:
  (a) be in writing; and
  (b) be in the approved form; and
  (c) contain the information specified by the Commissioner under subsection (1).

Note: The Commissioner may approve forms for the purposes of this Division: see section 585 of the Act.

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Division 3—Provider obligation—reporting to particular persons

Subdivision A—Vaccinations

166-5 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider registered in the provider registration category residential care.

166-10 Reports about service staff—influenza vaccinations

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider must, on request by the System Governor or the Commissioner, give the System Governor or the Commissioner a report, in a form approved by the System Governor, that sets out the following information as at the reporting day specified in the request:

(a) the total number of service staff in relation to the approved residential care home;

(b) the number of those service staff who have informed the registered provider, whether voluntarily or as required under a law of a State or Territory, that they have received the annual seasonal influenza vaccination for the calendar year that includes the reporting day (whether or not under the registered provider's influenza vaccination scheme (if any)).

(2) The System Governor or the Commissioner may, at any time, request a registered provider to give to the System Governor or the Commissioner a report under subsection (1).

(3) A request under subsection (2) must:

(a) be in writing; and

(b) specify a reporting day that is not more than 3 years before the request is made.

(4) A registered provider must comply with a request under subsection (2) within 7 days after the request is made, or such longer period as is agreed, in writing, between the System Governor or the Commissioner and the registered provider.

166-15 Reports about service staff—COVID-19 vaccinations

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider must, on request by the System Governor or the Commissioner, give the System Governor or the Commissioner a report, in a form approved by the System Governor, that sets out the following information as at the reporting day specified in the request:

(a) the total number of service staff in relation to the approved residential care home;

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(b) the number of those service staff who have voluntarily informed the registered provider that they have, in the period specified in the request before the reporting day, received a COVID-19 vaccination.

(2) The System Governor or the Commissioner may, at any time, request a registered provider to give to the System Governor or the Commissioner a report under subsection (1).

(3) A request under subsection (2) must:
(a) be in writing; and
(b) specify a reporting day that is not more than 3 years before the request is made.

(4) A registered provider must comply with a request under subsection (2) within 7 days after the request is made, or such longer period as is agreed, in writing, between the System Governor or the Commissioner and the registered provider.

166-25 Reports about individuals receiving residential care—COVID-19 vaccinations

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider must, on request by the System Governor or the Commissioner, give the System Governor or the Commissioner a report, in a form approved by the System Governor, that sets out the following information, as at the reporting day specified in the request:
(a) the total number of individuals accessing funded aged care services in an approved residential care home;
(b) the number of those individuals who have voluntarily informed the registered provider, in the period specified in the request before the reporting day, that they had received one or more COVID-19 vaccinations;
(c) the number of individuals covered by paragraph (b) who have informed the registered provider that they had received only one COVID-19 vaccination;
(d) the number of individuals covered by paragraph (b) who have informed the registered provider that they had received 2 COVID-19 vaccinations.

(2) The System Governor or the Commissioner may, at any time, request a registered provider to give to the System Governor or the Commissioner a report under subsection (1).

(3) A request under subsection (2) must:
(a) be in writing; and
(b) specify a reporting day that is not more than 3 years before the request is made.

(4) A registered provider must comply with a request under subsection (2) within 7 days after the request is made, or such longer period as is agreed, in writing, between the System Governor or the Commissioner and the registered provider.

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Subdivision B—Quality indicators

166-105 Application of Subdivision to certain registered providers

(1) Subject to subsection (2), this Subdivision applies to a registered provider registered in the provider registration category residential care.

(2) The requirements of this Subdivision do not apply to a registered provider in respect of the delivery of funded aged care services under a specialist aged care program.

166-110 Requirement to provide a quality indicators report

(1) For the purposes of paragraph 166(1)(a) of the Act, a registered provider must give a report (***the quality indicators report)*** on the quality indicators provided in this Subdivision to the System Governor each reporting period.

Note: For the reporting period for a quality indicators report, see section 166-115.

(2) To avoid doubt, if any individuals are excluded for any reason under this Subdivision, a registered provider is required to include information about the exclusion of those individuals in the report where required.

Example: If an individual is absent from the approved residential care home throughout the reporting period, as referred to in paragraph 166-135(1)(b) of this instrument, the registered provider is not required to include that individual in an assessment for falls and falls resulting in major injury, as referred to in paragraph 166-135(1)(a), but must include information about the exclusion of the individual under paragraph 166-135(1)(b).

166-112 Requirements for the collection of information for quality indicators reports—measurements and assessments

(1) For the purposes of paragraph 166(5)(a) of the Act, a registered provider must:
  (a) make measurements or other assessments relevant to indicating the quality of residential care; and
  (b) compile or otherwise derive information from those measurements and assessments mentioned in paragraph (a); and
  (c) give the information to the System Governor for the purposes of a quality indicator report.

(2) For paragraph (1)(a), measurements or assessments may include the collection or use of personal information and health information, within the meaning of the *Privacy Act 1988*, about the individual accessing funded aged care services.

(3) For paragraph (1)(b), the compiling or deriving of information must not include personal information about the individual accessing funded aged care services.

166-115 Timeframes for reporting under this Subdivision

For the purposes of subsection 166(4) of the Act:

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(a) the reporting period for a quality indicators report given to the System Governor under this Subdivision is a quarter, being a period of 3 months, beginning at the start of a financial year; and

(b) a registered provider must give a quality indicators report to the System Governor within 21 days after the end of the reporting period.

166-120 Quality indicator—pressure injuries

(1) A quality indicators report must include the following information on pressure injuries and the number of individuals accessing funded aged care services that:

(a) were assessed for pressure injuries;

(b) were excluded because of withholding consent to undergo an observational assessment for pressure injuries throughout the reporting period;

(c) were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(d) have one or more pressure injuries;

(e) have one or more pressure injuries with each injury measured and reported against the following sub-categories:

(i) Stage 1 Pressure Injury;

(ii) Stage 2 Pressure Injury;

(iii) Stage 3 Pressure Injury;

(iv) Stage 4 Pressure Injury;

(v) Unstageable Pressure Injury;

(vi) Suspected Deep Tissue Pressure Injury;

(f) have one or more pressure injuries acquired outside the approved residential care home during the reporting period;

(g) have one or more pressure injuries acquired outside the approved residential care home during the reporting period with each injury measured and reported against the following sub-categories:

(i) Stage 1 Pressure Injury;

(ii) Stage 2 Pressure Injury;

(iii) Stage 3 Pressure Injury;

(iv) Stage 4 Pressure Injury;

(v) Unstageable Pressure Injury;

(vi) Suspected Deep Tissue Pressure Injury.

Note: For paragraphs (e) and (g), the relevant sub-category of pressure injury is determined by reference to the ICD-10 Australian Modified Pressure Injury Classification System.

(2) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must:

(a) identify a date once every reporting period when assessment for pressure injuries is to be carried out for each individual residing at the approved residential care home; and

(b) collect data relating to pressure injures for each individual during a single observation assessment at approximately the same time every reporting period; and

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(c) carry out assessment on or around the same time each reporting period and complete assessment as part of the individual's routine personal care (such as bathing and toileting).

(3) Registered providers, in assessing and reporting pressure injuries acquired by individuals, must inform the individual about the proposed assessment and must seek consent from the individual before the assessment takes place.

166-125 Quality indicator—restrictive practices

(1) A quality indicators report must include the following information on restrictive practices:

(a) the collection date in the reporting period;

(b) the number of individuals whose records were assessed for the use of restrictive practices other than chemical restraint throughout the collection period;

(c) the number of individuals excluded because of an absence from accessing funded aged care services throughout the collection period;

(d) the number of individuals subjected to the use of restrictive practices other than chemical restraint throughout the collection period:

(i) on any occasion;

(ii) on any occasion only in a secured area.

Note: See section 17-5 (Practices and interventions that are restrictive practices in relation to individuals). Restrictive practices covered by this section include environmental restraint, mechanical restraint, physical restraint and seclusion as defined in section 17-5.

(2) For the purposes of subsection (1), a collection period for this quality indicator is a 3-day period during the reporting period.

(3) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must:

(a) identify and record a collection date which is to take place during each reporting period; and

(b) ensure that the collection date is varied and unpredictable to staff directly involved in the care of an individual; and

(c) ensure that the 3-day collection period consists of the selected collection date and the 2 days before that date; and

(d) ensure that the 3-day collection period is the same for all individuals receiving funded aged care services at the approved residential care home.

(4) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must review an individual's existing record over the 3- day collection period and assess whether the individual was subject to the use of restrictive practices other than chemical restraint at any stage during the collection period.

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166-130 Quality indicator—unplanned weight loss

(1) A quality indicators report must include information on unplanned weight loss, with information reported under the following categories:
  (a) significant unplanned weight loss;
  (b) consecutive unplanned weight loss.

(2) For the purposes of paragraph (1)(a), a quality indicators report must include the following information on significant unplanned weight loss and the number of individuals accessing funded aged care services that:
  (a) were assessed for significant unplanned weight loss;
  (b) were excluded because of withholding consent to be weighed on the finishing weight collection date;
  (c) were excluded because of receiving end-of-life care;
  (d) were excluded because the previous or finishing weights were not recorded, including comments on why any such weights were not recorded;
  (e) experienced a 5% or higher decrease in weight between the finishing weight and the previous weight.

(3) Registered providers, in preparing the quality indicators report for the purposes of paragraph (1)(a), must:
  (a) identify each individual's previous weight using the approved residential care home's weight records of individuals in the residential care home; and
  (b) collect and record the finishing weight for each individual residing at the approved residential care home in the final month of the current reporting period using a calibrated scale; and
  (c) seek the consent of the individuals concerned before making the assessment required and must record any refusal to provide consent by an individual being assessed for their finishing weight; and
  (d) weigh individuals at or around the same time each month and at around the same time of the day and ensure that the individual is wearing clothing of a similar weight; and
  (e) for each individual who provided their consent for the making of the assessment, compare their finishing weight from the current reporting period with their previous weight and calculate the percentage weight loss.

(4) For the purposes of paragraph (1)(b), a quality indicators report must include the following information on consecutive unplanned weight loss and the number of individuals accessing funded aged care services that:
  (a) were assessed for consecutive unplanned weight loss;
  (b) were excluded because of withholding consent to be weighed on any weight collection date;
  (c) were excluded because of receiving end-of-life care;
  (d) were excluded because any of the required weights were not recorded, including comments on why any such weights were not recorded;
  (e) experienced any decrease in weight between the previous weight, starting weight, middle weight and finishing weight.

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(5) Registered providers, in preparing the quality indicators report for the purposes of paragraph (1)(b), must:

(a) measure consecutive unplanned weight loss as the weight loss of any amount measured every month over 3 consecutive months of a reporting period, and the 3 monthly weights are compared against each other and against the finishing weight from the previous reporting period; and

(b) use their approved residential care home's weight records in identifying each individual's previous weight; and

(c) in the first month of the reporting period, collect and record the starting weight of each individual residing at the approved residential care home using a calibrated scale; and

(d) in the second month of the reporting period collect and record the middle weight of each individual residing at the approved residential care home using a calibrated scale; and

(e) in the third and final month of the reporting period collect and record the finishing weight of each individual at the approved residential care home using a calibrated scale; and

(f) where previous weights and finishing weights may already have been collected and recorded for the individual as part of assessments and measurements made for significant unplanned weight loss, the previous weight and finishing weights recorded and collected can be used for assessing consecutive unplanned weight loss and do not need to be collected again; and

(g) seek the consent of the individuals concerned before making the assessment required and must record any refusal to provide consent by an individual being assessed for their finishing weight; and

(h) weigh individuals at or around the same time each month and at around the same time of the day and ensure that the individual is wearing clothing of a similar weight; and

(i) for each individual who provided their consent for the making of the assessment, compare their previous, starting, middle and finishing weight to determine whether there has been weight loss in every month over 3 consecutive months of a reporting period.

(6) If an individual is assessed under one category of unplanned weight loss, this does not limit the ability to be assessed and reported under the other category.

166-135 Quality indicator—falls and major injury

(1) A quality indicators report must include the following information on falls and falls resulting in major injury, and the number of individuals accessing funded aged care services:

(a) whose records were assessed for falls and falls resulting in major injury;

(b) who were excluded because of an absence from accessing funded aged care services at the approved residential care home throughout the reporting period;

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(c) who experienced one or more falls at the approved residential care home during the reporting period;
(d) who experienced one or more falls at the approved residential care home resulting in major injury during the reporting period.

(2) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must:
(a) identify and record a collection date for the reporting period; and
(b) ensure that the collection date is in the 21 days after the end of the reporting period.

166-140 Quality indicator—medication management

(1) A quality indicators report must include information on medication management, with information reported under the following categories:
(a) polypharmacy;
(b) antipsychotics.

(2) For the purposes of paragraph (1)(a), a quality indicators report must include the following information on polypharmacy:
(a) the collection date in the reporting period;
(b) the number of individuals assessed for polypharmacy;
(c) the number of individuals excluded because they were admitted in hospital on the collection date;
(d) the number of individuals prescribed 9 or more medications based on a review of any of the following taken on the collection date:
(i) the individual's medication chart;
(ii) the individual's administration record.

(3) For the purposes of paragraph (1)(b), a quality indicators report must include the following information on antipsychotics:
(a) the collection date in the reporting period;
(b) the number of individuals assessed for antipsychotic medications;
(c) the number of individuals excluded because of they were admitted in hospital for at least 6 days prior to the collection date;
(d) the number of individuals that received an antipsychotic medication based on a review of any of the following taken on the collection date:
(i) the individual's medication chart;
(ii) the individual's administration record;
(e) the number of individuals that received an antipsychotic medication for a medically diagnosed condition of psychosis based on a review of any of the following taken on the collection date:
(i) the individual's medication chart;
(ii) the individual's administration record.

(4) For the purposes of paragraph (2)(a), the collection date is any date during the reporting period and the collection of data must involve a single review of

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medication charts and administration records for each individual on a particular collection date during the reporting period.

(5) Registered providers, in preparing a quality indicators report for the purposes of paragraph (1)(a), must:
  (a) identify and record a collection date for the reporting period;
  (b) use each individual's medication charts and administration records as at the identified collection date.

(6) For the purposes of paragraph (3)(a), the collection date is the final day in the collection period which for that subsection is a 7-day period during the reporting period.

(7) Registered providers, in preparing a quality indicators report for the purposes of paragraph (1)(b), must:
  (a) identify a collection date during the reporting period which is between the second week and the end of the reporting period;
  (b) assess and review all individual's medication charts and administration records during the assessment period which covers the collection date and the 6 days prior to that collection date;
  (c) ensure that the collection date is varied between reporting periods and must not be identified to staff directly involved in the care of individuals accessing funded aged care services;
  (d) ensure the assessment and review is not conducted by staff directly involved in the care of individuals receiving funded aged care services.

166-145 Quality indicator—activities of daily living

(1) A quality indicators report must include the following information on activities of daily living and the number of individuals receiving funded aged care services that:
  (a) were assessed for activities of daily living function;
  (b) were excluded because of receiving end-of-life care;
  (c) were excluded because of an absence from accessing funded aged care services throughout the entire reporting period;
  (d) were excluded because an assessment for activities of daily living function was not recorded for the previous reporting period, including comments on why any such previous assessment was not recorded;
  (e) were assessed for activities of daily living function and received a total score of zero in the previous reporting period;
  (f) were assessed for activities of daily living function and experienced a decline in the total score by one or more points.

(2) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must ensure the collection of information involves a single assessment of each individual, completed around the same time every reporting period, comparing the information to the activities of daily living assessment total score in the previous reporting period to determine decline.

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(3) For the purposes of subsection (1), registered providers must:

(a) identify each individual's activities for daily living assessment total score from the previous reporting period using their approved residential care home's care records;

(b) conduct activities for daily living assessment for each individual by completing the Barthel Index;

(c) compare the previous reporting period assessment total score with the current reporting period assessment total score in relation to an individual in order to determine if the individual experienced a decline of one or more points.

Note: Without limiting this section, activities of daily living includes fundamental skills typically needed to manage basic physical needs in the following areas:

(a) grooming and personal hygiene, such as oral care;

(b) dressing;

(c) toileting and continence;

(d) ambulating and movement;

(e) eating.

166-150 Quality indicator—incontinence care

(1) A quality indicators report must include the following information on incontinence care and the number of individuals receiving funded aged care services that:

(a) were assessed for incontinence care;

(b) were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(c) were excluded from an Incontinence Associated Dermatitis assessment because they did not have incontinence;

(d) have incontinence and Incontinence Associated Dermatitis measured and reported against the following Ghent Global Incontinence Associated Dermatitis Categorisation Tool sub-categories:

(i) 1A: persistent redness without clinical signs of infection;

(ii) 1B: persistent redness with clinical signs of infection;

(iii) 2A: skin loss without clinical signs of infection;

(iv) 2B: skin loss with clinical signs of infection;

(e) have incontinence;

(f) have incontinence and Incontinence Associated Dermatitis.

(2) Registered providers, in preparing a quality indicators report for the purposes of subsection (1), must:

(a) identify a date once every reporting period to assess each individual residing at the approved residential care home for incontinence as part of routine care and carry out that assessment on or around the same time each reporting period; and

(b) ensure that the assessment of Incontinence Associated Dermatitis is conducted by staff who understand the Ghent Global Incontinence

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Associated Dermatitis Categorisation Tool and have the necessary skills and experience to do so accurately and safely; and

(c) if personal care workers observe or identify signs of redness or skin loss during routine personal care, escalate to appropriately trained staff for further assessment; and

(d) consult with a suitably qualified health practitioner if there is uncertainty about the presence or severity of Incontinence Associated Dermatitis.

(3) For the purposes of subsection (1), registered providers must ensure that the collection of information involves a single assessment for each individual as part of routine care around the same time every reporting period.

166-155 Quality indicator—hospitalisation

(1) A quality indicators report must include the following information on hospitalisation and the number of individuals receiving funded aged care services that:

(a) were assessed for hospitalisation;

(b) were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(c) had one or more emergency department presentations during the reporting period;

(d) had one or more emergency department presentations or hospital admissions during the reporting period.

(2) In preparing a quality indicators report for the purposes of subsection (1), registered providers must:

(a) ensure that the collection of information involves a single review of the care records for each individual for the entire reporting period;

(b) view the care records within 21 days after the end of the reporting period.

166-160 Quality indicator—workforce

(1) A quality indicators report must include information on the workforce of a registered provider, reported against the following sub-categories of staff delivering funded aged care services:

(a) service managers;

(b) nurse practitioners and registered nurses;

(c) enrolled nurses;

(d) personal care workers and nursing assistants.

(2) A quality indicators report must include the following information reported against each sub-category specified in subsection (1):

(a) on the number of staff that have worked any number of hours in the previous reporting period;

(b) on the number of staff that:

(i) were employed at the start of the reporting period; and

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(ii) have worked for at least 120 hours in the previous reporting period;

(c) on the number of staff that:

(i) were employed at the start of the reporting period; and

(ii) did not work for at least 60 consecutive days in the reporting period.

(3) For the purposes of subsection (1), registered providers must review the records within 21 days after the end of the reporting period.

166-165 Quality indicator—Consumer Experience Assessment

(1) A quality indicators report must include the following information on an individual's experience obtained through a Consumer Experience Assessment and the number of individuals accessing funded aged care services that:

(a) were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(b) were excluded because of choosing not to complete the Consumer Experience Assessment in the reporting period;

(c) were offered a Consumer Experience Assessment during the reporting period through any of the following means:

(i) a self-completion assessment;

(ii) an interviewer facilitated assessment;

(iii) a proxy assessment;

(d) undertook the Consumer Experience Assessment during the reporting period, the number of individuals who reported against the following sub-categories and the means of assessment mentioned in paragraph (a) for the individuals in each sub-category:

(i) excellent: for individuals who score between 22 and 24;

(ii) good: for individuals who score between 19 and 21;

(iii) moderate: for individuals who score between 14 and 18;

(iv) poor: for individuals who score between 8 and 13;

(v) very poor: for individuals who score between 0 and 7;

(2) In preparing a quality indicators report for the purposes of subsection (1), registered providers must ensure that the collection of information for consumer experience assessment uses the Quality-of-Care Experience questions.

(3) In preparing a quality indicators report for the purposes of subsection (1), registered providers must collect information from each individual, once every reporting period.

(4) In preparing a quality indicators report for the purposes of subsection (1), registered providers must:

(a) in order to collect information, offer a copy of the QCE-ACC Self Complete Version document for self-completion by suitable individuals at the approved residential care home at around the same time every reporting period; and

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(b) allow an individual with no or mild cognitive impairment to self-complete the QCE-ACC Self Complete Version document; and

(c) arrange interviewer facilitated completion for all individuals requiring assistance to complete the QCE-ACC document (such as where the individual requires support with reading the questions or writing their responses) at around the same time every reporting period using the QCE-ACC Interviewer Facilitated Version; and

(d) arrange proxy-completion for all individuals who cannot complete the QCE-ACC through self-completion or interviewer facilitated completion such as in circumstances where the individual has moderate or cognitive impairment at around the same time every reporting period using the QCE-ACC Proxy Version.

166-170 Quality indicator—Quality of Life Assessment

(1) A quality indicators report must include the following information on an individual's quality of life obtained through a Quality of Life Assessment and the number of individuals accessing funded aged care services that:

(a) were offered a Quality of Life Assessment during the reporting period through any of the following means:

(i) a self-completion assessment;

(ii) an interviewer facilitated assessment;

(iii) a proxy assessment;

(b) were excluded because of an absence from receiving funded aged care services throughout the reporting period;

(c) were excluded because of choosing not to complete the Quality of Life Assessment in the reporting period;

(d) undertook the Quality of Life Assessment, the number of individuals who reported against the following sub-categories and the means of assessment mentioned in paragraph (a) for the individuals in each sub-category:

(i) excellent: for individuals who score between 22 and 24;

(ii) good: for individuals who score between 19 and 21;

(iii) moderate: for individuals who score between 14 and 18;

(iv) poor: for individuals who score between 8 and 13;

(v) very poor: for individuals who score between 0 and 7.

(2) For the purposes of subsection (1), registered providers must ensure that the collection and assessment of information relating to quality of life must use the Quality of Life questions.

(3) For the purposes of subsection (1), registered providers must collect information from each individual, once every reporting period.

(4) In preparing a quality indicators report for the purposes of subsection (1), registered providers must:

(a) in order to collect information, offer a copy of the QOL-ACC Self Complete Version document for self-completion by suitable individuals at

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the approved residential care home at around the same time every reporting period; and

(b) allow an individual with no or mild cognitive impairment to self-complete the QOL-ACC Self Complete Version document; and

(c) arrange interviewer facilitated completion for all individuals requiring assistance to complete the QOL-ACC document (such as where the individual requires support with reading the questions or writing their responses) at around the same time every reporting period using the QOL-ACC Interviewer Facilitated Version; and

(d) arrange proxy-completion for all individuals who cannot complete the QOL-ACC through self-completion or interviewer facilitated completion such as in circumstances where the individual has moderate or cognitive impairment at around the same time every reporting period using the QOL-ACC Proxy Version.

166-175 Quality indicator—allied health

(1) A quality indicators report must include the following information on allied health:

(a) the number of individuals accessing funded aged care services in the residential care home that were assessed for services delivered by an allied health professional during the reporting period;

(b) the number of individuals who were excluded because of an absence from accessing funded aged care services throughout the reporting period;

(c) the number of funded aged care services in the service type allied health and therapy that were recommended to be delivered by an allied health professional (including through a care and services plan under paragraph 148(e) of the Act), reported against the sub-categories set out in subsection (3);

(d) the number of funded aged care services in the service type allied health and therapy that were recommended to be delivered by an allied health professional (including through a care and services plan under paragraph 148(e) of the Act) and which were received, reported against the sub-categories set out in subsection (3).

Note: See section 148 of the Act (Delivery of funded aged care services).

(2) A quality indicators report must include the number of allied health professional labour hours (represented as minutes of care and services delivered to individuals each day) and reported separately as:

(a) allied health professional employee labour hours;

(b) allied health professional agency labour hours.

(3) For the purposes of paragraphs (1)(c) and (d) and subsection (2), a registered provider must report against each of the following sub-categories of allied health professionals;

(a) physiotherapist;

(b) occupational therapist;

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(c) speech pathologist;
(d) podiatrist;
(e) dietitian;
(f) allied health assistant;
(g) other allied health professionals.

(4) For the purposes of paragraph (3)(g) other allied health professionals include the following:
(a) art therapists;
(b) audiologists;
(c) exercise physiologists;
(d) music therapists;
(e) chiropractors;
(f) counsellors;
(g) osteopaths;
(h) psychologists;
(i) social workers.

(5) In preparing a quality indicators report for the purposes of subsection (1), registered providers must:
(a) collect information as to recommended funded aged care services in the service type allied health and therapy by undertaking a single review of all individual's care records for the entire reporting period; and
(b) only report once per allied health discipline.

166-180 Quality indicator—lifestyle officers

(1) A quality indicators report must include the following information on lifestyle officers delivering funded aged care services:
(a) the total labour hours worked in care minutes by lifestyle officers;
(b) the total labour hours worked as agency staff by lifestyle officers.

Note: For subsection (1), a lifestyle officer includes any of the following roles:
(a) diversional officer;
(b) recreation officer;
(c) activities officer.

(2) For the purposes of a quality indicators report and the quality indicator on lifestyle officers, a registered provider must also provide information on the number of occupied bed days for a provider for the reporting period.

166-185 Quality indicator—enrolled nursing

(1) A quality indicators report must include the following information on enrolled nursing with respect to direct care staff members that deliver funded aged care services:
(a) enrolled nursing total number of care minutes (in hours);
(b) registered nursing total number of care minutes (in hours);

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(c) personal care workers and nursing assistants total number of care minutes (in hours).

(2) For the purposes of subsection (1), direct care staff members covered under this section are those specified in paragraphs (a) to (d) of the definition of ***direct care staff member*** in section 7 of the Act.

Subdivision C—Complaints and feedback management report

166-205 Application of Subdivision

(1) This Subdivision applies to registered providers registered in one or more of the following provider registration categories:
(a) personal and care support in the home or community;
(b) nursing and transition care;
(c) residential care.

(2) This Subdivision applies to feedback received by a registered provider:
(a) that is managed in accordance with section 165-30; and
(b) raises an issue as referred to in subsection 165-30(2).

166-210 Requirements for reporting information relating to complaints and feedback management

(1) For the purposes of paragraph 166(1)(a) of the Act this section prescribes that a registered provider to whom this Subdivision applies must give a report about the management of complaints and feedback (the ***complaints and feedback management report***) to the Commissioner within 4 months after the end of the reporting period for the registered provider.

(2) The reporting period for a registered provider is:
(a) the period of 12 months starting on 1 July of a year; or
(b) another 12 month period that starts on the first day of a month of a year that is determined for the registered provider by the System Governor in accordance with the rules.

(3) The report must:
(a) be in the approved form; and
(b) be signed by a governing body of the registered provider; and
(c) include the information prescribed by subsection (4) of this section that is a summary of the management of complaints and feedback.

(4) For the purposes of paragraph 166(1)(a) of the Act, the following information is prescribed:
(a) information about complaints and feedback received, including the number of complaints and feedback and the nature of the complaints and feedback;

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(b) information about the action taken to resolve complaints or in response to feedback received, including any subsequent improvements made by the registered provider in relation to complaints and feedback;
(c) information about an evaluation of the effectiveness of the actions taken and their related outcome in relation to each complaint and feedback;
(d) information about the number of days taken to resolve each complaint and feedback;
(e) information about the education and training that has been delivered to the staff of the registered provider in relation to each complaint and feedback;
(f) an analysis of the patterns of, and underlying reasons for, complaints.

Subdivision D—Complaints and feedback information on request

166-215 Application of Subdivision to all registered providers

(1) This Subdivision applies to every kind of registered provider.

(2) This Division applies to feedback received by a registered provider:
(a) that is managed in accordance with section 165-30; and
(b) raises an issue as referred to in subsection 165-30(2).

166-220 Requirements for reporting information on request relating to complaints and feedback management

(1) For the purposes of paragraph 166(1)(a) of the Act this section prescribes that a registered provider to whom this Subdivision applies must on request by the System Governor or the Commissioner, give a report about the management of complaints and feedback (the ***complaints and feedback management report***) to the System Governor and the Commissioner.

(2) The System Governor or the Commissioner may, at any time, request a registered provider to give the System Governor and the Commissioner a report under subsection (1).

(3) A registered provider must comply with a request under subsection (1) within 14 days after the request is made, or such longer period as specified in the request.

(4) The report must:
(a) be in the approved form; and
(b) be signed by a governing body of the registered provider; and
(c) include the information prescribed by subsection (5) of this section.

(5) For the purposes of paragraph 166(1)(a) of the Act, the following information is prescribed:
(a) information about complaints and feedback received, including the number of complaints and feedback and the nature of the complaints and feedback;
(b) information about the action taken to resolve complaints or in response to feedback received including any subsequent improvements made by the registered provider in relation to complaints and feedback;

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(c) information about an evaluation of the effectiveness of the actions taken and their related outcome in relation to each complaint and feedback;
(d) information about the number of days taken to resolve each complaint and feedback;
(e) information about the education and training that has been delivered to the staff of the registered provider in relation to each complaint and feedback;
(f) an analysis of the patterns of, and underlying reasons for, complaints.

Subdivision E—Prudential and financial

166-310 Aged care financial report—general

Scope of this section

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(a) of the Act:
(a) every kind of registered provider is prescribed; and
(b) a registered provider must give a report about financial and prudential matters (the ***aged care financial report***) to the System Governor each reporting period for the registered provider.

Note: For the reporting period for an aged care financial report, see section 166-355 of this instrument.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services under any of the following specialist aged care programs:
(a) CHSP;
(b) NATSIFACP;
(c) TCP.

Note: For requirements relating to an annual prudential compliance statement, see section 166-360 of this instrument.

Requirements for an aged care financial report

(3) The aged care financial report must:
(a) be in the approved report form; and
(b) be signed by a member of the governing body of the registered provider; and
(c) be given to the System Governor within 4 months after the end of each reporting period for the registered provider; and
(d) if section 166-315 of this instrument applies—include a financial support statement; and
(e) if section 166-345 of this instrument applies—include a general purpose financial report; and
(f) if section 166-360 of this instrument applies—include an annual prudential compliance statement.

Note: The term ***governing body*** is defined in section 7 of the Act. The effect of this definition is that for registered providers who are not a body corporate with a board of directors (for example, State and Territory governments), the Aged Care Financial Report can be

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signed by a person or group of persons responsible for the executive decisions of the registered provider.

(4) To avoid doubt, the System Governor may, for the purposes of paragraph (3)(a), approve different forms in relation to specified provider registration categories or specified kinds of registered providers.

Additional requirements if registered in provider registration category residential care

(5) For a registered provider registered in the provider registration category residential care, in addition to the requirements in subsection (3), an aged care financial report must also include the following:

(a) subject to section 166-335 of this instrument, a care minutes performance statement;

(b) the amount of accommodation payments and accommodation contributions paid to the registered provider;

(c) the amounts of those accommodation payments and accommodation contributions paid as refundable deposits and daily payments;

(d) the amounts of accommodation bonds and accommodation charges paid to the registered provider;

(e) the extent of building, upgrading and refurbishment of residential care homes.

Requirement to comply with a notice for further information

(6) A registered provider must comply with a notice under subsection (8) within the period specified in the notice or, if no period is specified in the notice, within 28 days after the day when the notice is given.

(7) A registered provider complies with a notice under subsection (8) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of that subsection.

System Governor may request further information

(8) The System Governor may, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required under this section.

(9) A notice under subsection (8) may require a registered provider to give updated information about a matter in relation to a period that is:

(a) the same as the reporting period to which a report under this section relates; or

(b) different to the reporting period to which a report under this section relates.

Compliance with this section for part of reporting period

(10) If the registered provider:

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(a) is registered as a registered provider for part of the reporting period for the provider; or

(b) expands its services to a new registration category for part of the reporting period;

the provider is taken to have complied with this section if the provider complies with this section for that part of the reporting period.

166-315 Aged care financial report—provision of a financial support statement

Scope of this section

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(a) of the Act, a registered provider is prescribed if the provider:

(a) is registered in the provider registration category residential care; and

(b) is part of or is financially reliant on a related corporate entity; and

(c) is not a government entity or a local government authority; and

(d) is required under section 166-310 of this instrument to give the System Governor an aged care financial report for the provider for a reporting period.

(2) This section does not apply to registered providers that deliver funded aged care services under the MPSP.

Financial support statement to be given with aged care financial report

(3) If a registered provider is required to give the System Governor an aged care financial report for the provider for a reporting period, then the provider must, when giving the report to the System Governor, also give the System Governor a financial support statement for the provider signed within the period of 4 months starting on the day after the end of the reporting period.

(4) However, subsection (3) does not apply to a registered provider in relation to a reporting period if the aged care financial report for the provider for the year includes an explanation of why the provider has not complied with subsection (3) in relation to that year.

Financial support statement to be given on request

(5) The System Governor may at any time, by notice in writing, require a registered provider to give the System Governor a financial support statement for the provider signed within the period for signing specified in the notice.

Note: For who must sign a financial support statement, see subsection 166-320(4) of this instrument.

(6) A registered provider must comply with a notice under subsection (5) within the period for complying specified in the notice or, if no such period is specified in the notice, within 28 days after the day when the notice is given.

(7) However, subsection (6) does not apply to a registered provider in relation to a notice under subsection (5) if at or before the end of the period within which the

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provider would (but for this subsection) be required to comply with the notice, the provider gives the System Governor a written explanation of why the provider is not able to comply with the notice.

System Governor may request further information and documents

(8) The System Governor may at any time, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required under this section.

(9) A registered provider must comply with a notice under subsection (8) within the period for complying specified in the notice or, if no such period is specified in the notice, within 28 days after the day when the notice is given.

166-320 Aged care financial report—what is a financial support statement

(1) A ***financial support statement***, for a registered provider of a kind prescribed under subsection 166-315(1) of this instrument, is a written statement by the ultimate holding company in relation to the provider that satisfies the requirements in subsections (2), (4) and (5).

(2) The statement must either:
  (a) state that the ultimate holding company is willing and able, while the provider remains a registered provider, to provide any financial support to the provider that is needed in order to enable the provider to pay the debts of the provider specified under subsection (3) in relation to the statement; or
  (b) state that the ultimate holding company is not willing and able, while the provider remains a registered provider, to provide such financial support to the provider.

(3) For the purposes of paragraph (2)(a), the following debts of the provider are specified in relation to the statement (whether or not the debts relate to the provision of aged care services by the provider):
  (a) any debts of the provider that are outstanding immediately before the start of the day (the ***giving day***) when the statement is given to the System Governor;
  (b) any debts of the provider that:
    (i) are debts that become due during the period that starts on the giving day and ends immediately before the start of the first day after the giving day when the provider gives the System Governor another financial support statement for the provider; or
    (ii) if the provider never gives the System Governor another financial support statement for the provider after the giving day—are debts that become due on or after the giving day.

(4) A financial support statement must be signed by:

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(a) if the ultimate holding company is a body corporate that is incorporated, or taken to be incorporated, under the *Corporations Act 2001*—a director of the body corporate for the purposes of that Act; or

(b) otherwise—a member of the ultimate holding company's governing body.

(5) The statement must be in a form (if any) approved by the System Governor for the purposes of this subsection.

166-325 Aged care financial report—permitted uses reconciliation

(1) A form approved by the System Governor for an aged care financial report for a registered provider may require such a report to include a statement (a ***permitted uses reconciliation***) that sets out information about reportable uses of funds by the registered provider during a reporting period or reporting periods for the registered provider.

(2) For the purposes of subsection (1), a reportable use of funds is any of the following:

(a) a permitted use of refundable deposits or accommodation bonds;

(b) a use of funds (other than refundable deposits or accommodation bonds) which was such that, if the funds had been refundable deposits or accommodation bonds, the use would have been a permitted use of refundable deposits or accommodation bonds.

Note: For the permitted uses of refundable deposits, see section 310 of the Act. For the permitted uses of accommodation bonds, see section 287-101 of this instrument.

(3) To avoid doubt, the System Governor may, for the purposes of subsection (1), approve different forms in relation to specified provider registration categories or specified kinds of registered providers.

166-335 Aged care financial report—care minutes performance statement

Scope of this section

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(a) of the Act, a registered provider is prescribed if the provider:

(a) is registered in the provider registration category residential care; and

(b) is required under section 166-310 of this instrument to give the System Governor an aged care financial report for the provider for a reporting period.

(2) This section does not apply to registered providers that deliver funded aged care services under the MPSP.

(3) A registered provider of the kind prescribed under this section must provide a written statement that satisfies the requirements in subsections (4), (5) and (6) (a ***care minutes performance statement***).

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Care minutes performance statement to be given with aged care financial report

(4) A registered provider must, when giving the aged care financial report to the System Governor, also give the System Governor a care minutes performance statement for the provider in accordance with the requirements prescribed by subsection (5).

Requirements for a care minutes performance statement

(5) A care minutes performance statement for a reporting period for a registered provider must:
  (a) be in writing; and
  (b) be in a form approved by the System Governor; and
  (c) not contain false or misleading information; and
  (d) include the total number of care minutes (in hours) for each reporting period quarter as delivered by:
    (i) registered nurses; and
    (ii) enrolled nurses; and
    (iii) personal care workers and nursing assistants; and
  (e) include the total expenses for care minutes for each reporting period quarter as delivered by:
    (i) registered nurses; and
    (ii) enrolled nurses; and
    (iii) personal care workers and nursing assistants; and
  (f) include 24/7 registered nursing coverage across the reporting period by calendar month and expressed as a percentage; and
  (g) if there is a variance in the data submitted under paragraph (f) throughout the reporting period—the registered provider must include an explanation for the variance; and
  (h) if there is a variance between the care minutes reported in the care minutes performance statement and the care minutes reported in the previous quarterly financial reports—the registered provider must include an explanation for the variance; and
  (i) subject to subsection (6), include a signed audit report for the submitted care minutes performance statement by an independent auditor.

Auditing of care minutes performance statement

(6) A care minutes performance statement must be audited in accordance with the following requirements:
  (a) be audited by:
    (i) a registered company auditor within the meaning of the *Corporations Act 2001*; or
    (ii) a person approved by the System Governor under subsection (7);
  (b) be audited in accordance with the Assurance Engagements Other than Audits or Reviews of Historical Financial Information Standard (ASAE 3000).

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Note: For the purposes of paragraph (b), the Assurance Engagements Other than Audits or Reviews of Historical Financial Information Standard (ASAE 3000) is published by the Australian Auditing and Assurance Standards Board.

(7) The System Governor may approve a person to audit a care minutes performance statement if the System Governor is satisfied that the person has appropriate qualifications and experience.

(8) The System Governor may revoke an approval of a person under subsection (7) if the System Governor is satisfied that the person is no longer a fit and proper person to audit a care minutes performance statement.

166-340 Quarterly financial report

Scope of this section

(1) Subject to subsections (2) and (3), for the purposes of paragraph 166(1)(a) of the Act, every kind of registered providers is prescribed.

(2) The requirements of this section do not apply in respect to the delivery of funded aged care services under any of the following specialist aged care programs:
(a) CHSP;
(b) TCP.

(3) The requirements of this section do not apply in respect of the delivery of funded aged care services under the NATSIFACP where the registered provider is not registered in the provider registration category residential care.

(4) A registered provider of the kind prescribed under this section must give a report about matters provided in subsection (5) (the ***quarterly financial report***) to the System Governor for each quarter of a reporting period for the registered provider.

Note: For the reporting period for a quarterly financial report, see section 166-355 of this instrument.

Requirements for a quarterly financial report

(5) The quarterly financial report must:
(a) be in the approved report form; and
(b) be signed by a member of the governing body of the registered provider.

Note: The term ***governing body*** is defined in section 7 of the Act.

(6) To avoid doubt, the System Governor may, for the purposes of paragraph (5)(a), approve different forms in relation to specified provider registration categories or specified kinds of registered providers.

Timeframes to give System Governor a quarterly financial report

(7) The quarterly financial report for a quarter of a reporting period for the registered provider must be given to the System Governor:

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(a) for a quarter ending at the end of 31 December—within 45 days after the end of the quarter; and
(b) for any other quarter—within 35 days after the end of the quarter.

(8) Each of the following is a quarter of a reporting period for the registered provider:
(a) the period of 3 months beginning on the first day of the reporting period for the registered provider;
(b) each successive period of 3 months that occurs during the reporting period for the registered provider after the end of the period mentioned in paragraph (a).

Requirement to comply with a notice for further information

(9) A registered provider must comply with a notice under subsection (11) within the period specified in the notice or, if no period is specified in the notice, within 28 days after the day when the notice is given.

(10) A registered provider complies with a notice under subsection (11) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of that subsection.

System Governor may request further information

(11) The System Governor may, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required under this section.

(12) A notice under subsection (11) may require a registered provider to give updated information about a matter in relation to a period that is:
(a) the same as the reporting period to which a report under this section relates; or
(b) different to the reporting period to which a report under this section relates.

Compliance with this section for part of reporting period

(13) If the registered provider is registered as a registered provider for part of the reporting period for the registered provider or the registered provider expands its services to a new registration category for part of the reporting period, the registered provider is taken to have complied with this section if the registered provider complies with this section for that part of the reporting period.

166-345 Aged care financial report—general purpose financial report

Scope of this section

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(a) of the Act, a registered provider is prescribed if the provider is registered in the provider registration category residential care.

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(2) The requirements of this section do not apply to a registered provider if the registered provider:
  (a) is a government entity or a local government authority; or
  (b) is delivering funded aged care services under a specialist aged care program.

(3) A registered provider of a kind prescribed under this section must give a report on matters provided in subsection (4) (the ***general purpose financial report***) to the System Governor each reporting period for the registered provider.

Note: For the reporting period for a general purpose financial report, see section 166-355 of this instrument.

Requirements for a general purpose financial report

(4) The general purpose financial report must:
  (a) be a general purpose financial report within the meaning given by section 6 of the Statement of Accounting Concepts SAC 1; and
  (b) be in accordance with the Australian Accounting Standards in force at the time the report is prepared; and
  (c) give a true and fair view of the financial position and performance of the registered provider for the reporting period for each residential care home approved in relation to the registered provider; and
  (d) be written as if the registered provider were, so far as it provided those services, a distinct reporting entity within the meaning of the Statement of Accounting Concepts SAC 1; and
  (e) be given to the System Governor at the same time the registered provider gives an aged care financial report under section 166-310 of this instrument to the System Governor.

(5) If a general purpose financial report deals with a matter other than funded aged care services delivered through the service group residential care, the report must be prepared as if the funded aged care services delivered through the service group residential care it relates to were a reportable segment for the purposes of the Australian accounting standards related to segment reporting in force at the time the report is prepared.

(6) Despite subsections (4) and (5), if all the information about each residential care home approved in relation to the registered provider is included in the provider's aged care financial report for the reporting period, none of that information need be included in the general purpose financial report for the reporting period.

(7) A registered provider must give a copy of its most recently audited general purpose financial report to each person who asks for a copy and is:
  (a) an individual accessing funded aged care services at the approved residential care home; or
  (b) an individual who has an access approval in effect for a residential care home and is considering accessing funded aged care services through the residential care home; or
  (c) a supporter of an individual to whom paragraph (a) or (b) applies.

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Requirement to comply with a notice for further information

(8) A registered provider must comply with a notice under subsection (10) within the period specified in the notice or, if no period is specified in the notice, within 28 days after the day when the notice is given.

(9) A registered provider complies with a notice under subsection (10) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of that subsection.

System Governor may request further information

(10) The System Governor may, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required under this section.

(11) A notice under subsection (10) may require a registered provider to give updated information about a matter in relation to a period that is:
  (a) the same as the reporting period to which a report under this section relates; or
  (b) different to the reporting period to which a report under this section relates.

Compliance with this section for part of reporting period

(12) If the registered provider is registered as a registered provider for part of the reporting period or the registered provider expands its services to a new registration category for part of the reporting period, the registered provider is taken to have complied with this section if the registered provider complies with this section for that part of the reporting period.

(13) Registered providers covered by this section are required to publish the general purpose financial report for the relevant reporting period on the registered provider's website.

166-350 Aged care financial report—general purpose financial report audit requirements

(1) A general purpose financial report must:
  (a) be audited by:
    (i) a registered company auditor within the meaning of the *Corporations Act 2001*; or
    (ii) a person approved by the System Governor under subsection (2); and
  (b) include each of the following:
    (i) an audit opinion about the general purpose financial report from a registered company auditor or a person approved under subsection (2);
    (ii) a statement from the registered company auditor or the person approved under subsection (2) as to whether the report complies with paragraphs 166-345(4)(b) and (c) of this instrument.

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(2) The System Governor may approve a person to audit a general purpose financial report if the System Governor is satisfied that the person has appropriate qualifications and experience.

(3) The System Governor may revoke an approval of a person under subsection (2) if the System Governor is satisfied that the person is no longer a fit and proper person to audit a general purpose financial report.

166-355 Financial and prudential reports—reporting period

(1) For the purposes of subsection 166(4) of the Act, the reporting period for all reports given to the System Governor by a registered provider under this Subdivision means:
  (a) the financial year (the 12 month period beginning on 1 July and ending on 30 June); or
  (b) if under subsection (3), the System Governor determines another period of 12 months (being a period that begins on the first day of a month)—that other period.

(2) A registered provider may apply to the System Governor to determine a period of 12 months, other than the financial year, to be the registered provider's reporting period.

(3) If the System Governor receives an application from a registered provider for a determination under subsection (2), the System Governor must:
  (a) make, or refuse to make, the determination; and
  (b) notify the registered provider, in writing, of the System Governor's decision:
    (i) within 28 days; or
    (ii) if the Secretary has requested further information in relation to the application—within 28 days, excluding the period within which the information is requested and received.

(4) The System Governor may determine another period to be the registered provider's reporting period under subsection (3) only if the System Governor is satisfied, on reasonable grounds, that it would be impracticable for the registered provider to comply with the requirements of this Subdivision in relation to a financial year.

(5) If the System Governor refuses to make a determination for the registered provider under subsection (3), the System Governor must also give the registered provider a written statement of the reasons for the decision.

166-360 Aged care financial report—annual prudential compliance statement—general

Scope of this section

(1) For the purposes of paragraph 166(1)(a) of the Act, a registered provider is prescribed if the registered provider:

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(a) is registered in the provider registration category residential care; and
(b) receives or has received payment of any of the following from an individual, wholly or partly as a lump sum:
(i) a refundable deposit;
(ii) an accommodation bond;
(iii) an entry contribution.

(2) A registered provider of the kind prescribed under this section must give the System Governor a statement (the ***annual prudential compliance statement***) for a reporting period for the registered provider that includes the following:
(a) if the lump sum is a refundable deposit—information about refundable deposits and refundable deposit balances referred to in section 166-365 of this instrument;
(b) if the lump sum is an accommodation bond—information about the accommodation bond and accommodation bond balance referred to in section 166-365 of this instrument;
(c) if the lump sum is an entry contribution—information about entry contributions referred to in section 166-365 of this instrument;
(d) information about other fees referred to in section 166-375 of this instrument;
(e) the statements and other information referred to in section 166-380 of this instrument.

Requirements for an annual prudential compliance statement

(3) An annual prudential compliance statement for a reporting period for a registered provider must:
(a) be in writing; and
(b) be in a form approved by the System Governor; and
(c) further to subsection (2), include the information specified in that subsection; and
(d) not contain false or misleading information; and
(e) include a declaration that the registered provider has only charged the amount of refundable deposit the registered provider is permitted to charge; and
(f) if the registered provider has not complied with paragraph (e), include the number of times the provider has not complied with this requirement and the reasons for the non-compliance; and
(g) if the registered provider is required to prepare an aged care financial report for the reporting period—be included in the aged care financial report for the registered provider for the reporting period; and
(h) if paragraph (g) does not apply to the registered provider:
(i) be signed by a person who is one of the registered provider's responsible persons and is authorised by the registered provider to sign the statement; and

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(ii) be given to the System Governor within 4 months after the end of the reporting period for the registered provider.

Note: The annual prudential compliance statement must be supported by an independent audit (see section 166-385 of this instrument).

166-365 Annual prudential compliance statement—information about refundable deposits, accommodation bonds and entry contributions that must be included

(1) Further to section 166-360 of this instrument, this section prescribes the information to be included in an annual prudential compliance statement if the registered provider receives a refundable deposit, an accommodation bond or entry contribution from an individual.

(2) The information about a refundable deposit, an accommodation bond or entry contribution, a refundable deposit balance or an accommodation bond balance or entry contribution balance that must be included in a registered provider's annual prudential compliance statement for a reporting period is as follows:

(a) the total number of refundable deposit balances, or accommodation bond balances or entry contribution balances held by the registered provider as at the end of the reporting period;

(b) the total value of refundable deposit balances, or accommodation bond balances or entry contribution balances held by the registered provider as at the end of the reporting period;

(c) the total value of refundable deposits, accommodation bonds or entry contributions received by the registered provider during the reporting period;

(d) the total amount deducted by the registered provider during the reporting period from refundable deposit balances, accommodation bond balances or entry contribution balances, including:

(i) for refundable deposit balances or accommodation bond balances—any general deductions under section 307 of the Act or section 287-90 of this instrument; and

(ii) for refundable deposit balances only—any retention amounts deducted under section 308 of the Act by the registered provider during the reporting period from refundable deposit balances;

(iii) for accommodation bond balances only—any accommodation bond retention amounts deducted under section 287-95 of this instrument by the registered provider during the reporting period from accommodation bond balances;

(e) the total amount deducted by the registered provider during the reporting period from refundable deposits or accommodation bonds that were received during the year, including:

(i) for refundable deposit balances or accommodation bond balances—any general deductions under section 307 of the Act or section 287-90 of this instrument; and

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(ii) for refundable deposit balances only—any retention amounts deducted under section 308 of the Act by the registered provider during the reporting period from refundable deposit balances received during the reporting period;

(iii) for accommodation bond balances only—any accommodation bond retention amounts deducted under section 287-95 of this instrument by the registered provider during the reporting period from accommodation bond balances;

(f) any transfer of a refundable deposit made under section 312 of the Act, a transfer of an accommodation bond made under section 287-103 of this instrument, or transfer of entry contribution balances, including the amount, the date of transfer and the amount left on retention;

(g) the total value of refundable deposit balances, accommodation bond balances and entry contribution balances refunded by the registered provider during the reporting period;

(h) if, during the reporting period, refundable deposit balances or accommodation bond balances or entry contribution balances were not refunded in accordance with subsection 311(3) of the Act, subsection 287-102(2) of this instrument or section 287-160 of this instrument (other than a refundable deposit balance, or accommodation bond balance or entry contribution balance in relation to which the registered provider has made an agreement as referred to in section 311-20(3) of this instrument)—the following information:

(i) the total number of refundable deposit balances, accommodation bond balances or entry contribution balances that were not refunded in accordance with subsection 311(3) of the Act, subsection 287-102(2) of this instrument or section 287-160 of this instrument;

(ii) where entry contribution balances were not refunded in accordance with an applicable formal agreement with an individual—the number of entry contributions that were refunded under the formal agreement applying in respect of the relevant entry contribution balance;

(iii) the reason or reasons for the delay in refunding the refundable deposit balances, accommodation bond balances or entry contribution balances;

(iv) in respect of each reason provided—the total number of instances of delay attributable to the reason;

(i) if, for the whole or a part of the reporting period, the registered provider was not permitted to charge a refundable deposit or accommodation bond for entry by an individual to any aged care service that the registered provider is responsible for operating:

(i) the period or periods during which the registered provider was not permitted to charge a refundable deposit or accommodation bond; and

(ii) the funded aged care service in respect of which each period specified applies;

(j) the use of refundable deposits and accommodation bonds by the registered provider during the reporting period;

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(k) whether any use of refundable deposits, accommodation bonds by the registered provider during the reporting period was not permitted under section 310 of the Act or section 287-101 of this instrument;

(l) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on capital expenditure for which use of a refundable deposit or an accommodation bond was permitted under section 310 of the Act or section 287-101 of this instrument;

(m) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on investment in financial products for which use of a refundable deposit or an accommodation bond was permitted under section 310 of the Act or section 287-101 of this instrument;

(n) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on loans for which use of a refundable deposit or an accommodation bond was permitted under section 310 of the Act or section 287-101 of this instrument;

(o) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on repaying debt accrued for the purposes of:

  (i) capital expenditure of the kind described in paragraph (l); or

  (ii) refunding refundable deposit balances, accommodation bond balances or entry contribution balances;

(p) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on repaying debt that accrued before 1 October 2011 if the debt was accrued for the purpose of delivering funded aged care services to individuals;

(q) the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on each of the uses of refundable deposits or accommodation bonds permitted under section 310 of the Act or section 287-101 of this instrument;

(r) the amount that has been returned to the registered provider during the reporting period from the sale, disposal or redemption of financial products covered by subsection 310(3) of the Act, or subsection 287-101(4) of this instrument, that the registered provider invested in after 1 October 2011, whether or not the investment was obtained from refundable deposits or accommodation bonds;

(s) for each accommodation agreement entered for a room priced above the maximum accommodation payment amount, whether the provider ensured they were permitted to charge the price, including having a current approval from the Pricing Authority at the time the individual agreed to the payment of the higher room price;

(t) where there is a decrease or reduction in the payable amount from each resident’s daily accommodation contribution and refundable contribution

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held, information that the provider refunded the overpaid amount within 28 days of becoming aware of the reduced amount payable or paid by the individual;

(u) information regarding the overpayment of accommodation payments or contributions during prior reporting period that the provider has become aware of during the reporting period.

Note: Paragraph (h) does not apply to a registered provider that has transferred their refundable deposit balance to another registered provider under section 312 of the Act.

166-375 Annual prudential compliance statement—information about other fees that must be included

The information about other fees that must be included in a registered provider's annual prudential compliance statement for a reporting period is as follows:

(a) the fees (if any) other than individual contributions, accommodation payments and accommodation contributions that the registered provider charged to individuals during the reporting period;

(b) the total value of each such fee charged by the registered provider during the reporting period;

(c) what each such fee purports to cover;

(d) for individuals accessing ongoing funded aged care services, whether the provider has conducted, in accordance with subsection 284-11(4) of this instrument, an annual review of each individual's higher everyday living agreement during the reporting period.

166-380 Annual prudential compliance statement—Financial and Prudential Standards

The statements and other information that must be included in a registered provider's annual prudential compliance statement for a reporting period are as follows:

(a) a statement about whether the registered provider has, during the reporting period, complied with the following:

(i) the Financial and Prudential Standards;

(ii) section 287-20 of this instrument and subsection 293(1), subsections 311(1) and (2) and section 313 of the Act;

(iii) Division 3 of Part 4 of Chapter 4 of the Act;

(iv) section 287-101 of this instrument subsection 310(1) of the Act;

(b) if the registered provider has not complied with any of the Standards in the Financial and Prudential Standards—a statement about why the registered provider has not complied with the Standard;

(c) if the registered provider has not complied with the conditions applicable to disclosure in section 155-30, 155-35, 166-365, 166-375, and 166-385 of this instrument—the following information:

(i) the total number of occasions on which the registered provider did not comply;

(ii) the reason or reasons for the registered provider's failure to comply;

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(iii) in respect of each reason provided—the total number of occasions of non-compliance attributable to the reason;

(d) the amount set out in the registered provider's liquidity management strategy, as at the end of the reporting period, as the registered provider's minimum liquidity amount for the end of the most recent quarter;

(e) the date on which the registered provider's liquidity management strategy was last reviewed and assessed;

(f) the date on which the registered provider's financial and prudential management system was last reviewed and assessed;

(g) an audit opinion, provided by the person who provides the independent audit referred to in section 166-385 of this instrument, on whether the registered provider has complied with this Subdivision in the reporting period.

Note: The annual prudential compliance statement must be supported by an independent audit (see section 166-385 of this instrument).

166-385 Annual prudential compliance statement—audit requirements

(1) An annual prudential compliance statement must be supported by an independent audit provided by:

(a) a registered company auditor within the meaning of the *Corporations Act 2001*; or

(b) a person approved by the System Governor under subsection (2).

(2) The System Governor may approve a person to audit an annual prudential compliance statement if the System Governor is satisfied that the person has appropriate qualifications and experience.

(3) The System Governor may revoke an approval of a person under subsection (2) if the System Governor is satisfied that the person is no longer a fit and proper person to audit an annual prudential compliance statement.

Subdivision F—CHSP

166-600 Application of Subdivision

This Subdivision applies to a registered provider of a kind who is registered in one or more of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care;

and delivers funded aged care services under the CHSP.

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166-605 Annual financial declaration statement

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a statement (the ***annual financial declaration statement***) each financial year for the registered provider.

(2) The annual financial declaration statement for a financial year for the registered provider must be given to the System Governor by 31 August of that year.

(3) The annual financial declaration statement must be in a report form approved by the System Governor.

(4) The annual financial declaration statement must include the following information for the financial year:
  (a) certification that all financial assistance granted by the System Governor was spent for the purposes specified in the grant agreement;
  (b) the amount of financial assistance the System Governor has granted the registered provider under the grant agreement, excluding GST;
  (c) the registered provider's expenditure for the delivery of funded aged care services, excluding GST;
  (d) any surplus and uncommitted funds in the financial year;
  (e) any surplus and uncommitted funds from the previous financial year.

Statement of compliance to be given with annual financial declaration statement

(5) If a registered provider is required under subsection (1) to give the System Governor an annual financial declaration statement for the financial year, then the provider must, when giving the report to the System Governor, also give the System Governor a statement of compliance that the financial assistance granted under the grant agreement was only spent on individuals with an assessment approval for funded aged care services in one or more service groups for the individuals and the classification types for the service groups under section 65 of the Act.

(6) The annual financial declaration statement must be certified by the registered provider's governing body.

(7) For the purposes of subsection (1), the annual financial declaration statement must not include information about the registered provider's:
  (a) own funds; or
  (b) funds from another aged care program.

166-610 Monthly performance report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a report about activity and performance data matters (the ***monthly performance report***) each month.

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(2) The monthly performance report must be in an approved report form approved by the System Governor.

(3) Without limiting subsection (2), the monthly performance report must include:
  (a) client level data and service delivery information for all activities described in Item B of the grant agreement, including:
    (i) the output measure as per the service type; and
    (ii) the My Aged Care ID for each individual; and
  (b) any individual fees or contributions paid to the registered provider under Part 3 of Chapter 4 of the Act.

(4) The monthly performance report for a registered provider must be given to the System Governor within 14 days after the end of the month.

166-615 Annual wellness and reablement report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a report about the registered provider's progress in embedding wellness and reablement in its service delivery (the ***annual wellness and reablement report***).

(2) The System Governor may, at any time, request a registered provider to give the System Governor a report under subsection (1).

(3) A registered provider must comply with a request under subsection (1) within 28 days after the request is made.

(4) The report must be in a report form approved by the System Governor.

166-620 Compliance report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a report about any matters related to the registered provider's management of a grant agreement under section 264 of the Act (the ***compliance report***).

(2) The System Governor may, at any time, request a registered provider to give the System Governor a report under subsection (1).

(3) The compliance report for a registered provider must be given to the System Governor within 14 days after the request is made.

(4) The report must be in a report form approved by the System Governor.

166-625 Service delivery report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must, on request by the

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System Governor, give a report about service delivery (the ***service delivery report)***.

(2) The System Governor may, at any time, request a registered provider to give the System Governor a report under subsection (1).

(3) A registered provider must comply with a request under subsection (1) within 21 days after the request is made, or such longer period as specified in the request.

(4) The report must be in a report form approved by the System Governor.

166-627 Exemption process for certain reports

(1) For the purposes of paragraph 166(4)(b) of the Act, this section prescribes the exemption process in relation to the submission of the following:
  (a) annual financial declaration statement;
  (b) monthly performance report;
  (c) compliance report;
  (d) annual wellness and reablement report;

(2) A registered provider may apply to the System Governor for an exemption from subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), if the provider is affected by extenuating circumstances.

(3) The application:
  (a) may be in a form approved by the System Governor; and
  (b) must be made to the System Governor at least 14 days before the due date for the report listed in subsection (1).

(4) The System Governor must decide to grant or refuse an exemption within:
  (a) if the registered provider is given a notice under subsection (5) and gives the System Governor the further information or documents requested within the 14-day period, or such longer period specified in the notice—14 days after receiving the further information or documents; or
  (b) if the registered provider is given a notice under subsection (5) but does not give the System Governor the further information or documents requested within the 14-day period, or such longer period specified in the notice—14 days after the end of that period; or
  (c) otherwise—14 days after receiving the request.

(5) If the System Governor receives an application under subsection (2) from a registered provider, the System Governor may, by notice in writing given to the provider, request further information or documents specified in the notice for the purposes of considering the application.

(6) If the registered provider does not provide the requested information or documents within 14 days after the day when the notice is given, or within such longer period specified in the notice, the application is taken to have been withdrawn. The notice must contain a statement setting out the effect of this subsection.

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(7) If the System Governor receives an application under subsection (2) from a registered provider for an exemption under subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), the System Governor may grant the exemption only if the System Governor is satisfied that the provider is affected by extenuating circumstances.

(8) If the System Governor decides to grant an exemption, the System Governor must decide the period for which the exemption is to be in force.

(9) The period may:
  (a) be for the financial year; or
  (b) be a duration no longer than 12 months.

(10) If the System Governor grants an exemption from subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), to a registered provider, the System Governor must give the provider notice in writing of the decision that:
  (a) states an exemption has been granted; and
  (b) states the period for which the exemption is in force; and
  (c) the reasons for the decision.

(11) If the System Governor refuses to grant an exemption from subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), to a registered provider, the System Governor must give the provider notice in writing of the decision that:
  (a) states an exemption has not been granted; and
  (b) states the due date for the report; and
  (c) the reasons for the decision.

166-628 Child safety compliance statement

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (3) (the ***child safety compliance statement***) to the System Governor each year.

(2) The child safety compliance statement for the registered provider must be given to the System Governor by 31 March each year.

(3) The child safety compliance statement must include the following information:
  (a) a declaration that the registered provider has delivered grant activities consistent with the Child Safety supplementary term in the registered provider's grant agreement;
  (b) the activity name;
  (c) the activity ID;
  (d) the statement type in relation to the incidental contract term in the grant agreement;
  (e) the reporting start date;
  (f) the reporting end date.

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(4) If the registered provider has not complied with the Child Safety supplementary term in the registered provider's grant agreement, the registered provider must provide a description of the non-compliance and set out the reasons for the non-compliance in the child safety compliance statement.

(5) The child safety compliance statement must be in a report form approved by the System Governor.

Subdivision G—NATSIFACP

166-630 Application of Subdivision

This Subdivision applies to a registered provider of a kind who is registered in one or more of the following provider registration categories:

(a) home and community services;
(b) assistive technology and home modifications;
(c) personal and care support in the home or community;
(d) nursing and transition care;
(e) residential care;
(f) advisory and support services;

and delivers funded aged care services under the NATSIFACP.

166-635 Annual financial declaration statement

(1) For the purposes of section 166 of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give the System Governor a statement (the ***annual financial declaration statement***) each financial year for the registered provider.

(2) The annual financial declaration statement for a financial year for the registered provider must be given to the System Governor:

(a) annually; or
(b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual financial declaration statement must be in a report form approved by the System Governor.

(4) The annual financial declaration statement must include the following information for the financial year:

(a) certification that the provider, in relation to the use of financial assistance granted by the System Governor under subsection 264(2) of the Act, complied with the statutory funding condition under subsection 267(1) of that Act;
(b) the amount of financial assistance the System Governor, on behalf of the Commonwealth, granted the registered provider;
(c) the amount of expenditure for the delivery of funded aged care services by the provider;

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(d) the amount, if any, of unspent grant funding in the financial year;
(e) any unspent funds approved by the System Governor from previous financial year.

Note: It is a statutory funding condition that the financial assistance granted to a registered provider is used only for the purpose of delivering funded aged care services to individuals in the circumstances mentioned in subsection 267(1) of the Act.

(5) The annual financial declaration statement must be signed by a member of the registered provider's governing body.

166-640 Audited income and expenditure report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report about financial matters (the ***audited income and expenditure report***) to the System Governor each financial year for the registered provider.

(2) The audited income and expenditure report must be prepared by:
(a) a registered company auditor within the meaning of the *Corporations Act 2001*; or
(b) a member of:
(i) the Institute of Public Accountants; or
(ii) the Institute of Chartered Accountants in Australia.

Audited income and expenditure statement to be given with audited income and expenditure report

(3) If a registered provider is required under this section to give the System Governor an audited income and expenditure report for the financial year, then the provider must, when giving the report to the System Governor, also give the System Governor an audited income and expenditure statement.

(4) The audited income and expenditure statement must:
(a) be in accordance with the Australian accounting standards in force at the time the report is prepared; and
(b) be based on proper accounts and records of the registered provider; and
(c) verify that the provider, in relation to the use of financial assistance granted by the System Governor under subsection 264(2) of the Act, complied with the statutory funding condition under subsection 267(1) of that Act; and
(d) include other matters as specified in the funding agreement; and
(e) include the audit opinion; and
(f) include the amount of financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider under subsection 264(2) of the Act for the financial year; and
(g) include the amount of individual fees and contributions paid to the provider by individuals for the financial year; and
(h) include salary expenditure; and
(i) include rent or lease expenditure; and

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(j) include outbreak management expenditure; and
(k) include vehicle lease and maintenance cost; and
(l) include other expenditure; and
(m) include total expenditure.

166-645 Service activity report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report about the registered provider's progress in providing funded aged care services in accordance with the grant agreement (the ***service activity report***) to the System Governor every 6 months.

(2) The service activity report must be given to the System Governor:
(a) on 27 January for the 6 month period ending on 31 December; and
(b) on 27 July for the 6 month period ending on 30 June.

(3) The service activity report must:
(a) be in a report form approved by the System Governor; and
(b) include information about labour worked hours data for registered nurses, enrolled nurses, personal care workers and allied health professionals for the reporting period; and
(c) include information about labour cost for registered nurses, enrolled nurses, personal care workers and allied health professionals for the reporting period; and
(d) include information about the number of occupied beds for the reporting period; and
(e) include de-identified profiles of each aged care worker of the provider; and
(f) include the number of individuals accessing funded aged care services by service type; and
(g) include the number and type of health profession visits during the reporting period; and
(h) include the number and type of traditional or cultural events individuals accessing funded aged care services were supported to engage in during the reporting period.

166-646 Child safety compliance statement

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (3) (***child safety compliance statement***) to the System Governor each year.

(2) The child safety compliance statement for the registered provider must be given to the System Governor by 31 March each year.

(3) The child safety compliance statement must include the following information:

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(a) a declaration that the registered provider has delivered grant activities consistent with the Child Safety supplementary term in the registered provider's grant agreement;
(b) the activity name;
(c) the activity ID;
(d) the statement type in relation to the incidental contract term in the grant agreement;
(e) the reporting start date;
(f) the reporting end date.

(4) If the registered provider has not complied with the Child Safety supplementary term in the registered provider's grant agreement, the registered provider must provide a description of the non-compliance and set out the reasons for the non-compliance in the child safety compliance statement.

(5) The child safety compliance statement must be in a report form approved by the System Governor.

Subdivision H—Multi-Purpose Service Program

166-720 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under the MPSP.

166-725 Annual activity report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (the ***annual activity report***) to the System Governor each financial year.

(2) The annual activity report for a financial year for the provider must be given to the System Governor:
(a) by 31 July each year; or
(b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual activity report must be in a report form approved by the System Governor.

(4) The information that must be included in the annual activity report for the financial year is as follows:
(a) the number of individuals who have accessed funded aged care services in, or from, the approved residential care home;
(b) the number of individuals who commenced accessing funded aged care services without an access approval and were later approved through the alternative entry pathway under subsection 71(2) of the Act;
(c) the number of individuals waiting to access such funded aged care services;

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(d) any fees or contributions charged to individuals who accessed funded aged care services delivered in, or from, an approved residential care home;
(e) the service types delivered;
(f) the activities undertaken by the residential care home to prevent and manage disease outbreaks.

(5) A registered provider must provide the information prescribed in subsection (4) in respect of each residential care home operated by the registered provider.

166-730 Annual statement of financial compliance and income and expenditure

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (the ***annual statement of financial compliance and income and expenditure***) to the System Governor each financial year.

(2) The annual statement of financial compliance and income and expenditure must be given to the System Governor:
(a) by 31 October each year; or
(b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual statement of financial compliance and income and expenditure must be in a report form approved by the System Governor.

(4) The information that must be included in the annual statement of financial compliance and income and expenditure for the financial year is as follows:
(a) amount of subsidy received under Division 5 of Part 2 of Chapter 4 of the Act to deliver funded aged care services at each approved residential care home;
(b) individual fees or contributions paid to the provider under Part 3 of Chapter 4 of the Act by individuals accessing funded aged care services at each approved residential care home;
(c) the amount of expenditure on each of the following:
(i) salaries or wages of aged care workers and responsible persons;
(ii) any labour costs in addition to salaries in wages such as superannuation benefits, leave loadings, payroll tax, workers compensation and other liability insurance, cost of subsidised services to employees and training costs;
(iii) non-salary related other expenditure;
(iv) capital expenditure;
(v) disease outbreak management activities.

166-735 Service demographics report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on

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matters provided for in subsections (4) and (5) (***service demographics report***) to the System Governor each financial year.

(2) The service demographics report must be given to the System Governor:
  (a) by 31 July each year; or
  (b) at such other time as agreed between the System Governor and the registered provider.

(3) The service demographics report must be in a report form approved by the System Governor.

(4) The service demographics report must include a list of individuals who accessed funded aged care services delivered by the registered provider for the financial year.

(5) A report prepared for the purposes of subsection (1) of this section must also include the following information:
  (a) for each individual who accessed funded aged care service delivered by the provider, the service types, including the services where specified in the individual's access approval, delivered;
  (b) the classification type for the service group for each individual;
  (c) demographic information where requested in the report form approved by the System Governor, including:
    (i) the name of the individual; and
    (ii) the gender of the individual; and
    (iii) the date of birth of the individual; and
    (iv) whether the individual is an Aboriginal or Torres Strait Islander Person; and
    (v) whether the individual has been diagnosed with dementia or has suspected dementia symptoms;
  (d) whether the individual had an access approval when they commenced accessing services;
  (e) the date on which the individual commenced accessing funded aged care services;
  (f) the date on which the individual ceased accessing funded aged care services;
  (g) the reason for ceasing any funded aged care services.

(6) A registered provider must give the System Governor a service demographics report for each approved residential care home operated by the registered provider.

Subdivision J—Transition Care Program

166-740 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under the TCP.

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166-745 Annual accountability report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (***annual accountability report***) to the System Governor each financial year.

(2) The annual accountability report for a financial year for the provider must be given to the System Governor:
  (a) annually; or
  (b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual accountability report must be in a report form approved by the System Governor.

(4) The annual accountability report for the financial year must include the following information for the provider:
  (a) any subsidy received under section 249 of the Act;
  (b) any income derived from any individual fees and contributions under Part 3 or Chapter 4 of the Act;
  (c) State or Territory direct funding;
  (d) State or Territory in-kind contributions;
  (e) other income including;
    (i) donations; and
    (ii) interest; and
    (iii) expenditure recoveries and reimbursements; and
    (iv) client fees; and
    (v) any other income not specified in subparagraph (i) and (ii) of this paragraph or paragraph (a) to (d) of this subsection;
  (f) total income;
  (g) salary expenditure;
  (h) non-salary expenditure including:
    (i) office costs; and
    (ii) operating costs; and
    (iii) service agreements; and
    (iv) consumables and equipment for client use; and
    (v) travel; and
    (vi) capital costs;
  (i) other expenditure including:
    (i) asset related expenses including depreciation; and
    (ii) any other expenditure not specified in subparagraph (i) of this paragraph or paragraph (g) and (h) of this subsection;
  (j) total expenditure;
  (k) TCP activity for the financial year including;
    (i) total clients; and

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(ii) total care days; and
(iii) total residential care days; and
(iv) total home-based care days;

(l) surplus analysis and itemisation of surplus by income source including;
(i) Commonwealth government; and
(ii) State government; and
(iii) Territory government; and
(iv) client contributions; and
(v) any income specified in paragraph (e) of this subsection;

(m) the Commonwealth surplus expressed as a number of care days;

(n) any explanatory notes or commentary on the following;
(i) income;
(ii) expenditure;
(iii) activity for the financial year;
(iv) surplus analysis;
(v) additional activity;

(o) feedback, complaints and improvements including;
(i) the most common kinds of positive feedback; and
(ii) the most common kinds of complaints; and
(iii) improvements made by the provider;

(p) information in respect of whether the Fair Work Commission wage increase component of the Commonwealth subsidy has been passed on to any eligible workers;

(q) certification that the information provided in the report is true and correct.

Reporting period

(5) The reporting period for the provider is the period specified for a service activity report under section 166-645.

Subdivision K—Governing bodies

166-800 Application of this Subdivision

(1) Subject to subsection (2), this Subdivision applies to registered providers registered in one or more of the following provider registration categories:
(a) nursing and transition care;
(b) residential care.

(2) This Subdivision does not apply to the delivery of funded aged care services provided under any of the following specialist aged care programs:
(a) MPSP;
(b) NATSIFACP.

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166-805 Governing bodies must prepare and provide statements

(1) Subject to subsection (2), for the purposes of paragraph 166(1)(a) of the Act, it is prescribed that a registered provider to whom this Subdivision applies must give a report of a kind referred to in this section to the System Governor within 4 months after the end of the reporting period.

(2) This section does not apply to registered providers that deliver funded aged care services under the MPSP.

(3) The reporting period for a registered provider to whom this Subdivision applies is:
  (a) the period of 12 months starting on 1 July of a year; or
  (b) another 12 month period that starts on the first day of a month of a year that is determined for the registered provider by the System Governor in accordance with the rules.

(4) The report must:
  (a) be in the approved form; and
  (b) be signed by a member of the provider's governing body on behalf of all members of the governing body; and
  (c) include the information prescribed by subsection (5) of this section; and
  (d) include any other statements or information required by the approved form.

(5) The following information is prescribed:
  (a) whether the governing body of the provider believes that the provider has complied with the conditions, obligations and requirements of the provider under the Act;
  (b) if the governing body of the provider believes that the provider has failed to comply with one or more conditions, obligations or requirements of the provider under the Act—the details of:
    (i) each condition, obligation or requirement that the governing body believes that the provider has failed to comply with; and
    (ii) the reasons why the provider has failed to comply with the condition, obligation or requirement; and
    (iii) the actions that the provider has taken, has started to take or will take to rectify the non-compliance.

Example: For subparagraph (b)(iii), under Chapter 6 of the Act a registered provider may:
  (a) give an enforceable undertaking about remedying non-compliance (see Part 8 of Chapter 6 of the Act); or
  (b) agree to certain matters if revocation of registration is being considered (see section 133 of the Act).

166-810 Requirements for certain registered providers to give information relating to reporting periods

(1) For the purposes of paragraph 166(1)(a) of the Act, it is prescribed that a registered provider to whom this Subdivision applies must give the following additional information:

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(a) information about the kind of feedback and complaints received by the registered provider in the reporting period;
(b) information about improvements made by the registered provider in the reporting period in relation to quality of care;
(c) information about initiatives that the registered provider has implemented in the reporting period to support a diverse and inclusive environment for individuals accessing funded aged care services and aged care workers;
(d) information about the representation of different demographic groups in the membership of the governing body of the provider (but, for any group, only if a member of the governing body who is a member of that group consents to that information being provided);
(e) information on whether the registered provider was, in the reporting period, a government entity or a local government authority;
(f) for registered providers that are not government entities or local government authorities, whether the registered provider is a registered provider of a kind prescribed by the rules for the purposes of subsection 157(2) of the Act;
(g) for registered providers that are subject to the requirements of subsection 157(2) of the Act, whether the registered provider has complied during the reporting period with the requirements of subsection 157(2);
(h) whether subsection 157(3) or (4) of the Act applied to the registered provider during the reporting period.

(2) A registered provider registered in the registration category nursing and transition care must provide the information prescribed in subsections (1)(a) to (c) in respect of each service delivery branch operated by the registered provider.

(3) A registered provider registered in the registration category residential care must provide the information prescribed in subsections (1)(a) to (c) in respect of each residential care home operated by the registered provider.

166-815 Service provided during part only of reporting period

If a registered provider registered in the residential care category was responsible for the operations of a residential care home during part of a reporting period for the registered provider, the registered provider is taken to have complied with sections 166-805 and 166-810 in relation to the home for the reporting period if the registered provider complied with 166-805 and 166-810 in relation to the home and that part of the reporting period.

Subdivision L—Registered nurses

166-850 Application of this Subdivision

(1) Subject to subsection (2), this Subdivision applies to a registered provider registered in the provider registration category residential care.

(2) The requirements of this Subdivision do not apply to a registered provider only delivering funded aged care services under a specialist aged care program.

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166-855 Reporting requirements relating to registered nurses

(1) For the purposes of paragraph 166(1)(a) of the Act, a registered provider must give the System Governor a report about the obligation in subsection 175(1) of the Act in relation to each approved residential care home of the provider within 7 days after the end of each calendar month, or within a longer period specified by the System Governor by notice in writing given to the provider.

(2) A registered provider is not required to provide a report under subsection (1) of this section in relation to an approved residential care home for a calendar month if, during that calendar month, the registered provider did not deliver funded aged care services to at least one individual in the home.

(3) To avoid doubt, it is a requirement that a registered provider provide a report under subsection (1) of this section in relation to an approved residential care home regardless of whether the registered provider has been granted an exemption under paragraph 175(2)(a) of the Act from the obligation in subsection 175(1) of the Act in relation to that home.

(4) The report must:
  (a) be in a form approved, in writing, by the System Governor; and
  (b) specify in relation to each approved residential care home, whether a registered nurse was on site and on duty at all times for each day during the calendar month on which at least one individual received funded aged care services in the home; and
  (c) if a registered nurse was not on site and on duty at all times on any such day—specify the following information:
    (i) each period of 30 minutes or more that a registered nurse was not on site and on duty at the home;
    (ii) for each such period, the reasons why a registered nurse was not on site or on duty (or both) during that period;
    (iii) for each such period, the alternative arrangements that were made for the period to ensure the clinical needs of the individuals in the home were met, or a statement that no alternative arrangements were made.

Subdivision M—Status of service delivery branches

166-900 Application of this Subdivision

This Subdivision applies to a registered provider registered in one or more of the following categories:
  (a) home and community services;
  (b) assistive technology and home modifications;
  (c) advisory and support services;
  (d) personal and care support in the home or community;
  (e) nursing and transition care.

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166-905 Reporting requirements relating to service delivery branches

For the purposes of paragraph 166(1)(a) of the Act, this Subdivision prescribes:

(a) the reports a registered provider must give to the System Governor in relation to a service delivery branch of the provider; and

(b) the requirements relating to those reports.

166-910 Report for opening of a service delivery branch

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

(a) the provider intends to begin delivering funded aged care services through a service delivery branch; and

(b) either:

(i) the provider has not previously delivered any funded aged care services through this service delivery branch; or

(ii) the provider has previously given a report to the System Governor in accordance with section 166-925 in relation to closure of the service delivery branch.

Note: A separate notification must be given to the System Governor to establish a service delivery branch account for the service delivery branch: see subsection 203(1) of the Act.

Information to be included in the report

(2) The report must include the following information:

(a) the name of the service delivery branch;

(b) the date the provider proposes to begin delivering funded aged care services through the service delivery branch;

(c) the address of the service delivery branch;

(d) the contact details for the service delivery branch.

When report must be given

(3) The report must be given no later than the day the provider begins delivering funded aged care services through the service delivery branch.

166-915 Report for change to a service delivery branch

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

(a) the provider has given a report to the System Governor in accordance with section 166-910 for a service delivery branch of the provider; and

(b) there has been a change to any information relating to the service delivery branch that was included in the report given to the System Governor in accordance with section 166-910.

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Information to be included in the report

(2) The report must include the following:
  (a) the name of the service delivery branch;
  (b) any updated information relating to the service delivery branch that was included in the report given under section 166-910.

When report must be given

(3) The report must be given within 28 days after the day the change in paragraph (1)(b) has occurred.

166-920 Report for merger of service delivery branches

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:
  (a) the provider has given a report to the System Governor in accordance with section 166-910 for 2 or more service delivery branches of the provider; and
  (b) the provider intends to merge 2 or more of these service delivery branches into a single service delivery branch of the provider.

Information to be included in the report

(2) The report must include the following information:
  (a) the names of the service delivery branches that the provider proposes to merge, specifying;
    (i) the name of the service delivery branch through which the provider proposes to continue delivering funded aged care services; and
    (ii) the name of each service delivery branch the provider intends to close;
  (b) the date the provider proposes to merge the service delivery branches;
  (c) in relation to the individuals (if any) accessing funded aged care services through the service delivery branches that the provider proposes to merge:
    (i) whether the provider has notified the individuals of the proposed merger; and
    (ii) whether the provider has given a cessation notification to the System Governor and the Commissioner for each individual accessing funded aged care services through each service delivery branch mentioned in subparagraph (a)(ii).

When report must be given

(3) The report must be given at least 90 days, or such smaller number of days as is agreed in writing between the System Governor and the registered provider, before the date of the proposed merger.

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166-925 Report for closure of a service delivery branch

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:
  (a) the provider has given a report to the System Governor in accordance with section 166-910 for a service delivery branch of the provider; and
  (b) the provider intends to close the service delivery branch.

(2) Despite subsection (1), a registered provider does not have to give a report in accordance with this section in relation to a service delivery branch if:
  (a) the provider intends to merge the service delivery branch with one or more other service delivery branches of the provider; and
  (b) a report under section 166-920 has been given in relation to the service delivery branch.

Information to be included in the report

(3) The report must include the following information:
  (a) the name of the service delivery branch;
  (b) the date the provider proposes to close the service delivery branch;
  (c) in relation to the individuals (if any) accessing funded aged care services through the service delivery branch:
    (i) whether the provider has notified the individuals of the proposed closure; and
    (ii) whether the provider has given a cessation notification to the System Governor and the Commissioner for each individual.

When report must be given

(4) The report must be given at least 28 days before the date of the proposed closure.

166-930 Report if provider no longer intends to open, merge or close service delivery branch

(1) A registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:
  (a) the provider has given a report (the ***original report***) to the System Governor in accordance with sections 166-910, 166-920 or 166-925; and
  (b) the provider no longer intends to proceed with the opening, merger or closure described in the original report.

Information to be included in the report

(2) The report must include the following:
  (a) a description of the original report, including:
    (i) the name of each service delivery branch included in the original report; and

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(ii) whether the original report was in relation to an opening, merger or closure; and
(iii) the proposed date of the opening, merger or closure that was included in the original report;

(b) a statement that the provider no longer intends to proceed with the opening, merger or closure described in the original report;

(c) the reason why the provider no longer intends to proceed with the opening, merger or closure described in the original report.

When report must be given

(3) The report must be given no later than:

(a) for an opening or closure—the proposed date of the opening or closure; and

(b) for a merger—28 days before the proposed date of the merger.

Subdivision N—Pricing information

166-1000 Application of this Subdivision

(1) Subject to subsection (2), this Subdivision applies to a registered provider registered in one or more of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care.

(2) The requirements of this Subdivision do not apply in respect of the delivery of funded aged care services delivered under any specialist aged care program.

166-1005 Pricing information

(1) For the purposes of paragraph 166(1)(d) of the Act, a registered provider must:

(a) give a report about the information specified in subsection (3) to the System Governor for each reporting period; and

(b) do so within 30 days of the end of the relevant reporting period; and

(c) do so in the approved form.

Reporting period

(2) For the purposes of this section, a ***reporting period*** is a period of 2 months commencing on 1 January, 1 March, 1 May, 1 July, 1 September or 1 November of a year.

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Information to be included

(3) The information that must be included in a report given in accordance with subsection (1) is the most frequently charged price during standard business hours for the relevant reporting period that the provider charges individuals for each service in the following service types:

(a) allied health and therapy;
(b) care management;
(c) domestic assistance;
(d) home maintenance and repairs;
(e) home or community general respite;
(f) meals;
(g) nursing care;
(h) personal care;
(i) restorative care management;
(j) social support and community engagement;
(k) therapeutic service for independent living;
(l) transport.

(4) A registered provider is not required to report on a price for a service in accordance with subsection (1) if:

(a) the registered provider is not currently delivering the service and has not delivered the service in the last 12 months; or
(b) the service is delivered under a specialist aged care program.

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Part 3—Provider obligation—notifying of change in circumstances

Division 1—Obligation to notify

167-5 Purpose of this Part

This Part is made for the purposes of section 167 of the Act and prescribes:

(a) changes of a kind in relation to which prescribed kinds of registered providers must give notice to the Commissioner under that section; and

(b) circumstances in relation to which a notice must also be given to the System Governor under that section; and

(c) information that must be included in a notice given to the Commissioner or the System Governor under that section.

167-10 Notifying the Commissioner—kinds of registered providers and changes

The following table prescribes the kinds of registered providers and kinds of changes that those providers must give notice to the Commissioner under subsection 167(1) of the Act.

Kinds of registered providers and changes

Item	Column 1 Kind of registered providers	Column 2 Kinds of changes
1	every kind of registered provider	a change referred to in section 167-20 relating to the provider's suitability to be a registered provider
2	every kind of registered provider	a change referred to in section 167-25 relating to the suitability of a responsible person of the provider
3	every kind of registered provider	a change referred to in section 167-30 of responsible persons of the provider
4	every kind of registered provider	a significant change referred to in section 167-35 relating to the organisation arrangements of the provider
5	a registered provider to whom section 157 of the Act applies	a change referred to in section 167-40 relating to the governance arrangements of the provider
6	every kind of registered provider	a change referred to in section 167-45 relating to the scale of operations of the provider
7	a registered provider registered in the following provider registration categories: (a) home and community services;	a change referred to in section 167-50 relating to intended service types

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Kinds of registered providers and changes		
Item	**Column 1** **Kind of registered providers**	**Column 2** **Kinds of changes**
	(b) assistive technology and home modifications; (c) advisory and support services; (d) personal and care support in the home or community; (e) nursing and transition care	
8	a registered provider registered in the following provider registration categories: (a) personal and care support in the home or community; (b) nursing and transition care; (c) residential care	a change referred to in section 167-55 relating to associated providers
9	every kind of registered provider, except government entities	a change referred to in section 167-60 relating to financial and prudential matters, except a change prescribed in item 10 of this table
10	a registered provider that: (a) is registered in the provider registration category residential care; and (b) is not a government entity or a local government authority; and (c) is not delivering aged care services through the specialised aged care program NATSIFACP	a change referred to in section 167-65 relating to liquidity
11	a registered provider registered in the provider registration category residential care	a change referred to in section 167-70 relating to approved residential care homes

167-15 Notifying the System Governor—circumstances

For the purposes of subsection 167(2) of the Act, the circumstances in which a notice must also be given to the System Governor under that subsection are the circumstances in which a notice must be given to the Commissioner under subsection 167(1) of the Act relating to the following:

(a) the circumstances prescribed by item 4 of the table in section 167-10, to the extent that the circumstances relate to entering into administration;

(b) the circumstances prescribed by item 9 of the table in section 167-10 (relating to financial and prudential matters);

(c) the circumstances prescribed by item 10 of the table in section 167-10 (relating to liquidity);

(d) the circumstances prescribed by item 11 of the table in section 167-10 (relating to approved residential care homes).

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Division 2—Changes in circumstances

167-20 Suitability of a registered provider

(1) The change prescribed in item 1 of the table in section 167-10 is any change in circumstances for a registered provider that materially affects, or may materially affect, the provider's suitability to be a registered provider, taking into account the matters referred to in paragraph 109(1)(b) of the Act (which deals with suitability of registered providers).

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the date on which a responsible person for the provider first became aware of the change of circumstances that materially affects the provider's suitability to be a registered provider; and

(b) how the provider became aware of the change of circumstances; and

(c) details about the change of circumstances.

167-25 Suitability of a responsible person of a registered provider

(1) The change prescribed in item 2 of the table in section 167-10 is any change in circumstances relating to a responsible person of a registered provider that materially affects, or could materially affect, the responsible person's suitability to be a responsible person of the provider, having regard to the matters referred to in subsection 13(1) of the Act (which deals with suitability matters in relation to an individual).

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the name of the responsible person; and

(b) the date the provider first became aware of the change in circumstances; and

(c) how the provider became aware of the change in circumstances; and

(d) details of the change of circumstances; and

(e) whether, after considering those matters, the provider is reasonably satisfied that the responsible person continues to be suitable to be a responsible person of the provider; and

(f) what, if any, action the provider has taken, or proposes to take, in relation to the responsible person.

167-30 Change of responsible persons of a registered provider

(1) The change prescribed in item 3 of the table in section 167-10 is any change of responsible persons of a registered provider, including:

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(a) an individual becoming a responsible person of the provider; and
(b) an individual ceasing to be a responsible person of the provider.

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:
(a) for a change relating to an individual becoming a responsible person of the provider:
(i) the name and contact details of the individual; and
(ii) a description of the individual's responsibilities in their capacity as a responsible person of the provider; and
(iii) a statement to the effect that the provider has had regard to the suitability matters in relation to the individual, as referred to in subsection 13(1) of the Act, and that the provider is satisfied that the individual is suitable to be involved in the delivery of funded aged care services; and
(b) for a change relating to an individual ceasing to be a responsible person of the provider:
(i) the name of the individual ceasing to be a responsible person; and
(ii) the reason that the individual has ceased to be a responsible person of the provider; and
(iii) the name and contact details of another individual (if any) who is carrying out, or will carry out, the responsibilities of the individual ceasing to be a responsible person.

167-35 Organisation arrangements of a registered provider

(1) The change prescribed in item 4 of the table in section 167-10 is any change of the following kind to the organisation of a registered provider:
(a) if the provider is not a government entity—any significant change to the provider's legal and business structure, including any of the following:
(i) a restructure of the organisation of the provider;
(ii) a sale, acquisition, or merger relating to the provider;
(b) for any registered provider (including a government entity)—the entering into of an agreement by the provider with another entity in which the other entity agrees to deliver services that support the management or governance function of the provider;
(c) for any registered provider (including a government entity)—any significant change to an agreement (including the cessation of a such an agreement) by the provider with another entity in which the other entity agrees to deliver services that support the management or governance of the provider;
(d) if the provider is not a government entity—any of the following events:
(i) the provider enters into administration;
(ii) the provider appoints a restructuring practitioner (within the meaning of the *Corporations Act 2001*);

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(iii) an insolvency event (within the meaning of the *Aged Care (Accommodation Payment Security) Act 2006*) occurs in relation to the provider.

Note 1: See section 167-10, which relates to notifying the Commissioner.

Note 2: See section 167-15, which relates to notifying the System Governor of matters relating to entering administration.

(2) To avoid doubt, the circumstances referred to in paragraph (1)(b) relating to the provider entering into an agreement do not include the entering into of an agreement for the delivery of funded aged care services.

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) for a change to the provider's legal or business structure—details about the change to the provider's legal or business structure; and

(b) for an event referred to in paragraph (1)(b) or (c) (which relate to agreements):

(i) a detailed statement about the services that the other entity is to provide to the registered provider; and

(ii) the nature and duration of the agreement; and

(iii) if the notification is about the cessation of the agreement—the reason and date of cessation; and

(c) for an event set out in paragraph (1)(d) of this section (which relates to administration, restructuring and insolvency):

(i) the date on which the event occurred; and

(ii) the type of administration (where applicable); and

(iii) the name of the administrator or restructuring practitioner (where applicable).

167-40 Governance arrangements of a registered provider

(1) The change prescribed in item 5 of the table in section 167-10 is any change to the governance of a registered provider that would result in the registered provider no longer complying with subsection 157(2) of the Act.

Note 1: See sections 157-5 and 157-10, which prescribe the kinds of registered providers to whom section 157 of the Act applies.

Note 2: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) a statement that the provider no longer complies with a condition of registration set out in paragraph 157(2)(a) or (b) of the Act (whichever is relevant to the provider); and

(b) the names of incoming and outgoing members in relation to the non-compliance; and

(c) information on steps being taken to return to compliance, including whether an application under subsection 159(1) of the Act (which relates to

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determinations that certain conditions relating to the governing body of a registered provider do not apply) has been submitted, or will be submitted.

167-45 Change relating to the scale of operations of a provider

(1) The change prescribed in item 6 of the table in section 167-10 is any of the following changes:

(a) for a registered provider other than a registered provider registered in the provider registration category residential care—a change to the local government area in which the provider delivers a funded aged care service;

(b) for a registered provider (including a registered provider registered in the provider registration category residential care)—a significant increase or decrease in the number of aged care workers of the provider that materially affects the provider's ability to deliver funded aged care services.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) details of the change; and

(b) the aged care funded services that will be, or are likely to be, affected by the change; and

(c) any other anticipated effects of the change; and

(d) the reason for the change; and

(e) any actions that the provider has taken or will take to manage the effect on services, or other anticipated effects.

167-50 Changes relating to intended service types

(1) The change prescribed in item 7 of the table in section 167-10 is any change relating to a registered provider's intended service types.

Note 1: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note 2: See Division 4 of Part 4 of Chapter 4 of this instrument for provisions relating to starting and ceasing the provision of funded aged care services to a particular individual and continuity of those services.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the relevant service type; and

(b) the date on which the provider expects the change to take effect.

167-55 Changes relating to arrangements with associated providers

(1) The change prescribed in item 8 of the table in section 167-10 is any of the following changes:

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(a) the commencement of a new arrangement between the registered provider and an associated provider for the delivery of funded aged care services by the associated provider on behalf of the registered provider;
(b) the variation or extension of an existing such arrangement between the registered provider and an associated provider;
(c) the cessation of an existing such arrangement between the registered provider and an associated provider.

Note: See section 167-10, which relates to notifying the Commissioner.

(2) Subsection (1) does not apply to circumstances where the registered provider has entered into an arrangement with an associated provider for:
(a) the supply of labour under a labour hire arrangement; or
(b) the delivery of services that support the management or governance function of the registered provider; or
(c) the delivery of services that do not include services in the service types relating to one of the following provider registration categories:
(i) residential care;
(ii) personal and care support in the home or community;
(iii) nursing and transition care.

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:
(a) in all circumstances—information about the associated provider, including:
(i) the associated provider's business name; and
(ii) the associated provider's ABN; and
(iii) the associated provider's ACN (if any); and
(iv) the associated provider's business location; and
(b) in circumstances relating to the delivery of funded aged care services in a residential care home—information about the residential care home, including:
(i) the name of the residential care home; and
(ii) the address of the residential care home; and
(c) in circumstances relating to the commencement of a new arrangement:
(i) details of the services to be delivered under the new arrangement; and
(ii) the reasons for the new arrangement; and
(iii) the time period for the new arrangement (including the commencement date and expiry date of the arrangement); and
(d) in circumstances relating to the variation or extension of an arrangement:
(i) details of the variation or extension, including any new commencement dates or expiry dates for the arrangement; and
(ii) the reason for the variation or extension; and
(e) in circumstances relating to the cessation of an arrangement:
(i) the date on which the arrangement ceased or will cease; and
(ii) the reason for the cessation.

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167-60 Changes relating to financial and prudential matters

(1) The change prescribed in item 9 of the table in section 167-10 is any change to a registered provider's capacity to deliver funded aged care services that the provider is registered to deliver, including the following:

(a) the inability to pay the entitlements of the provider's aged care workers;

(b) any change that materially affects an existing or anticipated revenue source;

(c) any instance in which the provider is unable to pay the provider's debts as and when those debts become due and payable.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

(2) Subsection (1) does not apply to circumstances set out in section 167-65 (which relates to liquidity).

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) details about the change; and

(b) the impact that the provider expects the change to have on the provider's ability to deliver funded aged care services; and

(c) details about any mitigating strategies the provider has attempted, or will attempt, to manage this impact.

167-65 Changes relating to liquidity

(1) The change prescribed in item 10 of the table in section 167-10 is any circumstance where the registered provider is not maintaining, or is at risk of not maintaining, the provider's default minimum liquidity amount for a quarter or evaluated minimum liquidity amount for a quarter.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the provider's current and expected liquidity for the relevant quarter; and

(b) the reason for the reduction, or expected reduction in liquidity; and

(c) the provider's Liquidity Management Strategy; and

(d) the provider's plan to increase liquidity to a level that is sufficient for the purposes set out in subsection (1).

Note: The standards in relation to financial and prudential matters are set out in the Financial and Prudential Standards made by the Commissioner under subsection 376(1) of the Act.

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167-70 Changes relating to approved residential care homes

(1) The change prescribed in item 11 of the table in section 167-10 is any of the following changes relating to an approved residential care home of a registered provider:

(a) a change that may affect whether the approved residential care home of the provider continues to meet the definition of residential care home in the Act;

(b) a change to a building or the premises that comprise the approved residential care home that presents a risk to the delivery of quality and safe residential care;

(c) a planned construction or renovation activity relating to the approved residential care home that the provider reasonably expects will affect the delivery of funded aged care services at the residential care home;

(d) an unplanned event relating to the approved residential care home that the provider reasonably expects will cause sustained disruption to the delivery of funded aged care services at the residential care home;

(e) a change in the ownership of the premises at which the residential care home is located or a change to any agreement between the owner of the premises and the registered provider to use the premises as a residential care home;

(f) for any provider other than a provider referred to in paragraph (g)—a reduction in the availability of the total number of beds covered by the approval of the approved residential care home that the provider expects will continue for a continuous period of at least 3 months, except where the approved residential care home only delivers funded aged care services under a specialist aged care program;

(g) for a registered provider in the 2023 MM category known as MM 6 or MM 7—a reduction in the availability of the total number of beds covered by the approval of the approved residential care home for any period of time, except where the approved residential care home only delivers funded aged care services under a specialist aged care program;

(h) a change in circumstances that causes beds that were unavailable as referred to in paragraph (1)(f) or (g) to become available.

Note 1: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note 2: See section 136 of the Act, which relates to varying the approval of a residential care home of a registered provider.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the name of the approved residential care home; and

(b) the street address of the residential care home; and

(c) a description of the change of circumstances; and

(d) for circumstances referred to in paragraph (1)(f) or (g):

(i) the number of beds in respect of which the registered provider is, or will be, unable to provide residential care; and

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(ii) the period during which the registered provider is, or will be, unable to provide residential care for those beds; and

(iii) the reason for the change to the availability of beds; and

(e) details of the change in ownership, and in circumstances where the registered provider is not the owner of the premises used for the provision of services and there is a change in ownership, the information must include the date and details of the type of agreement under which permission to use the premises is given.

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Part 4—Responsible person obligation—change in circumstances relating to suitability

169-5 Kinds of registered provider to which the obligation applies

For the purposes of paragraph 169(1)(a) of the Act, every kind of registered provider is prescribed except a provider that is a sole trader.

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Part 5—Obligations relating to suitability of responsible persons

172-5 Kinds of registered provider to which the obligation applies

For the purposes of subsection 172(1) of the Act, every kind of registered provider is prescribed.

172-10 Requirements for records of suitability matters

For the purposes of paragraph 172(1)(b) of the Act, a registered provider must keep a record of its consideration of suitability matters in relation to a person that includes the following:

(a) the name of the person in relation to whom the suitability matters were considered;

(b) the date or dates on which the suitability matters were considered in relation to the person;

(c) the outcome of the provider's consideration of each suitability matter in relation to the person;

(d) the reasons for reaching that outcome.

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Part 6—Obligations relating to aged care workers etc.

Division 1—Registered nurses

Subdivision A—Preliminary

175-5 Specialist aged care programs to which the registered nurse obligation does not apply—MPSP and TCP

For the purposes of paragraph 175(2)(b) of the Act, a registered provider delivering funded aged care services at an approved residential care home under any of the following specialist aged care programs is prescribed:

(a) MPSP;

(b) TCP.

175-10 Purpose of this Division

(1) For the purposes of subsection 175(3) of the Act, this Division provides for:

(a) the circumstances in which an exemption from subsection 175(1) of the Act may be granted to a registered provider in relation to an approved residential care home; and

(b) the period for which an exemption may be in force; and

(c) the conditions that apply to that exemption.

(2) This Division also provides for the revocation of exemptions.

Subdivision B—Process for granting exemptions

175-15 Application for exemption

(1) A registered provider may apply to the System Governor for an exemption from subsection 175(1) of the Act in relation to an approved residential care home at which the provider delivers funded aged care services.

(2) An application under subsection (1) must be made in the approved form.

175-25 Decision whether to grant exemption

Criteria for granting exemption—approved residential care homes at which funded aged care services are not delivered only under the MPSP

(1) If the System Governor receives an application under section 175-15 of this instrument from a registered provider for an exemption from subsection 175(1) of the Act in relation to an approved residential care home, other than a home at which the provider delivers funded aged care services only under the MPSP, the System Governor may grant the exemption only if:

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(a) the home is located in the 2023 MM category known as MM 5, MM 6 or MM7; and
(b) there are no more than 30 operational beds in the home on the day of the System Governor's decision; and
(c) the System Governor is satisfied that the provider has taken reasonable steps to ensure that the clinical care needs of the individuals in the home will be met during the period for which the exemption is in force; and
(d) the registered provider has given to the System Governor the reports required under section 166-855 of this instrument in relation to the home for each calendar month.

Criteria for granting exemption—approved residential care homes at which funded aged care services are delivered only under the MPSP

(1A) If the System Governor receives an application under section 175-15 of this instrument from a registered provider for an exemption from subsection 175(1) of the Act in relation to an approved residential care home at which the provider delivers funded aged care services only under the MPSP, the System Governor may grant the exemption only if:
(a) the home is located in the 2023 MM category known as MM 5, MM 6 or MM7; and
(b) no more than 30 residential care places for the home are in effect under section 97-5 of this instrument on the day of the System Governor's decision; and
(c) the System Governor is satisfied that the provider has taken reasonable steps to ensure that the clinical care needs of the individuals in the home will be met during the period for which the exemption is in force; and
(d) for an application made on or after 1 November 2026—the registered provider has given to the System Governor the reports required under section 166-855 of this instrument in relation to the home for each calendar month beginning on or after 1 October 2026.

(2) In deciding whether to grant the exemption, the System Governor must have regard to:
(a) any variation to the registration of the registered provider by the Commissioner under paragraph 123(1)(a) of the Act to vary a condition to which the registration is subject to under section 143 of the Act; and
(b) any variation to the registration of the registered provider by the Commissioner under paragraph 123(1)(b) of the Act; and
(c) any notice given to the registered provider by the System Governor or Commissioner under:
(i) Division 2 of Part 10 of Chapter 6 of the Act; or
(ii) Part 11 of Chapter 6 of the Act; and
(d) any notice given to the registered provider under Part 5 of the Regulatory Powers Act (as applied by section 448 of the Act); and
(e) if the registered provider has given an undertaking under section 114 of the Regulatory Powers Act (as applied by section 458 of the Act); and

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(f) if the registered provider has given an undertaking under section 463 of the Act; and

(g) whether the registered provider has been convicted of an offence against the Act; and

(h) whether the registered provider has been found liable to pay a civil penalty under this Act.

(3) The System Governor may grant an exemption to a registered provider in relation to an approved residential care home for which the registered provider has previously been granted an exemption.

Period of exemption

(4) If the System Governor decides to grant an exemption, the System Governor must decide the period for which the exemption is to be in force.

(5) The period:

(a) must not be longer than 12 months; and

(b) must not begin before the day on which the System Governor grants the exemption.

Conditions that apply to exemption

(6) The following conditions apply to an exemption:

(a) the registered provider must give the System Governor notice in writing of any material change to the information given to the System Governor:

(i) in the application for the exemption; or

(ii) in response to a request by the System Governor under section 588 of the Act;

(b) any additional conditions that the System Governor decides to impose on the exemption.

175-30 Notice of decision

(1) If the System Governor grants an exemption from subsection 175(1) of the Act to a registered provider in relation to an approved residential care home, the System Governor must give the provider notice in writing of the decision that:

(a) states the period for which the exemption is in force; and

(b) states the conditions that apply to the exemption.

(2) If the System Governor refuses to grant an exemption from subsection 175(1) of the Act to a registered provider in relation to an approved residential care home, the System Governor must give the provider notice in writing of the decision, including:

(a) the reasons for the decision; and

(b) the date of the decision; and

(c) how the registered provider may apply for reconsideration of the decision.

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Subdivision C—Revocation of exemptions

175-45 Revocation on request

(1) The System Governor must revoke a registered provider's exemption from subsection 175(1) of the Act in relation to a residential care home if the registered provider requests the revocation in writing.

(2) The System Governor must give the registered provider notice in writing of the date that the exemption ceases to have effect, which may be the date of the notice or a later date.

175-50 Revocation on System Governor's initiative

Grounds for revocation

(1) The System Governor may revoke a registered provider's exemption from subsection 175(1) of the Act in relation to an approved residential care home if:
  (a) the System Governor is satisfied the registered provider has breached a condition of the exemption; or
  (b) the System Governor is not satisfied that the clinical care needs of individuals in the home:
    (i) are being met; or
    (ii) will be met during the period the exemption would otherwise be in force; or
  (c) the registration of the registered provider has been varied by the Commissioner under paragraph 123(1)(a) of the Act to vary a condition to which the registration is subject to under section 143 of the Act; or
  (d) the registration of the registered provider has been varied by the Commissioner under paragraph 123(1)(b) of the Act; or
  (e) in relation to a home other than a home at which the provider delivers funded aged care services only under the MPSP—the System Governor becomes aware there are more than 30 operational beds in the home; or
  (f) in relation to a home at which the provider delivers funded aged care services only under the MPSP—the System Governor becomes aware there are more than 30 residential care places for the home in effect under section 97-5 of this instrument.

Notice before revocation

(2) Before the System Governor revokes a registered provider's exemption under this section, the System Governor must give the provider written notice that the System Governor is considering revoking the exemption.

(3) The notice must:
  (a) set out the reasons why the System Governor is considering revoking the exemption, and what the effect of the revocation would be; and

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(b) invite the provider to make a submission, in writing, to the System Governor in relation to the matter within the period specified in the notice (which must not be less than 28 days after giving the notice); and

(c) inform the provider that the System Governor may decide to revoke the exemption:

(i) if no submission is made within the specified period; or

(ii) after considering any submission made by the provider within the specified period.

Request for further information

(4) The System Governor may also request, in the notice given under subsection (2), that the provider give the System Governor the information specified in the notice, within the period specified in the notice for the purposes of paragraph (3)(b), to assist the System Governor to decide whether to revoke the exemption.

Note: The provider is not obliged to give the information.

(5) If the provider makes a submission in accordance with the invitation under paragraph (3)(b), the System Governor may, by written notice, request the provider to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to revoke the exemption.

Note 1: The System Governor may request further information under this subsection regardless of whether information was requested or given under subsection (4).

Note 2: The provider is not obliged to give the information.

(6) The System-Governor may, at the request of the provider, extend the period specified for paragraph (3)(b) or subsection (5).

Deciding whether to revoke exemption

(7) The System Governor must:

(a) consider any submission made in accordance with the invitation under paragraph (3)(b) and any further information given in accordance with a request under subsection (4) or (5); and

(b) make a decision whether to revoke the exemption within 28 days from:

(i) if no submission is made in accordance with the invitation in the notice under paragraph (3)(b)—the end of the period specified in the notice (including that period as extended (if applicable) under subsection (6)); or

(ii) the later of:

(A) if a submission is made in accordance with the invitation in the notice under paragraph (3)(b) and no further information is requested under subsection (5)—the day the submission is made; and

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(B) if a submission is made in accordance with the invitation in the notice under paragraph (3)(b) and further information is requested under subsection (5)—the day the provider gives the System Governor the further information.

175-55 Notice of decision

If the System Governor decides under section 175-50 of this instrument to revoke a registered provider's exemption from subsection 175(1) of the Act in relation to an approved residential care home, the System Governor must give the registered provider notice in writing of the decision, including:

(a) the reasons for the decision; and

(b) the date that the exemption ceases to have effect, which may be the date of the decision or a later date; and

(c) how the registered provider may apply for reconsideration of the decision.

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Division 2—Delivery of direct care

Subdivision A—Delivery of direct care—mainstream providers

176-5 Kinds of provider to which the obligation applies, and requirements

For the purposes of section 176 of the Act:

(a) a registered provider registered in the provider registration category residential care is prescribed; and

(b) this Subdivision sets out the requirements for delivering direct care.

176-10 Application of this Subdivision

The requirements of this Subdivision do not apply in respect to the delivery of funded aged care services provided under any of the following specialist aged care programs:

(a) TCP;

(b) MPSP;

(c) NATSIFACP.

176-15 Care minutes that must be delivered

(1) This section applies if the provider is delivering funded aged care services in an approved residential care home in a quarter.

Requirement—care minutes delivered by direct care staff members

(2) The provider must ensure that the average number of care minutes delivered in the home by direct care staff members of the provider per counted mainstream individual per day is at least the required combined staff average number of care minutes per individual per day worked out under subsection 176-20(1) in respect of the home for the quarter.

Note: Direct care staff members of the provider include registered nurse staff members of the provider (see the definition of ***direct care staff member*** in section 7 of the Act).

Requirement—care minutes delivered by registered nurse staff members

(3) The provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members of the provider per counted mainstream individual per day is at least 90% of the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) in respect of the home for the quarter.

Responsibility—care minutes delivered by registered nurse staff members and enrolled nurse staff members

(4) The registered provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members and enrolled nurse staff

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members of the provider per counted mainstream individual per day is at least the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) in respect of the home for the quarter.

Counted individuals

(5) An individual accessing funded aged care services in an approved residential care home on a day is a ***counted mainstream individual*** on the day unless:
  (a) the individual accesses the funded aged care services through a specialist aged care program referred to in section 176-10; or
  (b) the individual is on extended hospital leave, and the day is on or after the 29th day of the individual's leave.

176-20 Average numbers of care minutes

Required combined staff average number of care minutes

(1) The ***required combined staff average number of care minutes*** per individual per day in respect of an approved residential care home for a quarter is worked out by:
  (a) starting with the sum of the combined staff daily amounts for all of the days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and
  (b) dividing that sum by the total number of days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and
  (c) rounding the result of that division to 2 decimal places (rounding up if the third decimal place is 5 or more).

Required registered nurse average number of care minutes

(2) The ***required registered nurse average number of care minutes*** per individual per day in respect of an approved residential care home for a quarter is worked out by:
  (a) starting with the sum of the registered nurse daily amounts for all of the days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and
  (b) dividing that sum by the total number of days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and
  (c) rounding the result of that division to 2 decimal places (rounding up if the third decimal place is 5 or more).

Daily amounts

(3) The following table sets out, for a day of recognised residential care provided in respect of an individual in an approved residential care home:
  (a) the combined staff daily amount for the day for the individual; and

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(b) the registered nurse daily amount for the day for the individual.

Daily amounts			
	Column 1	**Column 2**	**Column 3**
Item	**For an individual classified as …**	**the combined staff daily amount is … (minutes)**	**and the registered nurse daily amount is … (minutes)**
1	Class 1	268	51
2	Class 2	128	27
3	Class 3	178	36
4	Class 4	150	32
5	Class 5	185	41
6	Class 6	176	37
7	Class 7	215	46
8	Class 8	232	47
9	Class 9	214	44
10	Class 10	229	44
11	Class 11	253	48
12	Class 12	247	47
13	Class 13	268	51
14	Respite Class 1	176	37
15	Respite Class 2	223	48
16	Respite Class 3	262	51

Day of recognised residential care

(4) A ***day of recognised residential care*** is provided in respect of an individual in an approved residential care home if funded aged care services are delivered to the individual in the home through the residential care service category on that day.

(5) Despite subsection (4), a ***day of recognised residential care*** does not include a day where:
  (a) funded aged care services are delivered through a specialist aged care program referred to in section 176-10; or
  (b) funded aged care services are provided to an individual classified as:
    (i) Class 0; or
    (ii) Respite Class 0.

Reference period

(6) The ***reference period*** for a quarter is the period of 3 months beginning on the day that is 4 months before the first day of the quarter.

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Information to be disregarded for calculations

(7) For the purposes of a calculation under this section for a quarter:
  (a) information about an individual entering or exiting an approved residential care home during the reference period for the quarter is to be disregarded if it is given to the System Governor on or after the calculation day for the quarter; and
  (b) a change to a classification decision for an individual that is made on or after the calculation day for the quarter but takes effect before the calculation day is to be disregarded.

Calculation if no days of recognised residential care provided during reference period

(8) If no days of recognised residential care were provided in respect of individuals in an approved residential care home during the reference period for a quarter, the result of the calculations in subsections (1) and (2) in relation to the quarter is taken to be zero minutes per individual per day.

Note: This subsection is to avoid an undefined result when dividing by zero.

Subdivision B—Delivery of direct care—NATSIFACP providers

176-25 Kinds of provider to which the obligation applies, and requirements

For the purposes of section 176 of the Act:
  (a) a registered provider registered in the provider registration category residential care is prescribed; and
  (b) this Subdivision sets out the requirements for delivering direct care.

176-30 Application of this Subdivision

The requirements of this Subdivision do not apply in respect to the delivery of funded aged care services provided under any of the following specialist aged care programs:
  (a) TCP;
  (b) MPSP.

176-35 Care minutes that must be delivered—NATSIFACP providers

(1) This section applies if the registered provider is delivering funded aged care services in an approved residential care home in a quarter under the specialist aged care program NATSIFACP.

Requirement—care minutes delivered by direct care staff members

(2) The provider must ensure that the average number of care minutes delivered in the home by direct care staff members of the provider per counted NATSIFACP individual per day is at least 215 minutes per individual per day in respect of the home for the reporting period for the provider.

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Note: Direct care staff members of the provider include registered nurse staff members of the provider (see the definition of ***direct care staff member*** in section 7 of the Act).

Requirement—care minutes delivered by registered nurse staff members

(3) The provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members of the provider per counted NATSIFACP individual per day is at least 39.6 minutes per individual per day in respect of the home for the reporting period for the provider.

Responsibility—care minutes delivered by registered nurse staff members and enrolled nurse staff members

(4) The provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members and enrolled nurse staff members of the provider per counted NATSIFACP individual per day is at least 44 minutes per individual per day in respect of the home for the reporting period for the provider.

Counted individuals

(5) An individual accessing funded aged care services in an approved residential care home on a day under the specialist aged care program NATSIFACP is a ***counted NATSIFACP individual*** on the day unless:
  (a) the individual is on extended hospital leave; and
  (b) the day is on or after the 29th day of the individual's leave.

Reporting period

(6) The reporting period for the provider is the period specified for a service activity report under section 166-645.

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Part 7—Other obligations—cooperation with other persons

177-10 Giving data or records to the Pricing Authority

Application of this section

(1) Subject to subsection (2), this section applies to every kind of registered provider.

(2) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under the following specialist aged care programs:
  (a) CHSP;
  (b) TCP.

Requirement to comply with notice

(3) For the purposes of subsection 177(2) of the Act, it is a requirement that a registered provider must comply with a request made under subsection (4) or (6).

Notice to provide data or records

(4) The Pricing Authority may request, by written notice given to a registered provider, that the provider:
  (a) give the Pricing Authority data or records held by the provider, or copies of that data or records, that are necessary for the conduct of a Pricing Authority advice activity; and
  (b) do so in a form and manner specified in the notice; and
  (c) do so before or on a day specified in the notice.

(5) A notice given under subsection (4) must:
  (a) set out that the request is for the purposes of the Pricing Authority performing the function mentioned in paragraph 131A(1)(a) of the *National Health Reform Act 2011*; and
  (b) specify the details of the data or records that the registered provider is requested to give; and
  (c) specify a day by which the data or records must be given, which must be at least 14 days after the day on which the notice is given to the provider; and
  (d) set out the effect of subsection 177(4) of the Act.

Request for further data or records

(6) If:
  (a) a provider responds to a request to provide data or records made under subsection (4); and

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(b) the Pricing Authority considers that additional data or records are required before the Pricing Authority can carry out a function mentioned in paragraph 131A(1)(a) of the *National Health Reform Act 2011*;

the Pricing Authority may, by written notice given to the applicant, request the provider to give that additional data or records, or copies of that additional data or records, to the Pricing Authority.

177-15 Allowing access by the Pricing Authority to certain persons

Application of this section

(1) Subject to subsection (2), this section applies to every kind of registered provider.

(2) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under the following specialist aged care programs:
(a) CHSP;
(b) TCP.

Requirement to comply with notice

(3) For the purposes of subsection 177(2) of the Act, it is a requirement that a registered provider must comply with a request made under subsection (4).

Notice to allow access to certain persons

(4) The Pricing Authority may request, by written notice given to a registered provider, that the provider:
(a) allow and facilitate access by an official of the Pricing Authority to a person referred to in subsection (6) for the purposes of undertaking a Pricing Authority advice activity; and
(b) make arrangements before or on a day specified in the notice to allow and facilitate the access within a reasonable timeframe.

(5) A notice given under subsection (4) must:
(a) specify the form of the access, which may be in person, by audio link, or by audio-visual link; and
(b) specify a day by which the provider must make arrangements for the access, which must be at least 14 days after the day on which the notice is given to the provider; and
(c) set out the effect of subsection 177(4) of the Act.

(6) For the purposes of paragraph (4)(a), the persons are the following:
(a) a specified responsible person of the provider;
(b) any responsible person of the provider who is responsible for a specified matter for the provider;
(c) a specified aged care worker of the provider;

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(d) any aged care worker of the provider who is responsible for a specified matter for the provider.

177-20 Allowing access by the Pricing Authority to residential care homes

Application of this section

(1) Subject to subsection (2), this section applies to a registered provider in the provider registration category residential care.

(2) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under the following specialist aged care programs:
(a) CHSP;
(b) TCP.

Requirement to comply with notice

(3) For the purposes of subsection 177(2) of the Act, it is a requirement that a registered provider must comply with a request made under subsection (4).

Notice to allow access to residential care homes

(4) The Pricing Authority may request, by written notice given to a registered provider, that the provider:
(a) allow and facilitate access by an official of the Pricing Authority to a residential care home of the provider for the purposes of undertaking a Pricing Authority advice activity; and
(b) do so on a day specified in the notice.

(5) A notice given under subsection (4) must:
(a) specify a day on which the access must be facilitated, which must be at least 14 days after the day on which the notice is given to the provider; and
(b) set out the effect of subsection 177(4) of the Act.

(6) For the purposes of subsection 177(2) of the Act, it is a requirement that reasonable facilities and assistance provided by the registered provider to whom a notice has been given under subsection (4) must include:
(a) providing a site orientation to the official of the Pricing Authority undertaking the Pricing Authority advice activity to which the notice relates, including guidance on how to safely navigate the residential care home; and
(b) providing information in relation to the activity to any of the following:
(i) aged care workers of the provider;
(ii) individuals to whom the provider delivers funded aged care services;
(iii) supporters of the individuals; and
(c) providing the official with access to aged care workers of the provider who are at the residential care home; and

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(d) providing the official with access to individuals to whom the provider delivers funded aged care services who have consented to the access; and

(e) providing the official with access to all areas of the residential care home, excluding rooms and part rooms of individuals who have not consented to the access and private bathroom facilities; and

(f) providing the official with facilities (including a suitable workspace) for the purpose of undertaking the Pricing Authority advice activity; and

(g) providing the official with access to records held by the provider; and

(h) providing the official with instructions about how to access records held by the provider; and

(i) allowing the official to make copies of those records.

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Chapter 6—Obligations of operators of aged care digital platforms

Part 1—Introduction

187-1 Simplified outline of this Chapter

This Chapter requires operators of aged care digital platforms to check and display certain information about entities that represent via the platforms that they can deliver a service in the Commonwealth aged care system.

This Chapter imposes additional obligations on constitutional corporations that are operators of aged care digital platforms in relation to:

(a) notifying the Commission about the operation of the aged care digital platforms; and

(b) the management of complaints and reportable incidents; and

(c) reporting and record-keeping.

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Part 2—Obligations

188-1 Duty of operators of aged care digital platforms

For the purposes of subparagraph 188(1)(b)(vi) of the Act, the information that the operator of an aged care digital platform must check and display in relation to an entity that represents via the platform that the entity can deliver a service in the Commonwealth aged care system is:

(a) for an entity that is an aged care worker of a registered provider—that the entity complies with any applicable worker screening requirements prescribed by rules made under paragraph 152(1)(b) of the Act that apply to the entity; and

(b) for an entity that seeks to deliver services in the Commonwealth aged care system—that the entity holds the credentials or qualifications that are stated on the aged care digital platform; and

(c) general information about the processes undertaken in order to check an entity's credentials or qualifications for the purposes of paragraph (b) of this section.

189-1 Notifying Commissioner of operation of aged care digital platforms

Period within which notice must be given

(1) For the purposes of paragraph 189(1)(a) of the Act, a notice given by an entity that is both a constitutional corporation and the operator of an aged care digital platform must be given:

(a) not later than 14 days after the first day on which the platform displays a representation by another entity that the other entity can deliver a service in the Commonwealth aged care system; or

(b) if the entity becomes the operator of the aged care digital platform after the end of the period referred to in paragraph (a) of this subsection—not later than 14 days after the entity becomes the operator of the aged care digital platform.

Note: Paragraph (b) is to ensure that the provision covers changes in operators.

Content of notice

(2) The notice must include the following information:

(a) the name of the aged care digital platform;

(b) details of the operator, including a key contact person;

(c) if the operator has an ABN—the ABN;

(d) the date on which the operator started to operate the aged care digital platform;

(e) details of the service types that the operator intends to facilitate;

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(f) details of any relationships between the operator and registered providers in their corporate structures.

189-5 Managing complaints

Purpose for which requirements are prescribed

(1) For the purposes of paragraph 189(1)(b) of the Act, this section prescribes the requirements for managing complaints under a complaints management system implemented by an entity that is both a constitutional corporation and the operator of an aged care digital platform, being complaints about entities that represent that they can deliver, or have delivered, funded aged care services via the platform.

Note: Under subsection 189(3) of the Act, the requirements prescribed by this section may only be for the purpose of ensuring that systems implemented by operators of aged care digital platforms support compliance by registered providers with certain obligations.

General requirements relating to management of receipt etc. of complaints

(2) In managing complaints, the operator of the aged care digital platform must:
(a) ensure that each complaint received is recorded, and referred to the registered provider to which the complaint relates, in accordance with procedures that give effect to the requirements of subsections (3) and (4); and
(b) collect data relating to each complaint received for the purposes of meeting any applicable reporting requirements; and
(c) protect the security and confidentiality of information relating to each complaint received; and
(d) ensure that complaints:
(i) can be made by any person; and
(ii) can be made anonymously; and
(iii) can be withdrawn; and
(e) not impose a fee or charge (however described) for receiving a complaint or for dealing with a complaint.

Specific requirements relating to management of receipt and referral of complaints

(3) In managing complaints, the operator of the aged care digital platform must:
(a) acknowledge each complaint in writing within 3 days of receipt; and
(b) refer each complaint in writing to the registered provider to which the complaint relates no more than 7 days after receipt, if referral is appropriate; and
(c) ensure that information about the nature of each complaint, and contact details of the person making the complaint (if practicable), is provided to the registered provider to which the complaint relates, to the extent that the information is reasonably necessary to address the complaint; and

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(d) if a complaint that has been referred to a registered provider is withdrawn after the referral—notify the registered provider of the withdrawal no more than 2 days after the complaint is withdrawn.

Other requirements relating to management of complaints

(4) In managing complaints, the operator of an aged care digital platform must ensure:

(a) that the operator does not refer a complaint, or give information about a complaint, to a registered provider without the informed consent of the person making the complaint (or their authorised supporter or advocate); and

(b) that the operator provides support and assistance to a person making a complaint (or making an enquiry that may form a complaint), for example, by facilitating access to translation services; and

(c) that the operator provides information that complaints may be made directly to the registered provider to which the complaint relates; and

(d) that the operator undertakes reviews as required, and at least annually, to ensure the complaints management system meets the requirements of this section.

189-10 Managing reportable incidents

Purpose for which requirements are prescribed

(1) For the purposes of paragraph 189(1)(c) of the Act, this section prescribes the requirements for managing reportable incidents under an incident management system implemented by an entity that is both a constitutional corporation and the operator of the aged care digital platform, being reportable incidents involving entities that represent that they can deliver funded aged care services via the platform.

Note: Under subsection 189(3) of the Act, the requirements prescribed by this section may only be for the purpose of ensuring that systems implemented by operators of aged care digital platforms support compliance by registered providers with certain obligations.

General requirements relating to management of reportable incidents

(2) In managing reportable incidents, the operator of the aged care digital platform must:

(a) ensure that if a reportable incident is reported, it is recorded, and referral to the registered provider to which the reportable incident relates is facilitated, in accordance with procedures that give effect to the requirements of subsections (3) and (4); and

(b) collect data relating to each reportable incident that is reported, for the purposes of meeting reporting requirements; and

(c) protect the security and confidentiality of information relating to each reportable incident that is reported; and

(d) ensure that any person may report a reportable incident; and

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(e) not impose a fee or charge (however described) for reporting of reportable incidents or supporting registered providers in responding to such incidents.

Specific requirements relating to management of reportable incidents

(3) In managing reportable incidents, the operator of an aged care digital platform must:

(a) acknowledge each report of a reportable incident in writing; and

(b) refer a report of a reportable incident in writing to the registered provider to which the incident relates no more than 24 hours after receipt of the report; and

(c) ensure that each referral of a reportable incident covers the following (if known) in order to support the registered provider in meeting their obligations in relation to the reporting of reportable incidents:

(i) the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the reportable incident;

(ii) to the extent known—the consequences of that harm;

(iii) the time and date when the reportable incident was identified;

(iv) the name and contact details of the person recording the details of the reportable incident;

(v) whether or not the reportable incident was reported to the police;

(vi) to the extent known—the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;

(vii) to the extent known—the names and contact details of the persons directly involved in the reportable incident;

(viii) to the extent known—the names and contact details of any witnesses to the reportable incident.

Other requirements relating to management of reportable incidents

(4) In managing reportable incidents, the operator of an aged care digital platform must ensure:

(a) that the operator provides support and assistance to a person wishing to report a reportable incident (or making an enquiry that may relate to reporting such an incident), for example, by facilitating access to translation services; and

(b) that the operator provides advice to entities that represent that they can deliver funded aged care services via the platform on how to report a reportable incident; and

(c) that the operator provides information that reportable incidents may be reported directly to the registered provider to which the incident relates; and

(d) that the operator undertakes reviews as required, and at least annually, to ensure the incident management system meets the requirements of this section; and

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(e) that the operator has regard to the obligations of registered providers in relation to reporting reportable incidents, and gives them information in a manner that facilitates compliance with those obligations; and

(f) that the operator provides training to staff in identifying and taking responsibility for referring reportable incidents including, but not limited to, referring them to registered providers or emergency services if required.

Note: ***Reportable incident*** is defined in section 16 of the Act.

189-15 Reporting requirements

(1) For the purposes of paragraph 189(1)(e) of the Act, this section sets out the prescribed requirements in relation to a notice to be given to the Commissioner by an entity that is a constitutional corporation and the operator of an aged care digital platform.

(2) The operator must report the following information for each quarter:

(a) the number and type of complaints received, referred, or otherwise handled during that quarter about the following:

(i) registered providers;

(ii) aged care workers of registered providers;

(b) the number and type of reportable incidents reported, referred to another person or body, or otherwise handled, during that quarter about the following:

(i) registered providers;

(ii) aged care workers of registered providers;

(c) the number and details of the following that were removed from the platform by the operator during that quarter, and the reasons why they were removed:

(i) entities that represented via the platform that the entity could deliver funded aged care services;

(ii) individuals to whom funded aged care services were delivered via the platform;

(d) the aggregate number of the following on the platform during that quarter:

(i) aged care workers of registered providers;

(ii) registered providers;

(iii) other entities seeking to deliver funded aged care services via the platform;

(e) if available, the aggregate number of individuals to whom funded aged care services were delivered via the platform during that quarter.

(3) For the purposes of paragraphs (2)(a) and (b), the report must deal separately with each registered provider, and each aged care worker of a registered provider, about whom a complaint or a report of a reportable incident was received, referred, or otherwise handled during the quarter concerned.

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(4) For the purposes of paragraph (2)(c), the report must deal separately with each entity, and each individual, removed from the platform by the operator during the quarter concerned.

189-18 Reporting changes to the Commissioner

For the purposes of paragraph 189(1)(e) of the Act, if:

(a) an entity that is both a constitutional corporation and the operator of an aged care digital platform has given a notice to the Commissioner under paragraph 189(1)(a) of the Act in accordance with subsection 189-1(1) of this instrument; and

(b) there is a change in the information included in the notice;

the entity must report the change to the Commissioner not later than 14 days after the change.

189-20 Keeping and retaining records, etc.

(1) For the purposes of paragraph 189(1)(g) of the Act, the records to be kept and retained by an entity that is both a constitutional corporation and the operator of an aged care digital platform are prescribed by this section.

(2) The operator must keep and retain the following records for each complaint made and each report of a reportable incident received:

(a) the complaint made, or the report of the reportable incident, and any information relating to the complaint or report, as the case requires;

(b) how the complaint or report was managed through the operator's systems;

(c) details of when the complaint or report was referred to the relevant registered provider;

(d) the date of acknowledgement of receipt by the relevant registered provider.

(3) The operator must keep and retain records of the following entities that represent via the platform that they can deliver a funded aged care service:

(a) aged care workers of registered providers;

(b) registered providers and their associated providers.

(4) The operator must keep and retain records of:

(a) the funded aged care services delivered to an individual; and

(b) the aged care workers and the registered providers responsible for the delivery of those services.

(5) The operator must keep and retain records of the following that the operator removed from the platform, and the reasons why:

(a) the names and numbers of aged care workers of registered providers;

(b) registered providers and associated providers of registered providers;

(c) individuals to whom funded aged care services were delivered via the platform.

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(6) The operator must keep and retain records of the details of requests for corrections to information held on the platform, and the operator's responses to those requests.

(7) The operator must ensure that procedures are in place requiring that all records that must be kept and retained by the operator are retained for at least 7 years.

189-25 Disclosing information included in records, etc.

(1) For the purposes of paragraph 189(1)(g) of the Act, the information that is to be disclosed by an entity that is both a constitutional corporation and the operator of an aged care digital platform is prescribed by this section.

(2) If the operator has records about an individual to whom funded aged care services are being or have been delivered, the operator must provide that information on request in a timely manner:
  (a) to the individual; and
  (b) with the individual's informed consent—to their supporters or advocates, or to a registered provider.

189-30 Correcting records, etc.

(1) For the purposes of paragraph 189(1)(g) of the Act, this section applies to records that are kept and retained, as prescribed by section 189-20 of this instrument, by an entity that is both a constitutional corporation and the operator of an aged care digital platform.

(2) Another entity may request, in writing or orally, that the operator make a correction to information relating to the other entity that is included in the operator's records.

(3) If the operator is satisfied that information included in its records is inaccurate, incomplete, out of date, irrelevant or misleading, the operator must take reasonable steps to correct the information.

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Chapter 7—Funding of aged care services—Commonwealth contributions

Part 1—Introduction

190-5 Simplified outline of this Chapter

This Chapter provides for matters relating to Commonwealth contributions for funded aged care services under Part 2 of Chapter 4 of the Act.

Division 1 of Part 2 of this Chapter relates to person-centred subsidy for subsidy for home support, and deals with:

(a) certain classification levels that are not eligible for person-centred subsidy; and
(b) matters relating to credits to, and debits from, ongoing home support accounts and ceasing of accounts; and
(c) base individual amounts for classification types; and
(d) matters relating to debits from short-term home support accounts and ceasing of accounts; and
(e) primary person-centred supplements, the circumstances in which the supplements will apply to individuals for a day and the amounts of the supplements.

Division 2 of Part 2 of this Chapter relates to provider-based subsidy for subsidy for home support, and deals with:

(a) certain classification levels that are eligible for provider-based subsidy; and
(b) matters relating to credits to, and debits from, service delivery branch accounts and ceasing of accounts; and
(c) base provider amounts for the classification type ongoing; and
(d) the provider-based supplement care management, the circumstances in which the supplement will apply in relation to individuals for a day and the amount of the supplement.

Part 3 of this Chapter relates to subsidy for assistive technology, and deals with:

(a) certain classification levels that are not eligible for subsidy; and
(b) matters relating to periods of assistive technology accounts, credits to, and debits from, accounts and ceasing of accounts; and
(c) tier amounts for individuals for an account period for classification types for the service group assistive technology; and
(d) the primary person-centred supplement rural and remote supplement, the circumstances in which the supplement will apply to individuals for a day and the amount of the supplement.

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Part 4 of this Chapter relates to subsidy for home modifications, and deals with:

(a) certain classification levels that are not eligible for subsidy; and

(b) matters relating to periods of home modifications accounts and debits from accounts; and

(c) tier amounts for individuals for an account period for classification type short-term for the service group home modifications; and

(d) the primary person-centred supplement rural and remote supplement, the circumstances in which the supplement will apply to individuals for a day and the amount of the supplement.

Part 5 of this Chapter relates to the fee reduction supplement for the service groups home support, assistive technology and home modifications, and deals with circumstances for applicability of the supplement to individuals and the amount of the supplement.

Part 6 of this Chapter relates to unspent Commonwealth portions and home care accounts, and deals with matters relating to debits of accounts for return of unspent Commonwealth portions.

Division 1 of Part 7 of this Chapter relates to person-centred subsidy for subsidy for residential care, and deals with:

(a) base rates for classification types; and

(b) primary person-centred supplements, the circumstances in which the supplements will apply to individuals for a day and the amounts of the supplements; and

(c) defining accommodation supplement concepts; and

(d) secondary person-centred supplements, the circumstances in which the supplements will apply to individuals for a day and the amounts of the supplements; and

(e) person-centred subsidy reduction.

Division 2 of Part 7 of this Chapter relates to provider-based subsidy for subsidy for residential care, and deals with:

(a) base provider amounts for classification types; and

(b) provider-based supplements, the circumstances in which the supplements will apply in relation to individuals for a day and the amount of the supplements; and

(c) provider-based reduction amount; and

(d) approved residential care homes with specialised status.

Part 8 of this Chapter relates to the compensation payment reduction for the service groups home support, assistive technology, home modifications and residential care, and deals with circumstances for applicability of the supplement to individuals and the amount of the supplement.

Part 9 of this Chapter relates to subsidy for certain specialist aged care programs, and deals with:

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(a) circumstances that must apply for the System Governor to enter into agreements for delivery of funded aged care services under the Multi-Purpose Service Program and the amount of subsidy for the Multi-Purpose Service Program; and
(b) requirements for agreements for delivery of funded aged care services under the Transition Care Program and the amount of subsidy for the Transition Care Program.

Part 10 of this Chapter relates to subsidy claims and payments, and deals with:
(a) claims and payments for the service groups home support, assistive technology and home modifications and specialist aged care programs; and
(b) circumstances in which the System Governor must accept multiple claims; and
(c) matters relating to transfers of service delivery branches.

Part 11 of this Chapter sets out the Grantee Code of Conduct.

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Part 2—Subsidy for home support

Division 1—Person-centred subsidy

Subdivision AA—Eligibility

191-5 Ineligible funded aged care services

For the purposes of paragraph 191(2)(f) of the Act, the funded aged care service home support care management is prescribed for an individual who:

(a) has an access approval in effect for the classification type ongoing for the service group home support; or

(b) has the classification level SAH restorative care pathway in effect for the classification type short-term for the service group home support.

Subdivision A—Available ongoing home support account balance

193-5 Quarterly rollover credit

For the purposes of subsection 193(4) of the Act, the amount for a quarter is the higher of the following amounts:

(a) $1,000;

(b) the amount that is 10% of the sum of the following for the day on which the amount is credited, multiplied by the number of days in the quarter:

(i) the base individual amount for the individual for the classification type for the service group;

(ii) the sum of any primary person-centred supplements for the classification type for the service group that apply to the individual.

193-15 Circumstances for no credits

For the purposes of subsection 193(9) of the Act, each of the following are circumstances in which a credit to an individual's notional ongoing home support account, which would otherwise be required under subsection 193(3), (4), (5) or (6) of the Act, is not to be made:

(a) after the end of a quarter in which an ongoing funded aged care service was delivered to the individual through the service group home support, at least 4 consecutive quarters have passed in which an ongoing funded aged care service was not delivered to the individual through the service group home support;

(b) after a registered provider provided the System Governor and the Commissioner with a cessation notification in relation to the individual:

(i) at least 4 consecutive quarters have passed; and

(ii) a registered provider has not provided a start notification to the System Governor and the Commissioner in relation to the individual about starting the delivery of funded aged care services to the

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individual for the classification type ongoing through the service group residential care;

(c) after the start day included in a start notification given by the registered provider to the System Governor and the Commissioner about starting the delivery of funded aged care services to the individual for the classification type ongoing through the service group residential care;

(d) the individual has died.

193-20 Circumstances for ceasing of account

For the purposes of subsection 193(10) of the Act, the circumstances in which an individual's notional ongoing home support account ceases are that:

(a) more than 60 days have passed since the individual died; and

(b) any longer period determined by the System Governor under paragraph 251(3)(b) of the Act for a claim for person-centred subsidy that is payable to a registered provider under section 251 of the Act for the delivery of a funded aged care service to the individual has ended.

Subdivision B—Base individual amounts

194-5 Classification type ongoing

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

Non-transitional classification levels

(2) Subject to subsection (2A), the following table sets out the base individual amounts for individuals who have classification levels that are not transitional classification levels.

Base individual amounts for non-transitional classification levels

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	SAH class 1	26.46
2	SAH class 2	39.54
3	SAH class 3	54.16
4	SAH class 4	73.22
5	SAH class 5	97.88
6	SAH class 6	118.64
7	SAH class 7	143.38
8	SAH class 8	192.59

(2A) If an interim place is in effect for an individual for the classification type ongoing for the service group home support under section 92A of the Act, the

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base individual amount for the individual is the amount equal to 60% of the amount that applies to the individual under subsection (2), rounded to the nearest cent (rounding 0.5 cents upwards).

Transitional classification levels

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

Base individual amounts for transitional classification levels

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	HCP class 1	27.09
2	HCP class 2	47.64
3	HCP class 3	103.70
4	HCP class 4	157.21

194-10 Classification type short-term

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

Non-transitional classification levels

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

Base individual amounts for non-transitional classification levels

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	SAH restorative care pathway	53.67
2	SAH end-of-life pathway	298.04

Transitional classification levels

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

Base individual amounts for transitional classification levels

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	STRC class	260.97

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Subdivision C—Available short-term home support account balance

195-1 Number of days for initial credit

For the purposes of paragraphs 195(3)(a) and (b) of the Act, the number of days is:

(a) for the classification level SAH end-of-life pathway—84 days; and

(b) for the classification level SAH restorative care pathway—112 days.

195-3 Circumstances, day and amount for other credit

(1) For the purposes of subsection 195(3A) of the Act, for an individual's notional short-term home support account:

(a) the amount is an amount equal to the amount credited to the account under subsection 195(3) of the Act; and

(b) the circumstances are that:

(i) the System Governor has determined the amount for the individual under subsection (2); and

(ii) the individual has the classification level SAH restorative care pathway in effect for the classification type short-term for the service group home support; and

(iii) the individual has not had that classification level in effect 2 or more times in the 365 days before the start of the current period of effect of that classification level; and

(c) the day is the day the System Governor determines the amount for the individual under subsection (2).

(2) The System Governor must determine the amount for the individual on a day if:

(a) on or before the day, a registered provider gives the System Governor:

(i) a list of the funded aged care services (the existing services) that are set out in the individual's care and services plan as services that the provider will deliver to the individual through the service group home support in the period of effect of the classification level SAH restorative care pathway for the individual; and

(ii) a written certificate from a medical practitioner, registered nurse or allied health professional, or an aged care worker of the provider who is a restorative care partner, stating that, to achieve the goals in the plan, the individual needs to access funded aged care services in the service types nursing care and allied health and therapy (the additional services) in addition to the existing services; and

(iii) evidence of the total cost for the delivery of the existing services and the additional services; and

(b) the total cost for the delivery of the existing services and the additional services exceeds the total of the amounts credited to the individual's notional short-term home support account under subsections 195(3) and (4) of the Act in the period of effect of the classification level SAH restorative care pathway for the individual; and

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(c) if the individual also has a classification level in effect for the classification type ongoing for the service group—the total cost for the delivery of the existing services and the additional services exceeds the sum of:
  (i) the total of the amounts credited to the individual's notional short-term home support account under subsections 195(3) and (4) of the Act in the period of effect of the classification level SAH restorative care pathway for the individual; and
  (ii) the total of the amounts credited, or to be credited, to the individual's notional ongoing home support account under section 193 of the Act for the quarters during which the classification level SAH restorative care pathway is in effect for the individual; and
(d) on the day, the System Governor considers a place for the classification type short-term for the service group home support is available in accordance with a determination made under subsection 91(1) of the Act.

195-10 Circumstances for ceasing of account

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

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

Subdivision D—Primary person-centred supplements

196-5 Purpose of this Subdivision

For the purposes of section 196 of the Act, this Subdivision prescribes:

(a) primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group home support; and
(b) the circumstances in which the supplements will apply to individuals for a day; and
(c) the amounts of the supplements.

196-10 Primary person-centred supplements

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

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

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

The primary person-centred supplements for the classification type short-term will apply to an individual for a day only if, on the day:

(a) the individual does not have an access approval in effect for the classification type ongoing for the service group home support; or

(b) all of the following apply:

(i) the individual has an access approval in effect for the classification type ongoing for the service group home support;

(ii) a primary person-centred supplement for the classification type ongoing for the service group home support applies to the individual;

(iii) the individual has the classification level SAH end-of-life pathway in effect for the classification type short-term for the service group home support.

196-15 Oxygen supplement—circumstances for applicability and amount

Circumstances for applicability

(1) Oxygen supplement will apply to an individual for a day if:

(a) on the day, the individual's classification level for a classification type for the service group home support is other than STRC class; and

(b) on the day, the care and services plan for the individual:

(i) covers the delivery of the funded aged care service nursing care consumables to the individual; and

(ii) includes providing oxygen to the individual using materials and equipment hired, temporarily obtained or owned by the provider; and

(c) a medical practitioner or a nurse practitioner has certified, in writing, that the individual has a continual need for the provision of oxygen, other than on a short-term or episodic basis.

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Amount

(2) The amount of oxygen supplement for a day is $14.66.

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

Circumstances for applicability

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

Amount

(2) The amount of enteral feeding supplement for a day is:
  (a) for bolus feeding—$23.25; and
  (b) for non-bolus feeding—$26.11.

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

Circumstances for applicability

(1) Veterans' supplement will apply to an individual for a day if:
  (a) on the day, the individual's classification level for a classification type for the service group home support is other than STRC class; and
  (b) the individual is a veteran with an accepted mental health condition; and
  (c) the individual has, before, on or after that day, authorised either or both of the following to disclose to a registered provider that the individual is a veteran with an accepted mental health condition:
    (i) the Secretary of the Department administered by the Minister administering the Veterans' Entitlements Act;
    (ii) the Secretary of the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

Amount—classification type ongoing

(2) The amount of veterans' supplement for a day for an individual with a classification level for the classification type ongoing for the service group home support is the amount that is 11.5% of the sum of:

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(a) the base individual amount for the individual's classification level for the day; and
(b) for an individual covered by subsection 203(3) of the Act—the base provider amount for a registered provider in relation to the individual;

rounded to the nearest cent (rounding 0.5 cents upwards).

Amount—classification type short-term

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

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

Circumstances for applicability

(1) Dementia and cognition supplement will apply to an individual for a day if:
(a) on the day, the individual has the classification level HCP class 1, 2, 3 or 4 in effect for the classification type ongoing for the service group home support; and
(b) immediately before the transition time, the individual was eligible for a dementia and cognition supplement under section 83 of the *Subsidy Principles 2014*.

Amount

(2) The amount of dementia and cognition supplement for a day for an individual is the amount that is 11.5% of the sum of:
(a) the base individual amount for the individual's classification level for the classification type ongoing for the service group home support for the day; and
(b) for an individual covered by subsection 203(2) or (5) of the Act—the base provider amount for a registered provider in relation to the individual;

rounded to the nearest cent (rounding 0.5 cents upwards).

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

Circumstances for applicability

(1) Top-up supplement will apply to an individual for a day if:
(a) on the day, the individual has the classification level HCP class 1, 2, 3 or 4 in effect for the classification type ongoing for the service group home support; and

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(b) immediately before the transition time, top-up supplement applied to the individual under section 67M of the *Aged Care (Transitional Provisions) Principles 2014*.

Amount

(2) The amount of top-up supplement for a day is $3.45.

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Division 2—Provider-based subsidy

Subdivision A—Eligibility

201-5 Eligible funded aged care services

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

Subdivision B—Available service delivery branch account balance

203-10 Amount to be credited in first and second quarters of active operation—number of days for calculation

For the purposes of paragraphs 203(3)(a) and (b) of the Act, the number of days is:

(a) for an individual whose start notification is given on a day in the first quarter of operation in the first financial year—the number of days remaining in the first quarter of operation (including the day on which the notification is given); or

(b) for an individual whose start notification is given on a day in the second quarter of operation in the first financial year—the number of days remaining in the second quarter of operation (including the day on which the notification is given).

203-11 Time before which registered provider must give start notification

For the purposes of paragraph 203(5)(a) of the Act, 10.00 pm (by legal time in the Australian Capital Territory) on the last day in the quarter immediately before the relevant quarter is prescribed.

203-12 Amount to be credited for provider-based supplement starting to apply—number of days for calculation

For the purposes of subsection 203(7) of the Act, the number of days remaining in the quarter after the day the provider-based supplement starts applying to the provider in relation to the individual is prescribed.

203-15 Rollover credits

(1) This section is made for the purposes of subsection 203(8) of the Act.

(2) The following circumstance is prescribed for the account for a financial year (the ***relevant financial year***):

(a) the previous financial year was the first financial year referred to in that subsection of the Act;

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(b) the account for the first financial year was established between 1 January and 30 June in that year.

(3) The amount prescribed for the circumstance mentioned in subsection (2) is the available balance of the account for the first financial year immediately before the time at which the account for the relevant financial year is required to be credited in accordance with that subsection of the Act.

(4) The circumstance that subsection (2) of this section does not apply in relation to the account for a financial year (the ***relevant financial year***) is also prescribed.

(5) The amount prescribed for the circumstance mentioned in subsection (4) is the lesser of the following:

(a) the available balance of the account for the previous financial year immediately before the time at which the account for the relevant financial year is required to be credited in accordance with that subsection of the Act;

(b) the sum of the following amounts:

(i) the amount that was credited to the account for the final quarter of the previous financial year in accordance with subsection 203(4) of the Act;

(ii) the amount of any credit made to that account in that quarter in accordance with subsection 203(6) of the Act;

(iii) the amount of any credit made to that account in that quarter in accordance with subsection 203(7) of the Act.

203-25 Circumstances for ceasing of account

For the purposes of subsection 203(11) of the Act, each of the following is prescribed as a circumstance in which a notional service delivery branch account for a registered provider in relation to a service delivery branch of the provider ceases:

(a) both of the following apply:

(i) the registered provider has reported to the System Governor, under subsection 166(1) of the Act, that the provider proposes to close the service delivery branch;

(ii) after the report, the service delivery branch has closed;

(b) both of the following apply:

(i) the service delivery branch is a merging service delivery branch;

(ii) under subsection 263A-5(3) of this instrument, the available balance of the notional service delivery branch account of the provider in relation to the merging service delivery branch is credited to the notional service delivery branch account for the provider in relation to a continuing service delivery branch.

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Subdivision C—Base provider amount

204-5 Classification type ongoing

(1) For the purposes of section 204 of the Act, this section sets out the base provider amount for a registered provider in relation to an individual covered by subsection 203(5) of the Act for individuals for the classification type ongoing for the service group home support.

Non-transitional classification levels

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

Base provider amounts for non-transitional classification levels

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	SAH level 1	2.94
2	SAH level 2	4.39
3	SAH level 3	6.02
4	SAH level 4	8.14
5	SAH level 5	10.88
6	SAH level 6	13.18
7	SAH level 7	15.93
8	SAH level 8	21.40

(2A) If an interim place is in effect for an individual for the classification type ongoing for the service group home support under section 92A of the Act, the base provider amount in relation to the individual is the amount equal to 60% of the amount that applies in relation to the individual under subsection (2).

Transitional classification levels

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

Base provider amounts for transitional classification levels

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	HCP class 1	3.01
2	HCP class 2	5.29
3	HCP class 3	11.52
4	HCP class 4	17.47

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Subdivision D—Provider-based supplements

205-5 Care management supplement

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

205-10 Care management supplement—applicability

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

(a) one or more of the following subparagraphs applies in relation to the individual:
  (i) the individual is an Aboriginal or Torres Strait Islander person;
  (ii) the individual is homeless or at risk of homelessness; or
  (iii) the individual is a care leaver, that is, an individual who has spent time in institutional care or out of home care (such as orphanages and foster care), and includes an individual who is a Forgotten Australian, a former child migrant or an Aboriginal or Torres Strait Islander person from the stolen generations; or
  (iv) the individual is referred to the provider as an eligible client of the care finder program funded by the Department; or
  (v) veterans' supplement applies to the individual under section 196-25 of this instrument; and
(b) if subparagraph (a)(i), (ii), (iii) or (iv) applies to the individual—the System Governor has been notified of that fact:
  (i) through an aged care needs assessment for the individual; or
  (ii) in a notice from the registered provider in the approved form; and
(c) if subparagraph (a)(v) applies to the individual—the System Governor has been notified of that fact by the Department administered by the Minister administering the Veterans' Entitlements Act.

205-15 Care management supplement—amount

For the purposes of paragraph 205(2)(b) of the Act, the amount of care management supplement in relation to an individual for a day is $3.95.

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Part 3—Subsidy for assistive technology

Division 1—Eligibility

209-5 Excluded classification levels

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

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Division 2—Available assistive technology account balance

211-5 Account period for classification type ongoing

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

(a) the end of the day the individual dies;

(b) the end of the maximum period of effect for the classification level.

211-10 Account period for classification type short-term

(1) For the purposes of subsection 211(1) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, the account period for the account is:

(a) the period of 12 months beginning on the entry day for the individual; or

(b) if subsection (2) applies to the individual:

(i) the period of 24 months beginning on the entry day for the individual; or

(ii) if a registered provider notifies the System Governor, in accordance with subsection (3), that a longer account period is needed for the individual—the period of 48 months beginning on the entry day for the individual.

(2) This subsection applies to an individual if a medical practitioner has certified, in writing, that the individual has been diagnosed with any of the following conditions:

(a) cerebral palsy;

(b) epilepsy;

(c) Huntington's disease;

(d) motor neurone disease;

(e) multiple sclerosis;

(f) Parkinson's disease;

(g) polio;

(h) spinal cord injury;

(i) spinal muscular atrophy;

(j) stroke;

(k) other acquired brain injury;

(l) muscular dystrophy or muscular atrophy.

(3) For the purposes of subparagraph (1)(b)(ii), a registered provider may notify the System Governor that a longer account period is needed for an individual. The notification must:

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(a) be in the approved form; and
(b) be made before the end of 24 months beginning on the entry day for the individual.

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

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

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

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

(1) For the purposes of subsection 211(4A) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, and the individual has the classification level AT High:
   (a) the day is the day a determination of an amount under subsection (5) is made for the individual; and
   (b) the amount is the amount determined for the individual.

(2) A registered provider may apply to the System Governor for a determination of an amount for an individual under subsection (5).

(3) An application under subsection (2) must be made:
   (a) in the approved form; and
   (b) before the end of 12 months beginning on the entry day for the individual.

(4) The System Governor must consider an application under subsection (2) and decide whether to determine an amount under subsection (5).

(5) The System Governor may determine an amount for the individual if:
   (a) the registered provider has provided written evidence of:
      (i) the individual's need for one or more items; and
      (ii) the cost of each of those items; and
   (b) the total cost of the items covered by paragraph (a) exceeds the sum of the amounts credited to the individual's account under subsections 211(3) and (5) of the Act; and
   (c) the amount is the amount by which the total cost of the items exceeds the sum mentioned in paragraph (b).

(6) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.

(7) A notice under subsection (6) must include:
   (a) the reasons for the decision; and

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(b) how the registered provider may apply for reconsideration of the decision.

211-25 Day and amount for credit to account for classification type short-term—credit due to change in classification coming into effect

(1) For the purposes of subsection 211(4A) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, and subsection (2) applies:
   (a) the day is the day mentioned in subsection (3); and
   (b) the amount is the amount mentioned in subsection (4).

(2) This subsection applies if:
   (a) the System Governor makes a decision establishing a different classification level in the classification type for the individual on a day that is after the entry day for the individual; and
   (b) the tier amount (the ***new tier amount***) for the individual for the classification type for the service group is higher as a result of the decision coming into effect.

(3) The day is the day the different classification level comes into effect.

(4) The amount is the difference between the new tier amount and the total of the amounts debited from the account while the previous classification level was in effect.

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Division 3—Tier amounts

212-5 Classification type ongoing

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

Tier amounts for the classification type ongoing

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	Assistance dogs	2,000

212-10 Classification type short-term

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

Tier amounts for the classification type short-term

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	AT Transitional	0
2	AT Low	500
3	AT Medium	2,000
4	AT High	15,000

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Division 4—Primary person-centred supplements

213-5 Rural and remote supplement

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

(a) the supplement rural and remote supplement is prescribed; and

(b) the circumstances in which rural and remote supplement will apply to the individual are that the individual resides at a location in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7; and

(c) the amount of rural and remote supplement is the amount that is 50% of the tier amount for the individual for the account period for the classification type for the service group assistive technology, rounded to the nearest cent.

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Part 4—Subsidy for home modifications

Division 1—Eligibility

218-5 Excluded classification levels

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

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Division 2—Available home modifications account balance

220-5 Account period for classification type short-term

(1) For the purposes of subsection 220(1) of the Act, if an individual's notional home modifications account is established because an entry day for the individual occurs for the classification type short-term for the service group home modifications, the account period for the account is:

(a) the period of 12 months beginning on the entry day for the individual; or

(b) if the individual has the classification level HM High for that service type, and a registered provider has notified the System Governor, in accordance with subsection (2), that a longer period is needed for the individual—the period of 24 months beginning on the entry day for the individual.

(2) For the purposes of paragraph (1)(b), a registered provider may notify the System Governor that a longer account period is needed for an individual. The notification must:

(a) be in the approved form; and

(b) be made before the end of 12 months beginning on the entry day for the individual.

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Division 3—Tier amounts

221-5 Classification type short-term

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

Tier amounts for the classification type short-term

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is …
1	HM Transitional	$0
2	HM Low	$500
3	HM Medium	$2,000
4	HM High	the amount under subsection (2)

(2) For the purposes of column 2 of item 4 of the table in subsection (1), the amount for an individual with the classification level HM High is:

(a) if it is the first occasion that a notional home modifications account is established for the individual with that classification level—$15,000; and

(b) if it is not the first occasion that a notional home modifications account is established for the individual with that classification level—$15,000 reduced by the total of any amounts debited to the individual's previous notional home modifications accounts when the individual had that classification level.

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Division 4—Primary person-centred supplements

222-5 Rural and remote supplement

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

(a) the supplement rural and remote supplement is prescribed; and

(b) the circumstances in which rural and remote supplement will apply to the individual are that the individual resides at a location in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7; and

(c) the amount of rural and remote supplement is the amount that is 50% of the tier amount for the individual for the account period for the classification type for the service group home modifications, rounded to the nearest cent.

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

197-1 Purpose of this Part

For the purposes of subsections 197(2), 214(2) and 223(2) of the Act, this Part prescribes:

(a) the circumstances in which the fee reduction supplement will apply to an individual for a day; and

(b) the amount of the supplement.

Note 1: The fee reduction supplement is a secondary person-centred supplement for an individual for a day for a classification type for the service groups home support, assistive technology and home modifications (see paragraphs 197(1)(a), 214(1)(a) and 223(1)(a) of the Act).

Note 2: The amount of the fee reduction supplement for a day for an individual reduces the unreduced individual contribution for the delivery of a funded aged care service to the individual on the day in accordance with Step 4 in the method statement in subsection 273(2) of the Act.

197-5 Fee reduction supplement—circumstances for applicability, amount and reduction of contributions—home or community fee reduction supplement determinations (financial hardship)

Circumstances for applicability of fee reduction supplement

(1) Circumstances in which the fee reduction supplement will apply to an individual for a day in a fortnight are that:

(a) on the day, either:

(i) an individual contribution rate determination is in effect for the individual; or

(ii) the individual does not have means not disclosed status; and

(b) on the day, the value of the individual's assets, worked out in accordance with Division 1 of Part 3.12 of the Social Security Act and reduced by the value of any unrealisable assets, is not more than 1.5 times the sum of the annual amount of the following:

(i) the maximum basic rate under point 1064-B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple;

(ii) the pension supplement amount under point 1064-BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple;

(iii) the energy supplement amount under point 1064-C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple; and

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(c) on the day, the individual has not gifted more than $10,000 in the current financial year or in any of the previous 4 financial years; and

(d) on the day, the individual has not gifted more than $30,000 in the period comprising the current financial year and the previous 4 financial years; and

(e) on the day, a home or community fee reduction supplement determination is in effect for the individual; and

(f) the individual's fortnightly individual contribution cap for the fortnight is equal to or less than the individual's fortnightly base individual amount for the fortnight.

Amount of fee reduction supplement

(2) The amount of the fee reduction supplement for a day in a fortnight for an individual to whom the supplement applies under subsection (1) for the day is:

(a) if, on the day, the total of the unreduced individual contributions for the delivery of funded aged care services to the individual on the day and the preceding days in the fortnight does not exceed the individual's fortnightly individual contribution cap for the fortnight—zero; or

(b) if, on the day, the total of the unreduced individual contributions for the delivery of funded aged care services to the individual on the day and the preceding days in the fortnight exceeds the individual's fortnightly individual contribution cap for the fortnight—the amount by which that total exceeds that cap; or

(c) if the day is after the day mentioned in paragraph (b)—the amount of the total of the unreduced individual contributions for the delivery of funded aged care services to the individual on the day.

197-8 Applications for home or community fee reduction supplement determinations

(1) An individual may apply, subject to this section, to the System Governor for a home or community fee reduction supplement determination for the individual.

(2) An application must be in the approved form.

Note: For penalties for knowingly providing false or misleading information or documents in applications, see section 591 of the Act and Part 7.4 of the *Criminal Code*.

(3) If an individual has made an application (an ***existing application***) for a home or community fee reduction supplement determination for the individual, the individual must not make a further application for a home or community fee reduction supplement determination for the individual in the decision-making period (within the meaning of subsection 588(5) of the Act) for the existing application.

(4) If a home or community fee reduction supplement determination (an ***existing determination***) is made for an individual, the individual must not make an application for a further home or community fee reduction supplement

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determination for the individual within 90 days from the day the existing determination was made.

(5) If a home or community fee reduction supplement determination for an individual is revoked, the individual must not make an application for a further home or community fee reduction supplement determination for the individual within 28 days from the day the revocation takes effect.

197-10 Home or community fee reduction supplement determinations

(1) The System Governor must, within 28 days from receiving an application in accordance with section 197-8, determine:
  (a) the following for a particular fortnight:
    (i) the individual's fortnightly total income amount;
    (ii) the individual's fortnightly total essential expenses;
    (iii) the individual's fortnightly remaining income amount; and
  (b) the day the determination takes effect; and
  (c) the period for which the determination is in effect.

Note: See also section 588 (which allows the System Governor to request further information, and provides for the consequence of not giving any requested further information in the requested time, and the extension of the decision-making period if requested information is given in the requested time).

(2) For the purposes of paragraph (1)(b):
  (a) unless paragraph (b) applies—the System Governor must determine that the determination takes effect on the day the application was made; or
  (b) the System Governor must determine that the determination takes effect on a day that is earlier than the day the application was made, if:
    (i) the individual's application includes a request for the determination to take effect on an earlier day because the individual was experiencing financial hardship on and after the earlier day, and evidence of that financial hardship; and
    (ii) the System Governor is satisfied that the individual was experiencing financial hardship on and after the earlier day.

Essential expenses

(3) Without limiting subparagraph (1)(a)(ii), expenses that the System Governor may determine to be essential expenses in relation to an individual include the following:
  (a) food costs;
  (b) costs relating to the individual's 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

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(vi) telephone and internet costs;

(c) any of the following that are not already covered by other government schemes or programs or by private health insurance:

(i) medical expenses, including expenses incurred under the direction of a registered health practitioner or allied health professional;

(ii) dental care;

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

(iv) artificial limbs, eyes or hearing aids;

(v) wheelchair and mobility aids;

(vi) transport costs to attend medical appointments;

(d) ambulance cover;

(e) private health insurance;

(f) transport related costs (other than transport costs referred to in subparagraph (c)(vi)), including public transport costs, vehicle registration, vehicle repairs and vehicle insurance;

(g) if the individual is paying a funeral plan on a periodic basis—the funeral plan;

but do not include amounts that are spent by another person, who is authorised to act on the individual's behalf, other than for the benefit of the individual.

(4) The individual's ***fortnightly total income amount*** for a fortnight is worked out by working out the individual's total assessable income using section 323 of the Act and dividing that amount by 26.

(5) The individual's ***fortnightly total essential expenses*** is the amount that is the individual's total essential expenses, worked out on a fortnightly basis.

(6) The individual's ***fortnightly remaining income amount*** for a fortnight is worked out by reducing (but not below zero) the individual's fortnightly total income amount for the fortnight by the individual's fortnightly total essential expenses for the fortnight.

(7) The individual's ***fortnightly individual contribution cap*** for a fortnight is the amount equal to the difference between:

(a) the fee reduction supplement fortnightly threshold amount for the fortnight; and

(b) the fortnightly remaining income amount determined in the home or community fee reduction supplement determination that is in effect for the individual on the first day of the fortnight.

(8) The individual's ***fortnightly base individual amount*** for a fortnight is the amount obtained by adding together:

(a) the individual's fortnightly base home support individual amount for the fortnight; and

(b) the individual's fortnightly base AT-HM individual amount for the fortnight.

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(9) The individual's ***fortnightly base home support individual amount*** for a fortnight is the amount obtained by rounding down to the nearest cent the amount worked out by multiplying the following:

(a) the base individual amount for the individual, on the first day of the fortnight, for:

(i) if the individual has a classification level in effect only for the classification type ongoing for the service group home support—that classification level; or

(ii) if the individual has a classification level in effect only for the classification type short-term for the service group home support—that classification level; or

(iii) if the individual has classification levels in effect for the classification types ongoing and short-term for the service group home support—the classification level in effect for the classification type ongoing;

(b) 14;

(c) the individual contribution rate for the individual, on the first day of the fortnight, for the means testing category everyday living.

(10) The individual's ***fortnightly base AT-HM individual amount*** for a fortnight is the amount obtained by rounding down to the nearest cent the amount worked out by multiplying the following:

(a) if the individual has a tier amount for an account period including the fortnight:

(i) if the individual has a tier amount only for the classification type ongoing or short-term for the service group assistive technology—that tier amount; or

(ii) if the individual has a tier amount only for the classification type short-term for the service group home modifications—that tier amount; or

(iii) if the individual has both a tier amount for the service group assistive technology and a tier amount for the service group home modifications—the sum of those tier amounts;

(b) 1/365;

(c) the individual contribution rate for the individual, on the first day of the fortnight, for the means testing category independence.

197-15 Notice of home or community fee reduction supplement determinations

(1) The System Governor must, within 14 days after making a home or community fee reduction supplement determination for an individual, give written notice of the determination to the individual and to the registered provider delivering funded aged care services to the individual.

(2) The notice must include:

(a) each of the matters determined in the determination; and

(b) the reasons for the following decisions:

(i) the determination of the individual's fortnightly total income amount;

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(ii) the determination of the individual's fortnightly total essential expenses;
(iii) the day the determination takes effect;
(iv) the period for which the determination is in effect; and

(c) how the individual may apply for reconsideration of those decisions; and
(d) a statement of the effect of section 197-20.

197-20 Varying or revoking home or community fee reduction supplement determinations—general

(1) The System Governor may vary or revoke a home or community fee reduction supplement determination for an individual:
(a) if the System Governor has been notified of the occurrence of an event or a change in the individual's circumstances under Subdivision E of Division 1 of Part 2 of Chapter 10; or
(b) if an individual contribution rate determination for the individual is made, varied or revoked; or
(c) if the individual has means not disclosed status under section 314A of the Act; or
(d) on the System Governor's own initiative (see section 197-30 of this instrument).

(2) Without limiting subsection (1), the home or community fee reduction supplement determination may be varied or revoked if the System Governor is satisfied that the determination is incorrect.

Effect of decision

(3) If a home or community fee reduction supplement determination is varied or revoked, the variation or revocation takes effect on the day specified by the System Governor in the notice under section 197-35.

(4) The day specified may be before the day the notice is given but must not be earlier than the day the circumstances that are the reason for the variation or revocation occurred.

197-25 Varying or revoking home or community fee reduction supplement determinations—on notification of event or change in circumstances

(1) This section applies if the System Governor has been notified of the occurrence of an event or a change in an individual's circumstances under Subdivision E of Division 1 of Part 2 of Chapter 10.

(2) The System Governor must decide, within 28 days from the day the notification is made, whether to vary or revoke the home or community fee reduction supplement determination in effect for the individual.

(3) The System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice

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(which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the home or community fee reduction supplement determination.

Note: The individual is not obliged to give the information.

(4) The System-Governor may, at the request of the individual, extend the specified period.

197-30 Varying or revoking home or community fee reduction supplement determinations—on System Governor's initiative

Notice before variation or revocation

(1) Before the System Governor varies or revokes a home or community fee reduction supplement determination under section 197-20 in relation to an individual on the System Governor's own initiative, the System Governor must give the individual written notice that the System Governor is considering varying or revoking the determination.

(2) The notice must:
  (a) set out the reasons why the System Governor is considering varying or revoking the determination, and what the effect of the variation or revocation would be; and
  (b) invite the individual to make a submission, in writing, to the System Governor in relation to the matter within the period specified in the notice (which must not be less than 28 days after giving the notice); and
  (c) inform the individual that the System Governor may decide to vary or revoke the determination:
    (i) if no submission is made within the specified period; or
    (ii) after considering any submission made by the individual within the specified period.

Request for further information

(3) The System Governor may also request, in the notice given under subsection (1), that the individual give the System Governor the information specified in the notice, within the period specified in the notice for the purposes of paragraph (2)(b), to assist the System Governor to decide whether to vary or revoke the determination.

Note: The individual is not obliged to give the information.

(4) If the individual makes a submission in accordance with the invitation under paragraph (2)(b), the System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the determination.

Note 1: The System Governor may request further information under this subsection regardless of whether information was requested or given under subsection (3).

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Note 2: The individual is not obliged to give the information.

(5) The System Governor may, at the request of the individual, extend the period specified for paragraph (2)(b) or subsection (4).

Deciding whether to vary or revoke fee reduction supplement determination

(6) The System Governor must:
  (a) consider any submission made in accordance with the invitation under paragraph (2)(b) and any further information given in accordance with a request under subsection (3) or (4); and
  (b) make a decision whether to vary or revoke the determination within 28 days from:
    (i) if no submission is made in accordance with the invitation in the notice under paragraph (2)(b)—the end of the period specified in the notice (including that period as extended (if applicable) under subsection (5)); or
    (ii) the later of:
      (A) if a submission is made in accordance with the invitation in the notice under paragraph (2)(b) and no further information is requested under subsection (4)—the day the submission is made; and
      (B) if a submission is made in accordance with the invitation in the notice under paragraph (2)(b) and further information is requested under subsection (4)—the day the individual gives the System Governor the further information.

197-35 Notice of decision to vary or revoke home or community fee reduction supplement determination

Notice requirements

(1) The System Governor must give an individual written notice of a decision under subsection 197-20(1) to vary or revoke a home or community fee reduction supplement determination for the individual within 14 days after making the decision.

(2) The notice under subsection (1) must:
  (a) state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with Subdivision E of Division 1 of Part 2 of Chapter 10; and
  (b) if the decision is to vary the home or community fee reduction supplement determination:
    (i) include details of the variation (including specifying the amounts determined to be the individual's fortnightly total income amount and fortnightly total essential expenses); and
    (ii) specify the day the variation takes effect (see subsection 197-20(4)); and

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(c) if the decision is to revoke the home or community fee reduction supplement determination:
  (i) explain the consequences of the revocation of the determination; and
  (ii) specify the day the determination ceases to be in force (see subsection 197-20(4)); and
(d) set out the reasons for the following decisions:
  (i) varying or revoking the determination under subsection 197-20(1);
  (ii) the day the variation or revocation takes effect under subsection 197-20(4); and
(e) state how the individual may apply for reconsideration of the decision under subsection 197-20(1).

Copies to registered provider

(3) The System Governor must also give the registered provider delivering funded aged care services to the individual a copy of the notice referred to in subsection (1).

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Part 6—Unspent Commonwealth portions and home care accounts

226A-5 Day for reduction of portion—provider elects to return available balance

For the purposes of subsection 226A(6) of the Act, the prescribed day is the day the provider made the election.

226A-10 Day for reduction of portion—individual transfers between provider service delivery branches

For the purposes of subsection 226A(7) of the Act, the prescribed day is the day after the last day on which the registered provider could make a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

Note: For the period in which a registered provider may make a claim for person-centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

226A-15 Day for reduction of portion—provider ceases to deliver services

For the purposes of subsection 226A(8) of the Act, the prescribed day is the day after the last day on which the registered provider could make a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

Note: For the period in which a registered provider may make a claim for person-centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

226B-5 Return of unspent Commonwealth portion—provider election—written notice of election

For the purposes of subsection 226B(1) of the Act, the notice must be given through the information technology system relating to aged care payments operated by Services Australia.

226B-10 Period within which available balance must be returned—provider election

For the purposes of paragraph 226B(4)(a) of the Act, the period is 1 day.

226C-5 Period within which available balance must be returned—individual transfers between provider service delivery branches

For the purposes of subparagraph 226C(2)(b)(i) of the Act, the period is the period:

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(a) starting on the day after the section 226C of the Act begins to apply in relation to the registered provider and the individual; and

(b) ending at the end of the day after the last day on which the registered provider could make a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

Note: For the period in which a registered provider may make a claim for person-centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

226D-5 Period within which available balance must be returned—provider ceases to deliver services

For the purposes of subparagraph 226D(2)(b)(i) of the Act, the period is the period:

(a) starting on the day after the cessation; and

(b) ending at the end of the day after the last day on which the registered provider could make a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

Note: For the period in which a registered provider may make a claim for person-centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

226E-5 Day for credit of account—provider elects to return available balance

For the purposes of subsection 226E(4) of the Act, the prescribed day is the day the provider made the election.

226E-10 Day for credit of account—individual transfers between provider service delivery branches

For the purposes of subsection 226E(5) of the Act, the prescribed day is the day the provider next makes a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

226E-15 Day for credit of account—provider ceases to deliver services

For the purposes of subsection 226E(6) of the Act, the prescribed day is the day after the last day on which the registered provider could make a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

Note: For the period in which a registered provider may make a claim for person-centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

226E-20 Home care account—circumstances in which account is reduced to zero

For the purposes of subsection 226E(8) of the Act, the circumstances are that:

(a) both of the following apply:

(i) the individual is deceased;

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(ii) the period in which a registered provider could make a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual has ended; or

(b) both of the following apply:

(i) the individual is 115 years old;

(ii) the period in which a registered provider could make a claim under section 251 of the Act, for person-centred subsidy for the delivery of a funded aged care service to the individual through a service group other than residential care, has ended.

Note: For the period in which a registered provider may make a claim for person-centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

226E-25 Home care account—circumstances in which account ceases

For the purposes of subsection 226E(9) of the Act, the circumstances are that:

(a) the available balance of the account is reduced to zero; and

(b) no registered provider holds an unspent Commonwealth portion for the individual under section 226A of the Act; and

(c) no person is required to pay the Commonwealth the Commonwealth portion of an unspent home care amount (within the meaning of the old Act) of the individual.

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Part 7—Subsidy for residential care

Division 1A—Classes of individuals to which Division 4 of Part 2 of Chapter 4 of the Act does not apply

227A-5 Classes of individuals

For the purposes of section 227A of the Act, the classes are the following:

(a) the pre-2014 residential contribution class;

(b) the post-2014 residential contribution class.

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Division 1—Person-centred subsidy

Subdivision A—Base rates

229-5 Base rates—classification type ongoing

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

General—classification level Class 0

(2) If neither subsection (4) nor (5) apply to the individual, and the classification level for the individual is Class 0, the base rate is the amount worked out by multiplying the national efficient price by:

(a) if the funded aged care services delivered to the individual are in the form of palliative care—the NWAU specified for the classification level Class 1 in the table in subsection (3); or

(b) otherwise—the NWAU specified for the classification level Class 8 in the table in subsection (3).

General—classification levels Class 1 to Class 13

(3) If neither subsection (4) nor (5) apply to the individual, and the classification level for the individual is specified in the following table, the base rate is the amount worked out by multiplying the national efficient price by the NWAU specified for the classification level.

Base rates for the classification type ongoing

Item	Column 1 If the classification level for the individual is …	Column 2 the NWAU is …
1	Class 1	0.73
2	Class 2	0.21
3	Class 3	0.40
4	Class 4	0.29
5	Class 5	0.43
6	Class 6	0.39
7	Class 7	0.54
8	Class 8	0.60
9	Class 9	0.53
10	Class 10	0.59
11	Class 11	0.68
12	Class 12	0.66
13	Class 13	0.73

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

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

(5) If the individual is on extended hospital leave on the day, the base rate is nil for the day if:

(a) at the transition time, the individual is on extended hospital leave and the sum of the following periods (the ***combined period***) is 29 days or more:

(i) the period immediately before the transition time during which the individual was on extended hospital leave (within the meaning of the old Act);

(ii) the period beginning at the transition time during which the individual is on extended hospital leave; and

(b) the day is on or after the 29th day in the combined period.

229-10 Base rates—classification type short-term

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

Item	Column 1 If the classification level of the individual is …	Column 2 the NWAU is …
1	Respite Class 0	0.574
2	Respite Class 1	0.405
3	Respite Class 2	0.574
4	Respite Class 3	0.714

Note: For the maximum period of effect for a classification level for the classification type short-term for the service group residential care, see section 80-60 of this instrument.

Subdivision B—Primary person-centred supplements

230-3 Purpose of this Subdivision

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

(a) other primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care; and

(b) the circumstances in which the accommodation supplement, oxygen supplement and enteral feeding supplement will apply to individuals for a day; and

(c) the amounts of the supplements.

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

230-4 Other primary person-centred supplements

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

Other primary person-centred supplements

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

230-5 Hotelling supplement—amount

For the purposes of subsection 230(2) of the Act, the amount of hotelling supplement is $22.15.

230-10 Accommodation supplement—circumstances for applicability and amount

Circumstances for applicability

(1) For the purposes of paragraph 230(2)(a) of the Act, the circumstances in which accommodation supplement will apply to an individual for a day are that:
  (a) either or both of the following apply:
    (i) the individual is a low means individual;
    (ii) the fee reduction supplement applies to the individual for the day; and
  (b) the funded aged care services delivered to the individual on the day are ongoing funded aged care services; and
  (c) concessional resident supplement does not apply to the individual for the day.

Amount—general

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

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(b) otherwise—the amount worked out by reducing the building status amount for the individual for the day by 25%.

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

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

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

(4) If the daily means tested amount for the individual for the day (the ***first amount***) is greater than zero but less than the amount of the accommodation supplement (the ***second amount***) that would, apart from this subsection, apply under subsection (2) for the individual for the day, then the amount of the accommodation supplement for the individual for the day is the amount equal to the difference between:
(a) the first amount; and
(b) the second amount.

230-11 Oxygen supplement—circumstances for applicability and amount

Circumstances for applicability

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

Amount

(2) The amount of oxygen supplement is $14.45.

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

Circumstances for applicability

(1) The circumstances in which enteral feeding supplement will apply to an individual for a day are that:

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(a) on the day, the care and services plan for the individual:
(i) covers the delivery of the funded aged care service meals and refreshments to the individual; and
(ii) includes supplying enteral supplementary dietary products to the individual; and
(b) a medical practitioner has certified, in writing, that the individual has a medical need for enteral feeding, other than for intermittent or supplementary enteral feeding given in addition to oral feeding.

Amount

(2) The amount of enteral feeding supplement is:
(a) for bolus feeding—$22.90; and
(b) for non-bolus feeding—$25.71.

Subdivision C—Accommodation supplement concepts

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

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

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

where:

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

low means resident means:
(a) an individual to whom the concessional resident supplement applies (see section 242B-25); or
(b) a supported individual; or
(c) a low means individual.

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

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

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

(1) The ***building status amount*** for an individual to whom funded aged care services are delivered in an approved residential care home for a day is:

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(a) if, on the day, each building in which funded aged care services are delivered to individuals in the home meets the privacy and space requirements that apply to the building under this section:
  (i) if the home is a newly built home or a significantly refurbished home—$72.30; or
  (ii) if the home is not a newly built home or a significantly refurbished home—$47.15; or
(b) if, on the day, each building in which funded aged care services are delivered to individuals in the home does not meet the privacy and space requirements that apply to the building under this section—$39.60.

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

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

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

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

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

Pre-end-July 1999 buildings

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

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

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

Working out numbers of individuals per toilet and shower

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

230-20 Meaning of *newly built home*

(1) An approved residential care home is a ***newly built home*** if:
  (a) each building in which funded aged care services are delivered to individuals in the home was completed on or after 20 April 2012; or
  (b) each building in which funded aged care services are delivered to individuals in the home was converted, on or after 20 April 2012, from one or more buildings that, before that date, were used for a purpose other than delivering funded aged care services care to individuals in an approved residential care home.

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

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

(1) If an approved residential care home of a registered provider has been significantly refurbished, the provider may apply, in the approved form, to the System Governor for a determination under subsection 230-30(1) in relation to the home.

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(2) If it is proposed that an approved residential care home of a registered provider be significantly refurbished, the provider may apply, in the approved form, to the System Governor for a determination under subsection 230-35(1) in relation to the home.

(3) An application must not relate to more than one approved residential care home.

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

(1) If the System Governor receives an application under subsection 230-25(1) in relation to an approved residential care home, the System Governor may determine, in writing, that the home is a significantly refurbished home.

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

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

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

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

(c) a significant proportion of the areas of the home that have been refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services are being delivered in the home;

(d) the refurbishment provides significant benefits to low means residents to whom funded aged care services are being delivered in the home;

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

(i) the refurbishment consisted of structural improvements; or

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

(f) the refurbishment:

(i) has resulted in at least 40% of the individuals to whom funded aged care services are being delivered in the home having an individual's room that has been significantly refurbished; or

(ii) provides a significant benefit to at least 40% of the individuals to whom funded aged care services are being delivered in the home; or

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

(g) the proportion of the total number of individual's rooms in the home that are available after the refurbishment for low means residents is equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the refurbishment for low means residents;

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

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

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

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

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

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

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

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

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

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

(1) If the System Governor receives an application under subsection 230-25(2) in relation to an approved residential care home, the System Governor may determine, in writing, that the home is a significantly refurbished home, subject to the condition that the determination does not take effect unless:

(a) after the refurbishment is completed, the registered provider of the home gives the System Governor, in the approved form, the information about the refurbished home referred to in subsection (3); and

(b) the System Governor notifies the registered provider under paragraph (5)(b) that the System Governor is satisfied, having regard to the information given by the registered provider, that the requirements referred to in paragraphs (3)(a) to (h) are met in relation to the refurbished home.

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

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

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

(b) a significant proportion of the areas of the home that are proposed to be refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services will be delivered in the home;

(c) the proposed refurbishment will provide significant benefits to low means residents to whom funded aged care services will be delivered in the home;

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

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

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

(e) the proposed refurbishment:

(i) will result in at least 40% of the individuals to whom funded aged care services will be delivered in the home having an individual's room that has been significantly refurbished; or

(ii) will provide a significant benefit to at least 40% of the individuals to whom funded aged care services will be delivered in the home; or

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

(f) the proportion of the total number of individual's rooms in the home that will be available after the proposed refurbishment for low means residents will be equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the proposed refurbishment for low means residents;

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

(3) For the purposes of paragraph (1)(a), the information about the refurbished home that the registered provider must give the System Governor is information showing the following:

(a) the proposed refurbishment has been completed;

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

(c) a significant proportion of the areas of the home that have been refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services are being delivered in the home;

(d) the refurbishment provides significant benefits to low means residents to whom funded aged care services are being delivered in the home;

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

(i) the refurbishment consisted of structural improvements; or

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

(f) the refurbishment:

(i) has resulted in at least 40% of the individuals to whom funded aged care services are being delivered in the home having an individual's room that has been significantly refurbished; or

(ii) provides a significant benefit to at least 40% of the individuals to whom funded aged care services are being delivered in the home; or

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

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(g) the proportion of the total number of individual's rooms in the home that are available after the refurbishment for low means residents is equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the refurbishment for low means residents;

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

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

(5) The System Governor must, within 28 days after receiving information from the registered provider in relation to the refurbished home:

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

(b) notify the registered provider, in writing, of the System Governor's decision.

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

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

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

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

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

(a) routine repairs; or

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

(c) replacement of furniture; or

(d) fire safety improvements.

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230-45 Notification of System Governor's decision

(1) The System Governor must notify, in writing, the applicant for a determination under subsection 230-30(1) or 230-35(1) of the System Governor's decision on whether to make the determination.

(2) If:
  (a) the decision relates to an application in relation to an approved residential care home that has been significantly refurbished; and
  (b) the decision is to make the determination;

the notice must state the day on which the determination takes effect under subsection 230-50(1).

(3) If:
  (a) the decision relates to an application in relation to an approved residential care home that is proposed to be significantly refurbished; and
  (b) the decision is to make the determination;

the notice must include a statement setting out the condition referred to in subsection 230-35(1) (including the information referred to in subsection 230-35(3)).

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

230-50 Day of effect of determination

(1) A determination under subsection 230-30(1) in relation to an approved residential care home that has been significantly refurbished takes effect on the day the application was received.

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

Subdivision D—Secondary person-centred supplements

231-5 Purpose of this Subdivision

For the purposes of section 231 of the Act, this Subdivision prescribes:
  (a) other secondary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care; and
  (b) the circumstances in which secondary person-centred supplements will apply to individuals for a day; and
  (c) the amounts of the supplements; and
  (d) that the fee reduction supplement reduces certain fees, payments and contributions, and the method for those reductions.

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

231-10 Other secondary person-centred supplements

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

Other secondary person-centred supplements

Item	Column 1 For an individual for a day for the following classification type for the service group residential care …	Column 2 the supplements are the following:
1	Ongoing	(a) initial entry adjustment supplement; (b) veterans' supplement.
2	Short-term	(a) respite supplement; (b) veterans' supplement.

231-15 Fee reduction supplement—circumstances for applicability, amount and reduction of fees and contributions—residential care fee reduction supplement determinations (financial hardship)

Circumstances for applicability of fee reduction supplement

(1) Circumstances in which the fee reduction supplement will apply to an individual for a day are that:

(a) an income determination is in effect for the individual for the day; and

(b) an asset determination is in effect for the individual for the day; and

(c) on the day, the individual does not have means not disclosed status; and

(d) on the day, the value of the individual's assets, worked out in accordance with section 330 of the Act and reduced by the value of any unrealisable assets, is not more than 1.5 times the sum of the annual amount of the following:

(i) the maximum basic rate under point 1064-B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple;

(ii) the pension supplement amount under point 1064-BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple;

(iii) the energy supplement amount under point 1064-C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple; and

(e) on the day, the individual has not gifted more than $10,000 in the current financial year or in any of the previous 4 financial years; and

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(f) on the day, the individual has not gifted more than $30,000 in the period comprising the current financial year and the previous 4 financial years; and

(g) on the day, a residential care fee reduction supplement determination is in effect for the individual; and

(h) the individual's daily remaining income amount for the day, as determined in the residential care fee reduction supplement determination, is less than the fee reduction supplement daily threshold amount for the day.

Amount of fee reduction supplement

(2) The amount of the fee reduction supplement for a day for an individual to whom the supplement applies under subsection (1) for the day is the amount equal to the difference between:

(a) the fee reduction supplement daily threshold amount for the day; and

(b) the individual's daily remaining income amount for the day, as determined in the residential care fee reduction supplement determination that is in effect for the individual on the day.

Fee reduction supplement reduces unreduced daily amount of the resident contribution

(3) The amount of the fee reduction supplement for a day for the individual reduces the amounts worked out under each of Steps 1, 3 and 4 of the method statement in subsection 277(1) of the Act in accordance with section 231-25.

231-16 Applications for residential care fee reduction supplement determinations

(1) An individual may apply to the System Governor for a residential care fee reduction supplement determination for the individual.

(2) An application must be in the approved form.

Note: For penalties for knowingly providing false or misleading information or documents in applications, see section 591 of the Act and Part 7.4 of the *Criminal Code*.

231-17 Residential care fee reduction supplement determinations

(1) The System Governor must, within 28 days from receiving an application in accordance with section 231-16, determine:

(a) the following for a particular day:

(i) the individual's daily total essential expenses;

(ii) the individual's daily remaining income amount;

(iii) the individual's unreduced daily amount of the resident contribution;

(iv) the individual's reduced daily amount of the resident contribution; and

(b) the day the determination takes effect; and

(c) the period for which the determination is in effect.

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Note: See also section 588 of the Act (which allows the System Governor to request further information, and provides for the consequence of not giving any requested further information in the requested time, and the extension of the decision-making period if requested information is given in the requested time).

(2) For the purposes of paragraph (1)(b):

(a) unless paragraph (b) applies—the System Governor must determine that the determination takes effect on the day the application was made; or

(b) the System Governor must determine that the determination takes effect on a day that is earlier than the day the application was made, if:

(i) the individual's application includes a request for the determination to take effect on an earlier day because the individual was experiencing financial hardship on and after the earlier day, and evidence of that financial hardship; and

(ii) the System Governor is satisfied that the individual was experiencing financial hardship on and after the earlier day.

Essential expenses

(3) Without limiting subparagraph (1)(a)(i), expenses that the System Governor may determine to be essential expenses in relation to an individual include the following:

(a) unreduced daily amounts of the resident contribution, and other fees and contributions payable by the individual under Division 2 of Part 3 of Chapter 4 of the Act, other than the higher everyday living fee under section 284 of the Act;

(b) accommodation payment or accommodation contribution;

(c) if the individual's partner (if any) or a dependent child of the individual lives at the individual's principal home—rent or mortgage payments for the principal home;

(d) any of the following that are not already covered by other government schemes or programs or by private health insurance:

(i) medical expenses, including expenses incurred under the direction of a registered health practitioner or allied health professional;

(ii) dental care;

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

(iv) artificial limbs, eyes or hearing aids;

(v) wheelchair and mobility aids;

(vi) transport costs to attend medical appointments;

(e) ambulance cover;

(f) private health insurance;

(g) if the individual is paying a funeral plan on a periodic basis—the funeral plan;

but do not include amounts that are spent by another person, who is authorised to act on the individual's behalf, other than for the benefit of the individual.

(4) The individual's ***daily total essential expenses*** is the amount that is the individual's total essential expenses, worked out on a per day basis.

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(5) The individual's ***daily remaining income amount*** for a day is worked out by subtracting the individual's daily total essential expenses for the day from the individual's total assessable income, as determined in the income determination that is in effect for the individual (worked out on a per day basis) on the day.

(6) The individual's ***unreduced daily amount of the resident contribution*** for a day is the amount that would be the amount of the maximum daily amount of the resident contribution payable by the individual for the day if subsection 277(4) of the Act were disregarded.

(7) The individual's ***reduced daily amount of the resident contribution*** for a day is the amount of the maximum daily amount of the resident contribution payable by the individual for the day after applying subsection 277(4) of the Act.

231-18 Notice of residential care fee reduction supplement determinations

(1) The System Governor must, within 14 days after making a residential care fee reduction supplement determination for an individual, give written notice of the determination to the individual.

(2) The notice must include:
  (a) each of the matters determined in the determination; and
  (b) the reasons for the following decisions:
    (i) the determination of the individual's daily total essential expenses;
    (ii) the day the determination takes effect;
    (iii) the period for which the determination is in effect; and
  (c) how the individual may apply for reconsideration of those decisions; and
  (d) a statement of the effect of section 231-19.

231-19 Varying or revoking residential care fee reduction supplement determinations—general

(1) The System Governor may vary or revoke a residential care fee reduction supplement determination for an individual:
  (a) if the System Governor has been notified of the occurrence of an event or a change in the individual's circumstances under Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act (see also sections 336-5 and 337-5 of this instrument); or
  (b) if an income determination or asset determination in relation to the individual is made, varied or revoked; or
  (c) if the individual has means not disclosed status under section 320 of the Act; or
  (d) on the System Governor's own initiative (see section 231-21 of this instrument).

(2) Without limiting subsection (1), the residential care fee reduction supplement determination may be varied or revoked if the System Governor is satisfied that the determination is incorrect.

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Effect of decision

(3) If a residential care fee reduction supplement determination is varied or revoked, the variation or revocation takes effect on the day specified by the System Governor in the notice under section 231-22.

(4) The day specified may be before the day the notice is given but must not be earlier than the day the circumstances that are the reason for the variation or revocation occurred.

231-20 Varying or revoking residential care fee reduction supplement determinations—on notification of event or change in circumstances

(1) This section applies if the System Governor has been notified of the occurrence of an event or a change in an individual's circumstances under Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act.

(2) The System Governor must decide, within 28 days from the day the notification is made, whether to vary or revoke the residential care fee reduction supplement determination in effect for the individual.

(3) The System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the residential care fee reduction supplement determination.

Note: The individual is not obliged to give the information.

(4) The System-Governor may, at the request of the individual, extend the specified period.

231-21 Varying or revoking residential care fee reduction supplement determinations—on System Governor's initiative

Notice before variation or revocation

(1) Before the System Governor varies or revokes a residential care fee reduction supplement determination under section 231-19 in relation to an individual on the System Governor's own initiative, the System Governor must give the individual written notice that the System Governor is considering varying or revoking the determination.

(2) The notice must:
  (a) set out the reasons why the System Governor is considering varying or revoking the determination, and what the effect of the variation or revocation would be; and
  (b) invite the individual to make a submission, in writing, to the System Governor in relation to the matter within the period specified in the notice (which must not be less than 28 days after giving the notice); and

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(c) inform the individual that the System Governor may decide to vary or revoke the determination:
(i) if no submission is made within the specified period; or
(ii) after considering any submission made by the individual within the specified period.

Request for further information

(3) The System Governor may also request, in the notice given under subsection (1), that the individual give the System Governor the information specified in the notice, within the period specified in the notice for the purposes of paragraph (2)(b), to assist the System Governor to decide whether to vary or revoke the determination.

Note: The individual is not obliged to give the information.

(4) If the individual makes a submission in accordance with the invitation under paragraph (2)(b), the System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the determination.

Note 1: The System Governor may request further information under this subsection regardless of whether information was requested or given under subsection (3).

Note 2: The individual is not obliged to give the information.

(5) The System-Governor may, at the request of the individual, extend the period specified for paragraph (2)(b) or subsection (4).

Deciding whether to vary or revoke fee reduction supplement determination

(6) The System Governor must:
(a) consider any submission made in accordance with the invitation under paragraph (2)(b) and any further information given in accordance with a request under subsection (3) or (4); and
(b) make a decision whether to vary or revoke the determination within 28 days from:
(i) if no submission is made in accordance with the invitation in the notice under paragraph (2)(b)—the end of the period specified in the notice (including that period as extended (if applicable) under subsection (5)); or
(ii) the later of:
(A) if a submission is made in accordance with the invitation in the notice under paragraph (2)(b) and no further information is requested under subsection (4)—the day the submission is made; and
(B) if a submission is made in accordance with the invitation in the notice under paragraph (2)(b) and further information is

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requested under subsection (4)—the day the individual gives the System Governor the further information.

231-22 Notice of decision to vary or revoke residential care fee reduction supplement determination

Notice requirements

(1) The System Governor must give an individual written notice of a decision under subsection 231-19(1) to vary or revoke a residential care fee reduction supplement determination for the individual within 14 days after making the decision.

(2) The notice under subsection (1) must:
  (a) state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act; and
  (b) if the decision is to vary the residential care fee reduction supplement determination:
    (i) include details of the variation (including specifying the amounts determined to be the individual's fortnightly total income amount and fortnightly total essential expenses); and
    (ii) specify the day the variation takes effect (see subsection 231-19(3)); and
  (c) if the decision is to revoke the residential care fee reduction supplement determination:
    (i) explain the consequences of the revocation of the determination; and
    (ii) specify the day the determination ceases to be in force (see subsection 231-19(3)); and
  (d) set out the reasons for the following decisions:
    (i) varying or revoking the determination under subsection 231-19(1);
    (ii) the day the variation or revocation takes effect under subsection 231-19(3); and
  (e) state how the individual may apply for reconsideration of the decision under subsection 231-19(1).

Copies to registered provider

(3) The System Governor must also give the registered provider delivering funded aged care services to the individual a copy of the notice referred to in subsection (1).

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

The fee reduction supplement for the individual reduces (but not below zero) the following for the individual, in the following order:
  (a) basic daily fee;

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(b) hotelling contribution;
(c) non-clinical care contribution;
(d) if the individual:
(i) is in the pre-2014 accommodation class—accommodation bond or accommodation charge (as applicable); and
(ii) otherwise—accommodation payment or accommodation contribution (as applicable).

231-30 Respite supplement—circumstances for applicability and amount

Circumstances for applicability

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

Amount

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

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

Circumstances for applicability

(1) The circumstances in which initial entry adjustment supplement will apply to an individual for a day are that:
(a) it is the first day an individual accesses a funded aged care service for the classification type ongoing through the service group residential care in an approved residential care home; and
(b) the individual was not accessing ongoing funded aged care services, other than under a specialist aged care program, in the home immediately before that day.

Amount

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

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

Circumstances for applicability

(1) The circumstances in which veterans' supplement will apply to an individual for a day are that:

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(a) the individual is a veteran with an accepted mental health condition; and
(b) the individual has, before, on or after that day, authorised either or both of the following to disclose to a registered provider that the individual is a veteran with an accepted mental health condition:
(i) the Secretary of the Department administered by the Minister administering the Veterans' Entitlements Act;
(ii) the Secretary of the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

Amount

(2) The amount of veterans' supplement is $8.18.

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Division 2—Provider-based subsidy

Subdivision A—Base provider amount

238-5 Base provider amount

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

Requirements and amount

Item	Column 1 **If the approved residential care home in which the registered provider delivered a funded aged care service to the individual on the day meets the following requirements …**	Column 2 **the amount is …**
1	The approved residential care home: (a) has specialised Aboriginal or Torres Strait Islander status; and (b) is located in the 2023 MM category known as MM 7	The amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 1.80
2	The approved residential care home: (a) has specialised Aboriginal or Torres Strait Islander status; and (b) is located in the 2023 MM category known as MM 6	The amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.78
3	All of the following apply: (a) the approved residential care home does not have specialised status; (b) the approved residential care home is located in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7; (c) the number of operational beds in respect of the approved residential care home is less than 30	The amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.68
4	All of the following apply: (a) the approved residential care home does not have specialised status; (b) the approved residential care home is located in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7; (c) the number of operational beds in respect of the approved residential care home is 30 or more	The sum of the following amounts: (a) the amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.68 and that the number of operational beds were 29; (b) the amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.52 and that the number of operational beds were reduced by 29

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Requirements and amount		
Item	**Column 1** **If the approved residential care home in which the registered provider delivered a funded aged care service to the individual on the day meets the following requirements …**	**Column 2** **the amount is …**
5	The approved residential care home: (a) does not have specialised status; and (b) is located in the 2023 MM category known as MM 4 or the 2023 MM category known as MM 5	The amount worked out by multiplying the national efficient price by the NWAU of 0.58
6	The approved residential care home has specialised homeless status	The amount worked out by multiplying the national efficient price by the NWAU of 0.92
7	The approved residential care home: (a) does not have specialised status; and (b) is located in the 2023 MM category known as MM 2 or the 2023 MM category known as MM 3	The amount worked out by multiplying the national efficient price by the NWAU of 0.53
8	The approved residential care home: (a) does not have specialised status; and (b) is located in the 2023 MM category known as MM 1	The amount worked out by multiplying the national efficient price by the NWAU of: (a) for a day before 1 April 2026—0.50; or (b) for a day on or after 1 April 2026—0.387

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

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

Subdivision B—Provider-based supplements

239-1 Purpose of this Subdivision

For the purposes of section 239 of the Act, this Subdivision prescribes:

(a) provider-based supplements for an individual for the classification types ongoing and short-term for the service group residential care for a day; and

(b) the circumstances in which the supplements will apply in relation to individuals; and

(c) the amounts of the supplements.

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239-5 Provider-based supplements

The following supplements are prescribed for the classification types ongoing and short-term for the service group residential care:

(a) registered nurse supplement;

(b) care minutes supplement.

239-10 Registered nurse supplement—applicability

Circumstances in which registered nurse supplement will apply in relation to an individual for a day are that funded aged care services are delivered to the individual in a qualifying residential care home for the payment period in which the day occurs.

239-15 Meaning of *qualifying residential care home*

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

(2) An approved residential care home is a ***group A residential care home*** for a payment period if all of the following criteria are met:

(a) an exemption from subsection 175(1) of the Act in relation to the approved residential care home is not in force at any time during the period;

(b) a report in relation to the approved residential care home and the period has been submitted in accordance with section 166-855 of this instrument;

(c) the total number of days of eligible residential funded aged care services delivered in respect of individuals in the approved residential care home during the period, divided by the number of days in the period, is no more than 50;

(d) the total number of hours, on days during the period on which funded aged care services were delivered in the home, that a registered nurse was not on site and on duty at the home is no more than the number of such days in the period multiplied by 3.

(3) An approved residential care home is a ***group B residential care home*** for a payment period if all of the following criteria are met:

(a) an exemption from subsection 175(1) of the Act in relation to the approved residential care home is not in force at any time during the period;

(b) a report in relation to the approved residential care home and the period has been submitted in accordance with section 166-855 of this instrument;

(c) the total number of days of eligible residential funded aged care services delivered in respect of individuals in the approved residential care home during the period, divided by the number of days in the period, is no more than 30;

(d) the total number of hours, on days during the period on which funded aged care services were delivered in the home, that a registered nurse was not on site and on duty at the home is:

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(i) more than the number of such days in the period multiplied by 3; and
(ii) no more than the number of such days in the period multiplied by 12.

(4) A ***day of eligible residential funded aged care services*** is delivered in respect of an individual if a registered provider is eligible for provider-based subsidy for an ongoing or short-term funded aged care service delivered by the registered provider to the individual in an approved residential care home on the day.

239-20 Registered nurse supplement—amount

(1) The amount of registered nurse supplement for an individual for a day during a payment period is:

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

where:

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

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

Residential care home supplement amount—group A residential care homes in 2023 MM category MM 1

(2) The residential care home supplement amount for a payment period, for a group A residential care home for the period located in the 2023 MM category known as MM 1, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group A residential care homes in 2023 MM category MM 1

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount ($)
1	Less than or equal to 20	28,786
2	More than 20 but less than or equal to 25	25,667
3	More than 25 but less than or equal to 30	14,009
4	More than 30 but less than or equal to 35	11,370
5	More than 35 but less than or equal to 40	8,732
6	More than 40 but less than or equal to 45	6,093
7	More than 45 but less than or equal to 50	3,454

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Residential care home supplement amount—group A residential care homes in 2023 MM categories MM 2 and MM 3

(3) The residential care home supplement amount for a payment period, for a group A residential care home for the period located in the 2023 MM category known as MM 2 or the 2023 MM category known as MM 3, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group A residential care homes in 2023 MM categories MM 2 and MM 3

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount ($)
1	Less than or equal to 20	30,536
2	More than 20 but less than or equal to 25	27,228
3	More than 25 but less than or equal to 30	14,860
4	More than 30 but less than or equal to 35	12,062
5	More than 35 but less than or equal to 40	9,263
6	More than 40 but less than or equal to 45	6,464
7	More than 45 but less than or equal to 50	3,664

Residential care home supplement amount—group A residential care homes in 2023 MM categories MM 4 and MM 5

(4) The residential care home supplement amount for a payment period, for a group A residential care home for the period located in the 2023 MM category known as MM 4 or the 2023 MM category known as MM 5, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group A residential care homes in 2023 MM categories MM 4 and MM 5

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount ($)
1	Less than or equal to 5	72,840
2	More than 5 but less than or equal to 10	61,804
3	More than 10 but less than or equal to 15	50,767
4	More than 15 but less than or equal to 20	39,731
5	More than 20 but less than or equal to 25	27,912
6	More than 25 but less than or equal to 30	15,234
7	More than 30 but less than or equal to 35	12,364
8	More than 35 but less than or equal to 40	9,495
9	More than 40 but less than or equal to 45	6,626
10	More than 45 but less than or equal to 50	3,756

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Residential care home supplement amount—group A residential care homes in 2023 MM categories MM 6 and MM 7

(5) The residential care home supplement amount for a payment period, for a group A residential care home for the period located in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group A residential care homes in 2023 MM categories MM 6 and MM 7

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount ($)
1	Less than or equal to 5	86,378
2	More than 5 but less than or equal to 10	73,290
3	More than 10 but less than or equal to 15	60,203
4	More than 15 but less than or equal to 20	47,115
5	More than 20 but less than or equal to 25	33,099
6	More than 25 but less than or equal to 30	18,065
7	More than 30 but less than or equal to 35	14,663
8	More than 35 but less than or equal to 40	11,261
9	More than 40 but less than or equal to 45	7,857
10	More than 45 but less than or equal to 50	4,455

Residential care home supplement amount—group B residential care homes in 2023 MM category MM 1

(6) The residential care home supplement amount for a payment period, for a group B residential care home for the period located in the 2023 MM category known as MM 1, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group B residential care homes in 2023 MM category MM 1

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount ($)
1	Less than or equal to 20	14,393
2	More than 20 but less than or equal to 25	12,834
3	More than 25 but less than or equal to 30	7,005

Residential care home supplement amount—group B residential care homes in 2023 MM categories MM 2 and MM 3

(7) The residential care home supplement amount for a payment period, for a group B residential care home for the period located in the 2023 MM category known

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as MM 2 or the 2023 MM category known as MM 3, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group B residential care homes in 2023 MM categories MM 2 and MM 3

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount ($)
1	Less than or equal to 20	15,268
2	More than 20 but less than or equal to 25	13,614
3	More than 25 but less than or equal to 30	7,431

Residential care home supplement amount—group B residential care homes in 2023 MM categories 4 and 5

(8) The residential care home supplement amount for a payment period, for a group B residential care home for the period located in the 2023 MM category known as MM 4 or the 2023 MM category known as MM 5, is the amount set out in the following table for the average daily care count for the home for the period.

Residential care home supplement amount—group B residential care homes in 2023 MM categories MM 4 and MM 5

Item	Column 1 Average daily care count	Column 2 Residential care home supplement amount ($)
1	Less than or equal to 5	36,421
2	More than 5 but less than or equal to 10	30,902
3	More than 10 but less than or equal to 15	25,384
4	More than 15 but less than or equal to 20	19,866
5	More than 20 but less than or equal to 25	13,956
6	More than 25 but less than or equal to 30	7,618

Residential care home supplement amount—group B residential care homes in 2023 MM categories MM 6 and MM 7

(9) The residential care home supplement amount for a payment period, for a group B residential care home for the period located in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7, is the amount set out in the following table for the average daily care count for the home for the period.

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Residential care home supplement amount—group B residential care homes in 2023 MM categories MM 6 and MM 7		
Item	**Column 1** **Average daily care count**	**Column 2** **Residential care home supplement amount ($)**
1	Less than or equal to 5	43,190
2	More than 5 but less than or equal to 10	36,646
3	More than 10 but less than or equal to 15	30,102
4	More than 15 but less than or equal to 20	23,558
5	More than 20 but less than or equal to 25	16,550
6	More than 25 but less than or equal to 30	9,033

Average daily care count

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

239-30 Care minutes supplement—applicability

Circumstances in which care minutes supplement will apply in relation to an individual for a day are that funded aged care services are delivered to the individual in an approved residential care home that meets the requirements in column 1 of item 8 in the table in subsection 238-5(1).

239-35 Care minutes supplement—amount

(1) The amount of care minutes supplement for the individual for a day before 1 April 2026 is nil.

General

(2) Subject to this section, the amount of care minutes supplement for the individual for a day in a quarter (the ***supplement quarter***) that starts on or after 1 April 2026 is the amount worked out by multiplying the national efficient price by the NWAU specified in the cell of the following matrix that corresponds to the following for the second most recent quarter (the ***delivery quarter***) before the supplement quarter for the approved residential care home:

(a) the average number of care minutes delivered in the home by direct care staff members of the provider per counted mainstream individual per day for the delivery quarter expressed as a percentage of the required combined staff average number of care minutes per individual per day worked out under subsection 176-20(1) in respect of the home for the delivery quarter;

(b) the average number of care minutes delivered in the home by registered nurse staff members and enrolled nurse staff members of the provider per counted mainstream individual per day for the delivery quarter, worked out

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in accordance with subsection (3) of this section, expressed as a percentage of the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) in respect of the home for the delivery quarter.

Matrix for care minutes supplement—amount

	Percentage for paragraph (2)(a)							
Percentage for paragraph (2)(b)	Less than 85%	At least 85% but less than 87.5 %	At least 87.5 % but less than 90%	At least 90% but less than 92.5 %	At least 92.5 % but less than 95%	At least 95% but less than 97.5 %	At least 97.5 % but less than 100%	At least 100%
Less than 85%	0	0.002	0.004	0.006	0.008	0.009	0.010	0.010
At least 85% but less than 87.5%	0.019	0.021	0.023	0.024	0.026	0.028	0.028	0.029
At least 87.5% but less than 90%	0.037	0.039	0.041	0.043	0.045	0.047	0.047	0.048
At least 90% but less than 92.5%	0.056	0.058	0.060	0.062	0.064	0.066	0.066	0.067
At least 92.5% but less than 95%	0.075	0.077	0.079	0.081	0.082	0.084	0.084	0.085
At least 95% but less than 97.5%	0.094	0.095	0.097	0.099	0.101	0.103	0.103	0.104
At least 97.5% but less than 100%	0.096	0.098	0.100	0.101	0.103	0.104	0.105	0.106
At least 100%	0.103	0.105	0.107	0.109	0.110	0.111	0.112	0.113

(3) For the purposes of paragraph (2)(b) of this section, the average number of care minutes delivered in the home by registered nurse staff members and enrolled nurse staff members of the provider per counted mainstream individual per day for the delivery quarter must be worked out disregarding the amount (if any) by which the average number of care minutes delivered in the home by enrolled nurse staff members of the provider per counted mainstream individual per day in the delivery quarter exceeds 10% of the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) in respect of the home for the delivery quarter.

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First approval of homes

(4) Despite subsection (2), the amount of care minutes supplement for the individual for a day in a quarter that starts on or after 1 April 2026 is the amount worked out by multiplying the national efficient price by the NWAU of 0.113 if:
  (a) the approval of the home under section 112 of the Act, or deemed approval of the home under section 120 of the Act, in relation to the provider delivering funded aged care services to the individual on the day, occurred in a quarter (the ***approval quarter***); and
  (b) the home had not previously been approved in relation to any other entity; and
  (c) the day is any of the following:
    (i) the day the home was approved under section 112 of the Act, or taken to be approved under section 120 of the Act;
    (ii) a subsequent day in the approval quarter;
    (iii) a day in the first, second or third quarter after the approval quarter.

(5) In paragraph (4)(a) of this section, the reference to approval under section 112 of the Act does not include a determination under subitem 5(7) or 7(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*.

Approval of homes in relation to different entities

(6) Despite subsection (2), the amount of care minutes supplement for the individual for a day in a quarter that starts on or after 1 April 2026 is the amount worked out by multiplying the national efficient price by the NWAU of 0.113 if:
  (a) the approval of the home under section 112 of the Act, or deemed approval of the home under section 120 of the Act, in relation to the provider delivering funded aged care services to the individual on the day, occurred in a previous quarter (the ***new approval quarter***); and
  (b) the home had previously been approved in relation to another entity; and
  (c) the day is a day in the first, second or third quarter after the new approval quarter.

Change from zero operational beds

(7) Despite subsection (2), the amount of care minutes supplement for the individual for a day in a quarter that starts on or after 1 April 2026 is the amount worked out by multiplying the national efficient price by the NWAU of 0.113 if:
  (a) the number of operational beds in respect of the home changed from 0 to greater than 0 during a quarter (the ***operational beds change quarter***); and
  (b) the day is any of the following:
    (i) the first day in the operational beds change quarter on which the number of operational beds in respect of the home was greater than 0;
    (ii) a subsequent day in the operational beds change quarter;
    (iii) a day in the first, second or third quarter after the operational beds change quarter.

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Change to meeting supplement applicability requirements

(8) Despite subsection (2), the amount of care minutes supplement for the individual for a day in a quarter that starts on or after 1 April 2026 is the amount worked out by multiplying the national efficient price by the NWAU of 0.113 if:

(a) the home began to meet the requirements in column 1 of item 8 in the table in subsection 238-5(1) during a quarter (the ***supplement applicability change quarter***); and

(b) the day is any of the following:

(i) the first day in the supplement applicability change quarter on which the home met the requirements in column 1 of item 8 in the table in subsection 238-5(1);

(ii) a subsequent day in the supplement applicability change quarter;

(iii) a day in the first, second or third quarter after the supplement applicability change quarter.

Rounding

(9) Amounts of care minutes supplement worked out under this section are to be rounded to the nearest cent (rounding 0.5 cents upwards).

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

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

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

For the purposes of subsection 242(2) of the Act, the standard base provider amount for a day for an individual is the amount worked out by multiplying the national efficient price by the NWAU of 0.50.

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Division 3—Subsidy for transitional cohorts

Subdivision A—Method for calculating amount of subsidy

242B-5 Amount of residential care subsidy—pre-2014 residential contribution class

For the purposes of section 242B of the Act, the amount of subsidy a registered provider is eligible for under section 242A of the Act for an ongoing funded aged care service delivered to an individual in the pre-2014 residential contribution class through the service group residential care on a day is worked out as follows:

Method statement

Step 1. Work out the sum of the following for the day (as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual):

(a) the individual's base rate (see section 229-5);

(b) the provider's base provider amount (see section 238-5).

Step 2. Add to the amount worked out under Step 1, the sum of the following amounts for the classification type ongoing for the service group residential care for the day that apply in relation to the individual:

(a) the accommodation supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-10, and that a reference in that section to the fee reduction supplement were a reference to the transitional fee reduction supplement);

(b) the oxygen supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-11);

(c) the enteral feeding supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-12);

(d) the transitional accommodation supplement (see section 242B-10);

(e) the 2012 basic daily fee supplement (see section 242B-15);

(f) the accommodation charge top-up supplement (see section 242B-20);

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(g) the concessional resident supplement (see section 242B-25).

Step 3. Subtract (but not below zero) from the amount worked out under Step 2, the sum of the following:

(a) the income tested fee for the individual for the day (see section 285A-13);

(b) any transitional compensation payment reduction amount that applies to the individual for the day (see section 242B-55).

Step 4. Add to the amount worked out under Step 3, the sum of the following amounts for the classification type ongoing for the service group residential care for the day that apply to the individual:

(a) the hotelling supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-5);

(b) the transitional fee reduction supplement (see section 242B-27);

(c) the initial entry adjustment supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 231-35);

(d) the veterans' supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 231-50);

(e) the pensioner supplement (see section 242B-40);

(f) the registered nurse supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see sections 239-10, 239-15 and 239-20);

(g) the ex-hostel supplement (see section 242B-45).

242B-6 Amount of residential care subsidy—post-2014 residential contribution class

For the purposes of section 242B of the Act, the amount of subsidy a registered provider is eligible for under section 242A of the Act for an ongoing funded aged care service delivered to an individual in the post-2014 residential contribution class through the service group residential care on a day is worked out as follows:

Method statement

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Step 1. Work out the sum of the following for the day (as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual):

(a) the individual's base rate (see section 229-5);

(b) the provider's base provider amount (see section 238-5).

Step 2. Add to the amount worked out under Step 1, the sum of the following amounts for the classification type ongoing for the service group for the day that apply in relation to the individual (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual):

(a) the oxygen supplement (see section 230-11);

(b) the enteral feeding supplement (see section 230-12).

Step 3. Subtract (but not below zero) from the amount worked out under Step 2, the sum of the following:

(a) the means tested care fee for the individual for the day (see section 285A-14);

(b) any transitional compensation payment reduction amount that applies to the individual for the day (see sections 242B-50 and 242B-55).

Step 4. Add to the amount worked out under Step 3, the sum of the following amounts for the classification type ongoing for the service group for the day that apply to the individual:

(a) the hotelling supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-5);

(b) the accommodation supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-10, and that a reference in that section to the fee reduction supplement were a reference to the transitional fee reduction supplement);

(c) the transitional fee reduction supplement (see section 242B-27);

(d) the initial entry adjustment supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 231-35);

(e) the veterans' supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 231-50);

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(f) the registered nurse supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see sections 239-10, 239-15 and 239-20).

Subdivision B—Supplements

242B-10 Transitional accommodation supplement—circumstances for applicability and amount

Circumstances for applicability

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

Amount

(2) The amount of the transitional accommodation supplement for a day for an individual is the amount that is the difference between:
(a) the amount specified in the following table for the day on which the individual entered residential care (within the meaning of the old Act); and
(b) the amount of accommodation supplement that would apply for the individual for the day if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual.

Entry day and amount

Item	Column 1 Entry day	Column 2 Amount ($)
1	After 19 March 2008 and before 20 September 2010	10.77
2	After 19 September 2010 and before 20 March 2011	7.18
3	After 19 March 2011 and before 20 September 2011	3.59

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

242B-15 2012 basic daily fee supplement—circumstances for applicability and amount

Circumstances for applicability

(1) The circumstances in which 2012 basic daily fee supplement will apply to an individual for a day are that:
(a) the individual is in the pre-2014 residential contribution class; and

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(b) immediately before the transition time, the individual was eligible for 2012 basic daily fee supplement under section 39 of the *Aged Care (Transitional Provisions) Principles 2014*; and
(c) the individual has a classification level for the classification type ongoing for the service group residential care in effect; and
(d) the provider charged the individual for the day at least 1% less than the transitional basic daily fee that the provider could have charged the individual for that day.

Amount

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

242B-20 Accommodation charge top-up supplement—circumstances for applicability and amount

Circumstances for applicability

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

Amount

(2) The amount of the accommodation charge top-up supplement for a day for an individual is the amount that is the difference between:
(a) the maximum daily amount at which an accommodation charge would accrue under section 57A-6 of the *Aged Care (Transitional Provisions) Act 1997* for the entry of the individual to the residential care service (within the meaning of that Act) in question if the individual were not receiving an income support payment (within the meaning of that Act) on the day of entry; and
(b) the maximum daily amount at which an accommodation charge would accrue under subsection 118(2) of the *Aged Care (Transitional Provisions) Principles 2014* for the entry of the individual to the service if the individual were a post-2008 reform resident (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*) who was receiving an income support payment (within the meaning of that Act) on that day.

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

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242B-25 Concessional resident supplement—circumstances for applicability and amount

Circumstances for applicability

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

Amount

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

242B-27 Transitional fee reduction supplement—circumstances for applicability and amount

Circumstances for applicability of transitional fee reduction supplement

(1) Circumstances in which the transitional fee reduction supplement will apply to an individual for a day are that:
  (a) an income determination is in effect for the individual for the day; and
  (b) an asset determination is in effect for the individual for the day; and
  (c) on the day, the individual does not have means not disclosed status; and
  (d) on the day, the value of the individual's assets, worked out in accordance with subsection (2) and reduced by the value of any unrealisable assets, is not more than 1.5 times the sum of the annual amount of the following:
    (i) the maximum basic rate under point 1064-B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple;

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(ii) the pension supplement amount under point 1064-BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple;

(iii) the energy supplement amount under point 1064-C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple; and

(e) on the day, the individual has not gifted more than $10,000 in the current financial year or in any of the previous 4 financial years; and

(f) on the day, the individual has not gifted more than $30,000 in the period comprising the current financial year and the previous 4 financial years; and

(g) on the day, a residential care fee reduction supplement determination is in effect for the individual; and

(h) the individual's daily remaining income amount for the day, as determined in the residential care fee reduction supplement determination, is less than the fee reduction supplement daily threshold amount for the day.

(2) The value of the individual's assets is to be worked out:

(a) for an individual in the post-2014 residential contribution class—in accordance with section 330 of the Act; or

(b) for an individual in the pre-2014 residential contribution class—in accordance with section 330 of the Act but:

(i) taking into account only the assets of the individual of the kinds referred to in subsection 44(2) of the *Aged Care (Transitional Provisions) Principles 2014* as in force immediately before the transition time; and

(ii) disregarding subsection 330(7) of the Act (value of home).

Amount of transitional fee reduction supplement

(3) The amount of the transitional fee reduction supplement for a day for an individual to whom the supplement applies under subsection (1) for the day is the amount equal to the difference between:

(a) the fee reduction supplement daily threshold amount for the day; and

(b) the individual's daily remaining income amount for the day, as determined in the residential care fee reduction supplement determination that is in effect for the individual on the day.

Transitional fee reduction supplement determinations

(4) For the purposes of paragraph (1)(h) and subsection (3), sections 231-16 to 231-22 apply as though:

(a) Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual; and

(b) a reference in those sections to a fee reduction supplement were a reference to a transitional fee reduction supplement.

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Reduction of fees, contributions and payments

(5) For an individual in the pre-2014 residential contribution class, the transitional fee reduction supplement for the individual reduces (but not below zero) the following for the individual, in the following order:
  (a) transitional basic daily fee;
  (b) income tested fee;
  (c) accommodation bond or accommodation charge (as applicable).

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

242B-40 Pensioner supplement—circumstances for applicability and amount

Circumstances for applicability

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

Amount

(2) The amount of the pensioner supplement for a day for an individual is $10.77.

242B-45 Ex-hostel supplement—circumstances for applicability and amount

Circumstances for applicability

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

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(d) the individual has a classification level for the classification type ongoing for the service group residential care in effect; and
(e) the provider charged the individual for the day at least $0.80 less than the transitional basic daily fee that the provider could have charged the individual for that day.

Amount

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

Subdivision C—Transitional compensation payment reduction

242B-50 Transitional compensation payment reduction amount—circumstances for applicability

(1) A transitional compensation payment reduction for subsidy applies to an individual for a day if:
(a) the individual is entitled to compensation under a judgment, settlement or reimbursement arrangement (whether the judgment, settlement or reimbursement arrangement occurred before or after the transition time); and
(b) the compensation takes into account the future costs of delivering funded aged care services (however described) to the individual on that day; and
(c) the application of transitional compensation payment reductions to the individual for preceding days has not resulted in reductions in subsidy that, in total, exceed or equal the part of the compensation that relates, or is to be treated under subsection (2) or (3) as relating, to future costs of delivering funded aged care services (however described) to the individual.

Determinations relating to future costs of delivering funded aged care services

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

(3) If:
(a) an individual is entitled to compensation under a settlement; and
(b) the settlement takes into account the future costs of delivering funded aged care services (however described) to the individual; and
(c) the System Governor is satisfied that the settlement does not adequately take into account those future costs;

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the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual, the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.

(4) In making a determination under subsection (2) or (3):

(a) the System Governor must take into account the following matters:

(i) the amount of the judgment or settlement;

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

(iii) the proportion of liability apportioned to the individual;

(iv) the amounts spent on delivering funded aged care services (however described) to the individual at the time of the judgment or settlement; and

(b) the System Governor may take into account any other matters the System Governor considers relevant, including the following:

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

(ii) the amounts spent on care (other than funded aged care services (however described)) at the time of the judgment or settlement;

(iii) the likely future costs of delivering funded aged care services to the individual;

(iv) other costs of care for which the individual is likely to be liable;

(v) other reasonable amounts, not related to care, that the individual has spent at the time of the judgment or settlement, or is likely to be liable for.

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

(a) loss of income;

(b) costs of future care.

242B-55 Amount of transitional compensation payment reduction

Non-lump sum compensation with stated proportion of liability

(1) The amount of a transitional compensation payment reduction for subsidy for an individual for a day is worked out under subsection (2) if:

(a) the individual is entitled to compensation under a judgment or settlement; and

(b) the compensation is not paid in a lump sum; and

(c) the judgment or settlement states the individual's proportion of liability; and

(d) subsection (5) does not apply in relation to the individual.

(2) The amount of the transitional compensation payment reduction for subsidy for the individual for the day is that proportion of the sum of the following:

(a) whichever of the following amounts apply:

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(i) if the individual is in the pre-2014 residential contribution class—the amount worked out at Step 1 of the method statement in section 242B-5 (see also subsection (2A));

(ii) if the individual is in the post-2014 residential contribution class—the amount worked out at Step 1 of the method statement in section 242B-6 (see also subsection (2A));

(b) if oxygen supplement applies to the individual for the day—the amount of that supplement for the day;

(c) if enteral feeding supplement applies to the individual for the day—the amount of that supplement for the individual for the day.

(2A) For the purposes of subparagraph (2)(a)(i) or (ii), when working out the provider's base provider amount at paragraph (b) of Step 1 of the method statement in section 242B-5 or 242B-6 (as the case requires), assume that item 8 of the table in subsection 238-5(1) applies to the provider.

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

(3) The amount of a transitional compensation payment reduction for subsidy for an individual for a day is worked out under subsection (4) if:

(a) the individual is entitled to compensation under a judgment or settlement; and

(b) the compensation is paid in a lump sum; and

(c) the judgment or settlement states the amount or proportion of the lump sum that relates to future costs of delivering funded aged care services (however described) to the individual; and

(d) subsection (5) does not apply to the individual.

(4) The amount of the transitional compensation payment reduction for subsidy for the individual for the day is the lesser of the following:

(a) the amount, or the amount of the proportion, mentioned in paragraph (3)(c), reduced (but not below zero) by the total of the amounts of transitional compensation payment reduction for subsidy for the individual for preceding days;

(b) the sum of the following:

(i) the amount mentioned in subsection (4A);

(ii) if oxygen supplement applies to the individual for the day—the amount of that supplement for the day;

(iii) if enteral feeding supplement applies to the individual for the day—the amount of that supplement for the individual for the day.

(4A) For the purposes of subparagraph (4)(b)(i), the amount is whichever of the following apply:

(a) if the individual is in the pre-2014 residential contribution class—the amount worked out at Step 1 of the method statement in section 242B-5 (see also subsection (4B));

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(a) if the individual is in the post-2014 residential contribution class—the amount worked out at Step 1 of the method statement in section 242B-6 (see also subsection (4B)).

(4B) For the purposes of paragraph (4A)(a) or (b), when working out the provider's base provider amount at paragraph (b) of Step 1 of the method statement in section 242B-5 or 242B-6 (as the case requires), assume that item 8 of the table in subsection 238-5(1) applies to the provider.

Requirements for determining transitional compensation payment reductions for circumstances in which compensation information not known

(5) This section applies in relation to an individual if the System Governor believes, on reasonable grounds, that:
(a) an individual is entitled to a transitional compensation payment reduction in accordance with section 242B-50; and
(b) the System Governor does not have sufficient information to work out the transitional compensation payment reduction for the purposes of that section.

(6) The System Governor may, by notice in writing given to a person, require the person to give information or produce a document that is in the person's custody, or under the person's control, if the System Governor believes on reasonable grounds that the information or document may be relevant to working out of the transitional compensation payment reduction.

(7) The notice must specify:
(a) how the person is to give the information or produce the document; and
(b) the period within which the person is to give the information or produce the document; and
(c) the effect of subsection (8).

(8) If the information or document is not given or produced within the specified period, the System Governor may determine the transitional compensation payment reduction amount for the individual for the day, taking into account the following:
(a) the matter mentioned in subparagraph 242B-50(4)(a)(iv);
(b) any other matters the System Governor considers relevant, including the following (to the extent that the matters are known to the System Governor):
(i) the matters mentioned in subparagraphs 242B-50(4)(a)(i) to (iii);
(ii) the matters mentioned in paragraph 242B-50(4)(b).

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Division 4—Approved residential care homes with specialised status

Subdivision A—Specialised status determinations

243-5 Kinds of specialised status

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

(a) specialised Aboriginal or Torres Strait Islander status;

(b) specialised homeless status.

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

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

(a) whether, on the day before the application under subsection 243(1) of the Act in relation to the home was made:

(i) the home was located in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7; and

(ii) at least 50% of the individuals to whom funded aged care services were delivered in the home, other than individuals to whom funded aged care services were delivered under a specialist aged care program, were Aboriginal or Torres Strait Islander persons;

(b) whether the registered provider that delivers funded aged care services in the home, or a responsible person of the provider, has demonstrated experience in providing, or the capacity to provide, specialist Aboriginal or Torres Strait Islander programs;

(c) whether:

(i) the provider is delivering specialist Aboriginal or Torres Strait Islander programs in the home; or

(ii) the provider has given a written undertaking that the provider will begin delivering specialist Aboriginal or Torres Strait Islander programs in the home within 3 months after the application is made.

243-15 Specialised homeless status—criteria

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

(a) whether, on the day before the application under subsection 243(1) of the Act in relation to the home was made, at least 50% of the individuals to whom funded aged care services were delivered in the home, other than individuals to whom funded aged care services were delivered under a

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specialist aged care program, demonstrated complex behavioural needs and social disadvantage associated with their background as a homeless person;

(b) whether the registered provider that delivers funded aged care services in the home, or a responsible person of the provider, has demonstrated experience in providing, or the capacity to provide, specialist homeless programs;

(c) whether:

(i) the provider is delivering specialist homeless programs in the home; or

(ii) the provider has given a written undertaking that the provider will begin delivering specialist homeless programs in the home within 3 months after the application is made.

243-20 Specialised status—maximum period of effect

For the purposes of paragraph 243(5)(c) of the Act, the period of 3 years is prescribed.

Subdivision B—Revoking specialised status determinations on initiative of System Governor—circumstances

243A-5 Purpose of this Subdivision

For the purposes of subsection 243A(1) of the Act, this Subdivision prescribes circumstances in which the System Governor may revoke a determination made under subsection 243(3) of the Act in relation to a registered provider and an approved residential care home.

243A-10 Circumstances—transfer of approved residential care home to another registered provider

The circumstances prescribed by this section are that the Commissioner:

(a) under subsection 138(1) or (2) of the Act, revokes the approval of the approved residential care home in relation to the registered provider; and

(b) under subsection 112(1) of the Act, approves the residential care home in relation to another registered provider.

243A-15 Circumstances—revocation of specialised status and determination of different specialised status

The circumstances prescribed by this section are that:

(a) the determination is that the approved residential care home has a particular kind of specialised status; and

(b) the System Governor has decided to determine that the approved residential care home has a different kind of specialised status.

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243A-20 Circumstances—revocation of specialised Aboriginal or Torres Strait Islander status

(1) The circumstances prescribed by this section are that:
  (a) the determination is that the approved residential care home has specialised Aboriginal or Torres Strait Islander status; and
  (b) the System Governor is satisfied that:
    (i) for 3 consecutive payment periods, the Aboriginal or Torres Strait Islander care percentage for the home for the payment period was less than 50%; or
    (ii) the registered provider did not deliver specialist Aboriginal or Torres Strait Islander programs in the home on any day after the end of the period of 3 months after the application for the determination was made.

Aboriginal or Torres Strait Islander care percentage

(2) For the purposes of subparagraph (1)(b)(i), the Aboriginal or Torres Strait Islander care percentage for an approved residential care home for a payment period is worked out using the following formula:

$$\frac{\text{care for Aboriginal or Torres Strait Islander residents}}{\text{care for all residents}} \times 100$$

where:

care for Aboriginal or Torres Strait Islander residents means the total number of days in the payment period on which ongoing funded aged care services were delivered through the service group residential care to individuals in the home who are Aboriginal or Torres Strait Islander persons.

care for all residents means the total number of days in the payment period on which ongoing funded aged care services were delivered through the service group residential care to individuals in the home.

243A-25 Circumstances—revocation of specialised homeless status

(1) The circumstances prescribed by this section are that:
  (a) the determination is that the approved residential care home has specialised homeless status; and
  (b) the System Governor is satisfied that:
    (i) for 3 consecutive payment periods, the homeless care percentage for the home for the payment period was less than 50%; or
    (ii) the registered provider did not deliver specialist homeless programs in the home on any day after the end of the period of 3 months after the application for the determination was made.

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Homeless care percentage

(2) For the purposes of subparagraph (1)(b)(i), the homeless care percentage for an approved residential care home for a payment period is worked out using the following formula:

$$\frac{\text{care for homeless residents}}{\text{care for all residents}} \times 100$$

where:

care for all residents means the total number of days in the payment period on which ongoing funded aged care services were delivered through the service group residential care to individuals in the home.

care for homeless residents means the total number of days in the payment period on which ongoing funded aged care services were delivered through the service group residential care to individuals in the home who demonstrate complex behavioural needs and social disadvantage associated with their background as homeless persons.

Subdivision D—Revoking specialised status determinations on initiative of System Governor—notice requirements

243A-40 Purpose of this Subdivision

This Subdivision prescribes requirements for notices given, under subsection 243A(1) of the Act, of revocations of determinations made under subsection 243(3) of the Act in relation to a registered provider and an approved residential care home.

243A-45 Transfer of approved residential care home to another registered provider

If the circumstances set out in section 243A-10 of this instrument apply in relation to the determination, the notice given under subsection 243A(1) of the Act to the registered provider in relation to which the Commissioner has revoked the approval of the residential care home must:

(a) include reasons for the decision to revoke the determination; and

(b) include details about how the registered provider may apply for the reconsideration of the decision to revoke the determination; and

(c) state that the registered provider in relation to which the Commissioner has approved the home may, under subsection 243(1) of the Act, apply to the System Governor for a determination under subsection 243(3) of the Act that the home has specialised status.

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243A-50 Revocation of specialised status

If the circumstances set out in section 243A-20 or 243A-25 of this instrument apply in relation to the determination, the notice given under subsection 243A(1) of the Act to the registered provider must:

(a) include reasons for the decision to revoke the determination; and

(b) include details about how the registered provider may apply for the reconsideration of the decision to revoke the determination.

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

246A-5 Circumstances in which compensation information known

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

(a) a compensation payment reduction for person-centred subsidy; and

(b) a compensation payment reduction for provider-based subsidy;

apply to an individual for a day are that:

(c) the individual is entitled to compensation under a judgment, settlement or reimbursement arrangement (whether the judgment, settlement or reimbursement arrangement occurred before or after the transition time); and

(d) the compensation takes into account the future costs of delivering funded aged care services (however described) to the individual on that day; and

(e) the application of compensation payment reductions to the individual for preceding days has not resulted in reductions in subsidy that, in total, exceed or equal the part of the compensation that relates, or is to be treated under subsection (2) or (3) as relating, to future costs of delivering funded aged care services (however described) to the individual.

Determinations relating to future costs of delivering funded aged care services

(2) If an individual is entitled to compensation under a judgment or settlement that does not take into account the future costs of delivering funded aged care services (however described) to the individual, the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual:

(a) that, for the purposes of this section, the judgment or settlement is to be treated as having taken into account those future costs; and

(b) the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.

(3) If:

(a) an individual is entitled to compensation under a settlement; and

(b) the settlement takes into account the future costs of delivering funded aged care services (however described) to the individual; and

(c) the System Governor is satisfied that the settlement does not adequately take into account those future costs;

the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual, the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.

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(4) In making a determination under subsection (2) or (3):
  (a) the System Governor must take into account the following matters:
    (i) the amount of the judgment or settlement;
    (ii) for a judgment—the components stated in the judgment and the amount stated for each component;
    (iii) the proportion of liability apportioned to the individual;
    (iv) the amounts spent on delivering funded aged care services (however described) to the individual at the time of the judgment or settlement; and
  (b) the System Governor may take into account any other matters the System Governor considers relevant, including the following:
    (i) the amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;
    (ii) the amounts spent on care (other than funded aged care services (however described)) at the time of the judgment or settlement;
    (iii) the likely future costs of delivering funded aged care services to the individual;
    (iv) other costs of care for which the individual is likely to be liable;
    (v) other reasonable amounts, not related to care, that the individual has spent at the time of the judgment or settlement, or is likely to be liable for.

Note: For subparagraph (4)(a)(ii), examples of the components of a judgment include the following:
(a) loss of income;
(b) costs of future care.

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

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

Non-lump sum compensation with stated proportion of liability

(2) Subsections (3) and (4) apply if:
  (a) the individual is entitled to compensation under a judgment or settlement; and
  (b) the compensation is not paid in a lump sum; and
  (c) the judgment or settlement states the individual's proportion of liability.

(3) The amount of the compensation payment reduction for person-centred subsidy for the individual for the day is that proportion of the sum of the following:
  (a) the amount of the base rate for the individual for the day;
  (b) if oxygen supplement applies to the individual for the day—the amount of that supplement for the day;
  (c) if enteral feeding supplement applies to the individual for the day—the amount of that supplement for the individual for the day.

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

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

(5) Subsections (6) and (7) apply if:
  (a) the individual is entitled to compensation under a judgment or settlement; and
  (b) the compensation is paid in a lump sum; and
  (c) the judgment or settlement states the amount or proportion of the lump sum that relates to future costs of delivering funded aged care services (however described) to the individual.

(6) The amount of the compensation payment reduction for person-centred subsidy for the individual for the day is the lesser of the following:
  (a) the amount, or the amount of the proportion, mentioned in paragraph (5)(c), reduced (but not below zero) by the total of the amounts of compensation payment reduction for person-centred subsidy for the individual and compensation payment reduction for provider-based subsidy for the individual for preceding days;
  (b) the sum of the following:
    (i) the amount of the base rate for the individual for the day;
    (ii) if oxygen supplement applies to the individual for the day—the amount of that supplement for the day;
    (iii) if enteral feeding supplement applies to the individual for the day—the amount of that supplement for the individual for the day.

(7) The amount of the compensation payment reduction for provider-based subsidy for the individual for the day is the lesser of the following:
  (a) the amount, or the amount of the proportion, mentioned in paragraph (5)(c), reduced (but not below zero) by the total of the amounts of compensation payment reduction for person-centred subsidy for the individual and compensation payment reduction for provider-based subsidy for the individual for preceding days;
  (b) the standard base provider amount for the day for the individual.

246A-15 Circumstances in which compensation information not known

For the purposes of subsections 199(1), 216(1), 225(1), 233(1) and 241(1) of the Act, circumstances in which:
  (a) a compensation payment reduction for person-centred subsidy; and
  (b) a compensation payment reduction for provider-based subsidy;

apply to an individual for a day are that section 234 of the Act applies in relation to section 199, 216, 225, 233 or 241 of the Act (as applicable).

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Section 246A-20

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

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

(a) the System Governor must take into account the matter mentioned in subparagraph 246A-5(4)(a)(iv) of this instrument; and

(b) the System Governor may take into account any other matters the System Governor considers relevant, including the following (to the extent that the matters are known to the System Governor):

(i) the matters mentioned in subparagraphs 246A-5(4)(a)(i) to (iii) of this instrument;

(ii) the matters mentioned in paragraph 246A-5(4)(b) of this instrument.

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Part 9—Subsidy for certain specialist aged care programs

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

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

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

(a) the System Governor is satisfied that:
  (i) the entity, once registered as a registered provider, will deliver funded aged care services in an approved residential care home; and
  (ii) the entity will also deliver a health service in the same location as the home; and
  (iii) the home is not located in the 2023 MM category known as MM 1; and
  (iv) there has been adequate consultation about the delivery of funded aged care services by the entity as a registered provider;

(b) taking into account the outcomes of the consultation and the views of the State or Territory in which the home is located, the System Governor is satisfied that:
  (i) there is a demonstrated need for the delivery of funded aged care services under the MPSP to improve access to those services for individuals in the area surrounding the home; and
  (ii) it will be viable to have an arrangement for the integrated delivery of funded aged care services and health services in that area.

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

For the purposes of paragraph 247(4)(b) of the Act, the requirements that an agreement under paragraph 247(1)(b) of the Act (for the Transition Care Program) must meet are that:

(a) the agreement must state the following:
  (i) the period of the agreement;
  (ii) the circumstances in which the agreement can be varied or terminated;
  (iii) any conditions the System Governor considers necessary for the effective delivery of funded aged care services under the Program, that are not conditions of registration (see Part 4 of Chapter 3 of the Act) or conditions of the allocation of a place for the Program (see section 95 of the Act);

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(iv) any indemnity or insurance requirements that an entity is required to satisfy to be allocated a place for the Program under section 95 of the Act; and

(b) the agreement will take effect only if, and takes effect on the day that, the arrangement covered by the agreement meets the following requirements:

(i) the arrangement is for the delivery of funded aged care services to an individual after the conclusion of a hospital episode, and is targeted towards older people;

(ii) the funded aged care services delivered to an individual under the arrangement always include services in the service type assistance with transition care;

(iii) the delivery of services to an individual under the arrangement is time-limited; and

(c) the agreement will cease to have effect if the arrangement covered by the agreement ceases to meet the requirements referred to in paragraph (b).

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

249-5 Purpose of Division

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

249-10 Amount of subsidy

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

$$ACWSA + BDFSA + DCSA + DVEA + HCAA + HCPA + RCPA + RSEA + VEA$$

where:

ACWSA is the amount worked out by multiplying:

(a) the aged care wage supplement amount that applies under section 249-25 for the day for a place for the home; and

(b) the sum of the number of home or community places for the home, and the number of residential care places for the home, that are in effect on the day.

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

Note: BDFSA is short for the basic daily fee supplement amount.

DCSA is the amount worked out by multiplying:

(a) the direct care supplement amount that applies under section 249-30 for the day for a residential care place for the home; and

(b) the number of residential care places for the home that are in effect on the day.

DVEA is the amount worked out by multiplying the number of home or community places for the home that are in effect on the day by $1.39.

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

HCAA is the amount worked out by multiplying:

(a) the home or community additional amount that applies under section 249-35 for the day for a home or community place for the home; and

(b) the number of home or community places for the home that are in effect on the day.

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HCPA is the amount worked out by multiplying the number of home or community places for the home that are in effect on the day by $48.16.

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

RCPA is the amount worked out by multiplying:

(a) the residential care place amount that applies under section 249-40 for the day for a residential care place for the home; and

(b) the number of residential care places for the home that are in effect on the day.

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

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

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

249-25 Aged care wage supplement amount

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

Aged care wage supplement amount

Item	Column 1 Registered provider	Column 2 Amount ($)
1	Churches of Christ Care in Queensland	28.41
2	Huon Eldercare Limited	33.29
3	Norfolk Island Health and Residential Aged Care Services	16.14
4	Any other person	0.00

249-30 Direct care supplement amount

(1) The direct care supplement amount for a day for a residential care place for an approved residential care home is:

(a) if the home is in a State or Territory covered by subsection (2):

(i) if the home is located in a 2023 MM category mentioned in an item of the following table, and is not Injune—the amount (if any) specified in the item of the table for the 2023 MM category for the home's location; or

(ii) if the home is Injune—the amount (if any) specified in the item of the table for the 2023 MM category known as MM 7; or

(b) if paragraph (a) does not apply—nil.

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Direct care supplement amount

Item	Column 1 2023 MM category for the home's location	Column 2 Amount ($)
1	2023 MM category known as MM 2	0.00
2	2023 MM category known as MM 3	0.00
3	2023 MM category known as MM 4	16.35
4	2023 MM category known as MM 5	16.35
5	2023 MM category known as MM 6	17.75
6	2023 MM category known as MM 7	18.28

(2) This subsection covers a State or Territory that is participating in a trial that aims to ensure that set amounts of direct care are provided to individuals accessing funded aged care services through the residential care service group under the MPSP.

(3) The System Governor must, by notice published on the Department's website, specify each State or Territory covered by subsection (2).

249-35 Home or community additional amount

(1) The home or community additional amount for a day for a home or community place for an approved residential care home is:

(a) for a home or community place to which subsection (2) does not apply—the 2023 MM category additional amount for a day for a home or community place for the home; and

(b) for a home or community place to which subsection (2) applies—the ARIA value additional amount for a day for a home or community place for the home.

(2) This subsection applies to a home or community place for an approved residential care home on a day if:

(a) the home is a Category A residential care home, a Category B residential care home or a Category C residential care home; and

(b) on the day, the ARIA value additional amount for a day for a home or community place for the home is greater than the 2023 MM category additional amount for a day for a home or community place for the home.

ARIA value additional amount

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

ARIA value additional amount

Item	Column 1 ARIA value for the home's location	Column 2 Amount ($)
1	0 to 3.51 inclusive	0.00

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ARIA value additional amount		
Item	**Column 1** **ARIA value for the home's location**	**Column 2** **Amount ($)**
2	3.52 to 4.66 inclusive	6.30
3	4.67 to 5.80 inclusive	7.54
4	5.81 to 7.44 inclusive	10.55
5	7.45 to 9.08 inclusive	12.65
6	9.09 to 10.54 inclusive	17.72
7	10.55 to 12 inclusive	21.29

2023 MM category additional amount

(4) The 2023 MM category additional amount, for a day for a home or community place for an approved residential care home, means:

(a) for a home other than Injune—the amount specified in the following table for the 2023 MM category in which the home is located; or

(b) for Injune—the amount specified in the following table for the 2023 MM category known as MM 7.

MM category additional amount		
Item	**Column 1** **2023 MM category for the home's location**	**Column 2** **Amount ($)**
1	2023 MM category known as MM 2	0.00
2	2023 MM category known as MM 3	0.00
3	2023 MM category known as MM 4	1.22
4	2023 MM category known as MM 5	2.68
5	2023 MM category known as MM 6	17.72
6	2023 MM category known as MM 7	21.29

249-40 Residential care place amount

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

(a) $153.35;

(b) the viability supplement equivalent amount for the home for the day under this Division;

(c) the amount specified in the following table for the region that the home is in.

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Amounts for regions

Item	Column 1 Region	Column 2 Amount ($)
	New South Wales	
1	Central Coast	13.72
2	Central West	11.77
3	Far North Coast	12.50
4	Hunter	13.85
5	Illawarra	12.80
6	Inner West	14.30
7	Mid North Coast	13.10
8	Nepean	12.75
9	New England	8.44
10	Northern Sydney	8.24
11	Orana Far West	15.40
12	Riverina Murray	13.71
13	South East Sydney	13.33
14	Southern Highlands	14.43
15	South West Sydney	16.13
16	Western Sydney	12.88
	Victoria	
17	Barwon South Western	8.40
18	Eastern Metro	7.59
19	Gippsland	7.97
20	Grampians	14.06
21	Hume	8.16
22	Loddon-Mallee	12.98
23	Northern Metro	12.88
24	Southern Metro	8.38
25	Western Metro	8.32
	Queensland	
26	Brisbane North	12.54
27	Brisbane South	13.42
28	Cabool	13.48
29	Central West	11.77
30	Darling Downs	14.47
31	Far North	12.56
32	Fitzroy	7.36
33	Logan River Valley	14.67
34	Mackay	12.57

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Amounts for regions

Item	Column 1 Region	Column 2 Amount ($)
35	Northern	12.22
36	North West	18.40
37	South Coast	13.85
38	South West	12.57
39	Sunshine Coast	8.48
40	West Moreton	14.08
41	Wide Bay	12.85
	Western Australia	
42	Goldfields	7.36
43	Great Southern	8.35
44	Kimberley	18.00
45	Metropolitan East	13.48
46	Metropolitan North	13.67
47	Metropolitan South East	13.78
48	Metropolitan South West	15.07
49	Mid West	16.41
50	Pilbara	17.68
51	South West	12.57
52	Wheatbelt	12.92
	South Australia	
53	Eyre Peninsula	16.69
54	Hills, Mallee and Southern	14.61
55	Metropolitan East	13.48
56	Metropolitan North	13.67
57	Metropolitan South	13.78
58	Metropolitan West	15.07
59	Mid North	13.73
60	Riverland	15.24
61	South East	13.53
62	Whyalla, Flinders and Far North	13.91
63	Yorke, Lower North and Barossa	14.31
	Tasmania	
64	Northern	12.22
65	North Western	13.29
66	Southern	13.89
	Australian Capital Territory	
67	Australian Capital Territory	14.21

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Amounts for regions		
Item	**Column 1** **Region**	**Column 2** **Amount ($)**
	Northern Territory	
68	Alice Springs	20.18
69	Barkly	23.13
70	Darwin	17.37
71	East Arnhem	23.13
72	Katherine	12.56

249-45 Respite supplement equivalent amount

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

Respite supplement equivalent amount		
Item	**Column 1** **Number of residential care places that are in effect**	**Column 2** **Amount ($)**
1	Less than 11	59.07
2	More than 10 but less than 21	94.51
3	More than 20 but less than 31	106.30
4	More than 30 but less than 41	118.09
5	More than 40	129.95

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

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

(a) if the home is located in a Statistical Local Area with a classification under the RRMA Classification mentioned in an item of the following table—the amount specified in the item in the table that relates to that classification and the number of residential care places for the home that are in effect on the day; or

(b) if paragraph (a) does not apply—$3.87.

Viability supplement equivalent amounts—Category A residential care homes			
Item	**Column 1** **Statistical Local Area classification for the home's location**	**Column 2** **Number of residential care places for the home that are in effect**	**Column 3** **Amount ($)**
1	Other Remote	less than 16	63.46
2	Other Remote	more than 15 but less than 30	39.02

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Viability supplement equivalent amounts—Category A residential care homes

Item	Column 1 Statistical Local Area classification for the home's location	Column 2 Number of residential care places for the home that are in effect	Column 3 Amount ($)
3	Other Remote	more than 29	3.96
4	Remote Centre	less than 16	30.30
5	Remote Centre	more than 15 but less than 30	21.52
6	Remote Centre	more than 29	3.96
7	(a) Other Rural; or (b) Small Rural Centre	less than 16	12.76
8	(a) Other Rural; or (b) Small Rural Centre	more than 15 but less than 30	3.96
9	(a) Other Rural; or (b) Small Rural Centre	more than 29	3.96

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

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

Viability supplement equivalent amounts—Category B residential care homes

Item	Column 1 Score	Column 2 Amount ($)
1	40	3.96
2	50	4.42
3	60	12.76
4	70	21.52
5	80	30.30
6	90	39.02
7	100	63.46

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

Category B residential care homes—scoring

Item	Column 1 Criterion	Column 2 Points
1	ARIA value for the home's location: (a) more than 9.08 but not more than 12;	60

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Category B residential care homes—scoring		
Item	**Column 1** **Criterion**	**Column 2** **Points**
	(b) more than 5.8 but not more than 9.08;	50
	(c) more than 3.51 but not more than 5.8;	40
	(d) more than 1.84 but not more than 3.51;	30
	(e) 1.84 or less	0
2	Residential care places for the home that are in effect:	
	(a) less than 20;	30
	(b) more than 19 but less than 30;	20
	(c) more than 29 but less than 45	10
3	More than 50% of individuals accessing funded aged care services in the home are diverse individuals	10

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

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

Viability supplement equivalent amounts—Category C residential care homes		
Item	**Column 1** **Score**	**Column 2** **Amount ($)**
1	50	9.53
2	55	14.28
3	60	21.36
4	65	26.10
5	70	38.08
6	75	47.44
7	80	59.27
8	85	71.24
9	90	83.06
10	95	92.54
11	100	104.42

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

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Category C residential care homes—scoring

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

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

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

Viability supplement equivalent amounts—Category D residential care homes

Item	Column 1 Score	Column 2 Amount ($)
1	50	9.53
2	55	14.28
3	60	21.36
4	65	26.10
5	70	38.08
6	75	47.44
7	80	59.27
8	85	71.24
9	90	83.06
10	95	92.54
11	100	104.42

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

Category D residential care homes—scoring

Item	Column 1 Criterion	Column 2 Points
1	The home is not Injune and the 2023 MM category for the home's location is:	
	(a) the 2023 MM category known as MM 2;	0
	(b) the 2023 MM category known as MM 3;	0
	(c) the 2023 MM category known as MM 4;	30
	(d) the 2023 MM category known as MM 5;	40
	(e) the 2023 MM category known as MM 6;	55
	(f) the 2023 MM category known as MM 7	65
2	The home is Injune	65
3	Residential care places for the home that are in effect:	
	(a) less than 20;	30
	(b) more than 19 but less than 25;	25
	(c) more than 24 but less than 30;	20
	(d) more than 29 but less than 35;	15
	(e) more than 34 but less than 40;	10
	(f) more than 39 but less than 45	5
4	More than 50% of individuals accessing funded aged care services in the home are diverse individuals	5

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Division 3—Amount of subsidy—Transition Care Program

249-90 Amount of subsidy

For the purposes of subsection 249(1) of the Act, the amount of subsidy a registered provider is eligible for under section 248 of the Act on a day in relation to funded aged care services delivered to an individual through a service group under the TCP on the day is $262.62.

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Part 10—Subsidy claims and payment

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

251-5 Relevant period—assistive technology

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

251-10 Period within which claim must be given to the System Governor—prescribed events

For the purposes of subparagraph 251(3)(a)(ii) of the Act, the events are:

(a) the individual ceases accessing funded aged care services through the service delivery branch; or

(b) another registered provider provides a start notification to the System Governor and the Commissioner about starting the delivery of funded aged care services to the individual:

(i) through the classification type ongoing for the service group residential care; or

(ii) through the classification type ongoing or short term for the service group home support.

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Division 1A—Residential care

256-5 Timing of payments—working out amounts of advances

Purpose

(1) This section is made for the purposes of subsection 256(3) of the Act.

Application

(2) This section applies in relation to estimating, under subparagraph 256(2)(b)(i) of the Act, the amount of subsidy that will be payable under section 254 of the Act to a registered provider in relation to an approved residential care home for a payment period (the ***advance payment period***) referred to in paragraph 256(2)(b) of the Act.

Requirements for estimating amount

(3) Subject to subparagraph 256(2)(b)(i) of the Act, the amount must be estimated using the following method:

Step 1:	Using the information in the claim given to the System Governor by the provider under section 257 of the Act for subsidy in relation to the home for the second payment period (the ***base payment period***) before the advance payment period, work out the sum of subsidy for which the provider is eligible in relation to individuals to whom the provider delivered funded aged care services in the home for the days in the base payment period.
Step 2:	Divide the amount worked out under step 1 by the number of days in the base payment period.
Step 3:	Divide the amount worked out under step 2 by the number of operational beds for the home on the last day of the base payment period.
Step 4:	Multiply the amount worked out under step 3 by the number of days in the advance payment period that are within: (a) the approval period for the home in relation to the provider; and (b) the registration period for the provider.
Step 5:	Multiply the amount worked out under step 4 by the number of operational beds for the home on the day the amount is being estimated.

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Step 6:	Round the amount worked out under step 5 to 2 decimal places (rounding up if the third decimal place is 5 or more).

Note 1: Any deductions under subsection 261(1) of the Act for the days in the advance payment period must also be taken into account in estimating the amount (see subparagraph 256(2)(b)(i) of the Act).

Note 2: The estimated amount must be increased or reduced to make any adjustments that are necessary to take account of any underpayments or overpayments in respect of advances previously paid under section 256 of the Act (see subparagraph 256(2)(b)(ii) of the Act).

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Division 2—Specialist aged care programs

260-5 Purpose of this Division

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

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

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

(a) within 21 days after the start of that quarter; or

(b) on a day in that quarter or a subsequent quarter agreed between the System Governor and the provider.

260-15 Transition Care Program—claims

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

260-20 Transition Care Program—payments

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

Timing of payments

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

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

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

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Division 3—Transfers and mergers of service delivery branches

263-5 Purpose of this Division

For the purposes of paragraph 263(1)(a) and subsection 263A(1) of the Act, this Division makes provision for, and in relation to:

(a) the transfer of a service delivery branch of a registered provider to another registered provider; and

(b) the merger of 2 or more service delivery branches of a registered provider into a single delivery branch of the provider.

263-10 Application for approval to transfer service delivery branch

Application for approval

(1) A registered provider (the ***proposed transferor***) may apply, in the approved form, to the System Governor for approval to transfer a service delivery branch of the proposed transferor to another registered provider (the ***proposed transferee***).

(2) The application must be made at least 90 days, or such smaller number of days as is agreed in writing between the System Governor and the registered provider, before the day proposed in the application for the transfer of the service delivery branch.

(3) The System Governor must:

(a) consider an application made in accordance with this section and any further information given in accordance with a request under section 588 of the Act; and

(b) make a decision on the application within 28 days of receiving the application.

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

Notice of decision

(4) The System Governor must give notice of the System Governor's decision to the proposed transferor and the proposed transferee.

(5) The notice under subsection (4) must:

(a) be given as soon as practicable after the System Governor makes the decision; and

(b) if the System Governor decides not to approve the transfer of the service delivery branch—include the reasons for the decision and how the proposed transferor or the proposed transferee may apply for reconsideration of the decision.

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263-15 Transfer of service delivery branch

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

Claims for subsidy for days before transfer day

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

Home support—transfer of service delivery account to the transferee

(3) On the transfer day, the notional service delivery branch account for the transferor in relation to the branch (including the available balance of that account) is transferred to the transferee in relation to the branch.

263A-5 Merger of service delivery branches

(1) This section applies in relation to the merger of one or more service delivery branches (a ***merging service delivery branch***) of a registered provider into an existing service delivery branch of the provider (the ***continuing service delivery branch***).

Claims for subsidy for days before merger day

(2) The registered provider must ensure that, before the day (the ***merger day***) the merger takes effect, the provider has given to the System Governor claims under section 251 of the Act for subsidy payable to the provider under section 250 of the Act for days before the merger day in relation to funded aged care services delivered through each merging service delivery branch.

Transfer of balance of service delivery account for merging service delivery branches

(3) On the merger day, the available balance of the notional service delivery branch account for the provider in relation to the merging service delivery branch is credited to the notional service delivery branch account for the provider in relation to the continuing service delivery branch.

Note: If the available balance of a notional service delivery branch account for a registered provider in relation to a merging service delivery branch is credited under this subsection, that notional service delivery branch account ceases: see section 203-25.

Rollover credits

(4) If:

(a) a merging service delivery branch of a registered provider is merged during a financial year into a continuing service delivery branch of the provider; and

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(b) an amount was credited to the notional service delivery branch account of the merging service delivery branch in the final quarter of that financial year in accordance with any of the following provisions:
  (i) subsection 203(4) of the Act;
  (ii) subsection 203(6) of the Act;
  (iii) subsection 203(7) of the Act; and
(c) subsection 203-15(4) of this instrument applies in relation to the notional service delivery branch account (the ***relevant account***) of the continuing service delivery branch for the following financial year (the ***relevant financial year***);

then the sum of the amounts referred to in paragraph (b) of this subsection are taken to be added to the amount referred to in paragraph 203-15(5)(b) of this instrument for the relevant account for the relevant financial year.

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Part 11—Grants

Division 1—Power to enter into other arrangements

265-5 Grant of financial assistance—other purposes

(1) This section is made for the purposes of paragraph 265(2)(g) of the Act.

(2) It is a prescribed purpose to provide information to support independence, including information about healthy ageing, positive ageing, ageing well and active ageing.

(3) It is a prescribed purpose to carry out activities that assist older Australians who are experiencing sickness or are diverse individuals to access high quality care, including the following:

(a) activities that strengthen the capacity of the health and aged care sectors to provide services for older Australians, including consideration by those sectors for people experiencing behavioural or psychological symptoms of dementia;

(b) activities that support services for individual older Australians for whom eligibility determinations are in effect.

(4) It is a prescribed purpose to carry out activities that support the Commonwealth to implement an efficient and functional aged care system that keeps Australians ageing well, including the following:

(a) prevention, resilience, and early intervention activities that support older Australians:

(i) with continuity of care in emergency scenarios; or

(ii) by improving registered provider resilience, and early interventions; or

(iii) by improving workforce resilience;

(b) activities that promote equity and integration in the health and aged care systems and enable access, quality of care, and support for older Australians by doing any of the following:

(i) delivering outcomes which support the implementation or operation of the Act;

(ii) strengthening the capacity of the health and aged care sectors to provide services for older Australians;

(iii) providing support for services for individual older Australians for whom eligibility determinations are in effect;

(iv) supporting digital channels and online or technology-delivered support;

(v) providing support for the health and aged care sectors using online or other technology platforms;

(vi) supporting informed decision making and information awareness for individuals, the aged care sector and government;

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(vii) supporting activities which prepare Australians for ageing and reduce the financial burden on the health and aged care systems;

(viii) supporting reform, including by way of structural change, in the aged care sector so that medical services are available to older Australians;

(c) research, data development, modelling, and innovation projects that relate to national strategies and action plans;

(d) research, data development, modelling, and innovation projects that do any of the following:

(i) connect care outcomes across the aged care system and continuous care and care economy;

(ii) develop metrics and data capabilities which improve transparency of the aged care system; and

(iii) inform government and the aged care sector on ageing and aged care issues.

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Division 2—Grantee Code of Conduct

268-5 Purpose of this Division

This Division is made for the purposes of subsection 268(1) of the Act.

268-10 Grantee Code of Conduct

(1) This section sets out the Grantee Code of Conduct, which applies to the following:

(a) a person or body to which money may be payable under an arrangement made under subsection 265(1) of the Act;

(b) a person or body that receives a grant of financial assistance made under subsection 265(1) of the Act.

(2) In undertaking an activity under such an arrangement or grant, the person or body (the ***grantee***) must:

(a) undertake the activity in a safe and competent manner, with care and skill; and

(b) promptly take steps to raise and act on concerns about matters that may affect the quality and safety of the activity; and

(c) promptly disclose to the System Governor, and avoid or manage, any actual, perceived or potential conflicts of interest that could affect the proper undertaking of the activity by any of the following:

(i) the grantee;

(ii) key personnel of the grantee;

(iii) a person who is otherwise employed or engaged by the grantee; and

(d) act with integrity, honesty and transparency; and

(e) treat the following individuals with dignity and respect, and without bullying or harassment, including by valuing the individual's diversity:

(i) any individual for whom the activity is being undertaken;

(ii) any family member, carer or supporter of the individual for whom the activity is being undertaken;

(iii) any individual engaged in, or participating in, the activity;

(iv) any individual administering the arrangement or grant (whether the individual is an official of the Department or otherwise); and

(f) not provide false or misleading information:

(i) when undertaking the activity; or

(ii) in response to a request for information made for the purposes of this Act in relation to the arrangement or grant.

(3) For the purposes of subsection 268(2) of the Act, the grantee breaches the Grantee Code of Conduct because of an act, or an omission to perform an act, by another person or body if:

(a) the other person or body is a member of the key personnel of the grantee, or is otherwise employed or engaged by the grantee; and

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(b) the act, or the omission to perform the act, would be a breach of the Grantee Code of Conduct if it were done by the grantee; and

(c) the act, or the omission to perform the act, is done while the other person or body is doing any of the following (whether or not during their ordinary working hours):

(i) undertaking or participating in an activity for which money may be payable under an arrangement under subsection 265(1) of the Act or that is funded by a grant that has been made to the grantee under that subsection;

(ii) engaging with an individual or any family member, carer or supporter of the individual in relation to the individual's participation in such an activity;

(iii) doing anything incidental to any of the matters mentioned in paragraph (a) or (b).

(4) In this section, the expression ***conflict of interest*** has its ordinary meaning.

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

Part 1—Introduction

272-5 Simplified outline of this Chapter

This Chapter provides for matters relating to individual fees and contributions for funded aged care services under Part 3 of Chapter 4 of the Act.

Division 1 of Part 2 of this Chapter relates to fees and contributions payable in a home or community setting, and deals with:

(a) matters relating to working out the individual contribution for individuals; and
(b) requirements for prices charged by registered providers; and
(c) circumstances in which the individual contribution is zero; and
(d) requirements relating to unspent care recipient portions.

Divisions 2 of Part 2 of this Chapter relates to fees and contributions payable in an approved residential care home, and deals with:

(a) matters relating to working out the maximum daily amount of resident contribution; and
(b) certain classes of individuals to whom the hotelling contribution and non-clinical care contribution do not apply; and
(c) the maximum non-clinical care contribution and matters relating to working out the non-clinical care contribution; and
(d) requirements for fees, including refunds of amounts paid in advance in certain circumstances.

Division 2A of Part 2 of this Chapter relates to fees and contributions payable in an approved residential care home for transitional cohorts, and deals with:

(a) matters relating to working out the maximum daily amount of transitional resident contribution; and
(b) requirements for fees, including refunds of amounts paid in advance in certain circumstances.

Division 3 of Part 2 of this Chapter relates to fees and contributions for specialist aged care programs, and deals with:

(a) the amounts that registered providers delivering funded aged care services through a service group under a specialist aged care program may charge individuals; and
(b) refunds of amounts paid in advance in certain circumstances; and
(c) other requirements in relation to amounts that individuals may be charged.

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Section 272-5

Compliance with the requirements in this Chapter is a condition of registration under section 151 of the Act.

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Part 2—Individual fees and contributions

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

Subdivision A—Individual contributions

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

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

273-10 Working out individual contributions—circumstances and amounts

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

Amounts used to work out individual contributions in certain circumstances

Item	Column 1 For the following circumstances …	Column 2 the amount is …
1	(a) the funded aged care service is any of the following (which involve the sourcing and supply to the individual of included AT-HM items and conditionally included AT-HM items other than on loan): (i) managing body functions items (non-loan); (ii) self-care items (non-loan); (iii) mobility items (non-loan); (iv) domestic life items (non-loan); (v) communication and information management items (non-loan); (vi) home modifications items; and (b) the individual has an access approval in effect for, and the service is delivered to the individual through, the classification type ongoing or short-term for the service group assistive technology or home modifications	the amount of the cost for the delivery of the service
2	(a) the funded aged care service is any of the following (which involve the sourcing and supply to the individual of included AT-HM items and conditionally included AT-HM items on loan): (i) managing body functions items (loan); (ii) self-care items (loan); (iii) mobility items (loan);	the amount that is 33.3% of the cost for the delivery of the service

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Amounts used to work out individual contributions in certain circumstances		
	Column 1	**Column 2**
Item	**For the following circumstances …**	**the amount is …**
	(iv) domestic life items (loan); (v) communication and information management items (loan); and (b) the individual has an access approval in effect for, and the service is delivered to the individual through, the classification type ongoing or short-term for the service group assistive technology	
3	(a) a classification decision establishing the classification level HM High in a classification type for the service group home modifications is in effect for the individual; and (b) the service is delivered to the individual through that classification type for the service group; and (c) the individual resides at a street address, or in a suburb or locality, that is in the 2023 MM category known as MM 6 or 7	the amount that is 66.6% of the cost for the delivery of the service
4	(a) the individual is in the post-2014 home contribution class; and (b) immediately before the transition time, there was an income tested care fee for the individual under section 52D-2 of the old Act; and (c) the sum of any individual contributions charged to the individual under section 273 of the Act for the delivery of funded aged care services to the individual during the preceding fortnight exceeds the amount worked out by multiplying that incomes tested care fee by 14	zero

273-15 Requirements for prices charged for directly sourced services

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

(a) if, in accordance with an arrangement agreed with the registered provider, the individual directly sources the delivery of the funded aged care service at a particular price from an associated provider of the registered provider—the price charged by the registered provider must not exceed 110% of that particular price; and

(b) in any case—the price charged by the registered provider must not be unreasonable.

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

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

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

Subdivision B—Unspent care recipient portions

273A-5 Unspent care recipient portions

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

273A-10 Agreement with individual

A registered provider that holds an unspent care recipient portion for an individual must, within 70 days after the transition time, agree in writing one of the following with the individual:
(a) that the provider will return the portion to the individual;
(b) that the provider will retain the portion and will deal with the portion in accordance with this Subdivision.

273A-15 If agreement is to return portion

If the provider agrees that the provider will return the portion to the individual, the provider must:
(a) return the portion to the individual within 14 days after the day the agreement is made; or
(b) if the individual dies on or after the day the agreement is made and before the provider returns the portion to the individual—return the portion to the individual's estate within 14 days after the provider is shown the probate of the individual's will or letters of administration of the individual's estate.

273A-20 If agreement is to retain portion

If the provider agrees with the individual as mentioned in paragraph 273A-10(b) of this instrument, the provider must:
(a) reduce (but not below zero) the amount of the portion by the individual contributions charged to the individual by the provider under section 273 of the Act; and
(b) if the provider ceases to deliver funded aged care services to the individual and the balance of the portion is not zero:
(i) if the cessation of delivery of services is because the individual dies—pay the balance of the portion to the individual's estate within 14 days after the provider is shown the probate of the individual's will or letters of administration of the individual's estate; or

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(ii) otherwise—pay the balance of the portion to the individual within 70 days after the cessation of delivery of services.

Note: For obligations relating to providing information about unspent care recipient portions, see sections 149-45 and 155-40.

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

Subdivision A—Classes of individuals to which Division 2 of Part 3 of Chapter 4 of the Act does not apply

275A-5 Division 2 of Part 3 of Chapter 4 of Act not to apply to transitional cohorts

For the purposes of section 275A of the Act, the following classes of individuals are prescribed:

(a) individuals in the pre-2014 residential contribution class;

(b) individuals in the post-2014 residential contribution class.

Subdivision C—Hotelling contribution and non-clinical care contribution

279-5 Maximum non-clinical care contribution

For the purposes of subsection 279(3) of the Act, the amount is $107.32.

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

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

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

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

(a) the means tested care fees (within the meaning of section 52C-3(3) of the old Act) (if any) for the individual under the old Act;

(b) the income tested care fees (within the meaning of subsection 52D-2(3) of the old Act) (if any) for the individual under the old Act;

(c) for an individual in the post-2014 home contribution class or the post-2014 residential contribution class—the means tested care fees (if any) for the individual.

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

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

(a) the classes of individuals for whom both the hotelling contribution and non-clinical care contribution are taken to be zero for a day are the following:

(i) individuals who cease accessing funded aged care services in an approved residential care home, without starting to access funded

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aged care services in another approved residential care home, before the registered provider of the home has been informed of the individual's hotelling contribution and non-clinical care contribution;

(ii) individuals who start accessing funded aged care services in an approved residential care home, but who die before the registered provider of the home has been informed of the individual's hotelling contribution and non-clinical care contribution;

(iii) individuals whose start day was more than 6 months before the day they are informed of their daily means tested amount;

(iv) individuals who have one or more dependent children;

(v) individuals who are described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war); and

(b) a class of individuals for whom the non-clinical care contribution is taken to be zero for a day is individuals who have, before the day, elected in the approved form to cease being a member of the pre-2014 residential contribution class; and

(c) a class of individuals for whom the non-clinical care contribution is taken to be zero for a day is individuals who:

(i) were continuing home care recipients under the old Act on 12 September 2024; and

(ii) since that time, have been provided with funded aged care services through the service group residential care.

280-10 Hotelling contribution and non-clinical care contribution taken to be zero in some circumstances—matters to which System Governor must have regard

(1) For the purposes of subsection 280(4) of the Act, the matters to which the System Governor must have regard in deciding whether to make a determination under subsection 280(2) of the Act that the hotelling contribution and non-clinical care contribution for an individual is to be taken to be zero are the following:

(a) the individual's total assessable income (which is determined under section 322 of the Act) and the value of the individual's assets (which is determined under section 329 of the Act);

(b) the individual's financial arrangements;

(c) the individual's entitlement to:

(i) an income support payment; or

(ii) income from any other source;

(d) whether the individual has taken steps to obtain information about the individual's entitlement to income support payments;

(e) whether the individual:

(i) is eligible to make a request under section 1129 of the *Social Security Act 1991* (relating to access to financial hardship rules for pensions); or

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(ii) is qualified to participate in the home equity access scheme under Division 4 of Part 3.12 of the *Social Security Act 1991*; or

(iii) has access to financial assistance from any other source;

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

(g) whether there is a charge on the individual's income over which the payment of fees and contributions cannot practically take precedence;

(h) whether any assets of the individual are unrealisable assets (within the meaning of the *Social Security Act 1991)*;

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

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

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

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

282-5 Maximum amount of bed reservation fee chargeable

(1) For the purposes of subsection 282(3) of the Act, subsection (2) prescribes the maximum amount of the bed reservation fee that a registered provider delivering ongoing funded aged care services through the service group residential care to an individual in an approved residential care home may charge the individual under section 282 of the Act for a day.

(2) The amount is the sum of the following amounts, calculated as if the registered provider delivered an ongoing funded aged care service to the individual through that service group in that approved residential care home on the day:

(a) the maximum daily amount of the resident contribution that would have been payable by the individual for the day;

(b) the standard base provider amount for a day for the individual.

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

283-15 Booking fee

Purpose

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

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Maximum amount of booking fee

(2) The booking fee must not exceed the lesser of the following:
  (a) the total of the resident respite fees that the provider would charge the individual for or in connection with the services for a period of 7 days;
  (b) 25% of the total of the resident respite fees that the provider will charge the individual for the days in the respite period.

When booking fee must be refunded in full

(3) The provider must refund the whole of the booking fee if any of the following events occur:
  (a) the individual does not access the services because the individual enters hospital before the respite period;
  (b) the individual dies before the respite period;
  (c) the individual cancels the booking for the respite period more than 7 days before the start of the respite period.

When booking fee must be refunded in part

(4) The provider must refund the part of the booking fee referred to in subsection (5) if, during the lesser of the following (the ***booking fee period***):
  (a) the first 7 days of the respite period;
  (b) the first 25% of the respite period;

any of the following events occur:
  (c) the individual enters hospital;
  (d) the individual dies;
  (e) the provider requires the individual to leave the approved residential care home in which the services are being delivered.

(5) For the purposes of subsection (4), the part of the booking fee required to be refunded is the amount equal to the proportion of the booking fee that corresponds to the proportion of the booking fee period that remains after the event occurs.

(6) The provider must pay a refund required by subsection (3) or (4):
  (a) if the individual has died:
    (i) if, within 14 days after the provider becomes aware of the individual's death, the provider is shown the probate of the will of the individual or letters of administration of the estate of the individual—to the individual's estate within 14 days after the day on which the provider was so shown; or
    (ii) if subparagraph (i) does not apply—to a person that the provider is reasonably satisfied that it is appropriate to pay the refund to within 28 days after the provider becomes aware of the individual's death; or
  (b) otherwise—to the individual within 14 days after the later of:
    (i) the day the event mentioned in subsection (3) or (4) (as applicable) occurs; and

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(ii) the day the provider becomes aware of the event.

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

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

Subdivision F—Fees for higher everyday living

284-1 Purpose of this Subdivision

For the purposes of subsections 284(2), (3) and (6) of the Act, this Subdivision prescribes the following:
(a) requirements for entering into higher everyday living agreements;
(b) other requirements for higher everyday living agreements;
(c) how agreed amounts of higher everyday living fees are to be indexed;
(d) circumstances in which a registered provider must not charge an individual a higher everyday living fee;
(e) circumstances in which a registered provider must not enter into a higher everyday living agreement with an individual.

284-2 Kinds of higher everyday living agreement

A higher everyday living agreement must be either:
(a) a standing higher everyday living agreement; or
(b) an ad hoc higher everyday living agreement.

Note 1: A standing higher everyday living agreement may contain an agreed amount for:
(a) a single service that is to be delivered on a single occasion; or
(b) services that are to be delivered on an ongoing basis; or
(c) services that are to be delivered for a fixed term.

Note 2: An ad hoc higher everyday living agreement may contain only an agreed amount for a single funded aged care service, or a single additional service, to be delivered on a single occasion (see subsection 284-13(1)).

284-5 Entry requirements—all higher everyday living agreements

Fees for services must be for services at a higher standard

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

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Fees in connection with services must be for additional connected services

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

284-6 Additional entry requirements—standing higher everyday living agreements

A registered provider and an individual must not enter into a standing higher everyday living agreement unless, before the agreement is entered into, the provider gives the individual the following:

(a) a list of each funded aged care service for which the provider charges a higher everyday living fee and the standard at which the provider delivers the service;

(b) a list of each additional service that the provider delivers in connection with a funded aged care service and the funded aged care service that the additional service is delivered in connection with;

(c) if the provider does not offer the option of bundling of the charging of higher everyday living fees—the higher everyday living fee for each of the services referred to in paragraph (a) or (b);

(d) if the provider offers the option of bundling of the charging of higher everyday living fees for one or more services referred to in paragraph (a) or (b):

(i) the standalone fee for each of those services and the bundled fee for each of those services; and

(ii) that the individual is not required to agree to the bundling of the charging of higher everyday living fees; and

(iii) that the provider must offer to deliver, and the individual may choose to access, any of those services individually and not as part of a bundle.

Note: See also subsection 284-11(2), which deals with bundling the charging of higher everyday living fees.

284-7 Additional entry requirements—ad hoc higher everyday living agreements

Matters about which the individual must be informed before entry

(1) A registered provider and an individual must not enter into an ad hoc higher everyday living agreement unless, before the agreement is entered into, the provider informs the individual of the following:

(a) if the agreement relates to the delivery of a funded aged care service—the service, the standard at which the provider delivers the service, and the higher everyday living fee for the service;

(b) if the agreement relates to an additional service—the additional service, the funded aged care service that the additional service is delivered in

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connection with, and the higher everyday living fee for the additional service;

(c) that the individual will be charged at the time the service or additional service is delivered;

(d) that the individual will not be charged if the individual chooses not to, or is unable to, have the service, or the additional service, delivered.

Timing of entry—immediately before, or at time of, delivery of service

(2) A registered provider and an individual may enter into an ad hoc higher everyday living agreement relating to a funded aged care service or additional service only immediately before, or at the time, the service or additional service is to be delivered.

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

(1) A higher everyday living agreement must be expressed in plain language and be readily understandable by the individual.

Agreed amounts

(2) A higher everyday living agreement must:

(a) specify each agreed amount, the funded aged care service that it is charged for or in connection with, and the frequency at which it is charged; and

(b) for an agreed amount for a funded aged care service—specify the standard at which the provider must deliver the service; and

(c) for an agreed amount in connection with a funded aged care service—specify the additional service, connected to the funded aged care service, that the provider must deliver; and

(d) state that the agreed amounts are subject to indexation in accordance with section 284-15 of this instrument; and

(e) require the provider to notify the individual of the replacement agreed amounts as soon as practicable after each indexation day (within the meaning of section 284-15 of this instrument).

Note: An individual's accommodation agreement sets out when an individual may be required to move rooms on a non-voluntary basis: see section 294-5.

Agreement must be a standalone agreement

(3) The agreement must not be incorporated into:

(a) a service agreement; or

(b) an accommodation agreement.

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284-11 Additional requirements—standing higher everyday living agreements

Agreements to be in writing

(1) A standing higher everyday living agreement must be in writing.

Bundling the charging of higher everyday living fees

(2) A standing higher everyday living agreement must not require the bundling of the charging of higher everyday living fees for one or more funded aged care services or additional services unless:
  (a) the bundled fee for each of the services is agreed between the registered provider and the individual in the agreement; and
  (b) the total of the bundled fees does not exceed the total of the standalone cost of the services within those bundled services that the person is able to use.

Fixed term services

(3) If a funded aged care service to which the agreement relates is to be delivered over a fixed term rather than on an ongoing basis, the agreement must specify the fixed term.

Annual review—individuals accessing ongoing funded aged care services

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

(5) If the agreement provides for an annual review, the agreement must also require the provider to keep a written record of:
  (a) each annual review that has occurred; and
  (b) the findings of each annual review; and
  (c) if the individual and the provider agree to vary the agreement as a result of the annual review—the variations so agreed; and
  (d) any other agreement with the individual that has been reached as a result of an annual review.

Note: For variations as a result of an annual review, see subsection (9).

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

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

Variation and termination—general

(7) A standing higher everyday living agreement must provide that:
  (a) the individual may vary or terminate the agreement within 28 days after the agreement is entered into without giving notice to the provider and without the provider charging a fee for the variation or termination; and

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(b) the individual or the provider may vary or terminate the agreement with 28 days' notice to the other party, and without the provider charging a fee for the variation or termination, at any time after the end of 28 days after the agreement is entered into.

(8) The agreement must provide that a variation as mentioned in paragraph (7)(a) or (b) must not include a variation that consists only of a change to the agreed amount for a service.

Note: Examples of permitted variations include the addition of a funded aged care service or additional service connected to that service, the removal of such a service, or the frequency of such a service.

(9) To avoid doubt, if the agreement is varied or terminated as mentioned in paragraph (7)(b), the provider may continue to charge fees (other than a fee for the variation or termination) under the agreement until the end of the 28-day notice period.

Variation—annual review

(10) If the agreement provides for an annual review under subsection (4), the agreement must provide that the individual and the provider may agree to vary any part of the agreement as a result of the annual review, other than a variation that consists only of a change to the agreed amount for a service.

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

(11) The agreement must provide that, if the provider can no longer deliver a funded aged care service at the specified standard:

(a) the individual may terminate the agreement without giving notice to the provider and without the provider charging a fee for the termination; or

(b) the individual and provider may agree to vary the agreement to remove the service and the agreed amount for the service; or

(c) the individual and provider may agree to vary the agreement to specify a different standard at which the provider must deliver the service (which must still be a standard that is higher than the standard that the Act requires the service to be delivered at), and specify a different agreed amount for the service.

Variation and termination—provider can no longer deliver additional service

(12) The agreement must provide that, if the provider can no longer deliver an additional service, connected to a funded aged care service:

(a) the individual may terminate the agreement without giving notice to the provider and without the provider charging a fee for the termination; or

(b) the individual and provider may agree to vary the agreement to remove the additional service and the agreed amount in connection with the funded aged care service; or

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(c) the individual and provider may agree to vary the agreement to specify a different additional service, and specify a different agreed amount in connection with the funded aged care service.

Suspension while individual is on leave

(13) The agreement must provide that:
(a) if the individual is on extended hospital leave, the agreement is suspended until the day the leave ends; and
(b) if the individual is on another kind of leave, the individual and the provider may agree:
(i) to suspend the agreement; and
(ii) the period for which the agreement is suspended.

Refunds relating to variation, termination or suspension—general

(14) The agreement must provide that:
(a) if the agreement is terminated as mentioned in subsection (7), the provider must, within 14 days after the agreement is terminated, refund to the individual any agreed amounts paid in advance in respect of a period after the agreement is terminated; and
(b) if the agreement is varied:
(i) as mentioned in subsection (7) or (10); and
(ii) in a way that reduces any of the agreed amounts;
the provider must, within 14 days after the agreement is varied, refund to the individual the amount of the reductions in the agreed amounts paid in advance in respect of a period after the agreement is varied; and
(c) if the agreement is suspended as mentioned in subsection (13), the provider must, within 14 days after the beginning of the suspension, refund to the individual any agreed amounts paid in advance in respect of the period of suspension.

(15) However, if the agreement is varied or terminated on the initiative of the individual (other than as mentioned in paragraph (7)(a) or subsection (10), (11) or (12)), or the agreement is suspended as mentioned in subsection (13), the agreement must provide that the provider:
(a) may recover from the individual any unavoidable service cost for the individual, including by deducting the unavoidable service cost from a refund the individual is entitled to under subsection (14); and
(b) must provide evidence to the individual (if requested) supporting the provider's claim that a cost is an unavoidable service cost for the individual.

(16) An ***unavoidable service cost*** for an individual is a cost that:
(a) relates to a service that would have been delivered to the individual under the agreement, had the agreement not been varied, terminated or suspended; and

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(b) the registered provider is required to pay to another party whether or not the provider delivers the service to the individual.

(17) A cost ceases to be an ***unavoidable service cost*** at the end of the period of 90 days from:
(a) for a variation—the end of the applicable notice period (if any); or
(b) for a termination—the day the termination takes effect.

(18) The agreement must specify the unavoidable service costs for the individual.

Refunds relating to termination or variation referred to in subsection (11) or (12)

(19) The agreement must provide that:
(a) if the individual terminates the agreement as mentioned in paragraph (11)(a) or (12)(a), the provider must, within 14 days after the agreement is terminated, refund to the individual any agreed amounts paid in advance in respect of a period after the agreement is terminated; and
(b) if the agreement is varied as mentioned in paragraph (11)(b) or (12)(b) to remove an agreed amount, the provider must, within 14 days after the agreement is varied, refund to the individual any amount of the removed agreed amount paid in advance in respect of a period after the agreement is varied; and
(c) if the agreement is varied as mentioned in paragraph (11)(c) or (12)(c) in a way that reduces an agreed amount, the provider must, within 14 days after the agreement is varied, refund to the individual the amount of any reductions in the agreed amount paid in advance in respect of a period after the agreement is varied.

Notification of variation or termination

(20) The agreement must provide that:
(a) if the individual initiates a variation or termination of the agreement without giving notice under paragraph (7)(a), (11)(a) or (12)(a); or
(b) the individual or the provider initiate a variation or termination under paragraph (7)(b) or subsection (10);
the provider must, by written notice given to the individual by the end of the period of 14 days beginning on the day the relevant initiation occurs:
(c) acknowledge the variation or termination, or the proposed variation or termination (as the case requires); and
(d) if the provider initiates the variation or termination—set out the reasons for doing so; and
(e) in the case of a variation—set out any changes to be made to the agreement; and
(f) set out any unavoidable service costs for the individual; and
(g) set out any refund payable to the individual under subsection (14) or subsection (19) (taking into account the effect of subsection (15) about unavoidable service costs).

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284-13 Additional requirements—ad hoc higher everyday living agreements

Agreement may relate only to single service on single occasion

(1) An ad hoc higher everyday living agreement may only contain an agreed amount for a single funded aged care service, or a single additional service, that is to be delivered on a single occasion.

Termination

(2) An ad hoc higher everyday living agreement terminates when both of the following have occurred:
  (a) the funded aged care service or the additional service to which the agreement relates has been delivered to the individual;
  (b) the individual has paid the agreed amount for the service.

284-15 Indexation of agreed amounts—all higher everyday living agreements

(1) If the indexation factor on 1 July 2026 or a later 1 July (an ***indexation day***) is greater than 1, an agreed amount specified in a higher everyday living agreement is replaced by the amount worked out using the following formula:

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

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

Indexation factor

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

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

where:

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

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

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

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

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

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

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

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

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

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

Each of the following are circumstances in which a registered provider must not charge the individual a higher everyday living fee for or in connection with a particular funded aged care service:
  (a) the service is in the service type residential accommodation;
  (b) the fee is not agreed between the provider and the individual in a higher everyday living agreement that is in effect;
  (c) the provider charges the individual a higher everyday living fee for or in connection with the service under another higher everyday living agreement.

284-25 Circumstances in which higher everyday living agreements not to be entered into—all higher everyday living agreements

The following are circumstances in which a registered provider must not enter into a higher everyday living agreement with an individual:
  (a) the agreement contains a higher everyday living fee for or in connection with a funded aged care service in the service type residential accommodation;
  (b) the registered provider has not entered into a service agreement with the individual.

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Subdivision G—Other matters

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

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

(a) if the individual has died:

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

(ii) if subparagraph (i) does not apply—to a person that the provider is reasonably satisfied, on the basis of other evidence shown to the provider, that it is appropriate to pay the refund to within 14 days after the provider was shown the other evidence; or

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

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

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

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Division 2A—Fees and contributions payable in an approved residential care home for transitional cohorts

Subdivision A—Prescribed amounts

285A-3 Purposes of this Subdivision

For the purposes of subsection 285A(1) of the Act, this Subdivision prescribes amounts that a registered provider delivering ongoing funded aged care services through the service group residential care to an individual in a class of individuals referred to in section 275A of the Act may charge the individual for a day for or in connection with those services.

285A-5 Contributions for delivery of funded aged care services

(1) For the purposes of subsection 285A(1) of the Act, a registered provider delivering ongoing funded aged care services through the service group residential care to an individual in a class of individuals referred to in section 275A of the Act may charge the individual an amount (the ***transitional resident contribution***) for or in connection with those services.

(2) Subject to section 285A-25, the transitional resident contribution charged to the individual for the day must not exceed the maximum daily amount of the transitional resident contribution worked out for the day under section 285A-10.

(3) If the registered provider does not, or is taken not to, deliver funded aged care services to the individual on the day, the registered provider must not charge the individual a transitional resident contribution under this section for the day.

Note: The registered provider may charge an individual certain amounts for a day on which the provider does not deliver funded aged care services to the individual: see sections 285A-15 and 285A-20.

285A-10 Maximum daily amount of transitional resident contribution

(1) The ***maximum daily amount of the transitional resident contribution*** payable by an individual for a day is the amount worked out as follows:

Method statement

Step 1. Work out the transitional basic daily fee for the individual (see section 285A-11).

Step 2. Add the transitional compensation payment fee (if any) for the individual for the day (see subsection (2)).

Step 3. Add:

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(a) for an individual in the pre-2014 residential contribution class—any income tested fee (see section 285A-13); or

(b) for an individual in the post-2014 residential contribution class—any means tested care fee (see section 285A-14).

(2) The ***transitional compensation payment fee*** for the individual for the day is the amount equal to the transitional compensation payment reduction applicable to the individual on that day (see sections 242B-50 and 242B-55).

285A-11 Transitional basic daily fee

(1) The ***transitional basic daily fee*** for an individual for a day is the amount worked out in accordance with this section.

Pre-2014 residential contribution class—general

(2) If the individual is in the pre-2014 residential contribution class, the amount is whichever of the following applies:

(a) if the individual was a protected resident within the meaning of the *Aged Care (Transitional Provisions) Act 1997* immediately before the transition time—the amount obtained by rounding down to the nearest cent an amount equal to 77.5% of the basic age pension amount (worked out on a per day basis);

(b) if section 58-3C of the *Aged Care (Transitional Provisions) Act 1997* applied to the individual immediately before the transition time—the amount obtained by rounding down to the nearest cent an amount equal to 96.5% of the basic age pension amount (worked out on a per day basis);

(c) for any other individual—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis).

Post-2014 residential contribution class

(3) If the individual is in the post-2014 residential contribution class, the amount is the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis).

285A-13 Income tested fee

(1) Subject to subsections (2), (3), (4) and (5) the ***income tested fee*** for an individual in the pre-2014 residential contribution class is equal to the daily means tested amount for the individual for the day (see section 319-15).

Circumstances in which income tested fee is taken to be zero

(2) Despite subsection (1), the individual's income tested fee is zero on a day if any of the following apply on the day:

(a) the individual has one or more dependent children;

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(b) the individual is an individual described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war);

(c) the individual:

(i) was provided with residential care (within the meaning of the *Aged Care (Transitional Provisions) Principles 2014*, as in force before the transition time) at any time after 30 September 1997 and before 1 March 1998; or

(ii) was, before 1 March 1998, on leave, as described in subsection 42-3(3) of the *Aged Care (Transitional Provisions) Act 1997* (as in force before the transition time);

(d) the daily means tested amount for the individual for the day (see section 319-15) is less than $1.

Individual dies before being informed of the individual's income tested fee

(3) If:

(a) at a time that is after the transition time, the individual is accessing funded aged care services at an approved residential care home of a registered provider; and

(b) the individual dies before the registered provider is informed of the individual's income tested fee (as it would be but for the application of this subsection);

then, despite subsection (1), the individual's income tested fee is zero on each day starting after that time.

Individual is not informed of the individual's income tested fee within 6 months

(4) If the individual is not informed of the individual's income tested fee (as it would be but for the application of this subsection) within 6 months after the earlier of the following days (the ***applicable day***):

(a) the individual's start day;

(b) the individual's day of entry (within the meaning of the old Act) (if any);

then, despite subsection (1), the individual's income tested fee is zero for each day beginning on the applicable day until the day the individual is informed of the individual's income tested fee.

Registered provider not informed of individual's income tested fee before individual ceases service

(5) If:

(a) at a time that is after the transition time, the individual is accessing funded aged care services at an approved residential care home of a registered provider on a day; and

(b) on a later day the individual ceases accessing funded aged care services at the approved residential care home without starting to access funded aged care services at another approved residential care home of the registered provider or any other registered provider; and

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(c) the registered provider is not informed of the individual's income tested fee (as it would be but for the application of this subsection) before the later day;

then, despite subsection (1), the individual's income tested fee is zero on each day starting after that time.

285A-14 Means tested care fee

(1) Subject to subsections (2) to (8), the ***means tested care fee*** for an individual in the post-2014 residential contribution class for a day is worked out as follows:

Method statement

Step 1. Work out the daily means tested amount for the individual for the day (see section 319-20).

Step 2. Subtract from the amount worked out under Step 1 the amount referred to in subparagraph 230-15(1)(a)(i) (which is the highest maximum accommodation supplement amount that can apply in relation to an individual to whom Division 4 of Part 2 of Chapter 4 of the Act applies).

Step 3. If the amount worked out under Step 2 is a negative amount, the means tested care fee for the individual for the day is nil.

Step 4. If the amount worked out under Step 2 is greater than zero, work out the sum of the following amounts for the day (as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual):

(a) the individual's base rate (see section 229-5);

(b) the provider's base provider amount (see section 238-5) as if item 8 of the table in subsection 238-5(1) applies to the provider;

(c) the oxygen supplement (see section 230-11) (if applicable);

(d) the enteral feeding supplement (see section 230-12) (if applicable).

Step 5. If the amount worked out under Step 2 does not exceed the amount worked out under Step 4, and the individual does not have means not disclosed status, the means tested care fee for the individual for the day is the amount worked out under Step 2.

Step 6. If the amount worked out under Step 2 exceeds the amount worked out under Step 4, or the individual has means not disclosed status, the means tested care fee for the individual for the day is the amount worked out under Step 4.

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Circumstances in which the individual's means tested care fee is taken to be zero—contribution caps

(2) The ***annual cap period*** for the individual is the period of 12 months starting on the day, in the 12 month period before the transition time, that is:
  (a) the day (the ***first day***) on which the individual first entered an aged care service (within the meaning of the old Act) other than as a continuing care recipient (within the meaning of the old Act); or
  (b) a day that is an anniversary of the first day.

(3) Despite subsection (1), the individual's means tested care fee on a day is zero if:
  (a) the day occurs during the annual cap period for the individual; and
  (b) on a previous day the sum of the individual's means tested care fees under this instrument and the combined care subsidy reductions under sections 44-21 and 48-7 of the Act during the annual cap period for the individual exceeded $35,910.43.

(4) Despite subsection (1), the individual's means tested care fee on a day is zero if, on a previous day, the sum of all the individual's means tested care fees under this instrument and the combined care subsidy reductions under sections 44-21 and 48-7 of the old Act exceeds $86,185.23.

Circumstances in which the individual's means tested care fee is taken to be zero—other

(5) Despite subsection (1), the individual's means tested care fee on a day is zero if any of the following apply on the day:
  (a) the individual has one or more dependent children;
  (b) the individual is an individual described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war);
  (c) the individual was a continuing home care recipient (within the meaning of the old Act) on 12 September 2024;
  (d) the individual's means tested care fee is worked out as less than $1.

Individual dies before being informed of the individual's means tested care fee

(6) If:
  (a) at a time that is after the transition time, the individual is accessing funded aged care services at an approved residential care home of a registered provider; and
  (b) the individual dies before the registered provider is informed of the individual's means tested care fee (as it would be but for the application of this subsection);

then, despite subsection (1), the individual's means tested care fee is zero.

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Individual is not informed of the individual's means tested care fee within 6 months

(7) If the individual is not informed of the individual's means tested care fee (as it would be but for the application of this subsection) within 6 months after the earlier of the following days (the ***applicable day***):

(a) the individual's start day;

(b) the individual's day of entry (within the meaning of the old Act) (if any);

then, despite subsection (1), the individual's means tested care fee is zero for each day beginning on the applicable day until the day the individual is informed of the individual's means tested care fee.

Registered provider not informed of individual's means tested care fee before individual ceases services

(8) If:

(a) at a time that is after the transition time, the individual is accessing funded aged care services at an approved residential care home of a registered provider; and

(b) on a later day the individual ceases accessing funded aged care services at the approved residential care home without starting to access funded aged care services at another approved residential care home of the registered provider or any other registered provider; and

(c) the registered provider is not informed of the individual's means tested care fee (as it would be but for the application of this subsection) before the later day;

then, despite subsection (1), the individual's means tested care fee is zero on each day starting after that time.

285A-15 Fees for transitional pre-entry period

(1) For the purposes of subsection 285A(1) of the Act, a registered provider delivering funded aged care services through the service group residential care in an approved residential care home may charge an individual an amount (the ***transitional pre-entry fee***) for each day in the period set out in subsection (2) if:

(a) the individual is in a class of individuals referred to in section 275A of the Act; and

(b) the individual's access approval includes the ongoing classification type for the service group residential care.

(2) The period (the ***transitional pre-entry period***) is the period:

(a) starting on the later of the following:

(i) the day the individual enters into a service agreement with the provider;

(ii) the day that is 7 days before the individual's start day; and

(b) ending at the end of the day before that start day.

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Note: The registered provider is taken not to be delivering funded aged care services to the individual on a day in the transitional pre-entry period, so section 285A-5 does not apply to the day.

(3) The maximum amount of the transitional pre-entry fee that the registered provider may charge the individual under this section for a day in the transitional pre-entry period is the amount of the transitional basic daily fee for the individual.

285A-20 Fees for reserving a bed

(1) For the purposes of subsection 285A(1) of the Act, a registered provider delivering ongoing funded aged care services through the service group residential care to an individual in a class of individuals referred to in section 275A of the Act in an approved residential care home may charge the individual an amount (the ***transitional bed reservation fee***) for a day to reserve a bed if subsection (2) applies to the individual on that day.

(2) This subsection applies to the individual on the day if the individual:
(a) is absent from the approved residential care home on the day; and
(b) is not on leave from the approved residential care home on the day (see section 244 of the Act); and
(c) would have been on social leave from the approved residential care home on the day except that the individual has previously been on social leave during the current financial year for 52 days.

Note: The registered provider is taken not to be delivering funded aged care services to the individual on a day if subsection (2) applies to the individual on the day, so section 285A-5 does not apply to the day.

(3) The maximum amount of the transitional bed reservation fee that the registered provider may charge the individual under this section for the day is the sum of the following amounts:
(a) the maximum daily amount of the transitional resident contribution that would have been payable by the individual for the day (see section 285A-10);
(b) the individual's base rate (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual);
(c) the standard base provider amount for a day for the individual (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual);

calculated as if the registered provider delivered an ongoing funded aged care service to the individual through that service group in that approved residential care home on the day and as if item 8 of the table in subsection 238-5(1) applied to the provider.

285A-25 Fees for higher everyday living

(1) For the purposes of subsection 285A(1) of the Act, a registered provider that delivers funded aged care services through the service group residential care to

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an individual in a class of individuals referred to in section 275A of the Act may charge the individual an additional amount (the ***transitional higher everyday living fee***) for or in connection with a particular funded aged care service.

(2) The transitional higher everyday living fee for the individual for the service is the amount agreed (the ***transitional agreed amount***) between the registered provider and the individual in an agreement (the ***transitional higher everyday living agreement***):

(a) entered into in accordance with the requirements prescribed by Subdivision F of Division 2 of Part 2 of this Chapter; and

(b) that meets the requirements prescribed by that Subdivision.

Note: See also subsection (7) for how that Subdivision applies to transitional higher everyday living fees.

(3) The registered provider must not charge the individual the transitional higher everyday living fee for a service delivered on a day that occurs prior to the day the registered provider and individual enter into the transitional higher everyday living agreement.

(4) The registered provider must not, before the individual's start day:

(a) ask the individual to pay a transitional higher everyday living fee for a service; or

(b) offer to enter a transitional higher everyday living agreement with the individual.

(5) Despite subsection (1), the registered provider must not:

(a) charge the individual a transitional higher everyday living fee in circumstances prescribed by Subdivision F of Division 2 of Part 2 of this Chapter; or

(b) enter into a transitional higher everyday living agreement with the individual in circumstances prescribed by Subdivision F of Division 2 of Part 2 of this Chapter.

Note: See also subsection (7) for how that Subdivision applies to transitional higher everyday living fees.

(6) To avoid doubt, a transitional higher everyday living fee may be charged in accordance with subsection (1) for a service that is not included on the list of services referred to in subsection 8(1) of the Act if the service is incidental to, or capable of enhancing the quality of, a particular funded aged care service that is included on that list.

(7) For the purposes of subsections (2) and (5), Subdivision F of Division 2 of Part 2 of this Chapter applies as if:

(a) Division 2 of Part 3 of Chapter 4 of the Act applied in relation to the individual; and

(b) a reference in that Subdivision to a higher everyday living fee were a reference to a transitional higher everyday living fee; and

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(c) a reference in that Subdivision to an agreed amount were a reference to a transitional agreed amount; and

(d) a reference in that Subdivision to a higher everyday living agreement were a reference to a transitional higher everyday living agreement.

Subdivision B—Other matters

285A-30 Refund of amounts paid in advance if individual dies or stops accessing services

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

(a) if the individual has died:

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

(ii) if subparagraph (i) does not apply—to a person that the provider is reasonably satisfied, on the basis of other evidence shown to the provider, that it is appropriate to pay the refund to within 14 days after the provider was shown the other evidence; or

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

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Division 3—Fees and contributions for specialist aged care programs

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

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

(a) the amounts that a registered provider delivering funded aged care services through a service group under a specialist aged care program to an individual may charge the individual; and

(b) refunds of amounts paid in advance if the individual dies or stops accessing funded aged care services; and

(c) other requirements relating to amounts that may be charged under section 286 of the Act.

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

(1) A registered provider delivering funded aged care services through a service group under a specialist aged care program other than the CHSP on a day to an individual may charge the individual an amount (the ***specialist aged care program fee***) for or in connection with those services.

(2) Subject to subsection (3), the specialist aged care program fee for an individual for a day is the amount agreed between the registered provider and the individual in a written agreement.

(3) The specialist aged care program fee for an individual for a day must not exceed:

(a) if the funded aged care services are delivered through the residential care service group—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis); or

(b) if the funded aged care services are delivered through the home support, assistive technology or home modifications service group—the amount obtained by rounding down to the nearest cent the amount equal to 17.5% of the basic age pension amount (worked out on a per day basis).

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

(1) A registered provider delivering funded aged care services through a service group under the CHSP on a day to an individual may charge the individual an amount (the ***CHSP contribution***) for or in connection with those services.

(2) The CHSP contribution for the delivery of the funded aged care service to the individual on the day is the amount agreed between the registered provider and the individual in a written agreement.

(3) The written agreement must include how and when CHSP contributions are to be paid.

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286-17 Refund of amounts paid in advance if individual dies or stops accessing services

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

(a) if the individual has died:

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

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

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

286-20 Other requirements—financial hardship policy

(1) A registered provider delivering funded aged care services through a service group under a specialist aged care program must have a financial hardship policy that covers the following:

(a) how an individual can apply for a waiver or reduction of the specialist aged care program fee or CHSP contribution for the individual due to financial hardship;

(b) what evidence of financial hardship the individual must submit to the provider, and how that evidence must be submitted;

(c) the principles or calculations the provider will use to determine the amount and duration of the waiver or reduction of the fee or contribution if the individual's application is successful.

(2) The registered provider must make the financial hardship policy publicly available.

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

(1) A registered provider delivering funded aged care services through a service group under the CHSP or the NATSIFACP must:

(a) have a consumer contribution policy that takes into account the capacity of individuals to contribute toward the cost of the services delivered to them; and

(b) set their specialist aged care program fees and CHSP contributions in accordance with that policy.

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(2) The registered provider must make the consumer contribution policy publicly available.

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Section 287-5

Chapter 9—Funding of aged care services—accommodation payments and accommodation contributions etc.

Part 1—Introduction

287-5 Simplified outline of this Chapter

This Chapter provides for matters relating to payments made by individuals under Part 4 of Chapter 4 of the Act in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home.

Part 2 of this Chapter prescribes requirements in relation to accommodation bonds, accommodation charges and entry contributions for individuals in the pre-2014 accommodation class, and deals with:

(a) circumstances in which registered providers may enter into accommodation bond agreements with individuals and requirements for the accommodation bond agreements; and

(b) requirements for the charging of accommodation bonds, the maximum amount of accommodation bonds, permitted uses of accommodation bonds and matters relating to the payment of accommodation bonds; and

(c) the retention, deduction, refund and transfer of accommodation bond balances; and

(d) the payment of interest in relation to the refund of accommodation bond balances; and

(e) circumstances in which registered providers may enter into accommodation charge agreements with individuals and requirements for the accommodation charge agreements; and

(f) the maximum daily accrual amount of accommodation charges and matters relating to the payment of accommodation charges; and

(g) the payment of interest in relation to the refund of entry contribution balances.

Part 3 of this Chapter relates to accommodation payments and accommodation contributions, and deals with:

(a) prescribing certain provisions of Part 4 of Chapter 4 of the Act that do not apply in relation to certain specialist aged care programs; and

(b) maximum accommodation payment amounts and publication of certain amounts by the System Governor; and

(c) matters relating to accommodation agreements, including what must be set out in accommodation agreements, other requirements for

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agreements, and methods for working out payments, contributions and refunds; and

(d) requirements of registered providers in relation to charging accommodation payments and accommodation contributions; and

(e) matters relating to the charging of daily payments, including interest, indexation and refunds; and

(f) matters relating to refundable deposits, including deductions from refundable deposit balances, requirements for the use of refundable deposits, refunds of refundable deposits, transfers of refundable deposits between registered providers and payments of interest.

Compliance with the requirements in this Chapter is a condition of registration under section 151 of the Act.

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Part 2—Accommodation bonds, accommodation charges and entry contributions

Division 1—Application of this Part

287-10 Application of this Part

(1) For the purposes of subsection 287(2) of the Act, the class of individuals in the pre-2014 accommodation class is prescribed.

(2) For the purposes of subsection 287(3) of the Act, this Part prescribes requirements in relation to the following:

(a) the entering of agreements for, and the charging, payment and use of, accommodation bonds for the delivery of ongoing funded aged care services to an individual in the pre-2014 accommodation class;

(b) the retention of, deduction of amounts from, transfer of, refund of, and payment of interest in relation to the refund of, an accommodation bond balance in relation to an individual in the pre-2014 accommodation class;

(c) the entering of agreements for, and the charging and payment of, accommodation charges for the delivery of ongoing funded aged care services to an individual in the pre-2014 accommodation class;

(d) the transfer of, and the payment of interest in relation to the refund of, entry contribution balances in relation to an individual in the pre-2014 accommodation class.

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Division 2—Accommodation bond agreements

287-13 Entry into accommodation bond agreements

A registered provider may enter into an accommodation bond agreement with an individual in the pre-2014 accommodation class after the transition time in relation to an approved residential care home (the ***new home***) if:

(a) one of the following applies to the individual:

(i) immediately before the transition time, a formal agreement (within the meaning of the old Act) or an accommodation bond agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*) was in effect for the individual;

(ii) at the transition time, the most recent agreement under the old Act that had been in effect for the individual was an agreement of a kind mentioned in subparagraph (i);

(iii) immediately before the transition time, the individual was eligible under the old Act to enter into an accommodation bond agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*); and

(b) the individual ceased (whether before or after the transition time) accessing funded aged care services in another approved residential care home and will start, or has started, accessing funded aged care services in the new home.

Note 1: The new home and the former home may be approved in relation to the same registered provider.

Note 2: An individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class: see paragraph (b) of the definition of ***pre-2014 accommodation class***.

287-15 Information to be given before registered provider enters into an accommodation bond agreement with an individual

Before a registered provider enters into an accommodation bond agreement with an individual, the provider must:

(a) give the individual a copy of the proposed agreement that meets the requirements set out in section 287-25; and

(b) inform the individual of the following:

(i) that if the individual has given the provider sufficient information to determine the value of the individual's assets, the provider is required to leave the individual, after paying the accommodation bond, with assets with a value at least equal to the individual's pre-2014 minimum permissible asset value;

(ii) the interest rate to be charged on amounts owed under the agreement;

(iii) the capacity for amounts owed under the agreement and accrued interest to be deducted from the balance of the amount paid under the agreement before it is refunded;

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(iv) the amount to be charged under the agreement;
(v) the accommodation bond retention amount charged;
(vi) the interest rate on the accommodation bond if there is a delay in payment of the lump sum or the amount is paid in whole or in part by periodic payments;
(vii) the periods when the accommodation bond retention amount and interest are charged;
(viii) payment options (that is, by lump sum, periodic payment, or a combination of lump sum and periodic payment);
(ix) refund arrangements;
(x) the prudential arrangements applying to the accommodation bond balance;
(xi) when an accommodation bond is not required or, if paid, is refundable.

287-20 Time within which registered providers must enter into accommodation bond agreements

A registered provider must enter into an accommodation bond agreement with an individual in relation to an approved residential care home before, or within 21 days after, the individual's start day for the home.

287-25 Accommodation bond agreements

(1) An accommodation bond agreement between a registered provider and an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider must set out the following:
(a) the individual's start day, or proposed start day, for the home;
(b) the accommodation bond that:
(i) will be payable if the individual starts accessing the services in the home; or
(ii) is payable if the individual has already started to access the services in the home;
(c) how the accommodation bond is to be paid, and if the bond is to be paid by periodic payment, the conditions relating to the payments (which must comply with the requirements of section 287-70);
(d) when the accommodation bond is payable;
(e) the amount of each accommodation bond retention amount that will be deducted from the accommodation bond balance;
(f) when accommodation bond retention amounts and other amounts permitted by section 287-90 to be deducted from the accommodation bond balance will be deducted;
(g) the individual's room that the accommodation bond entitles the individual to be provided with;

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(h) any services that the accommodation bond entitles the individual to be provided with;
(i) that a transitional fee reduction supplement under section 242B-27 may apply to the individual and reduce the accommodation bond, including to nil;
(j) that, if the individual changes the individual's room in the home, this will not change the individual's start day for the home;
(k) the circumstances in which the accommodation bond balance must be refunded and the way the amount of the refund will be worked out;
(l) the rate of interest, or interest equivalent, payable if the accommodation bond:
(i) is paid in whole or in part as a lump sum after the due date; or
(ii) is paid by periodic payment; or
(iii) is not paid when it is due to be paid;
(m) the way interest, or interest equivalent, charges are calculated;
(n) the total amount of interest, or interest equivalent, charges payable under the agreement:
(i) if they can be calculated when the agreement is made; and
(ii) assuming that the individual will make all payments when they are due;
(o) the accommodation bond retention amounts payable if the provider delivers the services to the individual in the home for 2 months or less;
(p) the frequency at which interest, or interest equivalent, charges will be debited.

Additional matters in relation to periodic payments

(2) Subsection (3) applies if the individual elects to pay the accommodation bond by periodic payment, in whole or in part.

(3) In addition to the matters specified in subsection (1), the accommodation bond agreement must state:
(a) the amount of the lump sum equivalent; and
(b) the amount and frequency of the periodic payments; and
(c) the components of each periodic payment representing:
(i) the amount of the retention component; and
(ii) interest; and
(d) that the individual may, at any time, pay as a lump sum the whole or a part of the lump sum equivalent.

Additional matters in relation to voluntary moves to an approved residential care home of another registered provider

(4) The accommodation bond agreement must state that, if the individual wishes to move from the approved residential care home of the registered provider (the ***original home***) to an approved residential care home of another registered

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provider (the ***new home***), the registered provider of the original home may ask the individual for permission to provide the following information to the registered provider of the new home:

(a) whether the individual has agreed to pay an accommodation bond;

(b) if so, the amount agreed and, if the individual has agreed to pay the amount in whole or in part by periodic payments, the lump sum equivalent;

(c) the period remaining during which, under sections 287-95 and 287-100, accommodation bond retention amounts may be deducted from the individual's accommodation bond balance;

(d) amounts that may be deducted from the accommodation bond balance.

287-30 Accommodation bond agreements may be incorporated into other agreements

For the purposes of this Division, an individual is taken to have entered into an accommodation bond agreement if the individual has entered into an agreement that contains the provisions required by section 287-25.

287-35 Accommodation bond agreements cannot affect requirements of this Division

The requirements of this Division apply despite any provision of an accommodation bond agreement, or any other agreement, to the contrary.

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Division 3—Accommodation bonds

Subdivision A—Charging of accommodation bonds

287-40 Charging of accommodation bonds

A registered provider must comply with the following in relation to the charging of an accommodation bond to an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home (the ***new home***) of the provider:

(a) subject to this section, an accommodation bond must be charged if:

(i) the individual ceased accessing the services in another approved residential care home (the ***former home***) and started accessing the services in the new home; and

(ii) the individual paid an accommodation bond or entry contribution, or an accommodation bond was payable by the individual, to access the services in the former home;

Note 1: The new home and the former home may be approved in relation to the same registered provider.

Note 2: An individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class: see paragraph (b) of the definition of ***pre-2014 accommodation class***.

(b) the accommodation bond must not exceed the maximum amount under section 287-45, and the individual must not be charged more than one accommodation bond to access the services in the home;

(c) if a transitional fee reduction supplement under section 242B-27 applies to the individual—the accommodation bond must be reduced (but not below zero) to reflect any amount of the supplement that is applied towards the payment;

(d) payment of the accommodation bond can only be required during a period specified in section 287-65;

(e) payment of the accommodation bond by periodic payments must meet the requirements set out in section 287-70;

(f) the registered provider must not use the accommodation bond unless the use of the bond is permitted (see section 287-101);

(g) the registered provider is entitled to income derived from investing the accommodation bond balance (see section 287-85);

(h) amounts must not be deducted from the accommodation bond balance, except for amounts deducted under section 287-90.

Subdivision B—Accommodation bonds

287-45 Maximum amount of accommodation bonds

(1) Subject to subsection (2), the maximum accommodation bond that may be charged for the delivery of ongoing funded aged care services to an individual

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through the service group residential care in an approved residential care home of a registered provider is the lowest of the following:

(a) the amount of the accommodation bond that was specified in the most recent accommodation bond agreement that was in effect for the individual;

(b) an amount that, when subtracted from an amount equal to the value of the individual's assets at the start of the individual's start day for the home, leaves an amount at least equal to the individual's pre-2014 minimum permissible asset value (see subsection (3));

(c) if paragraph 287-40(a) applies in relation to an individual who paid an accommodation bond—the accommodation bond balance that was refunded or is payable to the individual under section 287-102 in respect of the accommodation bond referred to in subparagraph 287-40(a)(ii);

(d) if paragraph 287-40(a) applies in relation to an individual who paid an entry contribution—the entry contribution balance that was refunded or is payable to the individual in respect of the entry contribution referred to in subparagraph 287-40(a)(ii).

Note: The operation of this section may be modified if, before entering an accommodation bond agreement, the individual gives the registered provider a determination under section 329 of the Act of the value of the individual's assets: see subsection (5).

(2) If an individual seeking to access ongoing funded aged care services through the service group residential care in an approved residential care home of a registered provider does not, before entering into an accommodation bond agreement, give the provider sufficient information about the individual's assets for the provider to be able to determine the amount referred to in paragraph (1)(b), the maximum amount of the individual's accommodation bond is the lesser of:

(a) the amount referred to in paragraph (1)(a); and

(b) the amount referred to in paragraph (1)(c) or (d), as applicable.

(3) An individual's ***pre-2014 minimum permissible asset value*** is:

(a) if the individual's start day is before 20 September 2009—the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 2.5 times the basic age pension amount at the start of the individual's start day for the home; and

(b) if the individual's start day is on or after 20 September 2009—the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 2.25 times the basic age pension amount at the start of the individual's start day for the home.

(4) The value of an individual's assets is to be worked out in accordance with section 330 of the Act, but:

(a) taking into account only the assets of the individual of the kinds referred to in subsection 44(2) of the *Aged Care (Transitional Provisions) Principles 2014* as in force immediately before the transition time; and

(b) disregarding subsection 330(7) of the Act (value of home).

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(5) However, subsections (1), (2) and (3) are modified as described in the following table, and subsection (4) does not apply, if, before entering the accommodation bond agreement, the individual gives the registered provider a copy of a determination that:

(a) is a determination under section 329 of the Act of the value of the individual's assets at a time (the ***valuation time***) that is before or at the start of the individual's start day for the home; and

(b) is in force at the start of the start day, if that is after the valuation time.

Modifications of subsections (1), (2) and (3)

Item	Column 1 If …	Column 2 subsections (1), (2) and (3) have effect as if …
1	the valuation time is before the start of the start day for the home	(a) the references in paragraph (1)(a) and subsection (3) to the start of the individual's start day for the home were references to the valuation time; and (b) the value of the individual's assets at the valuation time were the value specified in the determination
2	the valuation time is at the start of the start day for the home	the value of the individual's assets at the start of the individual's start day for the home were the value specified in the determination

Subdivision C—Payment of accommodation bonds

287-65 Period for payment of accommodation bond

An individual must not be required to pay an accommodation bond before the day that is 6 months after the individual's start day for the approved residential care home to which the payment relates.

Note: However, under sections 287-85 and 287-95, amounts representing income derived and accommodation bond retention amounts are payable from the day an individual starts accessing ongoing funded aged care services.

287-70 Payment of accommodation bonds by periodic payment

(1) An individual may elect to pay an accommodation bond, in whole or in part, by periodic payment.

(2) If the individual elects to pay the bond by periodic payment, the registered provider for the approved residential care home to which the bond relates and the individual must agree on:

(a) the frequency of payments; and

(b) the amount of a payment, worked out in accordance with subsection (3).

(3) For the purposes of paragraph (2)(b), the formula for working out the amount of a periodic payment is as follows:

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$$\frac{(\text{LSE} \times \text{IR}) + \text{RC}}{\text{NPP}}$$

where:

IR is the lower of:

(a) the interest rate stated in the individual's accommodation bond agreement; and

(b) the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LSE is the amount of the individual's lump sum equivalent.

NPP is the number of periodic payments payable by the individual in the relevant year.

RC is the amount of the retention component worked out:

(a) if no part of the accommodation bond is paid as a lump sum—in accordance with subsection (4); or

(b) if part of the accommodation bond is paid as a lump sum—in accordance with subsections (5) and (6) and, if applicable, (7).

Note: See also section 287-95.

(4) The amount of the retention component must not exceed the maximum accommodation bond retention amount that may be deducted under section 287-95, during the year beginning on the individual's start day for the home, from the amount that would have been the accommodation bond balance if the individual had paid the whole of the accommodation bond as a lump sum.

Note: An amount deducted from an accommodation balance in accordance with section 57-19 of the old Act before the transition time is taken to have been deducted from an accommodation bond balance in accordance with section 287-90 of this instrument.

(5) If part of the accommodation bond is paid as a lump sum, the amount of the retention component of the periodic payments is reduced, on a proportionate basis, in accordance with the ratio of the lump sum equivalent to the amount of the accommodation bond.

(6) However, if the lump sum is sufficient to cover the total of the accommodation bond retention amounts for the period of 5 years for the whole of the accommodation bond, including the lump sum equivalent, and the individual elects:

(a) the amount of the retention component is nil; and

(b) the total of the accommodation bond retention amounts, including the retention component that would otherwise be payable on the lump sum equivalent, may be deducted from the amount paid as a lump sum.

(7) For the purposes of subsection (6):

(a) the period of 5 years begins on the individual's start day for the home; and

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(b) the individual's election must be made in writing and given to the registered provider.

287-75 Minimum amount of periodic payments

(1) The minimum amount of a periodic payment payable by an individual is the amount representing the periodic payments that would have been payable for 3 calendar months.

(2) If a registered provider ceases to deliver ongoing funded aged care services to an individual through the service group residential care in an approved residential care home of the provider, the provider may charge the individual the full amount of a periodic payment that is payable for the month in which the provider ceases to deliver the services.

287-80 Payment if agreed accommodation bond not paid

(1) This section applies if:
(a) an individual has agreed to pay an accommodation bond to a registered provider in whole or in part as a lump sum; and
(b) the provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in the approved residential care home to which the payment relates; and
(c) the provider delivered the services to the individual for more than 2 months; and
(d) the individual does not pay the accommodation bond before the provider ceases to deliver the services to the individual.

(2) The individual may be required to pay an amount (the ***interest equivalent amount***) worked out in accordance with subsection (3), in relation to the individual's accommodation bond balance, to the registered provider.

Note: This subsection has effect subject to section 287-86.

(3) For the purposes of subsection (2), the interest equivalent amount, in relation to the individual's accommodation bond balance, is the amount worked out in accordance with the following formula:

$$\frac{I \times LS \times D}{365}$$

where:

D is the number of days in the period:
(a) beginning on the first day of the month in which the lump sum was to be paid; and
(b) ending on the last day of the month in which the individual ceases to access the services.

I is the lower of:

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(a) the interest rate stated in the individual's accommodation bond agreement; and
(b) the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LS is the amount of the accommodation bond agreed to be paid as a lump sum.

Subdivision D—Retention, deduction and transfer of accommodation bond balances

287-85 Registered provider may retain income derived

(1) A registered provider may retain income derived from the investment of an accommodation bond balance in respect of an accommodation bond paid to the provider for the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home of the provider.

Note: This subsection has effect subject to section 287-86.

(2) Despite section 287-65, if an individual pays an accommodation bond to a registered provider in whole or in part as a lump sum after the individual's start day for the home to which the payment relates, the individual may be required to pay to the provider an amount (the ***interest equivalent amount***) worked out in accordance with subsection (3) that is equivalent to the income the provider could be expected to have derived, through investing the accommodation bond balance, during the period:
(a) beginning on the start day for the home; and
(b) ending on the day on which the accommodation bond was paid.

Note: This subsection has effect subject to section 287-86.

(3) For the purposes of subsection (2), the interest equivalent amount, in relation to the individual's accommodation bond balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

where:

IR is the lower of:
(a) the interest rate stated in the individual's accommodation bond agreement; and
(b) the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LS is the amount of the lump sum.

ND is the number of days in the period:
(a) beginning on the individual's start day for the home; and

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(b) ending on the day when the accommodation bond was paid in whole or in part as a lump sum.

(4) If a registered provider delivers ongoing funded aged care services to an individual through the service group residential care at an approved residential care home of the provider for 2 months or less, the individual may be required to pay to the provider an amount (the ***interest equivalent amount***) worked out in accordance with subsection (5) or (6) representing the income the provider could be expected to have derived, through investing the accommodation bond balance, during:

(a) the whole of the month in which the provider delivered the services; and

(b) the 2 following months.

Note: This subsection has effect subject to section 287-86.

Example: If a registered provider started delivering ongoing funded aged care services to an individual through the service group residential care at an approved residential care home of the provider on 20 January and the individual left on 3 March, the amount would be the amount the registered provider could have been expected to have derived if the provider delivered the services to the individual for the whole of January, February and March.

(5) If:

(a) the individual pays the accommodation bond in whole or in part as a lump sum; and

(b) the amount paid as a lump sum is refunded to the individual within 3 months after the individual's start day for the home;

the interest equivalent amount, in relation to the individual's accommodation bond balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

where:

IR is the lower of:

(a) the interest rate stated in the individual's accommodation bond agreement to which the payment relates; and

(b) the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LS is the amount of the lump sum.

ND is the number of days in the period:

(a) beginning on the day when the lump sum was refunded; and

(b) ending 3 months after the start day for the home.

(6) If the individual:

(a) has agreed to pay the accommodation bond in whole or in part as a lump sum; and

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(b) does not pay the lump sum before the individual ceases to access ongoing funded aged care services in the home;

the interest equivalent amount, in relation to the individual's accommodation bond balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

where:

IR is the lower of:

(a) the interest rate stated in the individual's accommodation bond agreement; and

(b) the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LS is the amount of the lump sum.

ND is the number of days in 3 calendar months from the individual's start day for the home.

(7) An individual cannot be required to pay the interest equivalent amounts worked out under both subsections (3) and (6).

(8) The registered provider may require payment of an amount less than the interest equivalent amount required to be paid under subsection (2) or (4).

287-86 Restriction on retention of income derived

Despite subsections 287-80(2) and 287-85(1), (2) and (4), if a transitional fee reduction supplement under section 242B-27 applies to an individual and is reducing the individual's accommodation bond, a registered provider must not do either of the following in respect of the period for which the supplement applies to the individual:

(a) retain income derived from the investment of the individual's accommodation bond balance in accordance with subsection 287-85(1);

(b) require the individual to pay an interest equivalent amount under subsection 287-80(2) or 287-85(2) or (4) in relation to the individual's accommodation bond balance.

287-90 Amounts to be deducted from accommodation bond balance

(1) A registered provider to whom an accommodation bond was paid by an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider may deduct from the accommodation bond balance:

(a) an accommodation bond retention amount in respect of the accommodation bond (see section 287-95); and

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(b) an amount owed to the registered provider by the individual under an accommodation bond agreement or a service agreement; and

(c) subject to subsection (3), an amount of interest on the amount referred to in paragraph (b) that does not exceed the pre-2014 maximum permissible interest rate for the individual's start day for the home.

(2) The registered provider must not deduct any other amounts from the accommodation bond balance.

(3) The registered provider may only charge interest for the period:

(a) beginning on the day that is 1 month after the day on which the amount was payable under the accommodation bond agreement or service agreement; and

(b) ending on the earlier of the following days:

(i) the day on which the amount was paid;

(ii) the day the provider ceased delivering the services to the individual at the home of the provider.

287-95 Accommodation bond retention amounts

(1) The maximum accommodation bond retention amount that may be deducted, from an individual's accommodation bond balance, during a year (the ***first year***) beginning on the individual's start day for an approved residential care home, or a year (a ***later year***) beginning on the anniversary of the individual's start day for the home, is:

(a) if the accommodation bond is not more than the lower threshold amount—10% of the lower threshold amount; or

(b) if the accommodation bond is more than the lower threshold amount but not more than the higher threshold amount—10% of the accommodation bond; or

(c) if the accommodation bond is more than the higher threshold amount—10% of the higher threshold amount.

(2) However, despite subsections (3) and (4), the maximum accommodation bond retention amount for the individual for a later year is the same as the maximum accommodation bond retention amount for the first year.

(3) In subsection (1):

higher threshold amount is:

(a) for a year beginning in a financial year beginning on or after 1 July 1997 and before 1 July 2025—an amount equal to the amount Y worked out for the year in accordance with sections 97 and 98 of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time; or

(b) for a year beginning in a later financial year—the amount specified in column 3 of the table in subsection (4) for the financial year.

lower threshold amount is:

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(a) for a year beginning in a financial year beginning on or after 1 July 1997 and before 1 July 2025—the amount equal to the amount X worked out for the year in accordance with sections 97 and 98 of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time; or

(b) for a year beginning in a later financial year—the amount specified in column 2 of the table in subsection (4) for the financial year.

(4) For the purposes of paragraph (b) of the definitions of ***lower threshold amount*** and ***higher threshold amount*** in subsection (3), the amount for a financial year is specified in the following table:

Amounts for financial years beginning on or after 1 July 2025

Item	Column 1 For the financial year beginning on …	Column 2 the lower threshold amount is …	Column 3 and the higher threshold amount is …
1	1 July 2025	$28,200	$54,540

(5) The maximum monthly accommodation bond retention amount is the amount worked out in accordance with subsection (1) divided by 12.

287-100 Restriction on deduction of accommodation bond retention amounts

(1) If a transitional fee reduction supplement under section 242B-27 applies to an individual and is reducing the accommodation bond balance, the registered provider delivering ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider must not deduct any accommodation bond retention amounts from the individual's accommodation bond balance during the period for which the supplement applies to the individual.

(2) Subject to subsections (3) and (5), a registered provider may deduct an accommodation bond retention amount from an accommodation bond balance for each month, or part of a month, during which the provider is delivering ongoing funded aged care services to the individual in an approved home of the provider in respect of which the accommodation bond was paid.

(3) Subject to subsection (5), accommodation bond retention amounts may only be deducted during the period of 5 years beginning on the individual's start day for the first approved residential care home for which the individual paid an accommodation bond.

(4) The 5 year period referred to in subsection (3) is extended by one day for each day during any period:

(a) for which a transitional fee reduction supplement under section 242B-27 applies to the individual and is reducing the accommodation bond balance; or

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(b) during which the individual is not accessing ongoing funded aged care services in an approved residential care home.

(5) If, before the accommodation bond was paid, amounts had already been deducted from an accommodation bond balance in respect of another accommodation bond previously paid by the individual for another approved residential care home, the period of 5 years referred to in subsection (3) is reduced by each month in respect of which an accommodation bond retention amount was so deducted.

Note: The effect of this subsection is that all periods spent accessing ongoing funded aged care services in the service group residential care after an accommodation bond is first paid will count towards the 5 year maximum under subsection (3) for deducting accommodation bond retention amounts.

Example: If an individual initially receives 6 weeks of ongoing funded aged care services through the service group residential care in an approved residential care home and then moves to another home, accommodation bond retention amounts can be deducted for 3 months in respect of the 6 weeks (see subsection (6)), but after that only for up to 4 years and 9 months.

(6) For the purposes of this section, if the registered provider delivers the services to the individual for 2 months or less, the individual is taken, for the purposes of working out the accommodation bond retention amounts payable, to have received the services during:

(a) the whole of the month in which the provider started delivering the services to the individual; and

(b) the 2 following months.

Example: An individual who started receiving ongoing funded aged care services on 20 January and left on 3 March would be taken to have received care for the whole of January, February and March. Therefore, accommodation bond retention amounts could be deducted for each of these months.

287-101 Accommodation bonds to be used only for permitted purposes

(1) A registered provider must not use an accommodation bond unless the use is permitted by this section.

Permitted uses

(2) A registered provider is permitted to use an accommodation bond for the following:

(a) for capital expenditure of a kind covered by subsection (3);

(b) to invest in a financial product (within the meaning of Division 3 of Part 7.1 of the *Corporations Act 2001*) covered by subsection (4);

(c) to make a loan in relation to which the following conditions are satisfied:

(i) the loan is not made to an individual;

(ii) the loan is made on a commercial basis;

(iii) there is a written agreement in relation to the loan;

(iv) it is a condition of the agreement that the money loaned will only be used as mentioned in paragraph (a), (b), (d) or (e) of this subsection;

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(d) to refund, or to repay debt accrued for the purposes of refunding, accommodation bond balances, entry contribution balances or refundable deposit balances;

(e) to repay debt accrued for the purposes of capital expenditure of a kind covered by subsection (3);

(f) to meet reasonable businesses losses that are incurred in the course of delivering funded aged care services within the period of 12 months after the day the registered provider begins to deliver funded aged care services to the individual through the service group residential care;

(g) to invest in a fund, but not a controlling entity of a fund, listed in item 2 of the first Schedule to *Banking exemption No. 1 of 2021* made under the *Banking Act 1959*.

(3) For the purposes of paragraphs (2)(a) and (e), the following kinds of capital expenditure are covered by this subsection:

(a) expenditure to acquire land on which are, or are to be built, the premises needed for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to those premises;

(b) expenditure to acquire, erect, extend or significantly alter premises used or proposed to be used for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to the delivery of those funded aged care services;

(c) expenditure to acquire or install furniture, fittings or equipment for premises used or proposed to be used for delivering funded aged care services through the service group residential care, when those premises are initially erected or following an extension, a significant alteration or a significant refurbishment, but only to the extent that the expenditure relates to the delivery of those funded aged care services;

(d) expenditure that is directly connected to expenditure covered by paragraph (a), (b) or (c).

(4) For the purposes of paragraph (2)(b), the following financial products are covered by this subsection:

(a) any deposit-taking facility made available by an ADI in the course of its banking business (within the meaning of the *Banking Act 1959*), other than an RSA;

(b) a debenture, stock or bond issued, or proposed to be issued, by the Commonwealth, a State or a Territory;

(c) a security;

(d) any of the following in relation to a registered scheme (within the meaning of the *Corporations Act 2001*):

(i) an interest in the scheme;

(ii) a legal or equitable right or interest in an interest covered by subparagraph (i);

(iii) an option to acquire, by way of issue, an interest or right covered by subparagraph (i) or (ii);

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(e) an interest in a scheme established for the purpose of investment in the delivery of funded aged care services through the service group residential care in an approved residential care home that:
  (i) is a managed investment scheme within the meaning of the *Corporations Act 2001*; and
  (ii) is not a registered scheme within the meaning of the *Corporations Act 2001*;
(f) a legal or equitable right or interest in an interest covered by paragraph (e);
(g) an option to acquire, by way of issue, an interest or right covered by paragraph (e) or (f).

287-102 Refund of accommodation bond balance

Circumstances in which accommodation bond balance must be refunded

(1) If an accommodation bond is paid to a registered provider, the provider must refund the accommodation bond balance if:
  (a) the individual dies; or
  (b) both of the following apply:
    (i) the registered provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in the approved residential care home to which the payment relates (other than because the individual is on leave);
    (ii) the registered provider has not transferred, or is not required to transfer, the accommodation bond balance to another registered provider under section 287-103.

Period within which accommodation bond balance must be refunded

(2) If paragraph (1)(a) applies, the accommodation bond balance must be refunded:
  (a) if the registered provider is shown the probate of the will of the individual or letters of administration of the estate of the individual—within 14 days after the day on which the provider was so shown; or
  (b) if the registered provider is not shown the probate of the will of the individual or letters of administration of the estate of the individual and the registered provider is shown other evidence that satisfies the provider that the accommodation bond balance is to be refunded to a person—within 14 days after the other evidence is shown to the provider.

(3) If paragraph (1)(b) applies, the accommodation bond balance must be refunded in accordance with the following table.

When an accommodation bond balance must be refunded if paragraph (1)(b) applies

Item	Column 1 If …	Column 2 the accommodation bond balance must be refunded …
1	both of the following apply:	on the day on which the registered provider ceased

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When an accommodation bond balance must be refunded if paragraph (1)(b) applies

Item	Column 1 If …	Column 2 the accommodation bond balance must be refunded …
	(a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care; (b) the individual notified the registered provider of the move more than 14 days before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i)	delivering the services mentioned in subparagraph (1)(b)(i)
2	both of the following apply: (a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care; (b) the individual notified the registered provider of the move within 14 days before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i)	within 14 days after the day on which the notice was given to the provider
3	both of the following apply: (a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care; (b) the individual did not notify the provider of the move before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i)	within 14 days after the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i)
4	items 1, 2 and 3 of this table do not apply	either: (a) within 14 days after the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i); or (b) if the individual has agreed with the registered provider as mentioned in subsection (4) and the individual has notified the registered provider, in writing, that they wish to cease that agreement—within 14 days after the day on which the individual has notified the provider.

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(4) The agreement is an agreement between the individual and the registered provider to delay refunding the accommodation bond balance on condition that, if the individual requests re-entry to the approved residential care home, the registered provider must allow entry to the individual if:

(a) a room, or part of a room, is vacant in the approved residential care home; and

(b) the individual has an access approval in effect that includes the classification type ongoing for the service group residential care.

287-103 Transfer of accommodation bond balance to another registered provider

(1) This section applies if:

(a) an accommodation bond was paid by an individual to a registered provider (the ***outgoing provider***) for accommodation in an approved residential care home through which the provider delivers ongoing funded aged care services through the service group residential care to the individual; and

(b) the accommodation bond was paid in whole or in part as a lump sum; and

(c) the outgoing provider ceases to deliver ongoing funded aged care services through the service group residential care in the residential care home; and

(d) there is continuity of the delivery of those services to the individual through that service group in the same residential care home by another registered provider (the ***incoming provider***).

(2) The accommodation bond balance must not be transferred to the incoming provider if:

(a) the incoming provider delivers ongoing funded aged care services through the service group residential care only under one or more specialist aged care programs; or

(b) the registered provider does not deliver any ongoing funded aged care services through the service group residential care.

Note: This means the accommodation bond balance is not required to be transferred under section 287-103 in these circumstances and instead must be refunded in accordance with section 287-102: see subparagraph 287-102(1)(b)(ii).

(3) The outgoing provider must, by written notice, give the following information in relation to the individual to the incoming provider before the transfer day:

(a) the transfer day;

(b) any amount of interest payable on or before the transfer day under section 287-103A in relation to the individual's accommodation bond balance and the amount of that interest;

(c) the entry in the refundable deposit register of the provider that relates to the individual.

(4) The outgoing provider must give written notice to the individual of the proposed transfer of the individual's accommodation bond balance before the transfer day, including:

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(a) details of the incoming provider; and
(b) the transfer day.

(5) If the transfer day is changed, the outgoing provider must give written notice to the individual of the new transfer day as soon as practicable before that day.

(6) The outgoing provider must transfer the accommodation bond balance to the incoming provider on the transfer day, as notified to the individual in accordance with this section.

287-103A Payment of interest—refund of accommodation bond balances—circumstances and amount

Circumstances in which payment of interest required

(1) If a registered provider is required under section 287-102 to refund an accommodation bond balance, the registered provider must pay an amount of interest in relation to the refund, worked out in accordance with this section, on the day on which the registered provider refunds the accommodation bond balance, unless subsection (2) of this section applies to the refund of the accommodation bond balance.

(2) This subsection applies to the refund of the accommodation bond balance if:
(a) item 1 of the table in subsection 287-102(3) applies to the refund of the accommodation bond balance; and
(b) the registered provider refunds the accommodation bond balance on the day referred to in column 2 of that item.

Amounts of interest if there is a refund period

(3) Subsections (4) and (5) of this section apply if subsection 287-102(2), or item 2, 3 or 4 of the table in subsection 287-102(3), applies to the refund.

If accommodation bond balance refunded on or before last day of refund period

(4) If the registered provider refunds the accommodation bond balance on or before the last day of the refund period in relation to the refund, the amount of interest is the amount worked out in accordance with the following formula:

$$\frac{BIR \times AB \times ND}{365}$$

where:

AB is the amount of the accommodation bond balance.

BIR is the base interest rate on the first day of the refund period.

ND is the number of days in the period:

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(a) beginning on the day after the day on which the refunding event in relation to the refund occurred; and
(b) ending on the day on which the accommodation bond balance is refunded.

If accommodation bond balance refunded after last day of refund period

(5) If the registered provider refunds the accommodation bond balance after the last day of the refund period, the amount of interest is the amount worked out in accordance with the following formula:

$$\frac{BIR \times AB \times ND(RP)}{365} + \frac{MPIR \times AB \times ND(PP)}{365}$$

where:

AB is the amount of the accommodation bond balance.

BIR is the base interest rate on the first day of the refund period.

MPIR is the pre-2014 maximum permissible interest rate for the day after the last day in the refund period.

ND(PP) is the number of days in the period:
(a) beginning on the day after the last day of the refund period; and
(b) ending on the day on which the accommodation bond balance is refunded.

ND(RP) is the number of days in the period:
(a) beginning on the day after the day on which the refunding event occurred; and
(b) ending on the last day of the refund period.

Amount of interest if there is a refund day—accommodation bond balance refunded after refund day

(6) If item 1 of the table in subsection 287-102(3) applies to the refund, and the registered provider refunds the accommodation bond balance after the day (the ***refund day***) referred to in column 2 of that item, the amount of interest is the amount worked out in accordance with the following formula:

$$\frac{MPIR \times AB \times ND(PP)}{365}$$

where:

AB is the amount of the accommodation bond balance.

MPIR is the pre-2014 maximum permissible interest rate for the day after the refund day.

ND(PP) is the number of days in the period:
(a) beginning on the day after the refund day; and

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(b) ending on the day on which the accommodation bond balance is refunded.

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Division 4—Accommodation charge agreements

287-104 Entry into accommodation charge agreement

A registered provider may enter into an accommodation charge agreement with an individual in the pre-2014 accommodation class after the transition time in relation to an approved residential care home (the ***new home***) if:

(a) one of the following applies to the individual:

(i) immediately before the transition time, an accommodation charge agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*, as in force immediately before the transition time) was in effect for the individual;

(ii) at the transition time, the most recent agreement that had been in effect for the individual was an agreement of the kind mentioned in subparagraph (i);

(iii) immediately before the transition time, the individual was eligible under the old Act to enter into an agreement of the kind mentioned in subparagraph (i); and

(b) the individual ceased (whether before or after the transition time) accessing funded aged care services in another approved residential care home and will start, or has started, accessing funded aged care services in the new home.

Note 1: The new home and the former home may be approved in relation to the same registered provider.

Note 2: An individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class: see paragraph (b) of the definition of ***pre-2014 accommodation class***.

287-105 Information to be given before registered provider enters into an accommodation charge agreement with an individual

Before a registered provider enters into an accommodation charge agreement with an individual, the provider must:

(a) give the individual a copy of the proposed accommodation charge agreement that meets the requirements set out in section 287-115; and

(b) inform the individual of the following:

(i) that, if the individual has given the provider sufficient information to determine the value of the individual's assets, the provider is required to leave the individual with assets with a value at least equal to the individual's pre-2014 minimum permissible asset value;

(ii) the interest rate to be charged on amounts owed under the accommodation charge agreement;

(iii) the accommodation charge;

(iv) when an accommodation charge is not required;

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(v) when an accommodation charge must not be charged at more than a specified daily amount because a transitional fee reduction supplement under section 242B-27 applies to the individual and is reducing the individual's accommodation charge;

(vi) if an accommodation charge is paid—when the charge is refundable.

287-110 Time within which registered providers must enter into accommodation charge agreement

A registered provider must enter into an accommodation charge agreement with an individual in relation to an approved residential care home before, or within 21 days after, the individual's start day for the home.

287-115 Accommodation charge agreements

An accommodation charge agreement between a registered provider and an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider must set out the following:

(a) the individual's start day, or proposed start day, for the home;

(b) the accommodation charge that:

(i) will accrue for each day (including a day on which the individual is on leave from the home) if the individual starts accessing the services at the home; or

(ii) if the individual has already started to access the services at the home—has accrued and will accrue for each day (including a day on which the individual is on leave from the home);

(c) how the accommodation charge is to be paid;

(d) when the accommodation charge is payable;

(e) the individual's room that the accommodation charge entitles the individual to be provided with;

(f) any services that the accommodation charge entitles the individual to be provided with;

(g) that a transitional fee reduction supplement under section 242B-27 may apply to the individual and reduce the accommodation charge, including to nil;

(h) that if the individual wishes to move from the approved residential care home (the ***original home***) of the provider to another approved residential care home (the ***new home***) of another registered provider, the registered provider of the original home may ask the individual for permission to provide the following information to the registered provider of the new home:

(i) whether the individual has agreed to pay an accommodation charge;

(ii) if so, the payment agreed;

(iii) the number of days for which the payment accrued under the agreement.

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287-120 Accommodation charge agreements may be incorporated into other agreements

For the purposes of this Division, an individual is taken to have entered into an accommodation charge agreement if the individual has entered into an agreement that contains the provisions required by section 287-115.

287-125 Accommodation charge agreements cannot affect requirements of this Division

The requirements of this Division apply despite any provision of an accommodation charge agreement, or any other agreement, to the contrary.

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Division 5—Accommodation charges

Subdivision A—Charging of accommodation charges

287-130 Charging of accommodation charges

A registered provider must comply with the following in relation to the charging of an accommodation charge to an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home (the ***new home***) of the provider:

(a) subject to this section, an accommodation charge must be charged if:
  (i) the individual ceased accessing the services in another approved residential care home (the ***former home***) of the provider or another registered provider and started accessing the services in the new home; and
  (ii) the individual paid an accommodation charge to access the services in the former home;

(b) the daily amount at which the accommodation charge accrues must not exceed the maximum provided for by section 287-135, and the individual must not be charged more than one accommodation charge to access the services in the home;

(c) the accommodation charge must not accrue after the day on which the registered provider ceases to deliver the services to the individual in the new home;

(d) if a transitional fee reduction supplement under section 242B-27 applies to the individual—the accommodation charge must be reduced (but not below zero) to reflect any amount of the supplement that is applied towards the payment;

(e) the registered provider must comply with the requirements of section 287-150 relating to payment of the accommodation charge;

(f) the individual may be required to pay interest to the registered provider in accordance with section 287-155 if some or all of the accommodation charge is not paid within the time that section permits.

Subdivision B—Daily accrual amounts of accommodation charges

287-135 Maximum daily accrual amount of accommodation charge

(1) Subject to subsection (2) and paragraph 287-130(d), the maximum daily amount at which an accommodation charge accrues is the lowest of the following:

(a) the amount of the daily accrual of the accommodation charge that was specified in the most recent accommodation charge agreement that was in effect for the individual;

(b) the amount (rounded down to the nearest cent) obtained by:

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(i) taking the amount that, when subtracted from an amount equal to the value of the individual's assets at the start of the individual's start day for the approved residential care home to which the payment relates, leaves an amount at least equal to the individual's pre-2014 minimum permissible asset value; and

(ii) dividing the result by 2,080;

(c) if sections 117 and 119, or section 118, of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time, applied to the individual as at that time—the amount worked out in accordance with whichever of those sections was applicable.

Note: The operation of this section may be modified if, before entering into an accommodation charge agreement, the individual gives the registered provider a determination under section 329 of the Act of the value of the individual's assets: see subsection (4).

(2) If an individual seeking to access ongoing funded aged care services through the service group residential care at an approved residential care home of a registered provider does not, before entering into an accommodation charge agreement, give the provider sufficient information about the individual's assets for the provider to be able to determine the amount referred to in paragraph (1)(b), the maximum daily amount at which the individual's accommodation charge accrues is:

(a) if sections 117 and 119, or section 118, of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time, applied to the individual as at that time—the lesser of:

(i) the amount referred to in paragraph (1)(a); and

(ii) the amount referred to in paragraph (1)(c); and

(b) otherwise—the amount referred to in paragraph (1)(a).

(3) The value of an individual's assets is to be worked out in accordance with section 330 of the Act, but:

(a) taking into account only the assets of the individual of the kinds referred to in subsection 44(2) of the *Aged Care (Transitional Provisions) Principles 2014* as in force immediately before the transition time; and

(b) disregarding subsection 330(7) of the Act (value of home).

(4) However, subsections (1) and (2) are modified as described in the following table, and subsection (3) does not apply, if, before entering into the accommodation charge agreement, the individual gives the registered provider a copy of a determination that:

(a) is a determination under section 329 of the Act of the value of the individual's assets at a time (the ***valuation time***) that is before or at the start of the individual's start day for the home; and

(b) is in force at the start of the start day, if that is after the valuation time.

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Modifications of subsections (1) and (2)		
Item	**Column 1** **If …**	**Column 2** **subsections (1) and (2) have effect as if …**
1	the valuation time is before the start of the start day for the home	(a) the reference in paragraph (1)(b) to the start of the individual's start day for the home were a reference to the valuation time; and (b) the value of the individual's assets at the valuation time were the value specified in the determination; and (c) subsection 287-45(3) defined ***pre-2014 minimum permissible asset value*** by reference to the basic age pension amount at the valuation time (instead of the start of the start day)
2	the valuation time is at the start of the start day for the home	the value of the individual's assets at the start of the individual's start day for the home were the value specified in the determination

Subdivision C—Payment of accommodation charges

287-150 Accommodation charge may be payable not more than one month in advance

(1) An individual may be required to pay an accommodation charge from the day that is one month before the day for which the payment will accrue.

(2) If the accommodation charge does not in fact accrue, the individual is entitled to a refund of the amount paid.

287-155 Registered provider may charge interest

(1) If:
  (a) an individual is required, under an accommodation charge agreement, to pay an amount of accommodation charge to a registered provider; and
  (b) the individual does not pay the required amount before the day that is one month after the day for which the payment accrues; and
  (c) the agreement provides for interest to be charged on the balance outstanding at a specified rate;

the individual may be required to pay interest to the registered provider from the day that is one month after the day for which the payment accrues while the balance remains unpaid.

(2) However, the rate at which interest is charged in respect of a day must not be more than twice the below threshold rate on the day.

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Division 6—Entry contributions

287-160 Payment of interest—refund of entry contribution balances

(1) A registered provider must pay an amount of interest relating to a refund of an entry contribution balance, worked out in accordance with subsection (2), to an individual in the pre-2014 accommodation class on the day on which the registered provider refunds the entry contribution balance to the individual if:

(a) the formal agreement between the registered provider and the individual requires the registered provider to refund the entry contribution balance to the individual; and

(b) either:

(i) the registered provider has not made an agreement with the individual to delay refunding the balance; or

(ii) such an agreement was made, but has ceased to be in effect between the registered provider and the individual.

(2) If the registered provider refunds the entry contribution balance after the last day specified in the formal agreement for the entry contribution balance to be refunded to the individual (the ***refund day***), the amount of interest on the entry contribution balance is the amount worked out in accordance with the following formula:

$$\frac{\text{MPIR} \times \text{ECB} \times \text{ND(PP)}}{365}$$

where:

ECB is the amount of the entry contribution balance.

MPIR is the pre-2014 maximum permissible interest rate for the day after the refund day.

ND(PP) is the number of days in the period:

(a) beginning on the day after the refund day; and

(b) ending on the day on which the entry contribution balance is refunded.

(3) Subsection (2) applies as if the reference in paragraph (a) of the definition of ***ND(PP)*** to the day after the refund day were a reference to the day after the day on which probate of the will of the individual is, or letters of administration of the estate of the individual are, shown to the registered provider if:

(a) the registered provider is required, under the formal agreement, to refund the entry contribution balance because the individual in relation to whom the entry contribution was paid has died; and

(b) the entry contribution balance is refunded after the refund day; and

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(c) the entry contribution balance is refunded after the refund day because neither the probate of the will nor letters of administration of the estate were shown to the registered provider before the refund day.

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Division 7—Miscellaneous

287-165 Pre-2014 maximum permissible interest rate

The ***pre-2014 maximum permissible interest rate*** for a day is worked out as follows:

Step 1.	Work out the general interest charge rate for the day under subsection 8AAD(1) of the *Taxation Administration Act 1953*.
Step 2.	Multiply the rate worked out at step 1 by the number of days in the calendar year in which the day falls.
Step 3.	Subtract 3 percentage points from the amount worked out at step 2.

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Part 3—Accommodation payments and accommodation contributions

Division 1—Application to specialist aged care programs

288-5 Provisions that do not apply in relation to certain specialist aged care programs

MPSP

(1) For the purposes of paragraph 288(1)(a) of the Act, the following provisions of the Act are prescribed in respect of the delivery of funded aged care services to an individual under the MPSP:
  (a) paragraph 294(1)(c);
  (b) paragraph 294(1)(d);
  (c) subsection 294(3);
  (d) subsection 294(4) (to the extent that it relates to subsection 294(3));
  (e) section 298;
  (f) subsection 307(3);
  (g) section 309.

NATSIFACP

(2) For the purposes of paragraph 288(1)(a) of the Act, the provisions of Part 4 of Chapter 4 of the Act are prescribed in respect of the delivery of funded aged care services to an individual under the NATSIFACP.

288-10 Specialist aged care programs for which specified provisions do not apply

For the purposes of paragraph 288(1)(c) of the Act, the following specialist aged care programs are prescribed:
  (a) MPSP;
  (b) NATSIFACP.

288-20 Specialist aged care programs—accommodation agreements

For the purposes of paragraph 288(2)(a) of the Act, an accommodation agreement between a registered provider delivering funded aged care services to an individual under the MPSP and the individual must set out information for the individual about accessing the provider's financial hardship policy.

Note: The accommodation agreement also must comply with the requirements in section 294-5.

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288-25 Specialist aged care programs—charging of accommodation payments and accommodation contributions

MPSP

(1) For the purposes of paragraph 288(2)(b) of the Act, if a registered provider is satisfied that an individual to whom the registered provider is delivering ongoing funded aged care services through the service group residential care in an approved residential care home under the MPSP is experiencing financial hardship, the provider must:

(a) provide the individual with a copy of the provider's financial hardship policy referred to in section 286-20; and

(b) comply with the policy (including reducing or waiving the accommodation payment in accordance with the terms of the policy).

Note: The registered provider also must comply with section 296-5 (which deals with the charging of accommodation payments).

NATSIFACP

(2) For the purposes of paragraph 288(2)(b) of the Act, a registered provider delivering funded aged care services to an individual through the service group residential care in an approved residential care home under the NATSIFACP must not charge the individual an accommodation payment for the delivery of those services.

MPSP and NATSIFACP

(3) For the purposes of paragraph 288(2)(c) of the Act, a registered provider delivering funded aged care services to an individual through the service group residential care in an approved residential care home under the MPSP or NATSIFACP must not charge the individual an accommodation contribution for the delivery of those services.

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Division 2—Maximum accommodation payment amounts and publication of certain amounts by the System Governor

Subdivision A—Maximum accommodation payment amount

289-5 Maximum accommodation payment amount

For the purposes of subsection 289(1) of the Act, $758,627 is prescribed as the maximum amount of accommodation payment (expressed as a refundable accommodation deposit amount).

289-10 Maximum accommodation payment amount—daily accommodation payment amount

For the purposes of subsection 289(3) of the Act, the method for working out the maximum accommodation payment amount expressed as a daily accommodation payment amount for a day is as follows:

Step 1.	Work out the maximum permissible interest rate for the day.
Step 2.	Multiply the rate worked out at step 1 by the maximum accommodation payment amount.
Step 3.	Divide the amount worked out at step 2 by 365 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).

Subdivision B—Application to Pricing Authority for approval of higher maximum accommodation payment amount

290-15 Requirements for application

For the purposes of paragraph 290(3)(a) of the Act, the application must:

(a) be in writing; and
(b) be in a form approved by the Pricing Authority; and
(c) be accompanied by any information or documents specified by the approved form; and
(d) relate to only one residential care home; and
(e) specify each room, or each part of a room, in the residential care home for which approval is sought to charge a higher maximum accommodation payment amount; and
(f) specify each of those higher maximum accommodation payment amounts (expressed as a refundable accommodation deposit amount).

Note: Although applications may be made under section 290 of the Act in relation to residential care homes that are not approved residential care homes, only a registered

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provider delivering funded aged care services through the service group residential care in an approved residential care home may charge, under Part 4 of Chapter 4 of the Act, an amount of accommodation payment.

290-20 Restriction on application period

For the purposes of subparagraph 290(3)(b)(i) of the Act, the period of 4 months is prescribed.

290-25 Decision of Pricing Authority on application

Purpose and application of this section

(1) This section is made for the purposes of subsections 290(6) and (12) of the Act and applies to an application, of any kind mentioned in subsection 290(2) of the Act, by a registered provider for approval of a higher maximum accommodation payment amount in relation to a room, or a part of a room, in a residential care home.

Matters that must be considered

(2) In deciding whether to approve the higher maximum accommodation payment amount for the room, or the part of the room, the Pricing Authority must consider the following:
  (a) the proposed higher maximum accommodation payment amount;
  (b) the location of the residential care home;
  (c) the quality, condition, size and amenity of the room or the part of the room;
  (d) whether the room has access to a shared bathroom or has a private ensuite;
  (e) whether the room, or the part of the room, has any specific accommodation or design features;
  (f) the number of individuals to whom ongoing funded aged care services may be delivered through the service group residential care in the room;
  (g) the quality, condition, size and amenity of the common areas in the residential care home that would be accessible to those individuals;
  (h) whether the residential care home has any specific accommodation or design features that would be accessible to those individuals.

Notification of decision

(3) If the Pricing Authority makes a decision to approve the higher maximum accommodation payment amount for the room, or the part of the room, the Pricing Authority must include the following in the notice of the decision given to the registered provider:
  (a) the unique identification number that corresponds to the registered provider's application;
  (b) if the approval is not subject to conditions:
    (i) the day on which the approval takes effect; and

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(ii) the period during which the approval is in effect (see subsection (8));

(c) if the approval is subject to conditions in accordance with section 290-30—the conditions to which the approval is subject.

Note 1: An approved higher maximum accommodation payment amount applies only to certain individuals: see subsections 290(8) and (9) of the Act.

Note 2: If the application relates to a room, or a part of a room, that is subject to construction or refurbishment, the approval is subject to the condition in subsection 290-30(2).

(4) If the Pricing Authority makes a decision not to approve the higher maximum accommodation payment amount for the room, or the part of the room, the Pricing Authority must include the following in the notice of the decision given to the registered provider:

(a) details of the decision;

(b) reasons for the decision;

(c) details about how the provider may apply for the reconsideration of the decision.

Note: A decision of the Pricing Authority not to approve a higher maximum accommodation payment amount in relation to a registered provider is a reviewable decision under section 558 of the Act.

(5) The notice may relate to more than one decision for a room or a part of a room.

Period within which decision must be made and notification given

(6) The Pricing Authority must make, and give notice of, a decision on an application made in accordance with subsection 290(3) of the Act within 60 days after the Pricing Authority receives the application.

(7) If the registered provider is required, under subsection 290(4) of the Act, to give the Pricing Authority further information for the purposes of making a decision on the application, the 60 day period referred to in subsection (6) 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.

When approval is in effect—approval not subject to conditions

(8) An approval of a higher maximum accommodation payment amount for a room, or a part of a room, that is not subject to conditions:

(a) takes effect at the start of the day specified in the notice given to the registered provider (as mentioned in subparagraph (3)(b)(i)); and

(b) is in effect during the period of 4 years beginning on that day.

Note: See subsection 290-30(6) for the time when, and the period during which, an approval that is subject to conditions in accordance with section 290-30 is in effect.

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290-30 Condition on approval relating to a room, or part of a room, subject to construction or refurbishment

Purpose and application of section

(1) This section is made for the purposes of subsections 290(7) and (12) of the Act and applies if the Pricing Authority approves a higher maximum accommodation payment amount for a room, or a part of a room, that is being, or is proposed to be, constructed or refurbished.

Condition on approval

(2) The approval is subject to the condition that the approval does not take effect unless the requirements in subsection (3) are met.

(3) The requirements are that, within the period of 4 years beginning on the day the Pricing Authority gave notice of the approval to the registered provider:

(a) the registered provider gives the following information, in writing, to the Pricing Authority:

(i) information showing that the construction or refurbishment of the room, or the part of the room, has been completed and that the completed or refurbished room, or the part of the room, is equivalent to or better than the proposal described in the application;

(ii) the total actual cost (the ***actual cost***) of the completed construction or refurbishment; and

(b) the Pricing Authority notifies the registered provider, under subsection (4), that the Pricing Authority is satisfied, having regard to the information given under paragraph (a) of this section, that the requirements referred to in subparagraph (a)(i) have been met in relation to the room, or the part of the room, and that:

(i) the actual cost of the completed construction or refurbishment is not significantly lower than the proposed cost of the construction or refurbishment; or

(ii) if the actual cost of the completed construction or refurbishment is significantly lower than the proposed cost of the construction or refurbishment and if the lower actual cost had been provided to the Pricing Authority with the application as the proposed cost—the Pricing Authority would still have approved the higher maximum accommodation payment amount applied for.

Decision on information and notification of decision

(4) If the registered provider gives the Pricing Authority information in accordance with paragraph (3)(a), the Pricing Authority must, within 28 days of receiving the information:

(a) decide whether the Pricing Authority is satisfied, as referred to in paragraph (3)(b); and

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(b) notify the registered provider, in writing, of the decision.

(5) If the Pricing Authority decides it is not so satisfied, the Pricing Authority must include the following in the notice of the decision given to the registered provider:
(a) details of the decision;
(b) reasons for the decision;
(c) details about how the provider may apply for the reconsideration of the decision.

Note: A decision of the Pricing Authority that it is not so satisfied, as referred to in paragraph (3)(b), is a reviewable decision under section 557 of the Act: see section 558-5 of this instrument.

When approval is in effect

(6) If the Pricing Authority decides it is so satisfied:
(a) the Pricing Authority must include the following in the notice of the decision given to the registered provider:
(a) the day on which the approval takes effect;
(b) the period during which the approval is in effect; and
(b) the approval of the higher maximum accommodation payment amount for the room, or the part of the room:
(i) takes effect at the start of the day specified in that notice; and
(ii) is in effect for the period of 4 years beginning on that day.

290-40 Indexation of higher maximum accommodation payment amount

(1) For the purposes of subsection 290(11) of the Act, a higher maximum accommodation payment amount that may be charged by a registered provider (the ***relevant registered provider***) may be indexed by the registered provider no earlier than the first day of the second, or a later, approval year (the ***current approval year***) for the amount, by multiplying the amount by the amount worked out using the formula:

$$\frac{\text{Most recent index number}}{\text{Previous index number}}$$

where:

most recent index number means the index number for the most recent quarter ending before the first day of the current approval year.

previous index number means the index number for the most recent quarter ending before the first day of the previous approval year.

(2) If a higher maximum accommodation payment amount is indexed under this section, the Act and this instrument have effect as if the indexed amount were substituted for the higher maximum accommodation payment amount.

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(3) If a higher maximum accommodation payment amount is indexed on a day under this section, the indexed amount applies only in relation to an individual if:

(a) both of the following apply:

(i) the individual has not, before that day, entered into an accommodation agreement with the relevant registered provider;

(ii) the registered provider starts delivering funded aged care services to the individual in the approved residential care home on or after that day; or

(b) all of the following apply:

(i) the individual's start day occurred before the date of the approval by the Pricing Authority;

(ii) the individual had entered into an accommodation agreement with the registered provider before the date of the approval;

(iii) the individual moves to another bed, whether in another room (the ***new room***) or another part of a room (the ***new part***), in the residential care home and the move is voluntary;

(iv) the higher maximum accommodation payment amount applies in relation to the part of the residential care home that includes the new room or the new part of a room.

(4) If, apart from this subsection, a higher maximum accommodation payment amount indexed under this section would be an amount of dollars and cents:

(a) the amount is to be rounded to the nearest whole dollar; and

(b) if the amount to be rounded is 50 cents, the amount is to be rounded down.

(5) If, at any time (whether before or after the commencement of this section), the Australian Statistician publishes an index number for a quarter in substitution for an index number previously published by the Australian Statistician for that quarter, the publication of the later index number is to be disregarded for this section.

(6) If, at any time (whether before or after the commencement of this section), the Australian Statistician changes the index reference period for the Consumer Price Index, then, in applying this section after the change is made, regard is to be had only to index numbers published in terms of the new index reference period.

Subdivision C—Notification and publication of accommodation payment amounts

291-5 Notification

(1) For the purposes of subsection 291(1) of the Act, the requirements are that the registered provider must give the System Governor a notice setting out the following information in relation to an accommodation payment the registered provider proposes to charge an individual for a room or part of a room in the approved residential care home:

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(a) a statement describing the key accommodation features of the room or the part of the room;
(b) the maximum accommodation payment amount (expressed as a refundable accommodation deposit amount, and as a daily accommodation payment amount worked out in accordance with section 294-10) that the provider could charge an individual for the room or the part of the room;
(c) if the registered provider proposes to charge an accommodation payment in relation to the room or the part of the room that exceeds the maximum accommodation payment amount—a copy of the notice given to the provider by the Pricing Authority under subsection 290(6) of the Act, and section 290-30 of this instrument (if applicable), that covers the charging of the higher amount.

(2) For the purposes of paragraph (1)(a), the statement describing the key accommodation features of the room or the part of the room must include the following information:
(a) a description of the quality, condition, size and amenity of the room or the part of the room;
(b) whether the room or the part of the room has access to a shared bathroom or has a private ensuite;
(c) a description of any specific accommodation or design features in the room or the part of the room;
(d) the number of individuals to whom ongoing funded aged care services may be delivered through the service group residential care in the room;
(e) a description of the quality, condition, size and amenity of the common areas in the approved residential care home that would be accessible to those individuals;
(f) a description of any specific accommodation or design features in the approved residential care home that would be accessible to those individuals.

291-10 Publication of notification

For the purposes of paragraph 291(4)(d) of the Act, the information is the information in paragraphs 291-5(2)(a) to (f).

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Division 3—Accommodation agreements

292-5 Information to be given before provider enters into an accommodation agreement with an individual—daily accommodation payment amount

For the purposes of subparagraph 292(b)(ii) of the Act, the method for working out a daily accommodation payment amount in relation to a published accommodation payment amount (expressed as a refundable accommodation deposit amount) that an individual is informed of is as follows:

Step 1.	Work out the maximum permissible interest rate for the day the individual is informed of the published accommodation payment amount (expressed as a refundable accommodation deposit amount).
Step 2.	Multiply the rate worked out at step 1 by the published accommodation payment amount (expressed as a refundable accommodation deposit amount).
Step 3.	Divide the amount worked out at step 2 by 365 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).

294-5 Accommodation agreements—other matters to be included in accommodation agreement

(1) For the purposes of paragraph 294(1)(l) of the Act, this section prescribes other matters that must be set out in an accommodation agreement between a registered provider and an individual.

Note: An accommodation agreement between a registered provider and an individual to whom the provider is delivering funded aged care services under the MPSP must also comply with section 288-20.

General matters

(2) The accommodation agreement must set out the following in relation to any accommodation payment the individual will pay:

(a) the individual's room that the accommodation payment entitles the individual to be provided with;

(b) any services that the accommodation payment entitles the individual to be provided with;

(c) that, if the individual changes the individual's room in the approved residential care home, this will not change the individual's start day for the approved residential care home.

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Additional matters in relation to voluntary moves within the approved residential care home

(3) The accommodation agreement must set out that, if the individual proposes to change the individual's room in the approved residential care home, and the move is voluntary:

(a) the accommodation agreement must be varied, before the move occurs, to specify the new room; and

(b) the day on which the agreement is varied will become the price agreement day for the individual and the approved residential care home; and

(c) the individual may be charged an accommodation payment amount, after the move, that is higher or lower than the accommodation payment amount the individual is paying before the move; and

(d) the individual must not be charged an accommodation payment amount that is higher than the published accommodation payment amount for the individual's new room on the day the agreement is varied; and

(e) if the individual is to be charged a higher accommodation payment amount for the individual's new room—the individual may choose to pay the additional accommodation payment amount by:

(i) daily payments; or

(ii) refundable deposit; or

(iii) a combination of refundable deposit and daily payments.

Additional matters in relation to non-voluntary moves within the approved residential care home

(4) The accommodation agreement must set out that, if an individual's room in the approved residential care home is to be changed for less than 28 days, and the move is not voluntary:

(a) the registered provider must, before the move occurs, notify the individual, in writing, of the change to the individual's room; and

(b) there will be no change to the individual's price agreement day for the approved residential care home; and

(c) the individual will continue to be charged the same accommodation payment amount that the individual is paying before the move.

(5) The accommodation agreement must set out that, if the individual's room in the approved residential care home is to be changed for 28 days or longer, and the move is not voluntary:

(a) the registered provider must, before the move occurs, notify the individual, in writing, of the change to the individual's room; and

(b) the day on which the notice is given will become the individual's price agreement day for the approved residential care home; and

(c) the individual must not be charged:

(i) an accommodation payment amount that is higher than the accommodation payment amount the individual is paying before the move; or

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(ii) if the published accommodation payment amount for the individual's new room on the day the notice is given is lower than the amount the individual is paying before the move—an accommodation payment amount that is higher than that published accommodation payment amount.

(6) For the purposes of subsections (4) and (5), a move by an individual to a new room in an approved residential care home is not voluntary if:

(a) the move is necessary on genuine medical grounds as assessed by:

(i) an approved needs assessor; or

(ii) at least 2 medical or other health practitioners who meet the criteria mentioned in subsection (7); or

(b) the move is necessary to carry out repairs or improvements to the premises of the approved residential care home.

(7) For the purposes of subparagraph (6)(a)(ii), the criteria are:

(a) one practitioner must be independent of the registered provider and the approved residential care home, and must be chosen by the individual; and

(b) both practitioners must be competent to assess the aged care needs of the individual.

294-10 Accommodation agreements—daily accommodation payment amount

For the purposes of subparagraph 294(2)(b)(iii) of the Act, the method to work out an individual's daily accommodation payment amount in relation to an agreed accommodation payment amount is the method referred to in subsection 296-5(3).

294-15 Accommodation agreements—method for working out amounts payable as a combination of refundable accommodation deposit and daily accommodation payments

For the purposes of paragraph 294(2)(d) of the Act, the method for working out amounts that would be payable as a combination of refundable accommodation deposit and daily accommodation payments is the method referred to in subsection 296-5(4).

294-20 Accommodation agreements—method for working out amounts payable by refundable accommodation contributions

For the purposes of subparagraph 294(3)(c)(i) of the Act, the method for working out an individual's refundable accommodation contribution is the method referred to in subsection 298-10(3).

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294-25 Accommodation agreements—method for working out amounts payable by combination of refundable accommodation contributions and daily accommodation contributions

For the purposes of subparagraph 294(3)(c)(ii) of the Act, the method for working out amounts payable by a combination of refundable accommodation contribution and daily accommodation contributions is the method referred to in subsection 298-10(4).

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Division 4—Charging of accommodation payments

296-5 Charging of accommodation payments—requirements

(1) For the purposes of paragraph 296(d) of the Act, this section sets out requirements a registered provider must comply with in relation to the charging of an accommodation payment to an individual.

Note: If the registered provider is delivering funded aged care services to the individual under the MPSP the registered provider must also comply with subsection 288-25(1).

(2) The registered provider must ensure that there is equivalence between:
(a) the refundable accommodation deposit amount that the provider could charge the individual for a day (the ***relevant day***); and
(b) the daily accommodation payment amount that the provider could charge the individual for the relevant day.

(3) For the purpose of complying with subsection (2), the daily accommodation payment amount that the registered provider could charge the individual for the relevant day if the individual has paid no refundable accommodation deposit on or before that day is worked out as follows:

Step 1. Work out the maximum permissible interest rate for the individual's price agreement day.

Note: If the individual's accommodation agreement is varied because the individual's room changes, the individual's price agreement day and agreed accommodation payment amount may change for the purposes of this section.

Step 2. Multiply the rate worked out at step 1 by the agreed accommodation payment amount.

Step 3. Work out the individual's ***maximum possible daily accommodation payment amount*** by dividing the amount worked out at step 2 by 365 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).

Step 4. Apply any applicable indexation to the step 3 amount in accordance with section 302-10.

Note: Indexation is not applied for certain classes of individuals: see section 302-17.

(4) For the purposes of complying with subsection (2), the daily accommodation payment amount that the registered provider could charge the individual for the relevant day if the individual has paid a refundable accommodation deposit on or before that day is worked out as follows:

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Step. 1	Work out under subsection (3) the amount the registered provider could charge as a daily accommodation payment amount (as if no refundable accommodation deposit had been made).
Step. 2	Work out the individual's refundable deposit balance for the relevant day (including if this is a zero amount) and add to that amount the sum of any deductions made under section 308 of the Act on or before the relevant day.
Step. 3	Divide the step 2 amount by the agreed accommodation payment amount.
Step. 4	Subtract the step 3 amount from 1.
Step. 5	Multiply the step 4 amount by the step 1 amount (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).

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Division 5—Charging of accommodation contributions

298-5 Charging of accommodation contributions—prescribed circumstances

(1) For the purposes of paragraph 298(c) of the Act, subsection (2) prescribes the circumstances in which that paragraph of the Act does not apply in relation to the charging of an accommodation contribution for the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home.

(2) The circumstances are that:
  (a) the individual is in the post-2014 residential accommodation class; and
  (b) immediately before the transition time, the individual was receiving residential care through a residential care service (within the meaning of the old Act); and
  (c) since the transition time, the individual has not ceased accessing ongoing funded aged care services through the residential care service group in an approved residential care home.

298-10 Charging of accommodation contributions—requirements

(1) For the purposes of paragraph 298(e) of the Act, this section prescribes requirements a registered provider must comply with in relation to the charging of an accommodation contribution to an individual for the delivery of ongoing funded aged care services to the individual in an approved residential care home.

(2) The registered provider must ensure that, for a day (the ***relevant day***), there is equivalence between:
  (a) the individual's daily accommodation contribution amount; and
  (b) the maximum refundable accommodation contribution amount that the individual may be charged.

(3) For the purpose of complying with subsection (2), the maximum refundable accommodation contribution amount that the registered provider could charge the individual for the relevant day must be the amount worked out as follows:

Step 1.	Work out the maximum amount of daily accommodation contribution the individual could be charged for the relevant day having regard to paragraphs 298(b) and (c) of the Act.
Step 2.	Multiply the amount worked out at step 1 by 365 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).
Step 3.	Divide the amount worked out at step 2 by the maximum permissible interest rate for the individual's start day for the classification type ongoing for the service group residential care in relation to the approved residential care home.

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Step 4.	Subtract from the amount worked out at Step 3 the sum of any deductions made on or before the relevant day from the refundable accommodation contribution in accordance with section 308 of the Act.

(4) For the purposes of complying with subsection (2), if the individual has paid part of the accommodation contribution in relation to the approved residential care home by refundable accommodation contribution on or before the relevant day, the daily accommodation contribution amount that the registered provider could charge the individual for the relevant day must be the amount worked out as follows:

Step 1.	Work out the maximum permissible interest rate for the individual's start day for the classification type ongoing for the service group residential care in relation to the approved residential care home.
Step 2.	Work out the amount that is the difference between: (a) the maximum refundable accommodation contribution amount for the individual for the relevant day worked out under subsection (3); and (b) the individual's refundable deposit balance for the relevant day.
Step 3.	Multiply the rate worked out at step 1 by the amount worked out at step 2.
Step 4.	Divide the amount worked out at step 3 by 365 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).

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Division 6—Charging of daily payments

301-5 Charging interest

For the purposes of subsection 301(3) of the Act, the maximum rate for a day is worked out as follows:

Step 1.	Work out the general interest charge rate for the day under subsection 8AAD(1) of the *Taxation Administration Act 1953*.
Step 2.	Multiply the rate worked out at step 1 by the number of days in the calendar year in which the day falls.
Step 3.	Subtract 3 percentage points from the amount worked out at step 2.

302-10 Daily accommodation payments—indexation

(1) For the purposes of paragraphs 302(b) and (c) of the Act, the maximum possible daily accommodation payment amount for an individual is indexed on an indexation day by replacing the amount with the amount worked out using the following method:

Step 1.	Work out the individual's maximum possible daily accommodation payment amount (disregarding any indexation previously applied to that amount in accordance with this section).
Step 2.	Work out the indexation factor by dividing the DAP index number for the indexation day by the DAP index number for the individual's reference indexation day (rounding the result to 4 decimal places, rounding up if the fifth decimal place is 5 or more). Note: For DAP index numbers see section 302-15.
Step 3.	Multiply the amount worked out under step 1 by the indexation factor worked out under step 2 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).

(2) In this section:

indexation day means:
(a) 20 March; and
(b) 20 September.

reference indexation day for an individual and an approved residential care home means the indexation day before the first indexation day that occurs after the later of the following:
(a) the individual's start day in relation to the approved residential care home;

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(b) if the individual moves to a new room, or part of a room, in the approved residential care home—the day the individual occupies the new room or the part of the room.

302-15 Daily payments—DAP index numbers

For the purposes of step 2 of the method in section 302-10, the ***DAP index number*** for an indexation day is worked out using the following table:

Indexation factor

Item	Column 1 For the following indexation day …	Column 2 the DAP index number is …
1	20 September 2025	1.0
2	20 March 2026	1.02

302-17 Daily payments—circumstances in which daily accommodation payment is not to be indexed

For the purposes of paragraph 302(ca) of the Act, the circumstance of being an individual in either of the following classes of individuals is prescribed:

(a) the post-2014 residential accommodation class;

(b) the post-2014 flexible accommodation class.

302-20 Daily payments—circumstances in which an amount of daily payment may be refunded

(1) For the purposes of paragraph 302(cb) of the Act, this section prescribes requirements that apply to registered providers in relation to the refund of an overpaid amount of daily accommodation payment or daily accommodation contribution.

Note: For the refund of an overpayment of refundable accommodation deposit or refundable accommodation contribution, see section 304-5.

(2) This section applies if an individual to whom funded aged care services are, or were, being delivered through the service group residential care in an approved residential care home has paid a higher amount of daily accommodation payment or daily accommodation contribution than was properly payable.

(3) The registered provider of the approved residential care home must refund to the individual the difference (the ***overpaid amount***) between the amount of daily accommodation payment or daily accommodation contribution that was properly payable and the amount of daily accommodation payment or daily accommodation contribution that was paid.

(4) The individual may request the registered provider, in writing, to refund the overpaid amount to the individual.

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(5) If the registered provider does not refund the overpaid amount to the individual within 28 days after the earlier of:

(a) the day the registered provider becomes aware of the overpaid amount; and

(b) if the individual makes a request under subsection (4)—the day the registered provider receives the request;

the registered provider must pay an amount of interest relating to the overpaid amount, worked out in accordance with the following formula:

$$\frac{\text{MPIR} \times \text{OA} \times \text{ND(PP)}}{365}$$

where:

MPIR is the maximum permissible interest rate for the day that is 28 days after the day referred to in paragraph (a) or (b) (as the case requires) of this subsection.

ND(PP) is the number of days in the period:

(a) beginning on the day that is 28 days after the day referred to in paragraph (a) or (b) (as the case requires) of this subsection; and

(b) ending on the day on which the overpaid amount is refunded.

OA is the overpaid amount.

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Division 7—Refundable deposits

304-5 Refundable deposits—circumstances in which an amount of refundable deposit may be refunded

(1) For the purposes of paragraph 304(a) of the Act, this section prescribes requirements that apply to registered providers in relation to the refund of an overpaid amount of refundable accommodation deposit or refundable accommodation contribution.

Note: For the refund of an overpayment of daily accommodation payment or daily accommodation contribution, see section 302-20.

Overpaid amount of refundable accommodation deposit or refundable accommodation contribution

(2) This section applies if an individual to whom funded aged care services are, or were, being delivered through the service group residential care in an approved residential care home has paid a higher amount of refundable accommodation deposit or refundable accommodation contribution than was properly payable.

(3) The registered provider of the approved residential care home must refund to the individual the difference (the ***overpaid amount***) between the amount of refundable accommodation deposit or refundable accommodation contribution that was properly payable and the amount of refundable accommodation deposit or refundable accommodation contribution that was paid.

(4) The individual may request the registered provider, in writing, to refund the overpaid amount to the individual.

(5) If the registered provider does not refund the overpaid amount to the individual within 28 days after the earlier of:
(a) the day the registered provider becomes aware of the overpaid amount; and
(b) if the individual makes a request under subsection (4)—the day the registered provider receives the request;

the registered provider must pay an amount of interest relating to the overpaid amount, worked out in accordance with the following formula:

$$\frac{\text{MPIR} \times \text{OA} \times \text{ND(PP)}}{365}$$

where:

MPIR is the maximum permissible interest rate for the day that is 28 days after the day referred to in paragraph (a) or (b) (as the case requires) of this subsection.

ND(PP) is the number of days in the period:

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(a) beginning on the day that is 28 days after the day referred to in paragraph (a) or (b) (as the case requires) of this subsection; and
(b) ending on the day on which the overpaid amount is refunded.

OA is the overpaid amount.

307-5 Amounts to be deducted from refundable deposit balances—deductible amount

For the purposes of paragraph 307(3)(a) of the Act, any amount of daily payment that is outstanding on the day the registered provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in an approved residential care home is prescribed.

308-10 Amounts that must be deducted from refundable deposit balances—retention amounts—timing of deductions

For the purposes of paragraph 308(3)(a) of the Act, the registered provider may deduct a retention amount from a refundable deposit balance if:

(a) there is a retention amount outstanding on the day the registered provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in an approved residential care home; and
(b) the provider deducts the retention amount prior to:
  (i) refunding the refundable deposit balance to the individual; or
  (ii) transferring the refundable deposit balance to another registered provider.

Note: Retention amounts must be deducted from a refundable deposit balance at least once in each 3 month period starting on the day the individual paid the refundable deposit, and must not be deducted more than once in any one month period or in certain other circumstances: see subsections 308(3A) and (4) of the Act.

308-11 Amounts that must be deducted from refundable deposit balances—retention amounts—circumstances in which a retention amount may be refunded

(1) For the purposes of paragraph 308(3)(b) of the Act, this section prescribes requirements that apply to registered providers in relation to the refund of an overcharged retention amount.

Overcharged retention amount

(2) This section applies if an individual to whom funded aged care services are, or were, being delivered through the service group residential care in an approved residential care home has been charged a higher retention amount than was properly chargeable.

(3) The registered provider of the approved residential care home must refund to the individual's refundable deposit balance the difference (the ***overcharged amount***)

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between the retention amount that was properly chargeable and the retention amount that was charged.

(4) The individual may request the registered provider, in writing, to refund the overcharged amount to the individual's refundable deposit balance.

(5) The registered provider must refund the overcharged amount to the individual's refundable deposit balance within 14 days after the earlier of:
  (a) the day the registered provider becomes aware of the overcharged amount; and
  (b) if the individual makes a request under subsection (4)—the day the registered provider receives the request.

(6) If the registered provider does not refund the overcharged amount to the individual's refundable deposit balance before the day (the ***cessation day***) funded aged care services cease to be delivered to the individual through the service group residential care in the approved residential care home, the registered provider must pay an amount of interest relating to the overcharged amount, worked out in accordance with the following formula:

$$\frac{\text{MPIR} \times \text{OA} \times \text{ND(PP)}}{365}$$

where:

MPIR is the maximum permissible interest rate for the day that is the day after the cessation day.

ND(PP) is the number of days in the period:
  (a) beginning on the day that is the day after the cessation day; and
  (b) ending on the day on which the overcharged amount is refunded.

OA is the overcharged amount.

308-12 Amounts that must be deducted from refundable deposit balances—retention amounts—classes of individuals for whom amounts must not be deducted

For the purposes of subsection 308(7) of the Act, the following classes of individuals are prescribed:
  (a) the post-2014 residential accommodation class;
  (b) the post-2014 flexible accommodation class;
  (c) the class of individuals that have ceased to be in the pre-2014 accommodation class.

Note: An individual ceases to be in the pre-2014 accommodation class if the 28 day period referred to in paragraph (b) of the definition of ***pre-2014 accommodation class*** is exceeded, or the individual gives an election in accordance with subparagraph (c)(i) of that definition.

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309-5 Rules about deductions

For the purposes of section 309 of the Act, deductions are to be made in the following order:

(a) amounts referred to in subsection 307(2) of the Act;
(b) amounts referred to in paragraph 307(3)(b) of the Act;
(c) amounts referred to in section 307-5 of this instrument;
(d) amounts referred to in section 308 of the Act.

310-5 Refundable deposits to be used only for permitted purposes—capital expenditure

For the purposes of paragraph 310(2)(a) of the Act, the following kinds of capital expenditure are prescribed:

(a) expenditure to acquire land on which are, or are to be built, the premises needed for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to those premises;
(b) expenditure to acquire, erect, extend or significantly alter premises used or proposed to be used for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to the delivery of those funded aged care services;
(c) expenditure to acquire or install furniture, fittings or equipment for premises used or proposed to be used for delivering funded aged care services through the service group residential care, when those premises are initially erected or following an extension, a significant alteration or a significant refurbishment, but only to the extent that the expenditure relates to the delivery of those funded aged care services;
(d) expenditure that is directly connected to expenditure covered by paragraph (a), (b) or (c).

310-15 Refundable deposits to be used only for permitted purposes—capital expenditure debt

For the purposes of paragraph 310(2)(e) of the Act, the kinds of capital expenditure are the kinds referred to in section 310-5.

310-20 Refundable deposits to be used only for permitted purposes—other

For the purposes of paragraph 310(2)(f) of the Act, the registered provider may use an individual's refundable deposit for the following purposes:

(a) to meet reasonable business losses that are incurred in the course of delivering funded aged care services within the period of 12 months after the day the registered provider begins to deliver funded aged care services to the individual through the service group residential care;

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(b) to invest in a fund, but not a controlling entity of a fund, listed in item 2 of the first Schedule to *Banking exemption No. 1 of 2021* made under the *Banking Act 1959*.

310-30 Refundable deposits to be used only for permitted purposes—financial product

For the purposes of paragraph 310(3)(e) of the Act, each of the following financial products is prescribed:

(a) an interest in a scheme established for the purpose of investment in the delivery of funded aged care services through the service group residential care in an approved residential care home that:
  (i) is a managed investment scheme within the meaning of the *Corporations Act 2001*; and
  (ii) is not a registered scheme within the meaning of the *Corporations Act 2001*;
(b) a legal or equitable right or interest in an interest covered by paragraph (a);
(c) an option to acquire, by way of issue, an interest or right covered by paragraph (a) or (b).

Note: A registered provider may use a refundable deposit to invest in a financial product specified in this section: see paragraphs 310(2)(b) and (3)(e) of the Act.

311-5 Refund of refundable balances—manner of refund

For the purposes of subsection 311(2) of the Act, the prescribed manner is cash, cheque, bank cheque or electronic transfer.

311-15 Refund of refundable deposit balances—death of individual—circumstances and period

For the purposes of paragraph 311(3)(b) of the Act:

(a) the circumstances are that:
  (i) the registered provider is not shown the probate of the will of the individual or letters of administration of the estate of the individual; and
  (ii) the registered provider is shown other evidence that satisfies the provider that the refundable deposit balance is to be refunded to a person; and
(b) the period is 14 days after the day the evidence mentioned in subparagraph (a)(ii) is shown to the provider.

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311-20 Refund of refundable deposit balances—registered provider ceases services and has not transferred refundable deposit balance—circumstances and period

(1) For the purposes of paragraph (b) of the column headed "the refundable deposit balance must be refunded…" in item 4 of the table in subsection 311(4) of the Act, this section prescribes:

(a) the circumstances in which a registered provider must refund a refundable deposit balance; and

(b) the period within which the refundable deposit balance must be refunded.

(2) If:

(a) the individual has agreed with the registered provider as mentioned in subsection (3); and

(b) the individual has notified the registered provider, in writing, that they wish to cease that agreement;

the registered provider must refund the refundable deposit balance within 14 days after the day on which the individual has notified the provider as mentioned in paragraph (b).

(3) The agreement is an agreement between the individual and the registered provider to delay refunding the refundable deposit balance on condition that, if the individual requests re-entry to the approved residential care home, the registered provider must allow entry to the individual if:

(a) a room, or part of a room, is vacant in the approved residential care home; and

(b) the individual has an access approval in effect that includes the classification type ongoing for the service group residential care.

312-5 Transfer of refundable deposit balance to another registered provider—requirements

(1) For the purposes of subsection 312(2) of the Act, this section prescribes requirements for the transfer of the individual's refundable deposit balance between the outgoing provider and the incoming provider referred to in subsection 312(1) of the Act.

(2) The outgoing provider must, by written notice, give the following information in relation to the individual to the incoming provider before the transfer day:

(a) the transfer day;

(b) any amount of interest payable on or before the transfer day under section 313-5 in relation to the individual's refundable deposit balance and the amount of that interest;

(c) the entry in the refundable deposit register of the provider that relates to the individual.

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(3) The outgoing provider must give written notice to the individual of the proposed transfer of the individual's refundable deposit balance before the transfer day, including:
  (a) details of the incoming provider; and
  (b) the transfer day.

(4) If the transfer day is changed, the outgoing provider must give written notice to the individual of the new transfer day as soon as practicable before that day.

(5) The outgoing provider must transfer the refundable deposit balance to the incoming provider on the transfer day, as notified to the individual in accordance with this section.

312-10 Circumstances in which refundable deposit balance must not be transferred to another registered provider

For the purposes of subsection 312(4) of the Act, the prescribed circumstances are that:
  (a) the incoming provider delivers ongoing funded aged care services through the service group residential care only under one or more specialist aged care programs; or
  (b) the registered provider does not deliver any ongoing funded aged care services through the service group residential care.

313-5 Payment of interest—refund of refundable deposit balances—circumstances

(1) For the purposes of subsection 313(1) of the Act, the circumstances in which interest is to be paid in relation to the refund of a refundable deposit balance by a registered provider are all the circumstances in which the registered provider is required under section 311 of the Act to refund the refundable deposit balance, other than the circumstances covered by subsection (2).

(2) The circumstances covered by this subsection are that:
  (a) item 1 of the table in subsection 311(4) of the Act applies to the refund of the refundable deposit balance; and
  (b) the registered provider refunds the refundable deposit balance on the day referred to in column 2 of that item.

313-10 Payment of interest—refund of refundable deposit balances—amount

(1) For the purposes of subsection 313(2) of the Act, this section prescribes the amount of interest to be paid in relation to the refund of a refundable deposit balance by a registered provider.

Amounts of interest if there is a refund period

(2) Subsections (3) and (4) of this section apply if subsection 311(3) of the Act, or item 2, 3 or 4 of the table in subsection 311(4) of the Act, applies to the refund.

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If refundable deposit balance refunded on or before last day of refund period

(3) If the registered provider refunds the refundable deposit balance on or before the last day of the refund period in relation to the refund, the amount of interest is the amount worked out in accordance with the following formula:

$$\frac{BIR \times RDB \times ND}{365}$$

where:

BIR is the base interest rate on the first day of the refund period.

ND is the number of days in the period:

(a) beginning on the day after the day on which the refunding event in relation to the refund occurred; and

(b) ending on the day on which the refundable deposit balance is refunded.

RDB is the amount of the refundable deposit balance.

If refundable deposit balance refunded after last day of refund period

(4) If the registered provider refunds the refundable deposit balance after the last day of the refund period, the amount of interest is the amount worked out in accordance with the following formula:

$$\frac{BIR \times RDB \times ND(RP)}{365} + \frac{MPIR \times RDB \times ND(PP)}{365}$$

where:

BIR is the base interest rate on the first day of the refund period.

MPIR is the maximum permissible interest rate for the day after the last day in the refund period.

ND(PP) is the number of days in the period:

(a) beginning on the day after the last day of the refund period; and

(b) ending on the day on which the refundable deposit balance is refunded.

ND(RP) is the number of days in the period:

(a) beginning on the day after the day on which the refunding event occurred; and

(b) ending on the last day of the refund period.

RDB is the amount of the refundable deposit balance.

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Amount of interest if there is a refund day—refundable deposit balance refunded after refund day

(5) If item 1 of the table in subsection 311(4) of the Act applies to the refund, and the registered provider refunds the refundable deposit balance after the day (the ***refund day***) referred to in column 2 of that item, the amount of interest is the amount worked out in accordance with the following formula:

$$\frac{\text{MPIR} \times \text{RDB} \times \text{ND(PP)}}{365}$$

where:

MPIR is the maximum permissible interest rate for the day after the refund day.

ND(PP) is the number of days in the period:

(a) beginning on the day after the refund day; and

(b) ending on the day on which the refundable deposit balance is refunded.

RDB is the amount of the refundable deposit balance.

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Chapter 10—Funding of aged care services—means testing

Part 1—Introduction

314-5 Simplified outline of this Chapter

This Chapter provides for matters relating to means testing for funded aged care services under Part 5 of Chapter 4 of the Act.

Division 1 of Part 2 relates to means testing in a home or community setting, and deals with:

(a) determining individual contribution rates for individuals for means testing categories; and
(b) working out means testing classes for individuals; and
(c) when an individual accessing funded aged care services in a home or community setting has means not disclosed status; and
(d) requirements for notifying of events or changes in circumstances; and
(e) varying or revoking individual contribution rate determinations.

Division 2 of Part 2 relates to means testing in an approved residential care home, and deals with:

(a) working out daily means tested amounts; and
(b) when an individual accessing funded aged care services in an approved residential care home has means not disclosed status; and
(c) determining an individual's total assessable income and the value of an individual's assets; and
(d) varying or revoking income determinations and asset determinations;
(e) requirements for notifying of events or changes in circumstances.

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Part 2—Means testing

Division 1—Means testing in a home or community setting

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

314-10 Method for determining individual contribution rate

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

Step 1.	Work out the individual's means testing class in accordance with Subdivision B.
Step 2.	Work out the percentage for the category and the class under subsection (2) to (10) (as applicable).

General

(2) The following table sets out percentages for individual contribution rates for individuals for means testing classes and categories, for an individual not covered by any of subsections (3) to (10).

Percentages for individual contribution rates—general

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

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

(3) The following table sets out percentages for individual contribution rates for individuals for means testing classes and categories, for an individual in the post-2014 home contribution class who:

(a) immediately before the transition time, was not a continuing home care recipient within the meaning of the old Act; and

(b) is not covered by any of subsections (6) to (12).

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

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

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

(4) The percentage for the individual contribution rate for each means testing category is 0% for an individual in the post-2014 home contribution class who:

(a) immediately before the transition time, was a continuing home care recipient within the meaning of the old Act; and

(b) is not covered by any of subsections (6) to (12).

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

(5) The percentage for the individual contribution rate for each means testing category is 0% for an individual who:

(a) is accessing funded aged care services through the service group home support; and

(b) has the classification level STRC class in the classification type short-term for that service group; and

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(c) is not covered by any of subsections (6) to (12).

Individuals accessing flexible care through an innovative care service

(6) The percentage for the individual contribution rate for each means testing category is 0% for an individual who, immediately before the transition time, was accessing flexible care through an innovative care service (within the meaning of the old Principles).

Individuals who are former prisoners of war

(7) The percentage for the individual contribution rate for each means testing category is 0% for an individual who is described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war).

Individuals who have been awarded the Victoria Cross or the Victoria Cross for Australia

(8) The percentage for the individual contribution rate for each means testing category is 0% for an individual who has been awarded the Victoria Cross or the Victoria Cross for Australia (both within the meaning of the Veterans' Entitlements Act).

Individuals who die before contribution rate first determined

(9) The percentage for the individual contribution rate for each means testing category is 0% for an individual who dies before the individual's contribution rate is first determined under subsection 314(1) of the Act.

Individuals who cease receiving services before contribution rate first determined

(10) The percentage for the individual contribution rate for each means testing category is 0% for an individual who:
(a) is being delivered funded aged care services through a service group; and
(b) ceases being delivered funded aged care services through that service group before the individual's contribution rate is first determined under subsection 314(1) of the Act.

Individuals who do not have contribution rate determined within 6 months of being provided with home care

(11) The percentage for the individual contribution rate for each means testing category is 0% for an individual:
(a) who was, immediately before the transition time, approved under section 22-1 of the old Act as a recipient of home care; and
(b) who provided the System Governor the information required to enable the working out of the individual's care subsidy reduction under sections 48-7 and 48-8 of the old Act; and

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(c) whose individual contribution rate was not determined within 6 months of first being provided with home care.

Individuals in the post-2014 home contribution class with an income tested care fee less than $1

(12) The percentage for the individual contribution rate for each means testing category is 0% for an individual in the post-2014 home contribution class for whom, immediately before the transition time, the income tested care fee for the individual under section 52D-2 of the old Act was less than $1.

314-15 Period for determining individual contribution rate

Purpose

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

Application

(2) This section applies to an individual if a registered provider provides a start notification on a day (the ***start notification day***) to the System Governor and the Commissioner about the delivery of funded aged care services to the individual, other than a start notification given in connection with:

(a) the transfer of a service delivery branch of a registered provider to another registered provider; or

(b) the merger of 2 or more service delivery branches of a registered provider into a single delivery branch of the provider.

If System Governor has required information

(3) If, on the start notification day, the System Governor has the information referred to in paragraphs 314A-5(1)(a) to (d) in relation to the individual (the ***required information***), the period is 28 days from the start notification day.

If individual provides required information without request from System Governor

(4) If:

(a) on the start notification day, the System Governor does not have the required information; and

(b) within 3 days from the start notification day, the individual provides the required information to the System Governor;

the period is 28 days from the day the individual provided the required information.

If individual provides required information on request from System Governor

(5) If:

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(a) on the start notification day, the System Governor does not have the required information; and
(b) within 3 days from the start notification day, the individual does not provide the required information; and
(c) the System Governor makes one or more requests for the required information from the individual under subsection 343(1) of the Act; and
(d) within 43 days from the day the System Governor first requested the required information, the individual provides the required information to the System Governor;

the period is 28 days from the day the individual provided the required information.

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

(6) If:
(a) paragraphs (5)(a) to (c) apply to the individual; and
(b) either:
(i) the individual does not, within the period mentioned in paragraph (5)(d), provide the required information to the System Governor; or
(ii) the individual makes an election under section 314B of the Act before the end of the period mentioned in paragraph (5)(d);

the period is 3 days from the end of the period mentioned in paragraph (5)(d).

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

For the purposes of paragraph 314(3)(e) of the Act, the other matters that must be included in a notice under subsection 314(2) of the Act in relation to an individual contribution rate determination for an individual are as follows:
(a) the previous individual contribution rate (if any) for the individual for each means testing category;
(b) the date of effect of the determination as worked out in accordance with section 314-25 of this instrument.

314-25 Day determination takes effect

For the purposes of subsection 314(4) of the Act, the day at the start of which an individual contribution rate determination for an individual takes effect is:
(a) if, on the day the determination was made, an individual contribution rate determination was not in force for the individual—the day the start notification mentioned in subsection 314-15(2) of this instrument relating to the individual was provided to the System Governor and the Commissioner; or
(b) in any other case—the day the determination was made.

Note: For the day of effect for determinations made following revocation of individual contribution rate determinations, see subsection 318A(5) of the Act.

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Subdivision B—Working out means testing classes for individuals

314-30 Full-pensioner

Individuals not permanently blind and receiving maximum income support payments

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

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

Individuals permanently blind or not receiving income support payments

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

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

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

Individual where certain events occur before the individual's contribution rate is first determined

(4) Despite any other provision of this Subdivision, an individual is in the means testing class full-pensioner on a day if:
  (a) the individual has accessed funded aged care services on or after the transition time; and
  (b) the individual has provided the System Governor the information referred to in paragraphs 314A-5(1)(a) to (d) to enable the first determination of the individual's contribution rate under subsection 314(1) of the Act; and
  (c) the individual's contribution rate has not been determined within 6 months of the day that information was provided.

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314-35 Part-pensioner

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

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

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

Individuals permanently blind or not receiving income support payments

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

314-40 Seniors health card holder

Holders of seniors health cards

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

Individuals who are not holders of seniors health cards

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

314-45 Self-funded retiree

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

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(a) the individual is not in the means testing class full-pensioner, part-pensioner or seniors health card holder; or
(b) the individual has means not disclosed status; or
(c) the individual is an individual in relation to whom subsection 48-7(3) of the old Act applied to as at immediately before the transition time.

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

314-55 Calculation method

General

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

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

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

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

Step 1.	Work out the income reduction amount under section 314-60.
Step 2.	Work out the maximum reduction amount under section 314-70.
Step 3.	Work out the input contribution rate under subsection 314-75(2).
Step 4.	Work out the amount of the percentage:

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(a) for the means testing category independence—under subsection 314-80(2); and

(b) for the means testing category everyday living—under subsection 314-85(2).

314-60 Working out the income reduction amount

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

Step 1. Work out the amount that would be worked out as the individual's ordinary income for the purpose of applying Module E of Pension Rate Calculator A.

Step 2. Work out the amount that would be worked out as the individual's ordinary income free area under point 1064-E4 of that Module.

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

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

The result is the income reduction amount.

314-65 Working out the assets reduction amount

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

Step 1. Work out the value of the individual's assets in accordance with:

(a) Division 1 of Part 3.12 of the Social Security Act; and

(b) if the individual is a member of a couple—point 1064-G2 of Module G of Pension Rate Calculator A.

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

Step 3. Subtract the amount under step 2 from the amount under step 1 and round down to the nearest multiple of $250.

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

The result is the assets reduction amount.

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314-70 Working out the maximum reduction amount

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

Step 1.	Work out the individual's senior's health card income limit under point 1071-12 of the Seniors Health Card Income Test Calculator at the end of section 1071 of the Social Security Act.
Step 2.	Subtract the individual's ordinary income free area (worked out under Step 2 of the method statement in section 314-60 of this instrument) from the individual's senior's health card income limit.
Step 3.	Multiply the amount under Step 2 by 0.5 and round to the nearest dollar.

The result is the maximum reduction amount.

314-75 Working out the input contribution rate

General

(1) The method for working out the input contribution rate for individuals covered by subsection 314-10(2) is as follows:

Step 1.	Divide the greater of the income reduction amount and the assets reduction amount by the maximum reduction amount.
Step 2.	Multiply the step 1 amount by 100.

The result is the input contribution rate.

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

(2) The method for working out the input contribution rate for individuals covered by subsection 314-10(3) is as follows:

Step 1.	Divide the income reduction amount by the maximum reduction amount.
Step 2.	Multiply the step 1 amount by 100.

The result is the input contribution rate.

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

General

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

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

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

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

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

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

General

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

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

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

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

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

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

Subdivision D—Means not disclosed status

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

Specified information

(1) For the purposes of subsection 314A(2) of the Act, the specified information is the following:
   (a) information relating to the individual's marital status;
   (b) information relating to whether the individual is a homeowner;
   (c) information relating to the individual's total assessable income under section 322 of the Act;
   (d) information relating to the value of the individual's assets under section 329 of the Act.

Specified period

(2) For the purposes of subsection 314A(2) of the Act, the specified period is 43 days from the day the System Governor first requests the specified information from the individual under subsection 343(1) of the Act (whether or not the System Governor makes a subsequent request for the specified information from the individual).

314A-10 Day determination takes effect

For the purposes of subsection 314A(3) of the Act, if the day specified by the System Governor in the notice under subsection 314A(5) of the Act as the day the determination takes effect is a day before the day the determination is made, the specified day must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 314-15(2) of this instrument for the individual relates.

Subdivision E—Requirement to notify event or change in circumstances

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

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

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

315-10 Period for notification of event or change in circumstances

For the purposes of paragraph 315(2)(a) of the Act, the period within which an individual must notify the System Governor of the occurrence of an event or a change in the individual's circumstances is 28 days from the day the event or change of circumstances occurs.

315-15 Manner for notification of event or change in circumstances

For the purposes of paragraph 315(2)(b) of the Act, the manner in which an individual must notify the System Governor of the occurrence of an event or a change in the individual's circumstances is the approved form.

Subdivision F—Varying or revoking individual contribution rate determination

316-5 Other matters to be included in notice of determination

For the purposes of paragraph 316(4)(f) of the Act, the other matter that must be included in a notice under subsection 316(3) of the Act in relation to a varied individual contribution rate determination for an individual is the individual contribution rate for the individual for each means testing category specified in the notice given under subsection 314(2) of the Act in relation to the old determination for the individual.

317-5 Period for deciding if individual contribution rate determination is no longer correct following certain social security decisions

For the purposes of subsection 317(2) of the Act, the period is 28 days from the day the decision mentioned in subparagraph 317(1)(b)(i) of the Act is made.

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318-5 Period for deciding whether to vary individual contribution rate determination following event or change in circumstances

For the purposes of subsection 318(2) of the Act, the period is 28 days from the day the System Governor is notified as mentioned in paragraph 318(1)(b) of the Act.

318-10 Variation following event or change in circumstances to take effect on specified day in specified circumstances

For the purposes of subsection 318(6) of the Act, in the circumstances that:

(a) a variation for an individual is made following the System Governor being notified, as mentioned in paragraph 318(1)(b) of the Act, of the occurrence of an event or change after the end of the period prescribed by section 315-10 of this instrument; and

(b) the variation results in an increase to the individual contribution rate for the individual for a means testing category;

the variation takes effect on the day the System Governor was notified as mentioned in paragraph 318(1)(b) of the Act of the event or change.

318A-5 Period for deciding whether to revoke incorrect individual contribution rate determination

For the purposes of subsection 318A(2) of the Act, the period is 28 days from the day the System Governor is satisfied as mentioned in paragraph 318A(1)(b) of the Act.

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Division 2—Means testing in approved residential care home

Subdivision A—Daily means tested amounts

319-5 Income and asset thresholds

(1) This section is made for the purposes of subsection 319(4) of the Act.

Income thresholds

(2) The ***first income threshold*** is:
  (a) for an individual who is a member of an illness separated couple—$87,219.60; or
  (b) for an individual who is not a member of a couple—$87,947.60.

(3) The ***second income threshold*** is $101,105.00.

(4) The ***third income threshold*** is $117,230.20.

(5) The ***fourth income threshold*** is:
  (a) for an individual who is a member of an illness separated couple—$138,340.80; or
  (b) for an individual who is not a member of a couple—$141,252.80.

Asset thresholds

(6) The ***first asset threshold*** is $214,884.00.

(7) The ***second asset threshold:***
  (a) for an individual in the post-2014 residential contribution class—is $515,652.00; or
  (b) in any other case—is $258,000.00.

(8) The ***third asset threshold*** is $361,366.66.

(9) The ***fourth asset threshold*** is $536,384.00.

319-10 Working out the daily means tested amount—classes of individuals

For the purposes of subsection 319(5) of the Act, the classes are the following:
  (a) the pre-2014 residential contribution class;
  (b) the post-2014 residential contribution class.

319-15 Working out the daily means tested amount—individuals in pre-2014 residential contribution class

(1) For the purposes of subsection 319(5) of the Act, the daily means tested amount for an individual in the pre-2014 residential contribution class is worked out as follows:

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Step 1.	Work out the individual's total assessable income (which is determined under section 322 of the Act).
Step 2.	Work out the individual's total assessable income free area (see subsection (2)).
Step 3.	If the individual's total assessable income does not exceed the individual's total assessable income free area, the daily means tested amount is zero.
Step 4.	If the individual's total assessable income exceeds the individual's total assessable income free area, the smallest of the following amounts (rounded down to the nearest cent) is the daily means tested amount: (a) the amount equal to $^{5}/_{12}$ of that excess, divided by 364; (b) the amount equal to 135% of the basic age pension amount for that day, divided by 364; (c) the sum of the following amounts for the day (as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual): (i) the individual's base rate (see section 229-5); (ii) the provider's base provider amount (see section 238-5) as if item 8 of the table in subsection 238-5(1) applies to the provider; (iii) the oxygen supplement (see section 230-11) (if applicable); (iv) the enteral feeding supplement (see section 230-12) (if applicable).
Step 5:	If the individual has means not disclosed status, the daily means tested amount is the amount equal to 135% of the basic age pension amount for that day divided by 364.

(2) For the purposes of this section, an individual's total assessable income free area is:

(a) if the individual was a protected resident within the meaning of the *Aged Care (Transitional Provisions) Act 1997* immediately before the transition time—the sum of:

(i) the amount for the day for the individual worked out by applying point 1064-B1 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act, as in force on 19 September 2009; and

(ii) the amount worked out under point 1064-BA4 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act; and

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(iii) the amount worked out by applying point 1064-E4 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act; or

(b) for any other individual—the sum of:

(i) the amount for the day for the individual worked out by applying point 1064-B1 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act; and

(ii) the amount worked out under point 1064-BA4 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act; and

(iii) the amount worked out by applying point 1064-E4 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act.

319-20 Working out the daily means tested amount—individuals in post-2014 residential contribution class

Daily means tested amount

(1) For the purposes of subsection 319(5) of the Act, the daily means tested amount for an individual in the post-2014 residential contribution class is the sum of:

(a) the per day income tested amount worked out under subsection (2); and

(b) the per day asset tested amount worked out under subsection (3).

Per day income tested amount

(2) The per day income tested amount is worked out as follows:

Step 1.	Work out the individual's total assessable income (which is determined under section 322 of the Act).
Step 2.	Work out the individual's total assessable income free area (see subsection 319(2) of the Act).
Step 3.	If the individual's total assessable income does not exceed the individual's total assessable income free area, the ***per day income tested amount*** is zero.
Step 4.	If the individual's total assessable income exceeds the individual's total assessable income free area, the ***per day income tested amount*** is 50% of that excess divided by 364.

Per day asset tested amount

(3) The per day asset tested amount is worked out as follows:

Step 1.	Work out the value of the individual's assets (which is determined under section 329 of the Act).

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Step 2. If the value of the individual's assets does not exceed the asset free area (see subsection 319(3) of the Act), the ***per day asset tested amount*** is zero.

Step 3. If the value of the individual's assets exceeds the asset free area but not the first asset threshold, the ***per day asset tested amount*** is 17.5% of the excess, divided by 364.

Step 4. If the value of the individual's assets exceeds the first asset threshold but not the second asset threshold, the ***per day asset tested amount*** is the sum of the following, divided by 364:

(a) 1% of the excess;

(b) 17.5% of the difference between the asset free area and the first asset threshold.

Step 5. If the value of the individual's assets exceeds the second asset threshold, the ***per day asset tested amount*** is the sum of the following, divided by 364:

(a) 2% of the excess;

(b) 1% of the difference between the first asset threshold and the second asset threshold;

(c) 17.5% of the difference between the asset free area and the first asset threshold.

Subdivision B—Means not disclosed status

320-5 Determination that individuals have means not disclosed status

For the purposes of subsection 320(2) of the Act:

(a) the specified information is information required to enable the System Governor to work out the individual's total assessable income in accordance with section 323 of the Act and the value of the individual's assets in accordance with section 330 of the Act; and

(b) the specified period is 28 days from the day the System Governor requests the specified information from the individual under subsection 343(1) of the Act.

320-10 Day determination takes effect

For the purposes of subsection 320(3) of the Act, the day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 322-5(2) or 329-5(2) of this instrument for the individual relates.

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Subdivision C—Determining an individual's total assessable income

322-5 Period for determining an individual's total assessable income

Purpose

(1) For the purposes of subsection 322(1) of the Act, this section sets out the period for determining an individual's total assessable income.

Application

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

If System Governor has required information

(3) If, on the start notification day, the System Governor has the information (the ***required information***) required to work out the individual's total assessable income in accordance with section 323 of the Act, the period is 28 days from the start notification day.

If individual provides required information without request from System Governor

(4) If:
(a) on the start notification day, the System Governor does not have the required information; and
(b) within 3 days from the start notification day, the individual provides the required information to the System Governor;
the period is 28 days from the day the individual provided the required information.

If individual provides required information on request from System Governor

(5) If:
(a) on the start notification day, the System Governor does not have the required information; and
(b) within 3 days from the start notification day, the individual does not provide the required information to the System Governor; and
(c) the System Governor requests the required information from the individual under subsection 343(1) of the Act; and
(d) within 28 days from the day the System Governor requested the required information, the individual provides the required information to the System Governor;
the period is 28 days from the day the individual provided the required information.

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If individual does not provide required information or makes an election under section 321 of the Act

(6) If:
  (a) paragraphs (5)(a) to (c) apply to the individual; and
  (b) either:
    (i) the individual does not, within the period mentioned in paragraph (5)(d), provide the required information to the System Governor; or
    (ii) the individual makes an election under section 321 of the Act before the end of the period mentioned in paragraph (5)(d);

the period is 3 days from the end of the period mentioned in paragraph (5)(d).

322-10 Day determination takes effect

For the purposes of subsection 322(6) of the Act, the day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 322-5(2) of this instrument for the individual relates.

322-15 Other matters to be included in notice of determination

For the purposes of paragraph 322(9)(g) of the Act, the other matters that must be included in a notice under subsection 322(8) of the Act are as follows:
  (a) a summary of the individual's sources of income;
  (b) the assessed amounts for each of those sources of income.

Subdivision D—Working out an individual's total assessable income—excluded amounts

323-5 Purpose of this Subdivision

For the purposes of subsection 323(7) of the Act, this Subdivision prescribes amounts that are to be taken, in relation to specified kinds of individuals, to be excluded from a determination under subsection 323(1) of the Act or paragraph 323(2)(b), (3)(b), (4)(b) or (5)(b) of the Act.

323-10 Disability pensions and permanent impairment compensation payments

Certain amounts of disability pensions under the Veterans' Entitlements Act

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

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Compensation for permanent impairment or Special Rate Disability Pensions

(2) In relation to an individual who is a member or former member (within the meaning of the MRC Act) or the partner of such an individual, each of the following is prescribed:
   (a) any amount of compensation for permanent impairment paid to the individual under Part 2 of Chapter 4 of the MRC Act;
   (b) any amount of Special Rate Disability Pension paid to the individual under Part 6 of Chapter 4 of the MRC Act.

323-15 Gifts

Disposal of ordinary income

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

is prescribed.

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

Disposal of assets

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

is prescribed.

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

323-20 Rent receipts

(1) This section applies to an individual:
   (a) for whom an accommodation contribution or an accommodation payment is payable; and
   (b) who first entered residential care (within the meaning of the old Act) on or before 31 December 2015; and
   (c) for whom, since the individual first entered residential care, there has not been a continuous period of more than 28 days in which the individual was not either:
      (i) receiving residential care (other than because the person was on leave) (within the meaning of the old Act); or

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(ii) accessing funded aged care services in an approved residential care home.

(2) The amount of any income received by the individual, or the individual's partner, from rental of the individual's principal home to another person is prescribed.

323-25 GST compensation

(1) This section applies in relation to:

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

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

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

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

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

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

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

(b) an individual receiving a pension under Part 6 of Chapter 4, or a weekly amount of compensation under Part 2 of Chapter 5, of the MRC Act at a rate determined under or by reference to one or more of the following provisions of that Act:

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

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

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

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

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

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

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

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323-30 Energy payments

In relation to an individual to whom funded aged care services are being delivered through the service group residential care, each of the following is prescribed:

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

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

Subdivision E—Working out an individual's total assessable income—application of social security law provisions

323-35 Application of Social Security Act provisions

(1) This section applies to an individual:

(a) who first entered residential care (within the meaning of the old Act) on or after 1 January 2016; and

(b) for whom, since the individual first entered residential care, there has not been a continuous period of more than 28 days in which the individual was not either:

(i) receiving residential care (other than because the person was on leave) (within the meaning of the old Act); or

(ii) accessing funded aged care services in an approved residential care home.

(2) For the purposes of subparagraph 323(8)(c)(ii) of the Act, paragraph 8(8)(znaa) of the Social Security Act is prescribed.

Note: Paragraph 8(8)(znaa) of the Social Security Act is about rental income from an individual's principal home.

323-40 Application of Veterans' Entitlements Act provisions

(1) This section applies to an individual:

(a) who first entered residential care (within the meaning of the old Act) on or after 1 January 2016; and

(b) for whom, since the individual first entered residential care, there has not been a continuous period of more than 28 days in which the individual was not either:

(i) receiving residential care (other than because the person was on leave) (within the meaning of the old Act); or

(ii) accessing funded aged care services in an approved residential care home.

(2) For the purposes of subparagraph 323(9)(b)(ii) of the Act, paragraph 5H(8)(nf) of the Veterans' Entitlements Act is prescribed.

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Note: Paragraph 5H(8)(nf) of the Veterans' Entitlements Act is about rental income from an individual's principal home.

Subdivision F—Varying or revoking an income determination

324-5 Day variation of income determination takes effect

Purpose

(1) For the purposes of subsection 324(5) of the Act, the day specified by the System Governor as the day a variation of an income determination in relation to an individual takes effect must be in accordance with this section.

Variation results in a decreased means tested amount

(2) If the variation does not result in an increase to the individual's daily means tested amount, the day specified must be the day the event or change in circumstances occurred.

Variation results in an increased means tested amount

(3) If the variation results in an increase to the individual's daily means tested amount, the day specified must be:
  (a) if the decision under subsection 324(1) of the Act to vary the income determination is made within 28 days of the day the event or change in circumstances occurred—the day notice of the decision is given; or
  (b) otherwise—28 days before the day notice of the decision under subsection 324(1) of the Act is given.

(4) Despite paragraph (3)(b), the day specified may instead be a day earlier than 28 days before the day notice of the decision is given, if the individual has provided false or misleading information under section 326 or 336 of the Act in relation to the decision.

325-5 Period for varying income determination—on notification of event or change in circumstances

For the purposes of subsection 325(2) of the Act, the period for varying the income determination is 28 days from the day the notification is made.

326-5 Period for varying or revoking income determination—on application

For the purposes of paragraph 326(2)(b) of the Act, the period for making a decision on an application by an individual for the purposes of paragraph 324(2)(b) of the Act is 28 days from the day the application is made.

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327-5 Period for varying or revoking income determination—on System Governor's initiative

For the purposes of paragraph 327(6)(b) of the Act, the period for making a decision under that paragraph is 28 days from:

(a) if no submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act—the end of the period specified in the notice (including that period as extended (if applicable) under subsection 327(5) of the Act); or

(b) the later of:

(i) if a submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act and no further information is requested under subsection 327(4) of the Act—the day the submission is made; and

(ii) if a submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act and further information is requested under subsection 327(4) of the Act—the day the individual gives the System Governor the further information.

328-10 Other matters to be included in notices of decisions other than reviewable decisions

For the purposes of paragraph 328(4)(b) of the Act, a notice given under subsection 328(3) of the Act must include the reasons for the decision.

Subdivision G—The value of an individual's assets

329-5 Period for determining the value of an individual's assets

Purpose

(1) For the purposes of subsection 329(1) of the Act, this section sets out the period for determining the value of an individual's assets.

Application

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

If System Governor has required information

(3) If, on the start notification day, the System Governor has the information (the ***required information***) required to work out the value of the individual's assets in accordance with section 330 of the Act, the period is 28 days from the start notification day.

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If individual provides required information without request from System Governor

(4) If:

(a) on the start notification day, the System Governor does not have the required information; and

(b) within 3 days from the start notification day, the individual provides the required information to the System Governor;

the period is 28 days from the day the individual provided the required information.

If individual provides required information on request from System Governor

(5) If:

(a) on the start notification day, the System Governor does not have the required information; and

(b) within 3 days from the start notification day, the individual does not provide the required information to the System Governor; and

(c) the System Governor requests the required information from the individual under subsection 343(1) of the Act; and

(d) within 28 days from the day the System Governor requested the required information, the individual provides the required information to the System Governor;

the period is 28 days from the day the individual provided the required information.

If individual does not provide required information or makes an election under section 321 of the Act

(6) If:

(a) paragraphs (5)(a) to (c) apply to the individual; and

(b) either:

(i) the individual does not, within the period mentioned in paragraph (5)(d), provide the required information to the System Governor; or

(ii) the individual makes an election under section 321 of the Act before the end of the period mentioned in paragraph (5)(d);

the period is 3 days from the end of the period mentioned in paragraph (5)(d).

329-10 Day determination takes effect

For the purposes of subsection 329(6) of the Act, the day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 322-5(2) of this instrument for the individual relates.

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329-15 Other matters to be included in notice of determination

For the purposes of paragraph 329(9)(g) of the Act, the other matters that must be included in a notice under subsection 329(8) of the Act are as follows:

(a) a summary of the individual's assets;

(b) the assessed amounts for each of the individual's assets.

Subdivision H—Working out the value of an individual's assets—excluded amounts

330-5 Value of home

For the purposes of subsection 330(7) of the Act, the amount is $214,884.00.

330-10 Other amounts

(1) For the purposes of subsection 330(9) of the Act, this section prescribes amounts that are to be taken, in relation to specified kinds of individuals, to be excluded from a determination under paragraph 330(2)(a) or (b) or (3)(a) or (b) or subsection 330(4) of the Act.

(2) In relation to all individuals, the following are prescribed:

(a) any compensation payments received by the individual under the following:

(i) the *Compensation (Japanese Internment) Act 2001*;

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

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

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

(b) any redress payment paid to the individual, or to an administrator for the individual, under section 48 of the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018*.

Subdivision J—Varying or revoking an asset determination

331-5 Day variation of asset determination takes effect

Purpose

(1) For the purposes of subsection 331(5) of the Act, the day specified by the System Governor as the day a variation of an asset determination in relation to an individual takes effect must be in accordance with this section.

Variation results in a decrease

(2) If the variation does not result in an increase to:

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(a) the amount of person-centred subsidy reduction for the individual for a day under section 235 of the Act; or
(b) the amount of provider-based subsidy reduction for the registered provider for the individual for a day under section 242 of the Act; or
(c) the amount of accommodation contribution that the individual may be charged under section 298 of the Act;

the day specified must be the day the event or change in circumstances occurred.

Variation results in an increase

(3) If the variation results in an increase to:
(a) the amount of person-centred subsidy reduction for the individual for a day under section 235 of the Act; or
(b) the amount of provider-based subsidy reduction for the registered provider for the individual for a day under section 242 of the Act; or
(c) the amount of accommodation contribution that the individual may be charged under section 298 of the Act;

the day specified must be:
(d) if the decision under subsection 331(1) of the Act to vary the asset determination is made within 28 days of the day the event or change in circumstances occurred—the day notice of the decision is given; or
(e) otherwise—28 days before the day notice of the decision under subsection 331(1) of the Act is given.

(4) Despite paragraph (3)(e), the day specified may instead be a day earlier than 28 days before the day notice of the decision is given, if the individual has provided false or misleading information under section 333 or 336 of the Act in relation to the decision.

332-5 Period for varying asset determination—on notification of event or change in circumstances

For the purposes of subsection 332(2) of the Act, the period for varying the asset determination is 28 days from the day the notification is made.

333-5 Period for varying or revoking asset determination—on application

For the purposes of paragraph 333(2)(b) of the Act, the period for making a decision on an application by an individual for the purposes of paragraph 331(2)(b) of the Act is 28 days from the day the application is made.

334-5 Period for varying or revoking asset determination—on System Governor's initiative

(1) For the purposes of paragraph 334(6)(b) of the Act, the period for making a decision under that paragraph is 28 days from:
(a) if no submission is made in accordance with the invitation in the notice under paragraph 334(2)(b) of the Act—the end of the period specified in

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the notice (including that period as extended (if applicable) under subsection 334(5) of the Act); or

(b) the later of:

(i) if a submission is made is made in accordance with the invitation in the notice under paragraph 334(2)(b) of the Act and no further information is requested under subsection 334(4) of the Act—the day the submission is made; and

(ii) if a submission is made in accordance with the invitation in the notice under paragraph 334(2)(b) of the Act and further information is requested under subsection 334(4) of the Act—the day the individual gives the System Governor the further information.

335-10 Other matters to be included in notices of decisions other than reviewable decisions

For the purposes of paragraph 335(4)(b) of the Act, a notice given under subsection 335(3) of the Act must include the reasons for the decision.

Subdivision K—Notifying of event or change in circumstances

336-5 Notifications by individuals—manner and period

For the purposes of subsection 336(2) of the Act:

(a) the manner in which an individual must make a notification of the occurrence of an event or a change in the individual's circumstances under subsection 336(1) of the Act is in the approved form; and

(b) the period in which the notification must be made is 28 days from the day the event or change of circumstances occurs.

337-5 Notifications by registered providers—manner and period

(1) For the purposes of subsection 337(2) of the Act, and subject to subsection (2) of this section:

(a) the manner in which a registered provider must make a notification of the occurrence of an event or a change in an individual's circumstances under subsection 337(1) of the Act is:

(i) in a claim made under section 257 of the Act (claim for subsidy); or

(ii) in the approved form; and

(b) the period in which the notification must be made is as soon as practicable after the end of the payment period in which the event or change of circumstances occurs.

(2) If the event or change in circumstances is a change in an individual's refundable deposit balance that has occurred since the most recent claim made by the registered provider under section 257 of the Act for subsidy for the delivery of a funded aged care service to the individual:

(a) the manner in which a registered provider must make a notification of the occurrence of the event or change under subsection 337(1) of the Act is in

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the next claim (the ***subsequent claim***) made under section 257 of the Act for subsidy for the delivery of a funded aged care service to the individual; and

(b) the period in which the notification must be made is the period within which the subsequent claim may be made.

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Chapter 11—Governance of the aged care system

Part 1—Introduction

338-1 Simplified outline of this Chapter

This Chapter provides for matters relating to governance of the aged care system under Chapter 5 of the Act.

Part 2 prescribes certain requirements for identity cards issued by the System Governor to approved needs assessors.

Division 1 of Part 3 set out the other functions of the Commissioner, being the function to reconsider certain decisions made personally by the Complaints Commissioner.

Division 2 of Part 3 sets out how the Commissioner may deal with reportable incidents notified by registered providers of funded aged care services.

Division 3 of Part 3 prescribes requirements in accordance with which the Complaints Commissioner must give the Minister written reports in relation to complaints and feedback received by the Complaints Commissioner.

Division 4 of Part 3 establishes a scheme for dealing with feedback given to the Complaints Commissioner about registered providers or a responsible person or aged care worked of a registered provider and complaints made to the Commissioner about the following matters:

(a) the compliance with the Act of a registered provider or a responsible person or aged care worker of a registered provider;
(b) a registered provider acting in a way that is incompatible with the Statement of Rights.

If the Commissioner receives a complaint, the Commissioner must decide to take no further action in relation to the complaint or decide to undertake a resolution process.

Certain persons may apply for the reconsideration of a decision to take no further action in relation to a complaint, or to not undertake a resolution process in relation to a complaint.

Division 5 of Part 3 prescribes certain matters that must be included in an annual report mentioned in section 372 of the Act for a reporting period.

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Part 2—System Governor

343A-5 Identity cards for approved needs assessors—form requirements

(1) For the purposes of paragraph 343A(2)(a) of the Act, an identity card must satisfy the requirements prescribed by this section.

Size of card

(2) The identity card must have dimensions of 85.60 mm by 53.98 mm (CR80 standard).

Front of card

(3) The identity card must contain the following elements on the front of the card:
- (a) the logo (if any) of the entity the approved needs assessor is employed or otherwise engaged by, as referred to in section 7-8 of this instrument;
- (b) the name or an abbreviation of the name of the entity;
- (c) the full name of the assessor;
- (d) the photograph of the assessor required by paragraph 343A(2)(b) of the Act.

(4) The photograph referred to in paragraph (3)(d) must:
- (a) be a coloured photograph; and
- (b) show the assessor's full face; and
- (c) have a resolution of at least 300 dpi; and
- (d) have an aspect ratio (being width divided by height) of 0.75; and
- (e) have dimensions of:
  - (i) 35 mm to 40 mm in width; and
  - (ii) 45 mm to 50 mm in height.

Back of card

(5) The identity card must contain the following elements on the back of the card:
- (a) the Australian Government logo and the words "Department of Health, Disability and Ageing";
- (b) a serial number;
- (c) an address for the card to be returned to if it is found;
- (d) the words in subsection (6).

(6) The words mentioned in paragraph (5)(d) must be the following:

"The bearer of this card is an approved needs assessor under the *Aged Care Act 2024* and may perform the functions and exercise the powers of an approved needs assessor.

A registered provider delivering funded aged care services under the *Aged Care Act 2024* must, in accordance with section 177 of that Act, cooperate

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with the bearer of this card, including by providing access to an approved residential care home of the provider when necessary for the needs assessor to perform the functions and exercise the powers of an approved needs assessor."

343A-10 Identity cards for approved needs assessors—requirements for carrying and producing identity cards

(1) For the purposes of subsection 343A(3) of the Act, an approved needs assessor must carry and produce the assessor's identity card in accordance with this section.

(2) When performing functions or exercising powers under the Act as an approved needs assessor, the assessor must:

(a) at all times, carry the assessor's identity card issued under subsection 343A(1) of the Act; and

(b) if a person who apparently represents a registered provider requests the assessor to show the assessor's identity card—do so when requested, or, if it is not reasonably practicable to do so when requested, do so as soon as reasonably practicable after that.

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Part 3—Aged Care Quality and Safety Commission

Division 1—Other functions of the Commissioner

348-5 Other functions of the Commissioner—reconsideration of certain decisions made personally by the Complaints Commissioner

For the purposes of paragraph 348(1)(d) of the Act, the Commissioner has the function to reconsider, under section 361-60 of this instrument, decisions made personally by the Complaints Commissioner.

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Division 2—Safeguarding functions of the Commissioner

349-5 Actions the Commissioner may take in dealing with reportable incidents

(1) The Commissioner must, upon receiving a notice about a reportable incident given by a registered provider under section 165A-25 or 165A-30, do the following:
  (a) acknowledge receipt of the notice;
  (b) take steps to consider the notice and the appropriateness of taking action in relation to that notice.

(2) The Commissioner may, upon receiving a notice about a reportable incident given by a registered provider under section 165A-25 or 165A-30, do one or more of the following:
  (a) refer the incident to whichever of the following the Commissioner considers appropriate:
    (i) the Australian Federal Police;
    (ii) the police force or police service of a State or Territory;
    (iii) a person or body with responsibilities in relation to the incident;
  (b) require or request the provider to undertake specified remedial action in relation to the incident within a specified period, including remedial action to ensure the safety, health and well-being of individuals receiving funded aged care services affected by the incident;
  (c) carry out an inquiry in relation to the incident in accordance with section 349-10;
  (d) take any other action to deal with the reportable incident that the Commissioner considers reasonable in the circumstances.

(3) The Commissioner may, upon receiving 2 or more notices about reportable incidents given by a registered provider under section 165A-30, and in circumstances where the Commissioner considers it appropriate to do so, manage 2 or more notices about such reportable incidents through a single action, including one or more of the following:
  (a) refer the incidents to whichever of the following the Commissioner considers appropriate:
    (i) the Australian Federal Police;
    (ii) the police force or police service of a State or Territory;
    (iii) a person or body with responsibilities in relation to the incidents;
  (b) require or request the provider to undertake specified remedial action in relation to the incidents within a specified period, including remedial action to ensure the safety, health and well-being of the individuals accessing funded aged care services affected by the incident;
  (c) carry out an inquiry in relation to the incidents in accordance with section 349-10;
  (d) take any other action to deal with the reportable incidents that the Commissioner considers reasonable in the circumstances.

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349-10 Commissioner's inquiries in relation to reportable incidents

(1) The Commissioner may inquire into any of the following:
  (a) a reportable incident for a registered provider;
  (b) a series of reportable incidents that relate to the delivery of funded aged care services delivered by one or more registered providers;
  (c) the compliance of one or more registered providers with:
    (i) Division 1 of Part 10 of Chapter 4; or
    (ii) Division 2 of Part 2 of Chapter 5.

(2) An inquiry may be carried out under subsection (1) whether or not any of the reportable incidents have been notified to the Commissioner under section 165A-25 or 165A-30.

(3) An inquiry may be carried out as the Commissioner thinks fit.

(4) Without limiting subsection (3), the Commissioner may:
  (a) consult with other persons, organisations and governments on matters relating to the inquiry; and
  (b) request information or documents that are relevant to the inquiry from any person; and
  (c) provide opportunities for individuals accessing funded aged care services to participate in the inquiry.

(5) The Commissioner may prepare and publish a report setting out the Commissioner's findings in relation to the inquiry.

349-15 Taking of other action not prevented by this Division

Nothing in this Division prevents the Commissioner from taking action under the Act in relation to:
  (a) a reportable incident for a registered provider; or
  (b) information or documents given to the Commissioner under:
    (i) this Division; or
    (ii) Division 1 of Part 10 of Chapter 4; or
    (iii) Division 2 of Part 2 of Chapter 5.

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Division 3—Establishment and functions of the Complaints Commissioner

358-5 Complaints functions of the Complaints Commissioner—requirements for giving written reports to the Minister

For the purposes of paragraph 358(m) of the Act, the requirements in accordance with which the Complaints Commissioner must give the Minister written reports, in relation to complaints and feedback received by the Complaints Commissioner, are that:

(a) a report must be for a period (the ***reporting period***) of 6 months beginning on 1 January or 1 July; and

(b) the report for a reporting period must contain the following for the reporting period:

(i) the matters referred to in section 372-5 of this instrument;

(ii) any other matters that the Complaints Commissioner considers relevant; and

(c) the report for a reporting period must be given to the Minister within 3 months after the end of the reporting period.

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Division 4—Complaints Commissioner—complaints and feedback

Subdivision A—Preliminary

361-5 Purpose of this Division

This Division is made for the purposes of subsection 361(1) of the Act.

Subdivision B—How complaints may be made and withdrawn, and how feedback may be given

361-10 How complaints may be made and feedback may be given

Complaints

(1) A person (the ***complainant***) may make a complaint to the Complaints Commissioner about:
  (a) the compliance with the Act of a registered provider or a responsible person or aged care worker of a registered provider; or
  (b) a registered provider acting in a way that is incompatible with the Statement of Rights.

Feedback

(2) A person may give the Complaints Commissioner feedback about a registered provider or a responsible person or aged care worker of a registered provider.

Complaints and feedback

(3) A complaint may be made, and feedback may be given, orally or in writing.

(4) A complaint may be made, and feedback may be given, anonymously.

(5) If:
  (a) a complainant makes a complaint or a person gives feedback; and
  (b) the complainant or person giving the feedback requests that any of the following information be kept confidential:
    (i) the identity of the complainant or person giving the feedback;
    (ii) the identity of a person identified in the complaint or feedback;
    (iii) any other details included in the complaint or feedback;

the Complaints Commissioner must take such steps as are reasonable in the circumstances to keep the information confidential.

Note: See also section 549 of the Act in relation to complaints or feedback that are disclosures that qualify for protection under section 547 of the Act (whistleblower protections), where the individual making the disclosure requests that the individual, or any other individual named in the request, remain anonymous.

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361-15 How complaints may be withdrawn

If a complainant makes a complaint to the Complaints Commissioner under section 361-10, the complainant may withdraw the complaint, either orally or in writing, at any time.

Note 1: The Complaints Commissioner must deal with complaints (see section 361-40), and must do so by deciding to take no further action in relation to the complaint for a reason referred to in section 361-50 or deciding to undertake a resolution process under this Division in relation to the complaint (see section 361-42).

Note 2: The withdrawal of a complaint is a reason for which the Complaints Commissioner may decide to take no further action in relation to the complaint or decide to end a resolution process in relation to the complaint (see paragraph 361-50(b)).

Note 3: A complainant who withdraws a complaint will not receive certain communications under this Division (see paragraphs 361-25(2)(e), 361-30(2)(d) and 361-35(2)(d)) or be able to apply under Subdivision D for the reconsideration of a decision of the Complaints Commissioner in relation to the complaint.

Subdivision C—Processes for dealing with complaints and feedback

361-20 Requirements for processes

General

(1) The Complaints Commissioner's processes for dealing with complaints and feedback must provide appropriate support and assistance (including access to advocates and language services) to:
  (a) complainants and persons giving feedback; and
  (b) individuals accessing funded aged care services to whom complaints or feedback relate.

Note: One of the complaints functions of the Complaints Commissioner is to uphold the rights under the Statement of Rights, and protect and enhance the safety, health, wellbeing and quality of life, of individuals accessing funded aged care services, by maintaining independent, transparent, accountable, accessible, safe and culturally safe processes for making complaints and giving feedback (see paragraph 358(a) of the Act).

Complaints that are also disclosures that qualify for protection under section 547 of the Act (whistleblower protections)

(2) The Complaints Commissioner's processes for dealing with complaints and feedback must include processes for dealing with complaints and feedback that are also disclosures that qualify for protection under section 547 of the Act (whistleblower protections).

361-25 Acknowledging receipt of complaints and feedback

(1) If:
  (a) a complainant makes a complaint to the Complaints Commissioner as mentioned in subsection 361-10(1); or

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(b) a person gives the Complaints Commissioner feedback as mentioned in subsection 361-10(2);

the Complaints Commissioner must, within 3 business days from the day the complaint was made or the feedback was given, give the complainant or the person who gave the feedback an acknowledgement of the receipt of the complaint or feedback.

(2) Subsection (1) does not apply to a complaint or feedback if:

(a) giving the complainant or the person who gave the feedback an acknowledgement of the complaint or feedback would contravene a provision of Chapter 7 of the Act (information management); or

(b) the complaint was made or the feedback was given anonymously; or

(c) the complainant or the person who gave the feedback cannot be contacted because of a request for confidentiality under subsection 361-10(5); or

(d) the complainant or the person who gave the feedback requested not to receive an acknowledgement of receipt of the complaint or feedback; or

(e) for a complaint—the complainant has withdrawn the complaint.

361-30 Referral of complaints and feedback to other persons or bodies

(1) This section applies if the Complaints Commissioner refers a complaint or feedback to another person or body under paragraph 358(e) of the Act.

Note: One of the complaints functions of the Complaints Commissioner is, for complaints and feedback that is better dealt with by other persons or bodies, to refer the complaints and feedback to those persons or bodies (see paragraph 358(e) of the Act).

Giving written notice of referral

(2) The Complaints Commissioner must give written notice of the referral to the complainant or person who gave the feedback, unless:

(a) giving written notice of the referral to the complainant or person who gave the feedback would contravene a provision of Chapter 7 of the Act (information management); or

(b) the complaint was made or the feedback was given anonymously; or

(c) the complainant or person who gave the feedback cannot be contacted because of a request for confidentiality under subsection 361-10(5) of this instrument; or

(d) for a complaint—the complainant has withdrawn the complaint.

Giving information and documents to other person or body

(3) Subject to Chapter 7 of the Act (information management) and subsection 361-10(5) of this instrument, the Complaints Commissioner must give the other person or body any information or documents that relate to the complaint or feedback and that are in the Complaints Commissioner's possession or under the Complaints Commissioner's control.

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361-35 Communications with complainant, entity against which complaint made and other persons

Communications with complainant

(1) If a complainant makes a complaint to the Complaints Commissioner as mentioned in subsection 361-10(1), the Complaints Commissioner must:
  (a) communicate regularly with the complainant, as agreed with the complainant, about progress in dealing with the complaint; and
  (b) give the complainant a proposed complaint determination (see section 361-40) and seek the complainant's views on the proposed complaint determination.

(2) Subsection (1) does not apply if:
  (a) communicating regularly with the complainant or giving the complainant a proposed complaint determination would contravene a provision of Chapter 7 of the Act (information management); or
  (b) the complaint was made anonymously; or
  (c) the complainant cannot be contacted because of a request for confidentiality under subsection 361-10(5) of this instrument; or
  (d) the complainant has withdrawn the complaint; or
  (e) the complainant has requested not to receive communications about the complaint.

Communications with entity against which complaint made

(3) The Complaints Commissioner must give the entity against which the complaint is made written notice of the complaint as soon as practicable after the complaint was made.

(4) Subsection (3) does not apply if:
  (a) the giving of the notice would contravene a provision of Chapter 7 of the Act (information management); or
  (b) the Complaints Commissioner considers that the giving of the notice will, or is likely to:
    (i) place the safety, health or well-being of the complainant, an individual accessing funded aged care services or any other person at risk; or
    (ii) place the complainant or an individual accessing funded aged care services at risk of intimidation or harassment; or
    (iii) interfere with the performance of any of the Commissioner's safeguarding functions under paragraphs 349(a), (d) and (e) of the Act.

Communications with other persons

(5) If the complaint was made on behalf of an individual accessing funded aged care services, the Complaints Commissioner must communicate regularly with the

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following persons, as agreed with those persons, about progress in dealing with the complaint:

(a) the individual;

(b) the individual's supporter (if any);

(c) an independent aged care advocate who is providing support to the individual (if any), if the individual has consented to the Complaints Commissioner communicating with the advocate about the complaint.

(6) Subsection (5) does not apply in relation to a person if:

(a) communicating regularly with the person would contravene a provision of Chapter 7 of the Act (information management); or

(b) the person cannot be contacted because of a request for confidentiality under subsection 361-10(5) of this instrument; or

(c) the complaint has been withdrawn and the Complaints Commissioner has decided to take no further action in relation to the complaint, or to end a resolution process in relation to the complaint; or

(d) the person has requested not to receive communications about the complaint; or

(e) it is not appropriate to communicate with the person.

Note: For paragraph (e):

(a) an example of when it is not appropriate to communicate with an individual accessing funded aged care services about progress in dealing with a complaint is if the individual lacks capacity for the communication; and

(b) an example of when it may not be appropriate to communicate with an individual accessing funded aged care services, or supporters or advocates for such individuals, about progress in dealing with a complaint is if the complaint was made on behalf of a large number of such individuals.

361-40 Complaint determinations and seeking feedback

Complaint determinations

(1) If a complaint is made to the Complaints Commissioner about:

(a) the compliance with the Act of a registered provider or a responsible person or aged care worker of a registered provider; or

(b) a registered provider acting in a way that is incompatible with the Statement of Rights;

the Complaints Commissioner must, by the end of the period referred to in subsection (2):

(c) deal with and resolve the complaint; and

(d) prepare a written statement (a ***complaint determination***) setting out:

(i) what action (if any) the Complaints Commissioner took to deal with and resolve the complaint; and

(ii) what action (if any) should be taken by another person to deal with and resolve the complaint; and

(iii) information relating to the review or reconsideration of decisions made under the scheme; and

(e) give the complainant a copy of the complaint determination.

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(2) For the purposes of subsection (1), the period is:
  (a) 90 days from the day the complaint is made, unless paragraph (b) or (c) applies; or
  (b) 120 days from the day the complaint is made, if:
    (i) the Complaints Commissioner is satisfied that there are circumstances requiring a period of more than 90 days; and
    (ii) the Complaints Commissioner has communicated the circumstances to the complainant; and
    (iii) paragraph (c) does not apply; or
  (c) 120 days from the day the complaint is made plus one or more additional periods of 30 days, for each of which:
    (i) the Complaints Commissioner is satisfied that there are exceptional circumstances requiring the additional period and the Complaints Commissioner has communicated the exceptional circumstances to the complainant; or
    (ii) the complainant has agreed to the additional period.

(3) The Complaints Commissioner must also give a copy of the complaint determination to:
  (a) each person with whom the Complaints Commissioner has been communicating under subsection 361-35(5); and
  (b) the entity against which the complaint is made.

Seeking feedback

(4) The Complaints Commissioner must also seek feedback from the following about how the complaint was dealt with and resolved:
  (a) the complainant, if the Complaints Commissioner has been communicating with the complainant under subsection 361-35(1);
  (b) each person with whom the Complaints Commissioner has been communicating under subsection 361-35(5);
  (c) the entity against which the complaint is made.

361-42 Dealing with complaints—general

The Complaints Commissioner must deal with a complaint by:
  (a) deciding to take no further action in relation to the complaint for a reason referred to in section 361-50; or
  (b) deciding to undertake a resolution process under this Division in relation to the complaint.

361-45 Dealing with complaints—resolution processes

(1) This section applies if the Complaints Commissioner decides to undertake a resolution process under this Division in relation to the complaint.

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Actions that may be taken

(2) The Complaints Commissioner may take any one or more of the following actions:

(a) require the entity against which the complaint is made to attempt to resolve the complaint and report back to the Complaints Commissioner within a specified period;

(b) require the entity against which the complaint is made to take other specified action in relation to the complaint within a specified period;

(c) investigate (other than under Part 3 of the Regulatory Powers Act (see Part 3 of Chapter 6 of the Act)) the circumstances giving rise to the complaint, including by:

(i) requiring the entity against which the complaint is made to give the Complaints Commissioner information or documents (or copies of documents); or

(ii) attending an approved residential care home or a home or community setting in which funded aged care services are delivered;

(d) consider information and documents;

(e) subject to Chapter 7 of the Act (information management), discuss the complaint, in person or by other means, with any of the following entities:

(i) the complainant;

(ii) the entity against which the complaint is made;

(iii) any other relevant person;

(f) facilitate a conciliation process, including by requesting any of the entities mentioned in paragraph (e) to participate in the process;

(g) conduct a restorative engagement process, including by requesting the entities mentioned in paragraph (e) to participate in the process.

Note: Other actions that the Complaints Commissioner may take under the Act are the following:

(a) request persons to give the Complaints Commissioner information or documents relevant to the Complaints Commissioner's functions (see section 359 of the Act);

(b) give a registered provider a required action notice in relation to a matter that relates to the registered provider that is raised in a complaint (see section 474 of the Act);

(c) require persons to attend before an authorised Commission officer to answer questions or give information or documents (or copies of documents) relevant to whether a registered provider, or a former registered provider, is complying with the Act in relation to a matter that relates to the Complaints Commissioner's functions (see section 488 of the Act).

Ending resolution process

(3) The Complaints Commissioner may decide to end the resolution process for a reason referred to in section 361-50.

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361-50 Dealing with complaints—reasons for taking no further action or ending resolution processes

For the purposes of paragraph 361-42(a) and subsection 361-45(3), the reasons for which the Complaints Commissioner may decide to take no further action in relation to a complaint, or to end a resolution process in relation to a complaint, are as follows:

(a) the complaint has been resolved because:
  (i) the complainant and the entity against which the complaint was made have agreed on an outcome; and
  (ii) the entity against which the complaint was made has addressed the complaint to the satisfaction of the Complaints Commissioner;
(b) the complaint has been withdrawn;
(c) the Complaints Commissioner refers the complaint to another person or body under paragraph 358(e) of the Act;
(d) the circumstances giving rise to the complaint cannot be determined;
(e) the complainant has been provided with an explanation in relation to the complaint and is satisfied with the explanation;
(f) the complaint is frivolous, vexatious or not raised in good faith;
(g) the complaint is, or has been, the subject of legal proceedings;
(h) the complaint is already being dealt with, or has already been dealt with, under section 361 of the Act or a former complaints scheme;
(i) the complaint is better dealt with, or is already being dealt with, through a different process (for example, through the Commissioner's safeguarding functions or under Chapter 6 of the Act (regulatory mechanisms));
(j) the circumstances giving rise to the complaint occurred more than one year before the complaint was made, and no longer exist;
(k) the complaint is subject to a coronial inquiry;
(l) an individual accessing funded aged care services who is identified in the complaint does not wish the complaint to be considered by the Complaints Commissioner;
(m) having regard to all the circumstances, no further action is required, or the continuation of the resolution process is not required.

Subdivision D—Reconsideration of decisions to take no further action or to end resolution processes

361-55 Requesting reconsideration of decisions

(1) If the Complaints Commissioner decides to take no further action in relation to a complaint, or to end a resolution process in relation to a complaint, the following entities may request the Complaints Commissioner to reconsider the decision:
  (a) the complainant, unless:
    (i) the complainant withdrew the complaint before the decision was made; or

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(ii) the reason for the decision was that the complaint is frivolous, vexatious or not raised in good faith;

(b) the entity against which the complaint was made.

(2) The request:

(a) may be made orally or in writing; and

(b) must identify the reasons for the request; and

(c) must be made within the following period:

(i) 42 days after the entity making the request receives the complaint determination for the complaint;

(ii) if the Complaints Commissioner determines a longer period for the request than would otherwise apply under subparagraph (i)—that period.

361-57 Withdrawing requests for reconsideration of decisions

(1) If an entity requests the reconsideration of a decision, the entity may withdraw the request, either orally or in writing, at any time.

(2) If the entity withdraws the request before a reconsideration decision is made under section 361-60 in relation to the decision, the Complaints Commissioner must end the reconsideration of the decision.

361-60 Reconsideration of decisions

(1) This section is subject to section 361-57.

(2) If a request is made under section 361-55 for reconsideration of a decision that was not made personally by the Complaints Commissioner, the Complaints Commissioner must:

(a) personally reconsider the decision; or

(b) cause the decision to be reconsidered by a person:

(i) to whom the Complaints Commissioner has delegated the Complaints Commissioner's functions and powers under this Division; and

(ii) who was not involved in making the decision; and

(iii) who occupies a position that is at least the same level as that occupied by the person who made the decision.

(3) If a request is made under section 361-55 for reconsideration of a decision that was made personally by the Complaints Commissioner, the Complaints Commissioner must cause the decision to be reconsidered by the Commissioner.

(4) The person who reconsiders the decision is the ***internal decision reviewer***.

Reconsideration decision

(5) After reconsidering the decision, the internal decision reviewer must:

(a) affirm the decision; or

(b) set the decision aside and:

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(i) if the decision was to take no further action in relation to a complaint—make a new decision under section 361-42 in relation to the complaint; or

(ii) if the decision was to end a resolution process in relation to a complaint—decide to undertake a new resolution process under this Division in relation to the complaint.

(6) The decision made by the internal decision reviewer is the ***reconsideration decision***.

(7) After the internal decision reviewer makes the reconsideration decision, the internal decision reviewer must, within the period referred to in subsection (8), give the entity who requested the reconsideration written notice of:

(a) the reconsideration decision; and

(b) the reasons for the decision.

(8) For the purposes of subsection (7), the period is:

(a) 60 days from the day the reconsideration request is made, unless paragraph (b) applies; or

(b) 60 days from the day the reconsideration request is made plus one or more additional periods, for each of which the Complaints Commissioner:

(i) is satisfied that there are reasonable grounds to believe that the additional period is required; and

(ii) has communicated the grounds to the entity who requested the reconsideration.

Note: For subparagraph (b)(i), an example of when a period of more than 60 days may be required is if the complaint is particularly complex.

Application of sections 588 and 589 of the Act to internal decision reviewers

(9) If the internal decision reviewer is a delegate of the Complaints Commissioner, section 588 and subsection 589(2) of the Act apply to the internal decision reviewer in the same way that those provisions would apply to the Complaints Commissioner if the Complaints Commissioner were the internal decision reviewer.

361-65 Period for completing resolution process following reconsideration decision

(1) This section applies if:

(a) a reconsideration decision under section 361-60 is to make a new decision under section 361-42 in relation to a complaint, and that new decision is to undertake a resolution process under this Division in relation to the complaint; or

(b) a reconsideration decision under section 361-60 is to undertake a new resolution process under this Division in relation to a complaint.

(2) The internal decision reviewer must complete the resolution process within:

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(a) 90 days from the day the reconsideration request is made, unless paragraph (b) applies; or

(b) 120 days from the day the reconsideration request is made, if the Complaints Commissioner:

(i) is satisfied that there are reasonable grounds to believe that a period of more than 90 days is required; and

(ii) has communicated the grounds to the entity who requested the reconsideration.

Note: For paragraph (b), the following are examples of when a period of more than 90 days may be required to complete a resolution process:

(a) if the complaint is particularly complex;

(b) if the internal decision reviewer requires extensive further information to assist in completing the process.

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Division 5—Reporting and planning

372-5 Annual report—other matters relating to complaints functions of the Complaints Commissioner

For the purposes of paragraph 372(i) of the Act, the other matters that an annual report mentioned in section 372 of the Act for a reporting period (within the meaning of that section) must include are the following:

(a) the total number of complaints received by the Complaints Commissioner in the reporting period about the following:
  (i) the compliance with the Act of a registered provider or a responsible person or aged care worker of a registered provider;
  (ii) a registered provider acting in a way that is incompatible with the Statement of Rights;

(b) of that total, the numbers of complaints that relate to the following:
  (i) each State or Territory;
  (ii) each provider registration category;
  (iii) each registered provider;
  (iv) each approved residential care home;

(c) of that total, the numbers of complaints:
  (i) that have been dealt with by the Complaints Commissioner; and
  (ii) that are ongoing; and
  (iii) of the numbers mentioned in subparagraphs (i) and (ii), the numbers of each that relate to each State and Territory;

(d) a summary of the topics of complaints;

(e) for each topic—the number of complaints that relate to the following:
  (i) each provider registration category;
  (ii) each registered provider;
  (iii) each approved residential care home;

(f) a summary of the outcomes of complaints;

(g) a summary of the feedback received under subsection 361-40(4);

(h) the average time taken to deal with complaints;

(i) the percentage of complaints in relation to which subsection 361-40(1) (complaint determinations) was complied with within each of the periods mentioned in subsection 361-40(2);

(j) for complaints in relation to which subparagraph 361-40(2)(c)(i) applied—a summary of the exceptional circumstances mentioned in that subparagraph relating to those complaints;

(k) the number of decisions to take no further action reconsidered under Subdivision D of Division 4, and of that number:
  (i) the number for which the reconsideration decision was to affirm the decision; and

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(ii) the number for which the reconsideration decision was to set the decision aside and decide to make a new decision under section 361-42 in relation to the complaint;

(l) the number of decisions to end resolution processes reconsidered under Subdivision D of Division 4 and, of that number:

(i) the number for which the reconsideration decision was to affirm the decision; and

(ii) the number for which the reconsideration decision was to set the decision aside and decide to undertake a new resolution process under Division 4;

(m) a summary of activities undertaken by the Complaints Commissioner in performing the complaints functions mentioned in paragraphs 358(f), (g), (h), (i) and (j) of the Act.

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Chapter 12—Regulatory mechanisms

Part 1—Introduction

396-5 Simplified outline of this Chapter

This Chapter relates to regulatory mechanisms under Chapter 6 of the Act.

Part 2 of this Chapter relates to the register of banning orders under Division 3 of Part 11 of Chapter 6 of the Act, and deals with:

(a) information that must be included in the register; and
(b) accessing and correcting information included in the register; and
(c) publication of the register.

Part 3 of this Chapter prescribes the method for working out certain amounts in certain circumstances under Division 3 of Part 13 of Chapter 6 of the Act.

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Part 2—Banning orders

507-5 Information that must be included in the register of banning orders in relation to individuals

For the purposes of paragraph 507(1)(i) of the Act, the following information is prescribed in relation to each individual against whom a banning order has been made at any time:

(a) the State or Territory, suburb or locality, and postcode of the individual's last known place of residence;

(b) if the Commissioner considers that further information is necessary to identify the individual—further information, including personal information, that the Commissioner considers is sufficient to identify the individual.

Note 1: For other information that must be included in the register in relation to each entity against which a banning order has been made at any time, see subsection 507(1) of the Act.

Note 2: For the application of subsection 507(1) of the Act to banning orders, see subsection 507(2) of the Act.

Example: For paragraph (b), if 2 individuals, each of whom is or was an aged care worker or responsible person of a registered provider, have the same name, suburb or locality, and postcode, and a banning order is made in relation to one of those individuals, the Commissioner could include information in the register to identify the individual in relation to whom the banning order is made.

507-10 Accessing and correcting information included in the register of banning orders in relation to individuals

(1) This section is made for the purposes of subsection 507(5) of the Act.

Accessing information in the register

(2) An individual against whom a banning order has been made may request that the Commissioner provide the individual with access to information (if any) that is included in the register of banning orders in relation to the individual.

Note: The Commissioner must, in certain circumstances, give an individual access to personal information that the Commissioner holds about the individual (see Australian Privacy Principle 12 in Schedule 1 to the *Privacy Act 1988*).

Seeking correction of information in the register

(3) An individual against whom a banning order has been made may request that the Commissioner make a correction to information that is included in the register of banning orders in relation to the individual.

Note: The Commissioner must, in certain circumstances, take reasonable steps to correct personal information that is wrong or misleading so that the information is accurate, up to date, complete, relevant and not misleading (see Australian Privacy Principle 13 in Schedule 1 to the *Privacy Act 1988*).

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Corrections on the Commissioner's initiative

(4) If the Commissioner considers that information that is included in the register of banning orders in relation to an individual is inaccurate, out-of-date, incomplete, irrelevant or misleading, the Commissioner may correct the information.

Note: The Commissioner must, in certain circumstances, take reasonable steps to correct personal information that is wrong or misleading so that the information is accurate, up to date, complete, relevant and not misleading (see Australian Privacy Principle 13 in Schedule 1 to the *Privacy Act 1988*).

507-15 Accessing information included in the register of banning orders in relation to entities other than individuals

(1) This section is made for the purposes of subsection 507(5) of the Act.

(2) An entity (other than an individual) against which a banning order has been made may request that the Commissioner provide the entity with access to information (if any) referred to in subsection 507(1) of the Act that is included in the register of banning orders in relation to the entity.

(3) If the Commissioner receives a request, the Commissioner must provide the entity with access to the requested information.

507-20 Correcting information included in the register of banning orders in relation to entities other than individuals—corrections sought by entities

(1) This section is made for the purposes of subsection 507(5) of the Act.

(2) An entity (other than an individual) may request that the Commissioner make a correction to information that is included in the register of banning orders in relation to the entity.

(3) If the Commissioner receives a request, the Commissioner must:
(a) make the requested correction; or
(b) decide to not make the requested correction.

Note: The Commissioner is not required to make a correction or decision on the request unless any further information or documents requested by the Commissioner are provided (see section 589 of the Act).

(4) The Commissioner must notify the entity of a correction or decision made under subsection (3).

507-25 Correcting information included in the register of banning orders in relation to entities other than individuals—corrections on the Commissioner's initiative

(1) This section is made for the purposes of subsection 507(5) of the Act.

(2) This section applies if:
(a) the Commissioner becomes aware of a matter; and

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(b) based on the matter, the Commissioner considers that information that is included in the register of banning orders in relation to an entity (other than an individual) requires a correction.

(3) The Commissioner must give a written notice to the entity:
(a) setting out the details of the matter and the proposed correction; and
(b) inviting the entity to give written comments on the matter and the proposed correction within the period specified in the notice.

(4) The period specified for the purposes of paragraph (3)(b) must not end earlier than 28 days after the day on which the notice is given.

(5) As soon as practicable after the earlier of:
(a) when the Commissioner receives comments from the entity; or
(b) the end of the period specified for the purposes of paragraph (3)(b);
the Commissioner must consider any comments given by the entity and:
(c) make the proposed correction; or
(d) make a different correction; or
(e) decide not to make a correction.

(6) The Commissioner must give the entity written notice of a correction or decision made under subsection (5).

507-30 Publication of register of banning orders

(1) This section is made for the purposes of paragraph 507(6)(a) of the Act.

(2) The Commissioner may publish the register of banning orders, in whole or in part, on the Commission's website.

Note: For the information that must be included in the register, see subsection 507(1) of the Act and section 507-5 of this instrument.

Commissioner may decide not to publish part of register or particular information

(3) The Commissioner may decide not to publish a part of the register or particular information that is included in the register if the Commissioner is reasonably satisfied that it is not in the public interest to publish that part of the register or that information, taking into account all relevant matters including:
(a) the interests of individuals whose interests may be affected by publishing that part of the register or that information; and
(b) the interests of individuals who are accessing, have accessed, or may access, funded aged care services.

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Part 3—Recoverable amounts

523-5 Circumstances for waiver—settlements between Commonwealth and debtors—method for working out present value of unpaid amount

For the purposes of subsection 523(6) of the Act, the method for working out the present value of an unpaid amount mentioned in subsection 523(5) of the Act in relation to a recoverable amount is to use the following formula:

$$\frac{\text{annual repayment}}{\text{interest}} \times \left[1 - \frac{1}{(1+\text{interest})^{\text{repayment period}}}\right]$$

where:

annual repayment is the amount of the recoverable amount that the System Governor believes would be recovered under Division 2 of Part 13 of Chapter 6 of the Act in a year if subsection 523(4) of the Act did not apply in relation to the recoverable amount.

interest has the same meaning as in subsection 1237AAB(6) of the Social Security Act.

repayment period is the number of years needed to repay the unpaid amount if repayments equal to the annual repayment were made each year.

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Chapter 13—Information management

Part 1—Introduction

534-5 Simplified outline of this Chapter

This Chapter provides for matters relating to record keeping and information sharing under Chapter 7 of the Act.

Part 2 of this Chapter relates to retention of records by former registered providers under Part 3 of Chapter 7 of the Act.

Part 3 of this Chapter relates to information sharing under Part 4 of Chapter 7 of the Act, and deals with:

(a) certain information about funded aged care services that the System Governor must publish; and

(b) certain information about particular funded aged care services that the System Governor may publish; and

(c) certain information relating to funded aged care services delivered in a particular residential care home or home or community setting by a particular registered provider that the Commissioner may publish.

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Part 2—Record-keeping

543-5 Retention of records by former registered provider

For the purposes of paragraph 543(1)(a) of the Act, every kind of registered provider is prescribed.

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Part 3—Information sharing

Division 1—Publication by System Governor

Subdivision A—System Governor must publish information about funded aged care services generally

544-5 Preliminary

(1) This Subdivision is made for the purposes of subsection 544(1) of the Act.

(2) Information published in accordance with this Subdivision must:
  (a) be published on a portal or website maintained by the Department; and
  (b) be published as soon as practicable after the information is given to the System Governor.

Note: See also subsection 544(3) of the Act, which relates to not publishing certain personal information.

544-10 Pricing information

If a registered provider gives a report to the System Governor under section 166 of the Act, in accordance with section 166-1005 of this instrument (relating to prices of services), the System Governor must publish the information in that report.

544-15 Approved residential care home—income and expenditure

(1) The System Governor must publish information about the following matters in relation to an approved residential care home of a registered provider:
  (a) the provider's income in relation to the approved residential care home in a financial year for the provider;
  (b) expenditure by the provider on the following matters in relation to the approved residential care home in the financial year:
    (i) the delivery of funded aged care services, including labour costs;
    (ii) catering;
    (iii) maintenance;
    (iv) cleaning and laundry;
    (v) administration;
  (c) the provider's profit or loss in relation to the approved residential care home in the financial year.

(2) To avoid doubt, the requirements in subsection (1) do not apply in respect of the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP.

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544-20 Approved residential care home—other information

(1) The System Governor must publish information about the following matters in relation to an approved residential care home of a registered provider registered in the provider registration category residential care:

(a) information given to the System Governor in accordance with paragraph 166-810(1)(a) (relating to kinds of feedback and complaints);

(b) information given to the System Governor in accordance with paragraph 166-810(1)(b) (relating to improvements made by the provider);

(c) information given to the System Governor in accordance with paragraph 166-810(1)(c) (relating to initiatives to support a diverse and inclusive environment);

(d) subject to subsection (3)—information given to the System Governor in accordance with paragraph 166-810(1)(d) (relating to the representation of different demographic groups in the membership of the governing body);

(e) information relating to the total number of individuals accessing funded aged care services in the approved residential care home;

(f) information relating to the occupancy rate of total available beds in the approved residential care home;

(g) information relating to the number of individuals who commenced accessing funded aged care services in the approved residential care home;

(h) information relating to the number of individuals who ceased accessing funded aged care services in the approved residential care home.

(2) To avoid doubt, the requirements in subsection (1) do not apply in respect of the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP.

(3) The System Governor must not publish information in accordance with paragraph (1)(d) relating to the demographic group of a member of a governing body of a registered provider unless that member has consented to the publishing of that information.

544-25 Nursing and transition care

(1) The System Governor must publish information about the following matters in relation to a registered provider registered in the provider registration category nursing and transition care:

(a) information given to the System Governor in accordance with paragraph 166-810(1)(a) (relating to kinds of feedback and complaints);

(b) information given to the System Governor in accordance with paragraph 166-810(1)(b) (relating to improvements made by the provider);

(c) information given to the System Governor in accordance with paragraph 166-810(1)(c) (relating to initiatives to support a diverse and inclusive environment);

(d) subject to subsection (2)—information given to the System Governor in accordance with paragraph 166-810(1)(d) (relating to the representation of different demographic groups in the membership of the governing body);

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(e) information relating to the total number of individuals to whom the provider delivers funded aged care services under the TCP.

(2) The System Governor must not publish information in accordance with paragraph (1)(d) relating to the demographic group of a member of a governing body of a registered provider unless that member has consented to the publishing of that information.

(3) To avoid doubt, the requirements in subsection (1) do not apply in respect of the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP.

(4) To avoid doubt, the requirements in paragraphs (1)(c) and (d) do not apply in respect of the delivery of funded aged care services delivered only under the TCP.

544-30 Approved residential care home—direct care responsibilities

(1) The System Governor must publish information about the following matters in relation to an approved residential care home of a registered provider:

(a) information relating to the required combined staff average number of care minutes per individual per day in respect of the approved residential care home for the quarter worked out under subsection 176-20(1);

(b) information relating to the required registered nurse average number of care minutes per individual per day in respect of the approved residential care home for the quarter worked out under subsection 176-20(2);

(c) information relating to the average number of care minutes delivered in the approved residential care home by direct care staff members of the registered provider per mainstream counted individual per day during the quarter;

(d) information relating to the average number of care minutes delivered in the approved residential care home by enrolled nurse staff members of the registered provider per mainstream counted individual per day during the quarter;

(e) information relating to the average number of care minutes delivered in the approved residential care home by registered nurse staff members of the registered provider per mainstream counted individual per day during the quarter.

Note: See also Subdivision A of Division 2 of Part 6 of Chapter 5 to this instrument (Delivery of direct care—mainstream providers).

(2) To avoid doubt, the requirements in subsection (1) do not apply in respect of the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP.

(3) The System Governor must publish the information mentioned in paragraphs (1)(a) and (b) as soon as practicable on or after the calculation day for the relevant quarter.

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Subdivision B—Information that System Governor may publish about particular funded aged care services

545-20 Additional matters that the System Governor may publish

For funded aged care services delivered in a particular residential care home or home or community setting, the matters are the following:

(a) any information included in a report referred to in section 166-855 of this instrument (relating to reporting requirements relating to registered nurses);

(b) if the provider has been granted an exemption from section 175 of the Act (relating to registered nurses) in relation to the residential care home:

(i) the steps the provider has taken to ensure that the clinical care needs of the care recipients residing in the residential care home will be met during the period for which the exemption is in force; and

(ii) confirmation that the System Governor is satisfied that those steps are reasonable;

(c) any information included in a report referred to in section 166-10, 166-15, 166-20 or 166-25 of this instrument (relating to service staff and individuals who have received certain vaccinations);

(d) any information included in any of the following:

(i) an aged care financial report referred to in section 166-310 of this instrument;

(ii) a response to a request for further information given under subsection 166-310(8) of this instrument (relating to an aged care financial report);

(iii) a financial support statement referred to in section 166-315 of this instrument;

(iv) a response to a request for further information given under subsection 166-315(8) of this instrument (relating to a financial support statement);

(v) a care minutes performance statement referred to in section 166-335 of this instrument;

(vi) an audit referred to in subsection 166-335(6) of this instrument of a care minutes performance statement;

(vii) a quarterly financial report referred to in section 166-340 of this instrument;

(viii) a response to a request for further information given under subsection 166-340(11) of this instrument (relating to a quarterly financial report);

(ix) a general purpose financial report referred to in section 166-345 of this instrument;

(x) a response to a request for further information given under subsection 166-345(10) of this instrument (relating to a general purpose financial report);

(xi) an audit referred to in section 166-350 of this instrument of a general purpose financial report;

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(xii) an annual prudential compliance statement referred to in section 166-360 of this instrument;

(xiii) an audit referred to in section 166-385 of this instrument of an annual prudential compliance statement;

(xiv) a report referred to in section 166-805 of this instrument (relating to governing body statements);

(xv) a report referred to in section 166-810 of this instrument (relating to provider operations reporting);

(e) any information included in an annual wellness and reablement report referred to in section 166-615 of this instrument (relating to CHSP reporting);

(f) the grade assigned to a provider in a final assessment report referred to in section 110-30 of this instrument (relating to an entity's conformance with the Aged Care Quality Standards);

(g) any information included in an audit referred to in section 110-38 of this instrument (relating to an entity's conformance with the Aged Care Quality Standards);

(h) any information relating to a compliance notice given under section 481 or 482 of the Act, including:

(i) the date the compliance notice was sent to the provider;

(ii) brief details of the non-compliance or possible non-compliance;

(iii) action that the provider must take, or refrain from taking, to address the non-compliance or possible non-compliance;

(iv) the period within which the provider must take, or refrain from taking, the action to address the non-compliance or possible non-compliance;

(v) whether the System Governor or the Commissioner (as applicable) is satisfied that the provider has complied with the compliance notice;

(vi) whether the compliance notice is varied or revoked;

(i) any information included in an annual activity report referred to in section 166-725 of this instrument (relating to MPSP reporting);

(j) any information included in an annual statement of financial compliance and income and expenditure referred to in section 166-730 of this instrument (relating to MPSP reporting);

(k) any information included in a service demographics report referred to in section 166-735 of this instrument (relating to MPSP reporting).

Note: See also subsection 545(2) of the Act, which relates to not publishing certain personal information.

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Division 2—Publication by Commissioner

546-5 Purpose of this Division

For the purposes of paragraph 546(1)(l) of the Act, this Division prescribes matters, about which the Commissioner may publish information, relating to funded aged care services delivered in a particular residential care home or home or community setting by a particular registered provider.

546-10 Matters included in or related to final assessment reports for approved residential care homes

For funded aged care services delivered in a particular residential care home, the matters are matters included in or related to the final assessment report of a home assessment of the home, including, but not limited to, the following:

(a) the report's findings;
(b) information considered in reaching those findings;
(c) the grade assigned for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home.

546-15 Matters included in or related to final audit reports

For funded aged care services delivered in a particular residential care home or home or community setting, the matters are matters included in or related to a final audit report of an entity's ability to conform with the Aged Care Quality Standards, including, but not limited to, the following:

(a) the name of the entity to which the final audit report relates;
(b) the date of completion of the final audit report;
(c) a summary of the outcome of the audit including the grade assigned for conformance with the Aged Care Quality Standards (as outlined in the audit methodology);
(d) to the extent that the audit relates to services delivered in a particular approved residential care home:
    (i) the name of the approved residential care home; and
    (ii) the date of completion of the home assessment conducted in accordance with subsection 110-26(2); and
    (iii) a summary of the outcome of the home assessment, including the grade assigned (as outlined in the audit methodology) for conformance with any of the Aged Care Quality Standards assessed at the approved residential care home.

Note: Home assessment outcomes about an approved residential care home in which funded aged care services are delivered by a registered provider may be published before the completion of the final audit report (see section 546-10).

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Chapter 14—Miscellaneous

Part 1—Introduction

555-5 Simplified outline of this Chapter

This Chapter provides for the reconsideration and review of certain decisions made by the Commissioner, System Governor and the Pricing Authority under this instrument.

It also provides for application fees and fees for services provided by the System Governor, Commissioner and Complaints Commissioner.

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Part 2—Reconsideration and review of decisions

556-5 Decisions by the Commissioner

The following table prescribes decisions and entities for the purposes of table item 31 in subsection 556(1) of the Act.

Decisions by the Commissioner

Item	Column 1 Decision	Column 2 Entity
1	A decision under subsection 507-20(3) of this instrument to not make a requested correction to information that is included in the register of banning orders in relation to an entity	The entity
2	A decision under subsection 507-25(5) of this instrument not to make a proposed correction, or to make a different correction, to information that is included in the register of banning orders in relation to an entity	The entity

557-5 Decisions by the System Governor

The following table prescribes decisions and entities for the purposes of table item 44 in section 557 of the Act.

Decisions by the System Governor

Item	Column 1 Decision	Column 2 Entity
1	A decision under subsection 166-335(7) of this instrument to approve a person to audit a registered provider's care minutes performance statement	The registered provider
2	A decision under subsection 166-350(2) of this instrument to approve a person to audit a registered provider's general purpose financial report	The registered provider
3	A decision under subsection 166-355(3) of this instrument to determine a period of 12 months, other than the financial year, to be a registered provider's reporting period	The registered provider
4	A decision under subsection 166-385(2) of this instrument to approve a person to audit a registered provider's annual prudential compliance statement	The registered provider
5	A decision under subsection 175-25(1) of this instrument to refuse to grant an exemption from subsection 175(1) of the Act to a registered provider in relation to a residential care home	The registered provider
6	A decision under subsection 175-50(1) of this instrument to revoke a registered provider's exemption from subsection 175(1) of the Act in relation to a residential care home	The registered provider

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Decisions by the System Governor

Item	Column 1 Decision	Column 2 Entity
7	A decision under paragraph 197-10(1)(a) of this instrument to determine an individual's fortnightly total income amount, fortnightly total essential expenses or fortnightly remaining income amount	Each of the following: (a) the individual; (b) the registered provider delivering funded aged care services to the individual
8	A decision under paragraph 197-10(1)(b) of this instrument to determine the day a determination made under subsection 197-10(1) takes effect	Each of the following: (a) the individual; (b) the registered provider delivering funded aged care services to the individual
9	A decision under paragraph 197-10(1)(c) of this instrument to determine the period for which a determination made under subsection 197-10(1) is in effect	Each of the following: (a) the individual; (b) the registered provider delivering funded aged care services to the individual
10	A decision under subsection 197-20(1) of this instrument to vary or revoke a home or community fee reduction supplement determination	Each of the following: (a) the individual; (b) the registered provider delivering funded aged care services to the individual
11	A decision under subsection 211-20(5) of this instrument on an application by a registered provider to determine an amount for an individual who has the classification level AT High for the classification type short-term for the service group assistive technology	Each of the following: (a) the individual; (b) the registered provider
12	A decision to refuse to make a determination under subsection 230-30(1) of this instrument that an approved residential care home is a significantly refurbished home	The registered provider
13	A decision to refuse to make a determination under subsection 230-35(1) of this instrument that an approved residential care home of a registered provider is a significantly refurbished home	The registered provider

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Section 557-5

Decisions by the System Governor		
Item	**Column 1** **Decision**	**Column 2** **Entity**
14	A decision under paragraph 230-35(5)(a) of this instrument that the System Governor is not satisfied, as referred to in paragraph 230-35(1)(b), that an approved residential care home of a registered provider meets the requirements in paragraphs 230-35(3)(a) to (h)	The registered provider
15	A decision under paragraph 231-17(1)(a) of this instrument to determine an individual's daily total essential expenses, daily remaining income amount, unreduced daily amount of the resident contribution and reduced daily amount of the resident contribution	Each of the following: (a) the individual; (b) the registered provider delivering funded aged care services to the individual
16	A decision under paragraph 231-17(1)(b) of this instrument to determine the day a determination made under subsection 231-17(1) takes effect	Each of the following: (a) the individual; (b) the registered provider delivering funded aged care services to the individual
17	A decision under paragraph 231-17(1)(c) of this instrument to determine the period for which a determination made under subsection 231-17(1) is in effect	Each of the following: (a) the individual; (b) the registered provider delivering funded aged care services to the individual
18	A decision under subsection 231-19(1) of this instrument to vary or revoke a residential care fee reduction supplement determination	Each of the following: (a) the individual; (b) the registered provider delivering funded aged care services to the individual
19	A decision under subsection 246A-5(2) of this instrument to determine that a judgment or settlement is to be treated as having taken into account the future costs of delivering funded aged care services to an individual, and the part of the compensation under the judgment or settlement that is to be treated as relating to those future costs	The individual
20	A decision under subsection 246A-5(3) of this instrument to	The individual

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Decisions by the System Governor		
Item	**Column 1** **Decision**	**Column 2** **Entity**
	determine the part of the compensation that is to be treated as relating to the future costs of delivering funded aged care services to an individual	
21	A decision under paragraph 263-10(3)(b) of this instrument not to approve the proposed transfer of a service delivery branch of a registered provider to another registered provider	Each registered provider

558-5 Decisions by the Pricing Authority

The following table prescribes decisions and entities for the purposes of the table item 2 in section 558 of the Act.

Decisions by the Pricing Authority		
Item	**Column 1** **Decision**	**Column 2** **Entity**
1	A decision under subsection 290-30(4) that the Pricing Authority is not satisfied of the matters referred to in paragraph 290-30(3)(b) in relation to information given by a registered provider	The registered provider

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Part 3—Application fees and fees for services provided by the System Governor, Commissioner and Complaints Commissioner

597-5 Fees—exemptions—fees that must accompany application or request made to System Governor, Commissioner or Complaints Commissioner

(1) For the purposes of subparagraph 597(d)(i) of the Act, the circumstances specified in column 2 of an item of the following table are prescribed for the fee specified in column 1 of the item.

Circumstances for the exemption of fees for certain applications or requests

Item	Column 1 Fee	Column 2 Circumstances
1	the application fee prescribed in section 104-5 of this instrument for an application made by an entity under section 104 of the Act to be registered as a registered provider	the circumstances are that on the day the application is made any of the following apply: (a) the entity intends to be registered as a registered provider delivering funded aged care services under the MPSP or TCP; (b) the entity intends that 85% of the individuals that the entity is to deliver funded aged care services to will be located in an area with a 2023 MM category known as MM 6 or MM 7; (c) the entity is known as an Aboriginal Community Controlled Organisation
2	the application fee prescribed in section 107-5 of this instrument for an application made by a registered provider under section 107 of the Act to renew the provider's registration	the circumstances are that on the day the Commissioner invites the registered provider under section 106 of the Act to renew the provider's registration any of the following apply: (a) the registered provider is delivering funded aged care services under the MPSP or TCP; (b) all of the individuals the entity is delivering funded aged care services to are located in an area with a 2023 MM category known as MM5, MM 6 or MM 7; (c) the Commissioner considers, based on the information held by the Commissioner as at that day, that the provider is in the smallest 10% of all registered providers based on the number of individuals to whom funded aged care services are delivered by the provider
3	the application fee prescribed in section 111-5 of this instrument for an application made by an entity under section 111 of the Act to approve a	the circumstances are that on the day the application is made any of the following apply: (a) the entity is, or intends to be, registered as a registered provider delivering funded aged care services under the MPSP or TCP; (b) the entity is, or intends to be, registered as a registered provider and 85% of the individuals the entity is delivering, or intends to deliver, funded aged care services to, are, or will be, located in an

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Circumstances for the exemption of fees for certain applications or requests

Item	Column 1 Fee	Column 2 Circumstances
	residential care home in relation to the entity	area with a 2023 MM category known as MM 6 or MM 7; (c) the entity is known as an Aboriginal Community Controlled Organisation
4	the application fee prescribed in section 124-5 of this instrument for an application made by a registered provider under section 124 of the Act to vary the provider's registration	the circumstances are that on the day the application is made any of the following apply: (a) the entity is a registered provider delivering funded aged care services under the MPSP or TCP; (b) 85% of the individuals the entity is delivering, or intends to deliver, funded aged care services to, are, or will be, located in an area with a 2023 MM category known as MM 6 or MM 7; (c) the registered provider is known as an Aboriginal Community Controlled Organisation
5	the application fee prescribed in section 124-10 of this instrument for an application made by a registered provider under section 124 of the Act to vary the provider's registration	the circumstances are that on the day the application is made any of the following apply: (a) the registered provider is delivering funded aged care services under the MPSP or TCP; (b) 85% of the individuals the registered provider is delivering funded aged care services to are located in an area with a 2023 MM category known as MM 6 or MM 7; (c) the registered provider is known as an Aboriginal Community Controlled Organisation

597-10 Fees—refunds—fees that must accompany application or request made to System Governor, Commissioner or Complaints Commissioner

(1) For the purposes of subparagraph 597(d)(ii) of the Act, the circumstances specified in subsections (2) and (3) are prescribed for a fee for an application specified in subsection (5).

Circumstances for full refund

(2) The circumstances in which a fee specified in subsection (5) may be refunded in whole in relation to an application and an entity are that:

(a) either or both of the following apply:

(i) the entity makes the application in a form other than the approved form; or

(ii) the entity fails to include information in the application that is required under the Act to be included; and

(b) the entity pays the applicable fee in relation to the application.

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Circumstances for partial refund

(3) The circumstance in which a fee specified in subsection (5) may be refunded in part in relation to an application and an entity is that both of the following apply:
  (a) the entity makes the application;
  (b) the entity pays an amount which exceeds the applicable fee in relation to the application.

(4) If subsection (3) applies in relation to an application and an entity, the amount by which the amount referred to in paragraph (3)(b) exceeds the applicable fee may be refunded.

Fees for which circumstances apply

(5) For the purposes of subsections (2) and (3), the fees are the following:
  (a) for an application made under section 104 of the Act—the application fee prescribed in section 104-5 of this instrument;
  (b) for an application made under section 107 of the Act—the application fee prescribed in section 107-5 of this instrument;
  (c) for an application made under section 111 of the Act—the application fee prescribed in section 111-5 of this instrument;
  (d) for an application made under section 124 of the Act—the application fee prescribed in section 124-5 of this instrument;
  (e) for an application made under section 124 of the Act—the application fee prescribed in section 124-10 of this instrument.

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Chapter 15—Transitional provisions

Part 1A—Aged Care Amendment (Motor Neurone Disease Priority) Rules 2026

610-1A Priority categories and eligibility criteria for classification type ongoing for the service group home support

Section 87-5 of this instrument, as amended by item 1 of Schedule 1 to the *Aged Care Amendment (Motor Neurone Disease Priority) Rules 2026*, applies on or after 1 November 2025.

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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[x] = Compilation No. x

ch = Chapter(s)

cl = clause(s)

cont. = continued

def = definition(s)

Dict = Dictionary

disallowed = disallowed by Parliament

div = Division(s)

ed = editorial change

exp = expires/expired or ceases/ceased to have effect

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)

Ord = Ordinance

orig = original

p = page(s)

para = paragraph(s)/subparagraph(s) /sub-subparagraph(s)

pres = present

prev = previous

(prev…) = previously

pt = Part(s)

r = regulation(s)/Court rule(s)

reloc = relocated

renum = renumbered

rep = repealed

rs = repealed and substituted

s = section(s)/subsection(s) /rule(s)/subrule(s)/order(s)/suborder(s)

sch = Schedule(s)

SLI = Select Legislative Instrument

SR = Statutory Rules

sub ch = Sub-Chapter(s)

sub div = Subdivision(s)

sub pt = Subpart(s)

<u>underlining</u> = whole or part not commenced or to be commenced

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Endnote 3—Legislation history

Name	Registration	Commencement	Application, saving and transitional provisions
Aged Care Rules 2025	24 Sept 2025 (F2025L01173)	1 Nov 2025 (s 2-5(1) item 1)	
Aged Care Amendment (Care Minutes) Rules 2025	12 Dec 2025 (F2025L01555)	13 Dec 2025 (s 2(1) item 1)	—
Aged Care Legislation Amendment (2026 Measures No. 1) Rules 2026	2 Feb 2026 (F2026L00074)	sch 3: 3 Feb 2026 (s 2(1) item 1)	—
Aged Care Legislation Amendment (March Indexation and Other Measures) Rules 2026	19 Mar 2026 (F2026L00292)	sch 1 (items 1-60): 20 Mar 2026 (s 2(1) item 2) sch 2: 23 Mar 2026 (s 2(1) item 3) sch 3: 1 Apr 2026 (s 2(1) item 4) sch 4: 1 July 2026 (s 2(1) item 5) sch 5: 1 Oct 2026 (s 2(1) item 6)	—
Aged Care Amendment (Motor Neurone Disease Priority) Rules 2026	5 June 2026 (F2026L00693)	6 June 2026 (s 2(1) item 1)	—

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Endnote 4—Amendment history

Provision affected	How affected
Chapter 1	
Part 1	
s 2-5	rep LA s 48D
Part 2	
Division 1	
s 5-5	am F2026L00292
Division 2	
s 7-20	am F2026L00292
Chapter 2	
Part 3	
Division 2	
Subdivision B	
s 80-15	am F2026L00292
Subdivision BA	
Subdivision BA	ad F2026L00074
s 80-47	ad F2026L00074
s 80-49	ad F2026L00074
Part 4	
Division 3	
Subdivision A	
s 87-5	am F2026L00693
Part 5	
Division 1	
Subdivision A	
s 92A-5	rs F2026L00074
s 92A-10	rs F2026L00074
Chapter 3	
Part 2	
Division 2	
Subdivision G	
s 110-5 (second occurring)	renum ed C4
s 110-51 (prev s 110-5 second occurring)	

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Endnote 4—Amendment history

Provision affected	How affected
Chapter 4	
Part 4	
Division 3	
Subdivision C	
s 148-70	am F2026L00292
Division 4	
Subdivision D	
s 149-35	am F2026L00292
Part 5	
s 150A-15	am F2026L00292
s 150A-25	am F2026L00292
Part 6	
Division 2	
s 153-10	rs F2026L00292
s 153-15	rep F2026L00292
Part 7	
Division 2	
s 155-60	am F2026L00292
Chapter 5	
Part 2	
Division 3	
Subdivision A	
s 166-20	rep F2026L00292
Subdivision B	
s 166-145	am F2026L00292
s 166-165	am F2026L00292
s 166-170	am F2026L00292
Subdivision E	
s 166-310	am F2026L00292
Subdivision L	
s 166-850	am F2026L00292
Subdivision N	
s 166-1005	am F2026L00292
Part 6	
Division 1	
Subdivision A	
s 175-5	rs F2026L00292
s 175-10	am F2026L00292
Subdivision B	
s 175-15	am F2026L00292

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Provision affected	How affected
s 175-20	rep F2026L00292
s 175-25	am F2026L00292
s 175-30	am F2026L00292
Subdivision C	
s 175-50	am F2026L00292
s 175-55	am F2026L00292
Division 2	
Subdivision A	
s 176-20	am F2025L01555
Chapter 7	
Part 2	
Division 1	
Subdivision B	
s 194-5	am F2026L00292
Subdivision D	
s 196-25	am F2026L00292
s 196-30	am F2026L00292
Part 5	
s 197-30	ed C6
Part 7	
Division 1	
Subdivision C	
s 230-15	am F2026L00292
Subdivision D	
s 231-17	am F2026L00292
s 231-35	am F2026L00292
Division 3	
Subdivision B	
s 242B-10	am F2026L00292
s 242B-40	am F2026L00292
Division 4	
Subdivision A	
Subdivision A heading	ad F2026L00292
Subdivision B	
s 243A-5	ad F2026L00292
s 243A-10	ad F2026L00292
s 243A-15	ad F2026L00292
s 243A-20	ad F2026L00292
s 243A-25	ad F2026L00292

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Endnote 4—Amendment history

Provision affected	How affected
Subdivision D	
s 243A-40	ad F2026L00292
s 243A-45	ad F2026L00292
s 243A-50	ad F2026L00292
Part 9	
Division 1	
s 247-15	am F2026L00292
Part 10	
Division 1A	
Division 1A	ad F2026L00292
s 256-5	ad F2026L00292
Part 11	
Division 1	
s 265-5	rs F2026L00292
Chapter 8	
Part 2	
Division 2	
Subdivision C	
s 279-5	am F2026L00292
s 280-10	am F2026L00292
Division 2A	
Subdivision A	
s 285A-13	am F2026L00292
s 285A-14	am F2026L00292
Chapter 9	
Part 2	
Division 3	
Subdivision D	
s 287-103A	rs F2026L00292
Division 5	
Subdivision C	
s 287-155	am F2026L00292
Part 3	
Division 2	
Subdivision B	
s 290-25	am F2026L00292
Division 6	
s 302-15	am F2026L00292
Division 7	
s 311-5	am F2026L00292

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Provision affected	How affected
s 313-5	rs F2026L00292
s 313-10	rs F2026L00292
Chapter 10	
Part 2	
Division 1	
Subdivision A	
s 314-10	am F2026L00292
s 314-15	am F2026L00292
Subdivision C	
s 314-55	am F2026L00292
s 314-65	am F2026L00292
s 314-75	rs F2026L00292
Subdivision D	
s 314A-5	am F2026L00292
Division 2	
Subdivision A	
s 319-5	am F2026L00292
	ed C3
Subdivision H	
s 330-5	am F2026L00292
Subdivision K	
s 337-5	am F2026L00292
Chapter 11	
Part 2	
s 343A-5	am F2026L00292
Chapter 15	
Chapter 15	ad F2026L00693
Part 1A	
s 610-1A	ad F2026L00693

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Endnote 5—Editorial changes

In preparing this compilation for registration, the following kinds of editorial change(s) were made under the *Legislation Act 2003*.

Subsection 197-30(5)

Kind of editorial change

Correct a typographical error

Details of editorial change

Subsection 197-30(5) refers to “System-Governor” rather than “System Governor”.

This compilation was editorially changed to omit “System-Governor” and substitute “System Governor” in subsection 197-30(5) to correct the typographical error.

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