Aged Care Rules 2025

made under the

Aged Care Act 2024

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This compilation is in 2 volumes

Volume 1: Chapters 1 to 5
sections 1-5 to 177-20

Volume 2: Chapters 6 to 15
sections 187-1 to 610-15
Endnotes

Each volume has its own contents

Prepared by the Office of Parliamentary Counsel, Canberra

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 1 July 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If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.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 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 (4), 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	27.14
2	SAH class 2	40.56
3	SAH class 3	55.57
4	SAH class 4	75.13
5	SAH class 5	100.43
6	SAH class 6	121.73
7	SAH class 7	147.11
8	SAH class 8	197.60

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Transitional classification levels

(3) Subject to subsection (4), 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	27.79
2	HCP class 2	48.88
3	HCP class 3	106.40
4	HCP class 4	161.30

Individuals for whom interim place in effect

(4) 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 individual amount for the individual is the amount equal to 60% of the amount that applies to the individual under subsection (2) or (3) (as applicable).

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	55.07
2	SAH end-of-life pathway	305.79

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 $15.04.

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—$23.85; and
  (b) for non-bolus feeding—$26.79.

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 $3.54.

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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	3.02
2	SAH level 2	4.51
3	SAH level 3	6.17
4	SAH level 4	8.35
5	SAH level 5	11.16
6	SAH level 6	13.53
7	SAH level 7	16.35
8	SAH level 8	21.96

(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	3.09
2	HCP class 2	5.43
3	HCP class 3	11.82
4	HCP class 4	17.92

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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 $4.05.

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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 previous tier amount.

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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	2,052.00

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	513.00
3	AT Medium	2,052.00
4	AT High	15,390.00

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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	513.00
3	HM Medium	2,052.00
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—$15,390.00; 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 $15.04.

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—$23.84; and
(b) for non-bolus feeding—$26.76.

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 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 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).

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(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.

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

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(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).

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

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(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.

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).

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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;
(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.

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

Circumstances for applicability

(1) The circumstances in which veterans' supplement will apply to an individual for a day are that:

(a) the individual is a veteran with an accepted mental health condition; and

(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 $8.51.

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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 $1.43.

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 $49.41.

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	29.15
2	Huon Eldercare Limited	34.16
3	Norfolk Island Health and Residential Aged Care Services	16.56
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	16.78
4	2023 MM category known as MM 5	16.78
5	2023 MM category known as MM 6	18.21
6	2023 MM category known as MM 7	18.76

(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	6.46
3	4.67 to 5.80 inclusive	7.74
4	5.81 to 7.44 inclusive	10.82
5	7.45 to 9.08 inclusive	12.98
6	9.09 to 10.54 inclusive	18.18
7	10.55 to 12 inclusive	21.84

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	1.25
4	2023 MM category known as MM 5	2.75
5	2023 MM category known as MM 6	18.18
6	2023 MM category known as MM 7	21.84

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) $157.34;

(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	14.08
2	Central West	12.08
3	Far North Coast	12.83
4	Hunter	14.21
5	Illawarra	13.13
6	Inner West	14.67
7	Mid North Coast	13.44
8	Nepean	13.08
9	New England	8.66
10	Northern Sydney	8.45
11	Orana Far West	15.80
12	Riverina Murray	14.07
13	South East Sydney	13.68
14	Southern Highlands	14.81
15	South West Sydney	16.55
16	Western Sydney	13.21
	Victoria	
17	Barwon South Western	8.62
18	Eastern Metro	7.79
19	Gippsland	8.18
20	Grampians	14.43
21	Hume	8.37
22	Loddon-Mallee	13.32
23	Northern Metro	13.21
24	Southern Metro	8.60
25	Western Metro	8.54
	Queensland	
26	Brisbane North	12.87
27	Brisbane South	13.77
28	Cabool	13.83
29	Central West	12.08
30	Darling Downs	14.85
31	Far North	12.89
32	Fitzroy	7.55
33	Logan River Valley	15.05
34	Mackay	12.90

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Amounts for regions

Item	Column 1 Region	Column 2 Amount ($)
35	Northern	12.54
36	North West	18.88
37	South Coast	14.21
38	South West	12.90
39	Sunshine Coast	8.70
40	West Moreton	14.45
41	Wide Bay	13.18
	Western Australia	
42	Goldfields	7.55
43	Great Southern	8.57
44	Kimberley	18.47
45	Metropolitan East	13.83
46	Metropolitan North	14.03
47	Metropolitan South East	14.14
48	Metropolitan South West	15.46
49	Mid West	16.84
50	Pilbara	18.14
51	South West	12.90
52	Wheatbelt	13.26
	South Australia	
53	Eyre Peninsula	17.12
54	Hills, Mallee and Southern	14.99
55	Metropolitan East	13.83
56	Metropolitan North	14.03
57	Metropolitan South	14.14
58	Metropolitan West	15.46
59	Mid North	14.09
60	Riverland	15.64
61	South East	13.88
62	Whyalla, Flinders and Far North	14.27
63	Yorke, Lower North and Barossa	14.68
	Tasmania	
64	Northern	12.54
65	North Western	13.64
66	Southern	14.25
	Australian Capital Territory	
67	Australian Capital Territory	14.58

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Amounts for regions		
Item	**Column 1** **Region**	**Column 2** **Amount ($)**
	Northern Territory	
68	Alice Springs	20.70
69	Barkly	23.73
70	Darwin	17.82
71	East Arnhem	23.73
72	Katherine	12.89

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	60.61
2	More than 10 but less than 21	96.97
3	More than 20 but less than 31	109.06
4	More than 30 but less than 41	121.16
5	More than 40	133.33

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—$4.06.

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	65.11
2	Other Remote	more than 15 but less than 30	40.03

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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	4.06
4	Remote Centre	less than 16	31.09
5	Remote Centre	more than 15 but less than 30	22.08
6	Remote Centre	more than 29	4.06
7	(a) Other Rural; or (b) Small Rural Centre	less than 16	13.09
8	(a) Other Rural; or (b) Small Rural Centre	more than 15 but less than 30	4.06
9	(a) Other Rural; or (b) Small Rural Centre	more than 29	4.06

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	Less than 40	0.00
2	40	4.06
3	50	4.53
4	60	13.09
5	70	22.08
6	80	31.09
7	90	40.03
8	100	65.11

(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:	

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Category B residential care homes—scoring		
Item	**Column 1** **Criterion**	**Column 2** **Points**
	(a) more than 9.08 but not more than 12;	60
	(b) more than 5.8 but not more than 9.08;	50
	(c) more than 3.51 but not more than 5.8;	40
	(d) more than 1.84 but not more than 3.51;	30
	(e) 1.84 or less	0
2	Residential care places for the home that are in effect:	
	(a) less than 20;	30
	(b) more than 19 but less than 30;	20
	(c) more than 29 but less than 45	10
3	More than 50% of individuals accessing funded aged care services in the home are diverse individuals	10

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

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

Viability supplement equivalent amounts—Category C residential care homes		
Item	**Column 1** **Score**	**Column 2** **Amount ($)**
1	Less than 50	0.00
2	50	9.78
3	55	14.65
4	60	21.92
5	65	26.78
6	70	39.07
7	75	48.67
8	80	60.81
9	85	73.09
10	90	85.22
11	95	94.95
12	100	107.13

(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	Less than 50	0.00
2	50	9.78
3	55	14.65
4	60	21.92
5	65	26.78
6	70	39.07
7	75	48.67
8	80	60.81
9	85	73.09
10	90	85.22
11	95	94.95
12	100	107.13

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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 $269.44.

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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 of service delivery branches

263-5 Purpose of this Division

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

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Division 4—Transfers of approved residential care homes

263-50 Purpose of this Division

For the purposes of paragraph 263(1)(b) of the Act, this Division makes provision for, and in relation to, the transfer of an approved residential care home of a registered provider to another registered provider.

263-55 Transfer of entitlement to subsidy

(1) This section applies if the Commissioner:

(a) under subsection 123(1) or 124(1) of the Act, varies the registration of a registered provider (the ***transferor***) to remove an approved residential care home from the approved residential care homes covered by the registration; and

(b) under paragraph 124(1)(e) of the Act, varies the registration of another registered provider (the ***transferee***) to add the approved residential care home in relation to the provider to be covered by the registration.

Entitlement to subsidy

(2) Any entitlement of the transferor to an amount of subsidy, in respect of funded aged care services delivered by the transferor to individuals through the service group residential care in the home, that is payable under section 254 of the Act, but has not been paid, immediately before the day on which the decision to vary referred to in paragraph (1)(a) of this section takes effect, passes to the transferee on the day on which the decision to vary referred to in paragraph (1)(b) of this section takes effect.

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Division 5—Mergers of service delivery branches

263A-1 Purpose of this Division

For the purposes of subsection 263A(1) of the Act, this Division makes provision for, and in relation to, the merger of 2 or more service delivery branches of a registered provider into a single service delivery branch of the provider.

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

(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

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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 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.

Note: See also Division 13 of Part 5 of the *Aged Care (Consequential and Transitional Provisions) Rules 2025* (which deals with extra service fees and additional service fees).

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)).

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Step 3. Add:

(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).

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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;
  (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 services

(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

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(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 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.

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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.

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);

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then, despite subsection (1), the individual's means tested care fee is zero.

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

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(b) ending at the end of the day before that start day.

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.

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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 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

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(b) a reference in that Subdivision to a higher everyday living fee were a reference to a transitional higher everyday living fee; and
(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) subject to subsection (5)—to meet reasonable businesses losses that are incurred, in the course of delivering (other than under a specialist aged care program) funded aged care services to individuals through the service group residential care in an approved residential care home of the registered provider, in the first subsidy year for the approved residential care home and the registered provider;

(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);

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(iii) an option to acquire, by way of issue, an interest or right covered by subparagraph (i) or (ii);

(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).

(5) Paragraph (2)(f) does not apply to an approved residential care home and a registered provider if:

(a) the registered provider (the ***transitioned entity***) was an entity that was taken, at the transition time, to be registered as a registered provider under subitem 5(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*; and

(b) the approved residential care home (the ***transitioned place***) was a place that, under subitem 5(7) of that Schedule, was taken to be an approved residential care home of that entity; and

(c) as at immediately before 1 July 2025, the transitioned place was a place:

(i) through which the transitioned entity provided a residential care service (within the meaning of the old Act) that met its accreditation requirement (within the meaning of the old Act); or

(ii) through which the transitioned entity provided a flexible care service (within the meaning of the old Act) through which the entity provided flexible care (within the meaning of the old Act) in the form of transition care (within the meaning of the old Principles); or

(iii) that was covered by an agreement between the transitioned entity and the Commonwealth for the entity to provide flexible care (within the meaning of the old Act) through a multi-purpose service (within the meaning of the old Principles).

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);

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(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: (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)	on the day on which the registered provider ceased 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:	within 14 days after the day on which the provider

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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 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)	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.

(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***).

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(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:
  (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

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(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:

(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:

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(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
(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, $789,686.00 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

(1) For the purposes of paragraph 310(2)(f) of the Act, the registered provider may use a refundable deposit for the following purposes:

(a) subject to subsection (2)—to meet reasonable businesses losses that are incurred, in the course of delivering (other than under a specialist aged care program) funded aged care services to individuals through the service group residential care in an approved residential care home of the registered provider, in the first subsidy year for the approved residential care home and the registered provider;

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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*.

(2) Paragraph (1)(a) does not apply to an approved residential care home and a registered provider if:

(a) the registered provider (the ***transitioned entity***) was an entity that was taken, at the transition time, to be registered as a registered provider under subitem 5(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*; and

(b) the approved residential care home (the ***transitioned place***) was a place that, under subitem 5(7) of that Schedule, was taken to be an approved residential care home of that entity; and

(c) as at immediately before 1 July 2025, the transitioned place was a place:

(i) through which the transitioned entity provided a residential care service (within the meaning of the old Act) that met its accreditation requirement (within the meaning of the old Act); or

(ii) through which the transitioned entity provided a flexible care service (within the meaning of the old Act) through which the entity provided flexible care (within the meaning of the old Act) in the form of transition care (within the meaning of the old Principles); or

(iii) that was covered by an agreement between the transitioned entity and the Commonwealth for the entity to provide flexible care (within the meaning of the old Act) through a multi-purpose service (within the meaning of the old Principles).

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.

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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.

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.

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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.

(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

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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.

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:

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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.

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—$87,427.60; or
  (b) for an individual who is not a member of a couple—$88,155.60.

(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—$139,172.80; or
  (b) for an individual who is not a member of a couple—$142,084.80.

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 $547,884.00.

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 either or both (as applicable) of the following:
  - (i) the entity (the ***employing entity***) the approved needs assessor is employed or otherwise engaged by, as referred to in subsection 7-8(2);
  - (ii) if the employing entity is engaged by a prescribed entity (within the meaning of subsection 7-8(2))—the prescribed entity;
- (b) the name or an abbreviation of the name of either or both (as applicable) of the entities referred to in paragraph (a);
- (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:

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"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 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.

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 under Subdivision A of Division 3 of Part 2 of Chapter 5 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 person
1A	A decision under subsection 166-335(8) of this instrument to revoke the approval of a person to audit a care minutes performance statement	The person
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 person
2A	A decision under subsection 166-350(3) of this instrument to revoke the approval of a person to audit a general purpose financial report	The person
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 person
4A	A decision under subsection 166-385(3) of this instrument to revoke	The person

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Decisions by the System Governor		
Item	**Column 1** **Decision**	**Column 2** **Entity**
	the approval of a person to audit an annual prudential compliance statement	
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
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	Each of the following: (a) the individual; (b) the registered

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Section 557-5

Decisions by the System Governor

Item	Column 1 Decision	Column 2 Entity
	technology	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
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

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Decisions by the System Governor		
Item	**Column 1** **Decision**	**Column 2** **Entity**
18A	A decision under subsection 242B-50(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
18B	A decision under subsection 242B-50(3) of this instrument to determine the part of compensation under a settlement that is to be treated as relating to the future costs of delivering funded aged care services to an individual	The individual
18C	A decision under subsection 242B-55(8) of this instrument to determine the transitional compensation payment reduction amount for an individual for a day	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 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	The 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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Part 1—Aged Care Amendment (July and August Indexation and Other Measures) Rules 2026

610-1 Definition of *Aged Care Assessment Manual*

Despite the amendments of the definition of ***Aged Care Assessment Manual*** in section 5-5 of this instrument made by item 1 of Schedule 1 to the *Aged Care Amendment (July and August Indexation and Other Measures) Rules 2026*, that definition, as in force immediately before 29 June 2026, continues to apply to classification assessments referred to in subsection 76-10(2) of this instrument that had commenced, but had not been completed, before 29 June 2026.

610-5 Definition of *Integrated Assessment Tool*

Despite the amendments of the definition of ***Integrated Assessment Tool*** in section 5-5 of this instrument made by item 2 of Schedule 1 to the *Aged Care Amendment (July and August Indexation and Other Measures) Rules 2026*, that definition, as in force immediately before 29 June 2026, continues to apply to the following:

(a) aged care needs assessments that had commenced, but had not been completed, before 29 June 2026;
(b) decisions under subsection 65(2) of the Act on the basis of an assessment report provided under section 63 of the Act before 29 June 2026;
(c) classification assessments referred to in subsection 76-10(2) of this instrument that had commenced, but had not been completed, before 29 June 2026.

610-6 Classification levels—Disability Support for Older Australians Program

The amendment made by item 4 of Schedule 1 to the *Aged Care Amendment (July and August Indexation and Other Measures) Rules 2026* applies to:

(a) classification assessments that had commenced, but had not been completed, before 29 June 2026; and
(b) classification assessments that commence on or after 29 June 2026.

610-10 Permitted purposes for use of accommodation bonds and refundable deposits

Paragraphs 287-101(2)(f) and 310-20(a) of this instrument, as in force immediately before 1 July 2026, apply as if the references in those paragraphs to "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" were references to "the period beginning the day after the day the registered provider begins to deliver funded aged care services to the individual through the service group residential care and ending at the end of 30 June 2026".

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610-15 Reconsideration and review of decisions

The amendments made by item 47 of Schedule 2 to the *Aged Care Amendment (July and August Indexation and Other Measures) Rules 2026* apply to decisions made before, on or after 1 July 2026.

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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)

underlining = 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)	—
Aged Care Amendment (July and August Indexation and Other Measures) Rules 2026	26 June 2026 (F2026L00862)	sch 1: 29 June 2026 (s 2(1) item 2) sch 2: 1 July 2026 (s 2(1) item 3) sch 3: 1 Aug 2026 (s 2(1) item 4) sch 4: 1 Oct 2026 (s 2(1) item 5) sch 5: 1 Nov 2025 (s 2(1) item 6)	—

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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; F2026L00862 (sch 5 (items 1, 2)
Division 2	
s 7-8	am F2026L00862
s 7-20	am F2026L00292
Part 3	
Division 1	
s 8-12	am F2026L00862
Division 2	
s 8-16	ad F2026L00862
s 8-36	ad F2026L00862
s 8-46	ad F2026L00862
s 8-51	ad F2026L00862
s 8-56	ad F2026L00862
s 8-61	ad F2026L00862
s 8-71	ad F2026L00862
s 8-81	ad F2026L00862
s 8-86	ad F2026L00862
s 8-91	ad F2026L00862
Division 3	
s 8-100	am F2026L00862
s 8-105	am F2026L00862 (sch 4 (item 1))
s 8-106	ad F2026L00862
	am F2026L00862 (sch 4 (item 2))
Part 4	
s 11-5	am F2026L00862
Part 6	
Division 1	
s 15-5	am F2026L00862

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Endnote 4—Amendment history

Provision affected	How affected
Chapter 2	
Part 2	
Division 2	
Subdivision B	
s 64-10	am F2026L00862
s 64-11	ad F2026L00862
Division 3	
Subdivision A	
s 65-5	am F2026L00862
Subdivision AB	
Subdivision AB	ad F2026L00862
s 69-5	ad F2026L00862
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
Division 3	
Subdivision B	
s 81-10	am F2026L00862
s 81-25	am F2026L00862
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 1	
Subdivision B	
s 109-25	am F2026L00862
s 109-30	ad F2026L00862
s 109-35	ad F2026L00862

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Provision affected	How affected
Division 2	
Subdivision G	
s 110-5 (second occurring)	renum
	ed C4
s 110-51 (prev s 110-5 second occurring)	
Chapter 4	
Part 4	
Division 1	
s 146-5	rs F2026L00862
Division 2	
s 147-10	rs F2026L00862
Division 3	
Subdivision B	
s 148-20	am F2026L00862
s 148-25	rs F2026L00862
s 148-30	am F2026L00862
Subdivision C	
s 148-65	am F2026L00862
s 148-70	am F2026L00292; F2026L00862
Subdivision D	
s 148-80	am F2026L00862
s 148-85	am F2026L00862
Division 4	
Subdivision D	
s 149-35	am F2026L00292
s 149-48	ad F2026L00862
Part 5	
s 150A-1	am F2026L00862
s 150A-15	am F2026L00292; F2026L00862
s 150A-25	am F2026L00292
Part 6	
Division 2	
s 153-10	rs F2026L00292
s 153-15	rep F2026L00292
Part 7	
Division 2	
s 155-20	am F2026L00862
s 155-40	am F2026L00862
s 155-41	ad F2026L00862

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Provision affected	How affected
s 155-45	am F2026L00862
s 155-50	am F2026L00862
s 155-60	am F2026L00292; F2026L00862
s 155-70	am F2026L00862
Part 10	
Division 1	
Subdivision A	
s 164-1	am F2026L00862
Chapter 5	
Part 2	
Division 3	
Subdivision A	
s 166-10	am F2026L00862
s 166-15	am F2026L00862
s 166-20	rep F2026L00292
s 166-25	am F2026L00862
Subdivision B	
s 166-110	am F2026L00862
s 166-112	am F2026L00862
s 166-145	am F2026L00292
s 166-165	am F2026L00292
s 166-170	am F2026L00292
Subdivision C	
s 166-205	am F2026L00862
Subdivision D	
s 166-220	am F2026L00862
Subdivision E	
s 166-310	am F2026L00292; F2026L00862
s 166-315	am F2026L00862
s 166-335	am F2026L00862
s 166-340	am F2026L00862
s 166-345	am F2026L00862
s 166-360	am F2026L00862
s 166-380	am F2026L00862
Subdivision F	
s 166-605	am F2026L00862
s 166-610	am F2026L00862
s 166-615	am F2026L00862
s 166-620	am F2026L00862
s 166-625	am F2026L00862

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Provision affected	How affected
s 166-628	am F2026L00862
Subdivision G	
s 166-635	am F2026L00862
s 166-640	am F2026L00862
s 166-645	am F2026L00862
s 166-646	am F2026L00862
Subdivision H	
s 166-725	am F2026L00862
s 166-730	am F2026L00862
s 166-735	am F2026L00862
Subdivision J	
s 166-745	am F2026L00862
Subdivision K	
s 166-805	am F2026L00862
s 166-810	am F2026L00862
Subdivision L	
s 166-850	am F2026L00292
s 166-855	am F2026L00862
Subdivision M	
s 166-905	am F2026L00862
Subdivision N	
s 166-1005	am F2026L00292
Part 3	
Division 1	
s 167-10	am F2026L00862
Division 2	
s 167-55	am F2026L00862
Part 6	
Division 1	
Subdivision A	
s 175-5	rs F2026L00292
s 175-10	am F2026L00292
Subdivision B	
s 175-15	am F2026L00292
s 175-20	rep F2026L00292
s 175-25	am F2026L00292
s 175-30	am F2026L00292
Subdivision C	
s 175-50	am F2026L00292
	ed C8

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Endnote 4—Amendment history

Provision affected	How affected
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; F2026L00862 (sch 3 (items 1, 2))
s 194-10	am F2026L00862 (sch 3 (item 3))
Subdivision D	
s 196-15	am F2026L00862 (sch 3 (item 7 (table item 1)))
s 196-20	am F2026L00862 (sch 3 (item 7 (table items 2, 3)))
s 196-25	am F2026L00292
s 196-30	am F2026L00292
s 196-35	am F2026L00862 (sch 3 (item 7 (table item 4)))
Division 2	
Subdivision C	
s 204-5	am F2026L00862 (sch 3 (items 4, 5))
Subdivision D	
s 205-15	am F2026L00862 (sch 3 (item 7 (table item 5)))
Part 3	
Division 2	
s 211-25	am F2026L00862
Division 3	
s 212-5	am F2026L00862
s 212-10	am F2026L00862
Part 4	
Division 3	
s 221-5	am F2026L00862
Part 5	
s 197-25	ed C8
s 197-30	ed C6
Part 7	
Division 1	
Subdivision B	
s 230-11	am F2026L00862
s 230-12	am F2026L00862
Subdivision C	
s 230-15	am F2026L00292

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Provision affected	How affected
Subdivision D	
s 231-17	am F2026L00292
s 231-18	am F2026L00862
s 231-20	ed C8
s 231-21	ed C8
s 231-35	am F2026L00292
s 231-50	am F2026L00862
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
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
Division 2	
s 249-10	am F2026L00862
s 249-25	am F2026L00862 (sch 3 (item 6))
s 249-30	am F2026L00862
s 249-35	am F2026L00862
s 249-40	am F2026L00862
s 249-45	am F2026L00862
s 249-50	am F2026L00862
s 249-55	am F2026L00862
s 249-60	am F2026L00862
s 249-65	am F2026L00862
Division 3	
s 249-90	am F2026L00862 (sch 3 (item 7 (table item 6)))

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Provision affected	How affected
Part 10	
Division 1A	
Division 1A	ad F2026L00292
s 256-5	ad F2026L00292
Division 3	
Division 3 heading	am F2026L00862
s 263-5	rs F2026L00862
Division 4	
Division 4	ad F2026L00862
s 263-50	ad F2026L00862
s 263-55	ad F2026L00862
Division 5	
Division 5	ad F2026L00862
s 263A-1	ad F2026L00862
Part 11	
Division 1	
s 265-5	rs F2026L00292
Chapter 8	
Part 2	
Division 1	
Subdivision A	
s 273-15	am F2026L00862
Division 2	
Subdivision C	
s 279-5	am F2026L00292
s 280-10	am F2026L00292
Division 2A	
Subdivision A	
s 285A-3	am F2026L00862 (sch 5 (item 3))
s 285A-13	am F2026L00292; F2026L00862
s 285A-14	am F2026L00292
Chapter 9	
Part 2	
Division 3	
Subdivision D	
s 287-101	am F2026L00862
s 287-103A	rs F2026L00292
Division 5	
Subdivision C	
s 287-155	am F2026L00292

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Provision affected	How affected
Part 3	
Division 2	
Subdivision A	
s 289-5	am F2026L00862
Subdivision B	
s 290-25	am F2026L00292
Division 6	
s 302-15	am F2026L00292
Division 7	
s 310-20	rs F2026L00862
s 311-5	am F2026L00292
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
	am F2026L00862
Subdivision H	
s 330-5	am F2026L00292
Subdivision K	
s 337-5	am F2026L00292
Chapter 11	
Part 2	
s 343A-5	am F2026L00292; F2026L00862
Chapter 12	
Part 2	
s 507-30	am F2026L00862

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Provision affected	How affected
Chapter 13	
Part 3	
Division 1	
Subdivision B	
s 545-20	am F2026L00862
Chapter 14	
Part 2	
s 557-5	am F2026L00862
Chapter 15	
Chapter 15	ad F2026L00693
Part 1A	
s 610-1A	ad F2026L00693
Part 1	
Part 1	ad F2026L00862
s 610-1	ad F2026L00862
s 610-5	ad F2026L00862
s 610-6	ad F2026L00862
s 610-10	ad F2026L00862
s 610-15	ad F2026L00862

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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*.

Subsections 175-50(6), 197-25(4), 231-20(4) and 231-21(5)

Kind of editorial change

Correct typographical errors

Details of editorial change

Subsections 175-50(6), 197-25(4), 231-20(4) and 231-21(5) refer to “System-Governor” rather than “System Governor”.

This compilation was editorially changed to omit “System-Governor” and substitute “System Governor” in subsections 175-50(6), 197-25(4), 231-20(4) and 231-21(5) to correct the typographical errors.

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