FOREWORD .......................................................................................................................... 6

1.1. The Aged Care Assessment Program........................................................................... 6

PART A - INTRODUCTION .................................................................................................. 7

1. The Aged Care Reform package ...................................................................................... 7
2. Roles and Responsibilities ............................................................................................... 7
   2.1. Australian Government ........................................................................................... 7
   2.2. State and Territory Government ............................................................................. 8
   2.3. Aged Care Assessment Teams ................................................................................. 8
   2.4. Evaluation Units ...................................................................................................... 9

PART B - THE ASSESSMENT PROCESS ............................................................................. 10

1. Assessment under the Aged Care Act 1997 .................................................................. 10
2. Referral ........................................................................................................................... 11
3. Priority categories ........................................................................................................... 12
4. Consenting to Assessment ............................................................................................... 13
5. Assessing for Eligibility for Services ............................................................................. 14
   5.1. Core Assessment Activities ..................................................................................... 14
       5.1.1 Initial Client Assessment and Needs Identification .............................................. 14
       5.1.2 Development of a Care Plan .............................................................................. 15
       5.1.3 Care Coordination to the Point of Effective Referral ......................................... 15
6. Involvement of Family and Carers .................................................................................. 16
7. ACAT Assessment Principles ......................................................................................... 16
   7.1. Comprehensive and Holistic .................................................................................... 16
   7.2. Independent .............................................................................................................. 17
   7.3. Multi-disciplinary and Multi-dimensional ............................................................... 17
   7.4. Client-focused ......................................................................................................... 17
       7.4.1 Carer or Advocate Involvement ........................................................................ 18
       7.4.2 Privacy and Confidentiality .............................................................................. 18
       7.4.3 Right to be Informed ......................................................................................... 18
       7.4.4 Right to Appeal ................................................................................................. 19
       7.4.5 Right to Complain ............................................................................................. 19
8. Components of the Assessment ...................................................................................... 19
   8.1. Medical Condition .................................................................................................. 19
   8.2. Physical Capability ................................................................................................. 20
   8.3. Cognitive and Behavioural Factors ....................................................................... 20
   8.4. Social Factors ......................................................................................................... 20
   8.5. Physical Environmental Factors ........................................................................... 21
   8.6. Personal Choice ..................................................................................................... 21
9. Availability of Care Services ......................................................................................... 21
10. Assessment in a Hospital Environment ......................................................................... 21
11. Assessments of People with Special Needs .................................................................. 22
   11.1. Aboriginal and Torres Strait Islander People ......................................................... 22
PART F - THE APPROVAL PROCESS

1. Approval as a Care Recipient
2. Who can complete an ACCR?
3. Functions and Powers Delegated to ACAT Positions
   3.1. Appointment of Delegates
   3.2. Delegations Round
   3.3. Delegate ID
4. Occupants of Delegate Positions
   4.1. Principles of Delegation
   4.2. Delegate Selection Criteria
   4.3. Nomination Process
   4.4. Changes in Occupation of a Position
   4.5. Conflict of Interest
   4.6. Liaison with the Department of Human Services
   4.7. Roles and Responsibilities of Delegates
5. Types of Care
6. Eligibility for Approval as a Care Recipient
7. Limitation of Approvals
   7.1. Limitation to Dementia Specific Care
   7.2. Limitation to Residential Respite Care
   7.3. Additional Residential Respite Care
   7.4. Varying a limitation
8. Date of Effect of Approval
9. Approvals Ceasing to have Effect
   9.1. Expire
   9.2. Approvals that lapse
   9.3. Approvals that do not Lapse
10. Entry Period
11. Break in Care
12. Revocation
13. Reassessment Requirements following the 2013 Legislation Changes

PART G - APPROVAL IN EMERGENCY CIRCUMSTANCES
2.2. Referral .................................................................................. 60
2.3. Assessment and Approval .............................................................. 60
3. Emergencies ................................................................................. 60
4. Extension of the Five Business Day Rule ........................................... 61
5. Example of the Emergency Care Process ........................................... 61
6. Recipient Dies Prior to ACAT Assessment ......................................... 62

PART H - NOTIFICATION OF DECISIONS ..................................... 64
1. Notifying People of Decisions ............................................................. 64

PART I - RECONSIDERATION AND REVIEW OF DECISIONS .......... 66
1. Reconsideration and Review of Decisions ........................................... 66
2. Types of Reconsiderations ................................................................. 67
   2.1. Own Motion Reconsiderations ..................................................... 67
   2.2. On Request Reconsiderations ...................................................... 67
3. Appellants ...................................................................................... 67
4. The Review Process ......................................................................... 68
5. The role of ACATs in the Review Process ........................................ 68
6. Advice on the Outcome of the Review ............................................ 69
7. Administrative Appeals Tribunal (AAT) .......................................... 69
8. Ombudsman ................................................................................... 69

PART J - RECORD KEEPING .......................................................... 70
1. Protection of Information ................................................................ 70
2. Using Protected Information ........................................................... 70
3. Exceptions to the General Prohibition ............................................ 71
4. Additional Exceptions for People Conducting Assessments ............. 72
5. Privacy Principle ............................................................................ 72
6. Retention of the ACCR and Related Information ............................. 74
7. Commonwealth Requirements ....................................................... 74
8. Destruction of Records .................................................................. 76
9. State and Territory Requirements .................................................. 76

APPENDIX 1 - THE AGED CARE ACT 1997 AND THE AGED CARE PRINCIPLES ............................................................................. 77

APPENDIX 2 - DEPARTMENT OF SOCIAL SERVICES CONTACT DETAILS ................................................................. 78

APPENDIX 3 - DEPARTMENT OF HUMAN SERVICES CONTACT DETAILS ................................................................. 79

GLOSSARY ......................................................................................... 80
FOREWORD

These Guidelines inform and guide the implementation of the Aged Care Assessment Program (ACAP) and Aged Care Assessment Team (ACAT) members in the assessment and approval of people for residential care, home care and flexible care, under the Aged Care Act 1997 (the Act).

The Guidelines outline the principles that govern the implementation of the ACAP while allowing some flexibility to accommodate regional differences. These Guidelines also provide background and information for ACATs about changes under the Aged Care Reform package being introduced by the Australian Government.

Further revisions of the Guidelines will be made as elements of the reforms are progressively introduced.

The Guidelines are primarily for use by State and Territory Governments responsible for the day to day delivery of the ACAP and ACAT, although they have been written with a broader audience in mind.

1. The Aged Care Assessment Program

The responsibility for approving people for Australian Government subsidised care is delegated under the Act. The ACAP is an important and integral part of Australia’s aged care system. The objective of the ACAP is to comprehensively assess the care needs of frail older people and to facilitate access to available care services appropriate to their needs. In meeting this objective, ACATs determine eligibility for a range of Australian Government subsidised aged care services.

Importantly for ACATs the Act and the associated Aged Care Principles (the Principles) prescribe the processes to be followed when assessing and approving people for subsided care, and provide the basis for these ACAP Guidelines.

The Guidelines should be read in conjunction with:

- the Act and the Aged Care Principles on the Comlaw website.

Other ACAP documents to assist ACATs include:

- Aged Care Assessment Program Data Dictionary
- Aged Care Client Record (ACCR) User Guide

Other Program specific resources, which may also assist ACAT members include the:

- Residential Care Manual
- Home Care Package Program Guidelines
- National Respite for Carers Program Respite Service Providers’ Program Manual
- Transition Care Program Guidelines
- ACAT Chat newsletters

Current editions of these ACAP documents and Program specific resources are available from the Department’s elearning website at www.acattraining.net.au.
PART A - INTRODUCTION

Part A Covers

The Aged Care Reform Package

Roles and responsibilities of:

- Australian Government
- State and Territory Government
- Aged Care Assessment Teams
- Evaluation Units

1. The Aged Care Reform package

The Productivity Commission produced the *Caring for Older Australians* report, which was released on 8 August 2011. The report is available on the Productivity Commission’s website.

The Productivity Commission found that Australia’s aged care system has many weaknesses and is not well placed to meet the future challenges associated with an ageing population. In particular, the Commission argued the aged care system is difficult to navigate; provides limited services and consumer choice; supplies services of variable quality; suffers from workforce shortages that are exacerbated by low wages and some workers having insufficient skills; and is characterised by marked inequities and inconsistencies in the availability of services, pricing arrangements and user co-contributions.

In response, the Commission proposed an integrated reform package, which would fundamentally change the structure and dynamics of Australia’s aged care system. The Commission’s analysis has informed the Aged Care Reform package.

Of particular interest to ACATs is the staged implementation of My Aged Care which will improve access to information about aged care. From 1 July 2013, older people, their families and carers have been able to access the My Aged Care website and the national contact centre on 1800 200 422, for information about aged care services.

2. Roles and Responsibilities

The ACAP is an initiative of the Australian Government.

In administering the ACAP, the Australian Government focuses primarily on strategic and national issues. The Commonwealth engages state and territory governments for the day-to-day management of the ACAP.

2.1. Australian Government

Implementation of the Australian Government’s role in the ACAP is undertaken by the Department of Social Services (the Department). The Department’s roles and responsibilities in relation to the ACAP are to:

- provide strategic direction for the ACAP;
- administer the ACAP nationally, including the development of program guidelines;
- manage the delegations framework;
- establish, monitor and report on performance targets;
• support the ACAP National Training Strategy and develop and maintain nationally consistent training resources; and

• manage the process of appeals of reviewable decisions under the Act.

2.2. State and Territory Government

The State and Territory Governments’ roles in relation to the ACAP are to:

• manage the day to day operations of the ACAP (including the management of complaints) in their state/territory in accordance with the Act;

• establish mechanisms to ensure that the Australian Government’s Guidelines and conditions for managing the ACAP are met, including monitoring the performance of ACATs;

• support the agreed objectives of the ACAP and ensure that the terms and conditions of the agreement with the Commonwealth are adhered to;

• provide input into the delegations process;

• provide the environment necessary for ACATs and Evaluation Units to operate effectively and independently by ensuring appropriate management structures are established and maintained, particularly for ACATs co-located with hospitals;

• ensure that ACATs meet the requirements of the ACAP National Training Strategy; and

• report against the ACAP Minimum Data Set (MDS).

It is recognised that ACAT structures may need to be reviewed and that ACATs may need to be amalgamated or split from time to time. Approval must be sought from the Department of Social Services prior to any restructuring. Amalgamations and splits of ACATs and changes to ACAT Client Management System database systems must be completed in accordance with Australian Government requirements to maintain the integrity of the ACAP MDS and the continuing operation of the electronic transmission of approval data to the aged care payment systems located with the Department of Human Services (DHS).

2.3. Aged Care Assessment Teams

ACATs provide assessment, information, advice and assistance to frail older people who want to remain at home with support or who are considering living in an aged care home. People who are not aged are eligible for aged care services in some circumstances. The Approval of Care Recipients Principles 1997 set out the eligibility requirements for the various types of Commonwealth subsidised aged.

ACATs comprehensively assess frail older people taking account of the restorative, physical, medical, psychological, cultural and social dimensions of their care needs. ACATs should involve clients, their carers, and service providers in the assessment and care planning process. ACATs are also encouraged to involve the person’s General Practitioner.

Under the Act, the Secretary of the Commonwealth Department of Social Services has the power to approve people for Australian Government subsidised care. The Secretary has delegated the authority to make these approvals to selected members of ACATs.

In meeting program aims and objectives, ACATs have the following responsibilities:

• conduct assessments in accordance with the Act, Principles and these guidelines;

• respond to assessment referrals in a timely manner; and

• keep abreast of related Australian Government policy and program developments that may affect their work.
Importantly, any documents prepared by ACAT members in their capacity as delegates of the Secretary – such as the Aged Care Client Record (ACCR) – remain the property of the Commonwealth.

The composition of an ACAT, and the experience of its members, is important in determining how effective its assessments will be. Ideally, the members of an ACAT should have extensive experience in the field of aged care and broad knowledge of residential and community resources.

Each ACAT should have a designated ACAT leader or coordinator or manager who is responsible primarily for the management and coordination of ACAT operations.

The characteristics of the region in which an ACAT operates should be carefully considered during the selection of members of an ACAT. For example, the special needs of culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander communities, people living in rural areas and people with dementia should be taken into account. In areas with high concentrations of particular groups, or areas with significant Aboriginal or Torres Strait Islander populations, the employment of staff with appropriate language skills and knowledge of the relevant cultural background is desirable. Refer to Part B.11 of these Guidelines for more detailed information on assessments of people with special needs.

2.4. **Evaluation Units**

Evaluation Units (EUs) have responsibility for the collation and provision of ACAP MDS data to the Australian Government. EUs also work to ensure that ACAT computer systems support the work of ACATs in their jurisdiction and enable collection and transmission of complete and accurate MDS data.
PART B -THE ASSESSMENT PROCESS

Part B Covers

- Assessment under the Aged Care Act 1997
- Referral
- Priority Categories
- Consenting to Assessment
- Assessing for Eligibility for Services, including:
  - Core Assessment Activities
- Involvement of family and carers
- ACAT Assessment Principles
- Components of the Assessment
- Availability of care services
- Assessment in a hospital environment
- Assessment of people with special needs and other groups with significant needs

1. Assessment under the Aged Care Act 1997

Aged Care Assessment Teams (ACATs) play a pivotal role in the Aged Care Assessment Program (ACAP). The focus of the ACATs’ work is the assessment of the care needs of frail older people. In doing so, they use a multi-disciplinary and multi-dimensional approach as outlined in Part B 7.3 below.

Under subsection 96-2(5) of the Aged Care Act 1997, (the Act), the Secretary has delegated to certain members of ACATs the power under Part 2.3 of the Act to approve a person as eligible to receive different types of aged care. Subsection 22-4(1) of the Act states that "Before deciding whether to approve a person under this Part, the Secretary must ensure the care needs of the person have been assessed".

This Part of the Guidelines explains the role of the ACAT in assessing a person’s care needs. The approval process is outlined in Part F of these Guidelines. The assessment and approval functions have been presented separately to indicate there can be no assumption that assessment automatically leads to a person’s approval as a care recipient.

A person is eligible for approval for care if the person meets the eligibility requirements under Division 21 of the Act. Where a person is determined as not meeting the eligibility requirements of any care program under the Act, the assessment would result in “No Care Approved”. The specific eligibility requirements for the different types of care and the limitations that can be placed on an approval are set out in Divisions 21 and 22 of the Act and in the Approval of Care Recipients Principles 1997. These eligibility requirements are set out under the respective Residential Care, Home Care and Flexible Care Parts of these Guidelines.

ACATs may also recommend other forms of care and support that are not provided under the Act, including in cases where no care under the Act is approved. For example, services provided under the Home and Community Care Program (HACC) or the National Respite for Carers Program (NRCP) may be more appropriate to meet the needs of the person being assessed.
Approval does not mean that a person is obliged to take up the approved care. It simply means that if the person decides that they will take up such care, the Commonwealth will subsidise the cost. It is a matter for the person themselves and/or their guardian or other legal representative whether they wish to receive the aged care they have been approved for.

Broadly, ACATs aim to:

- conduct a comprehensive assessment of the restorative, physical, medical, psychological, cultural and social dimensions of a client’s care needs, and provide a choice of appropriate services to meet their needs; and
- provide information and refer clients to services that are appropriate and available (including facilitating access to broader services such as HACC, mental health or disability services) to meet their needs and preferences.

In undertaking this work, ACATs:

- focus on the needs and preferences of the person being assessed;
- take into account the needs and preferences of the person’s carer or advocate, if any;
- have the capacity to refer to a range of services (including home care and rehabilitation services);
- actively encourage client and provider involvement in the planning, development and management of assessment services at the regional and state or territory level;
- promote how they can assist potential clients;
- establish and maintain links with providers of residential care, home care and flexible care and other health services, and GPs in their region;
- ensure equity of access to assessment services by clients and potential clients, including those with special needs;
- ensure that clients understand and are able to exercise their rights; and
- participate in ACAP data collection processes.

ACAT’s responsibilities in meeting the objectives of the ACAP and in fulfilling their role under the Act are described in these Guidelines. The operations and practices of ACATs in implementing their responsibilities vary widely, reflecting the diversity of health systems and local environments in which they operate. It is not possible to classify teams into distinct operating models.

2. Referral

ACATs can receive requests or referrals for assessment from any source. Screening within the ACAT intake process will assist people requesting assessment by ensuring that only appropriate clients progress to an assessment and those with urgent needs are seen in a timely manner in line with the priority category ratings (see item 3 of this part).

Referrals can be accepted for any person who is present in Australia or about to enter Australia. This includes Australian citizens, permanent residents, people in Australia on any kind of visa and people whose visas have expired or who have entered the country without a visa. All of these people may also be approved as care recipients if they meet the relevant eligibility criteria.

Processes must be in place to determine if it is appropriate to accept a request for an ACAT assessment. All requests and referral details must be recorded from the point of initial contact, whether or not the request is determined to be an appropriate referral for ACAT assessment. Details are to be recorded even if the request or referral is not accepted for ACAT assessment because a request that is not accepted may be reviewed.
An appropriate referral would establish whether the person:

- has a condition of frailty or disability requiring at least low level care;
- is incapable of living in the community without support;
- is a person with special needs (refer to Section 11.3 of the Act); and
- if there are any culturally specific assessment requirements (i.e. an interpreter, Aboriginal Liaison Officer).

It is important to note that the Act does not define the age of an older person.

In accordance with the Act and associated Principles, referral of a person who is not an aged person to an ACAT for assessment and approval of aged care services can occur where the person meets the eligibility criteria for aged care services and where it can be demonstrated that ‘there are no other care facilities or care services more appropriate to meet the person’s needs’.

ACATs may redirect a referral to other services such as Disability Services or the HACC program or NRCP where appropriate. An accepted referral for ACAT assessment is generally a precursor to an Application for Approval.

If the request or referral is accepted for ACAT assessment, the ACAT should:

- gather appropriate client information using intake documentation that may include an intake tool or screening questions;
- seek the person’s agreement to contact a carer or advocate, GPs and relevant service providers and involve them in the assessment process, (GPs, in particular, may be able to provide background information to support the assessment process);
- allocate the client an assessment priority category according to the urgency of the client’s needs as set out in Section 3 Priority Categories below;
- identify any risks and implement mitigation strategies – this may include referral back to the person’s GP, hospital or emergency care provider, or conducting the visit with a second team member; and
- provide written information to the client (and carer) on its role and responsibilities, the assessment process, the client’s rights and the care planning process.

ACATs store information on a client management system (CMS) database. These systems provide ACAT data to the Department of Social Services for the ACAP Minimum Data Set (MDS) in accordance with the requirements of the National Transaction File Format (NTFF), and most are capable of transmitting approval data to the Department of Human Services (DHS). All accepted referrals for ACAT assessments must be entered on the ACAT’s CMS database at the time of referral and be available to be included in the data provided to the MDS.

3. Priority categories

ACATs should respond to referrals in a timely and efficient manner by allocating a priority category based on the client’s needs at the time of acceptance for referral for an assessment.

The allocation of a priority category for referral time to first face-to-face assessment should be based on the information available to the ACAT at referral and should reflect factors related to client need rather than the priority with which the referrer would like the ACAT to respond.
Priority Category 1

Within 48 hours: refers to a client who, based on information available at referral, requires an immediate response (i.e. response within 48 hours). An urgent assessment is required if the person’s safety is at risk (e.g. high risk of falls or abuse), or there is a high likelihood that the person will be hospitalised or required to leave their current residence because they are unable to care for themselves, or their carer is unavailable. This may be due to a crisis in the home involving either the client or the carer or a sudden change in the client or carer’s, medical, physical, cognitive or psychological status.

Priority Category 2

Between 3 and 14 days: should be used when information available at referral indicates that the client is not at immediate risk of harm. Referrals that indicate progressive deterioration in the client’s physical, mental or functioning status, or that the level of care currently available to the client does not meet their needs or is not sustainable in the long-term, should be allocated to this priority category.

Priority Category 3

More than 14 days: refers to cases where the referral information indicates that the client has sufficient support available at present, but that they require an assessment in anticipation of their future care requirements. Examples include the carer planning a holiday, which will result in the care recipient requiring the provision of substitute care or recognition that the person is having increased difficulty living independently and options for future care need to be discussed with the client and their carer or family. In deciding to use this code the ACAT is making a judgement that delaying an assessment for more than 14 calendar days will not jeopardise the client’s health and well-being.

4. Consenting to Assessment

ACATs must obtain consent, written or verbal, from the person or the person’s representative prior to undertaking an assessment. This must be documented. Where a person is not able to understand the assessment process, consent must be obtained from their legal representative. ACATs must ensure that people referred for an ACAT assessment understand what the assessment process involves and their rights and responsibilities. ACATs should explain the role of the ACAT and service providers when obtaining the person’s consent to the assessment, and inform them that information ACATs gather could be provided to appropriate service providers.

ACATs should use consent forms which meet the legal requirements of their State or Territory. ACATs should also be aware, and should explain to clients, that the Application Form in the Aged Care Client Record (ACCR) is an application for approval to receive aged care under the Act, and not a consent form for the assessment or for the ACAT to obtain information from other parties. However, the Application Form does authorise the ACAT to provide information to service providers.

The client should also be made aware that the information gathered on the ACCR is part of a national, de-identified data set, which assists in the monitoring and management of the ACAP.

Before contacting the person’s GP, other health professionals, or family members or carers as appropriate, the ACAT must obtain consent from the person to do so. This should be documented by the ACAT.

If a person is unable to consent and does not have a legally appointed representative, such as a guardian or powers of attorney, consent from the next of kin or the person’s carer should be obtained.
5. Assessing for Eligibility for Services

ACAT assessments are comprehensive and holistic, independent, multi-disciplinary and multi-dimensional, and client-focused.

As part of the process, a person’s medical, physical, social and psychological needs are assessed to determine the person’s care needs and the type of services that would be most appropriate to meet those needs. The ACAT should also consider the person’s usual accommodation arrangement, financial circumstances, access to transport and community support systems and any other relevant matters.

ACATs should include, or have access to, a range of disciplines, skills and expertise sufficient to make accurate and complete assessments of the person’s needs. Geriatricians, medical specialists, GPs, rehabilitation specialists, nurses, social workers, physiotherapists, occupational therapists and psychologists, for example, can all play a role in the assessment process and in determining care needs. Face to face contact is a core element of any ACAT comprehensive assessment and must take place where possible. Where face-to-face contact between the ACAT member and a person is not possible, for example when assessing a client in a remote area, a phone assessment may be undertaken or another suitably qualified person (such as a local health worker) may attend the assessment with the client to assist the assessment process. In these cases the ACAT should undertake a follow up face-to-face assessment as soon as is practicable.

An ACAT approval is only required for the following Australian Government subsidised aged services under the Act:

- Residential aged care (permanent and/or respite)
- Home Care; or
- some forms of Flexible Care.

However, ACATs can refer to a variety of services, such as HACC services, NRCP services and any other locally available services.

5.1. Core Assessment Activities

The three core activities that are critical to an ACAT comprehensive assessment are detailed below.

5.1.1 Initial Client Assessment and Needs Identification

Assessment is a process of consultation, observation, negotiation and liaison between the assessor, the person being assessed, the person’s carer or family or partner and/or independent advocate and service providers. The process may also involve diagnosis where a medical professional is involved in the assessment.

The Department has developed an ACAP Toolkit and recommends its use to promote national consistency of assessment and the use of appropriately validated tools.

If possible the initial assessment should be made in the client’s usual accommodation setting. This does not mean that assessments cannot take place in other settings including hospital. Assessment in the client’s usual accommodation setting will assist the ACAT to complete the environmental, physical and social components of the comprehensive assessment by observing the client’s level of independence and functioning and existing support arrangements in familiar surroundings.

Where the client is in hospital the ACAT must ensure that a carer or other advocate is advised of the assessment in all circumstances and is present during an assessment where possible.
During the initial assessment all aspects of the process should be explained to the person being assessed and their carer, including:

- the role of the assessor and the overall team, including the use of a multi-disciplinary case conference;
- possible referral to other services; and
- follow-up or re-assessment procedures.

The process should incorporate a discussion of the person’s needs and expectations, including the client’s preference to receive home care services or residential care. The assessment will consider the care needs and preferences of the client and carer in the assessment process rather than the interests of service providers or other organisations. Decisions about recommendations or approvals of eligibility for care must not be based on the interests or wishes of service providers.

The use of other documentation, such as care notes and the ACFI appraisal, where the client is a resident of an aged care home, can also provide additional information which may assist in determining the person’s care needs and eligibility for care.

The ACAT must notify the client of the outcome of an assessment in writing using the templates which have been developed for this purpose as soon as the delegate has finalised the approval process. If a person has dementia or other conditions including confusion, the outcome must be provided through their carer or advocate. Consent should be sought from the client to provide this information to their GP and/or other health professionals involved in the referral or their care.

5.1.2 Development of a Care Plan

Considering all of the information gathered during the initial assessment and needs identification, and in collaboration with the client, the ACAT should develop a suitable care plan that provides a choice of available services. Where the care plan includes the provision of Australian Government-subsidised aged care under the Act, approval of the person as a recipient of that care should be given by an ACAT Delegate.

Where the person and/or their carer are unable to arrange care, the ACAT should coordinate the provision of services up to the point of effective referral as described below.

Where a person has been approved for Transition Care, the hospital geriatric rehabilitation services and the Transition Care provider play a key role in developing a care plan.

5.1.3 Care Coordination to the Point of Effective Referral

Care coordination is:

- any activity, additional to assessment, undertaken by ACATs that involves monitoring referrals and care plans;
- assistance in implementing a care plan, including helping the client access services, advocacy on the client’s behalf, liaising with the client and service providers to ensure that appropriate services are received, negotiating for alternative services if necessary; and
- supporting the client and their family during care plan implementation.

Examples of effective referral include:

- the client being admitted to an aged care home with a current approval;
- a carer who is willing to assume responsibility for coordinating service provision being identified and taking on that role; or
- a home care provider agreeing to provide a Home Care Package for the client.
Referral for a type of care without that care being provided (i.e. when a client is placed on a waiting list) does not represent an effective referral. In such cases the ACAT will need to arrange alternative options (such as the provision of HACC services or a lower level Home Care Package as an interim measure) to meet the client’s needs.

The decision to transfer care coordination responsibility to another person or organisation must factor in:

- the capability and willingness of formal services to assume a care coordination role, particularly if the client requires services outside the scope of the identified service provider; and
- any informal carer’s capability and willingness to continue to care for the client and the sustainability of that arrangement.

Care coordination activities normally take place after the assessment end date. However in some exceptional circumstances, activity prior to the assessment end date can be regarded as care coordination, including where the ACAT undertakes substantial activity to facilitate immediate access to services in the interests of client safety.

6. Involvement of Family and Carers

Where possible, in assessing a person and developing a care plan, an ACAT should involve the person’s carer, family or other nominated representative, as they also play an integral part in developing the most suitable care plan.

The person being assessed has a right to privacy and confidentiality, and the person’s consent must be sought before other parties, including family members become involved in the assessment and discussion of care options.

In circumstances where family and carers are not able to be physically involved, the ACAT should (with the person’s consent) contact them to gain an understanding of their wishes for the person and their capacity to continue in a caring role.

In assessing care needs where family and carers are involved, ACATs may find that they need to balance the person’s concerns and preferences with those of their family and/or carers.

7. ACAT Assessment Principles

There are a number of principles underpinning ACAT assessments that distinguish them from other assessment types.

7.1. Comprehensive and Holistic

A comprehensive assessment should include an evaluation of a person’s restorative, physical, medical, psychological, cultural and social dimensions of care needs. The Department has developed an ACAP Toolkit and recommends its use to promote national consistency of assessment and the use of appropriately validated tools.

It is important that ACATs take into consideration all of the client’s care needs during the assessment process, including the needs of their carer or advocate, so that the most appropriate combination of services may be recommended. ACATs can achieve this by undertaking a multi-disciplinary and multi-dimensional assessment.

Once provided with information about the range of options available, the client will be in the best possible position to choose services that suit their care needs.
The ACAT should take into account practical issues such as the client’s usual accommodation setting, financial state, need for legal assistance, suitability of accommodation and access to transport, in addition to their care needs. The use of residential and day respite care and other programs to support carers should also be considered.

The assessment process should always address the client’s potential for rehabilitation and restorative care and provide health information about options and choices appropriate to their needs.

7.2.  **Independent**

ACATs are funded by the Commonwealth independently of other services. ACATs need to have some autonomy within the health system and as such decisions made by ACAT delegates need to be made objectively and based on evidence. Other requirements about reporting and auspice arrangements for ACATs are determined locally by state and territory governments. However, it is critical that these arrangements support the role of ACATs to provide independent assessments and decisions.

Regardless of location, ACATs should establish a separate identity as a regional service.

7.3.  **Multi-disciplinary and Multi-dimensional**

Each ACAT should include members from a range of health-related disciplines such as geriatrics, medicine, registered nursing, social work, physiotherapy, occupational therapy and psychology. Access to other disciplines such as speech therapy, neuropsychology, podiatry and dietetics outside the formal structure of the ACAT should be available, if necessary, on a sessional basis.

Many frail older people have medical or physical conditions that underlie or contribute to increased dependency. Therefore, ACATs should have access to a geriatrician, or a medical practitioner experienced in gerontology, so that full medical assessments and accurate diagnoses are made and appropriate follow-up recommended. If this is not possible there should be close consultation with a practitioner who can advise on the medical aspects of the assessment process.

Multi-disciplinary assessment can be achieved through case conferencing, joint assessments with other service providers where necessary, follow-up visits, cross referral, multi-disciplinary consultations, or delegation processes. A case-conference, where all relevant members of the team contribute their professional expertise to a discussion of a client’s condition, is a vital component of comprehensive assessment, particularly for complex or difficult assessments.

7.4.  **Client-focused**

As part of the client focus, ACATs should promote the client’s right to:

- involve a carer or other advocate;
- privacy and confidentiality;
- be informed;
- make a complaint; and
- appeal the decision.
7.4.1 Carer or Advocate Involvement

The importance of the role of carers should be acknowledged during the assessment process. Carers may include family members, friends or neighbours who have been identified as providing regular and sustained care and assistance to the client without payment other than a pension or benefit. In the absence of a carer, clients have the right to have an advocate present during the assessment. An independent advocate could be a GP, legal representative, person appointed by the guardianship board or another person who can represent the interests of the client adequately.

ACATs must use their professional judgment if a client has dementia or is confused. In these cases the input of carers or advocates is particularly important.

Preferably the client should determine who is involved in the assessment process. The client’s right to privacy and confidentiality must be preserved, and outsider participation in the process should only occur if the client gives consent to have someone else present.

7.4.2 Privacy and Confidentiality

A client’s right to confidentiality must always be respected. If an ACAT member considers that maintaining confidentiality will interfere with or compromise their role in relation to a client, the matter should be discussed with the client or their carer. The client must be able to make an informed decision about whether they want personal information disclosed to others.

Information collected by ACATs in the course of conducting assessments is “Protected Information” under Division 86 of the Act. It is an offence to disclose protected information except in certain circumstances specified in the Act. The maximum penalty for this offence is imprisonment for 2 years.

A client’s Aged Care Client Record contains “Protected Information” under Division 86 of the Act and the record or its contents must not be shared or accessed by others unless the client is aware and has provided consent.

Under Section 86-4 of the Act, an ACAT delegate can disclose a person’s assessment information for the purpose of providing aged care or other community, health or social services to the person.

Any systems developed for the collection and analysis of data should incorporate adequate procedures to protect the privacy of people being assessed. If data is to be used for purposes other than assessment, or individual care planning, ACATs must have procedures in place to ensure that client confidentiality is maintained and individuals cannot be identified.

7.4.3 Right to be Informed

Members of ACATs must make all relevant information available to their clients so they are able to make informed choices. This will include information on the range of residential, rehabilitation, home care and other support services which may be available.

ACATs are to provide information about the assessment, appeals and complaints processes and other services to clients, carers, independent advocates and representatives. The information provided should be up-to-date and easy to understand.

Members of the ACAT should ensure that clients and carers have access to the information and support needed to make informed decisions concerning the care options available. They could also provide clients with the links to ACAT information which explains the ACAT role.

Clients and their carers should be advised that they are not compelled to enter an aged care home or accept a Home Care Package or any other service recommended by an ACAT once eligibility has been determined.
Similarly, clients should be made aware that being assessed as eligible for an aged care service does not ensure the availability of that service.

Clients must be advised promptly in writing of the outcome of their assessment using the template letters developed for this purpose.

### 7.4.4 Right to Appeal

People who are not satisfied with an assessment outcome, with respect to residential care, home care and flexible care, can request the Secretary to reconsider that decision under Section 85 of the Act. Information about review rights is included in the templates for letters to advise clients of the outcome of their assessment. ACATs must ensure that this material is not deleted from the template when the letters are drafted for individual clients.

The reconsideration process may involve a reassessment of the client prior to the Secretary making a new decision. It is not desirable for the reassessment to be conducted by the ACAT who did the initial assessment. If this is unavoidable then the reassessment should be undertaken by an ACAT member who was not involved in the original assessment.

### 7.4.5 Right to Complain

Clients and their carers or advocates have the right to complain and to have their complaints dealt with promptly and impartially.

If a complaint is related to Australian Government policies, guidelines or decisions, then members of ACATs, clients, service providers or any party whose interests are affected may contact the Department for advice and assistance.

Complaints relating to the conduct or operation of individual ACATs or an ACAT member should be directed to the ACAT initially. If the complaint cannot be resolved at this level it should be directed to the State or Territory Health Department, or Complaints Unit in its capacity as the ACAT’s employer.

Contact details for the Department of Social Services are at Appendix 2.

Clients, carers or advocates may also contact the Aged Care Complaints Scheme on 1800 550 552 for complaints relating to Approved Aged Care Providers. This Scheme provides free independent advice and assistance and an officer will be assigned to investigate the complaint and negotiate on behalf of the client.

### 8. Components of the Assessment

A fundamental requirement of an ACAT assessment is that it is comprehensive. To ensure this, several components of a person’s circumstances need to be considered in all assessments. Specific considerations for assessing for Australian Government funded services under the Act are outlined in the relevant sections of these Guidelines.

An ACAP Toolkit for Assessors has been developed by the Department of Social Services and is available for use by all ACATs. The Toolkit provides ACATs with a set of nationally consistent assessment tools and guidance on the correct indicators for use of these tools. ACATs are to make use of the Toolkit in conducting assessments.

The following factors should be a part of every assessment.

#### 8.1. Medical Condition

A person’s medical condition, if diagnosed by suitably qualified medical personnel, should be considered in the assessment. If the person’s medical condition is unstable, the assessment should not proceed until their condition is stabilised and any rehabilitation is completed.
8.2. **Physical Capability**

The assessor should use appropriate validated tools to gather evidence of the person’s capacity to perform the activities of daily living, with specific regard to:

- mobility, including walking, transfers and climbing stairs;
- maintaining personal hygiene, including bathing, grooming, toileting, continence and dressing;
- eating and drinking;
- their level of independence, including capacity to use transport, shop, prepare meals (including special dietary requirements), engage in home maintenance and housekeeping, and manage personal finances; and
- ability to manage health conditions, including medication compliance and management.

The ACAP Toolkit includes validated tools to assist provide this evidence.

For assessments conducted in hospital, the assessor should also consider the person’s potential for rehabilitation, which might be based, for example, on their capacity to benefit from a period of short-term low-intensity therapy and support, such as physiotherapy, occupational therapy and social work, that might be provided in Transition Care. ACATs may need to use the expertise of the geriatric rehabilitation service (or equivalent) of the hospital to help assess rehabilitative potential.

For assessments conducted in the client’s home, the assessor should consider the need to refer the client to other rehabilitation options in the community.

8.3. **Cognitive and Behavioural Factors**

An assessor should consider whether the person has cognitive difficulties, or behavioural problems related to such difficulties and/or the presence of depression or delirium, with specific regard to:

- evidence of verbal and physical aggressiveness and disruption, self-destructive behaviour, confusion and/or impaired judgement, reasoning or attention; and
- medical tests from the person’s GP or medical specialist for a more detailed picture of their cognitive status.

The ACAP Toolkit includes validated tools to assist provide this evidence. Other psychosocial factors such as the person’s experience of loneliness, bereavement or loss of motivation, and their impact on cognitive functioning also need to be considered.

8.4. **Social Factors**

ACATs should fully explore the person’s support networks, including the identification of the social needs of the person and the extent of social support available (including family, carers, neighbours and friends). The needs and resources of a person’s carer should also be considered to confirm their ability to continue to provide care and support. Referral to carer specific support services should also be considered.

If a person does not have appropriately supportive informal social networks, other ways to assist them to meet their social needs should be considered.

Social factors may also include cultural considerations, financial considerations and possible cases of neglect or abuse. ACATs must comply with relevant laws in their state or territory if neglect or abuse is suspected. ACATs should also be familiar with any protocols or procedures in their state or territory which address the neglect or abuse of older people.
8.5. **Physical Environmental Factors**

Physical environmental factors relate to facilities and limitations within the person’s living environment. ACATs should consider the nature and suitability of the physical environment of the person’s home, including safety issues which may require resolution, and modifications or equipment that a person may require to remain in their home for as long as possible and as independently as possible.

8.6. **Personal Choice**

ACAT assessments involve a consultative process. ACATs therefore need to ensure the person being assessed has access to information about the process and all appropriate care options available to them. The person’s preferences for care services and living arrangements must be considered within the assessment process.

9. **Availability of Care Services**

ACATs should consider all care options available to meet the needs of the person being assessed. Consideration should be given to both the availability and the capability of services to meet the person’s care needs. This may include transition care, NRCP or respite services, other services funded under the Act, and any other services available in the region such as HACC services. ACATs should note that a care service is “available” if there are allocated places in the area, regardless of whether there is a vacancy at the time of the assessment and approval of the client.

ACATs need to establish strong links with service providers in their local regions and be informed of services that are in place and their capacity to cater to particular types of clients. Options for services may be affected by their proximity to the person or cultural appropriateness of the services. Where a particular care service is not available (ie there are no Home Care Packages at the level required by the client in the local area), the ACAT will need to recommend alternative care options, whether provided under the Act or other types of care, to meet the person’s assessed needs.

10. **Assessment in a Hospital Environment**

Approvals for all types of care can be made following an assessment in a hospital environment. For a person to be approved for the Transition Care Program, the assessment must be conducted while the person is in hospital or in a hospital-auspiced program such as Hospital in the Home.

ACATs should not be pressured to approve older people for residential or transition care before the full range of clinical and rehabilitation support has been exhausted and the client is in a stable condition. A stable condition is required to ensure that the care needs of a person can be accurately assessed and the most appropriate care services recommended. There should be no presumption that older people will progress from hospital to residential care, as they may be able to return to their previous living arrangements.

People assessed in hospital should be assessed in the same way as those assessed at home, including consideration of the home environment and social issues. Hospital based ACAT assessments must also be multidisciplinary and comprehensive.

The usual consent and privacy considerations must be followed for assessments in hospitals. That is a client’s Aged Care Client Record contains “Protected Information” under Division 86 of the Act and the record or its contents must not be shared or accessed by others unless the client is aware and has provided consent.
11. Assessments of People with Special Needs

To assist in achieving more equitable access to ACAT services, Section 11-3 of the Act identifies the following people with special needs:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural and remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless or at risk of becoming homeless;
- care-leavers; and
- lesbian, gay, bisexual, transgender and intersex people.

In conducting assessments of such people, ACATs should be aware of their special needs and engage in relevant training to help meet this requirement.

11.1. Aboriginal and Torres Strait Islander People

Assessments of Aboriginal and Torres Strait Islander people should be carried out in a culturally appropriate manner by people who are acceptable to both the client and their community and who are qualified to carry out such assessments.

It is desirable that ACATs develop a good understanding of the communities in which they operate. This will ensure that advice and assistance provided to clients is appropriate for their needs. ACATs should be aware of culturally appropriate services for frail older people in their region and establish links with Aboriginal and Torres Strait Islander community and health services.

If it is not possible for the ACAT to fulfil this requirement, ACAT members should seek advice from indigenous health workers in local clinics, who are known and accepted by their clients and would be willing to assist the ACAT in undertaking the assessment.

The approval of care remains with the ACAT. ACATs operating in areas with established indigenous communities should consider engaging suitably qualified staff from relevant backgrounds. ACATs are encouraged to explore ways of facilitating culturally appropriate assessments guided by indigenous communities.

11.2. People from Culturally and Linguistically Diverse Backgrounds

ACATs should identify, facilitate and promote culturally sensitive forms of assessment for people from culturally and linguistically backgrounds.

To ensure an accurate exchange of information, independent, qualified interpreters should be used to assist people whose main language spoken at home (or most recent private residential setting) is not English. Client or carer consent regarding the use of an interpreter must be sought in all cases. ACATs in areas with culturally diverse populations should consider engaging liaison workers from relevant backgrounds.

ACATs should be aware of culturally appropriate residential and home care services for frail older people in their region. It would be appropriate to establish links with culturally diverse organisations, services and welfare officers in the region.

ACATs may also utilise the services of specialised workers for older people from culturally diverse backgrounds, contact a local migrant resource centre or refer to the Federation of Ethnic Communities’ Councils of Australia for information on specific support groups.
There are no citizenship, residency or visa tests for an ACAT assessment or for admission to care. Any person who is present in Australia may be assessed and approved for care if the eligibility requirements are met.

A National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds has been released by the Australian Government. The Strategy is designed to inform the way the Australian Government supports the aged care sector to deliver care that is appropriate and sensitive to the needs of older people from CALD backgrounds. The Strategy will assist the Department in implementing the activities outlined in the Aged Care Reform package and assist in guiding future funding priorities.

The Strategy is available on the governments My Aged Care website.

11.3. People from Rural and Remote Areas

A small number of ACAT teams service areas which cannot be routinely visited due to geographical isolation.

Assessments may be conducted by telephone where no other options are available. In all such cases a suitably qualified person from within the local health or community care environment should be present to support the client and to facilitate the assessment under direction from the ACAT assessor.

The introduction of broadband internet connectivity in remote areas should be used wherever possible to facilitate the provision of ACAT services to clients in such areas.

ACATs should endeavour to develop good working relationships with health and community workers in rural/remote communities, who may be called on to assist with assessments. This should include training community workers in the objectives and guidelines of the ACAP program to ensure the best outcome for the client is achieved in all instances.

In the case of a Multi Purpose Service where assessment and approval by an ACAT are not required to determine eligibility for services, ACATs still have a role in providing advice on the most suitable types of care available for older people.

11.4. People who are Financially or Socially Disadvantaged

Financial or social disadvantage can often create a significant barrier to a wide range of services in the community. ACATs should ensure that they develop and promote links with organisations in their area which attempt to overcome these barriers, and provide ACAT assessments to people who may benefit from an ACAT approval regardless of their financial or social circumstances.

People who are financially or socially disadvantaged may also experience difficulties in accessing services after their approval. ACATs should be prepared to engage in a wider range of care coordination activities on behalf of these clients to ensure that they receive the care which they need and to which they are entitled.

A consumer’s access to a Home Care Package must not be affected by their ability to pay consumer fees, but should be based on the need for care, and the capacity of the home care provider to meet that need.

11.5. Veterans and War Widows and Widowers

The Australian Government recognises the special aged care needs of the veteran community.

The veteran community is ageing at a faster rate than the general population, and the majority of veterans and their widows or widowers are now aged over 70 years. The ageing of the veteran community is creating demand for a wider range of health care and support services including residential and home care services.
ACATs should establish links with relevant veterans’ organisations in their communities and foster links between veterans and home care and residential care services. They should aim to facilitate an understanding of veterans’ particular needs and to improve integrated care and access.

11.6. People who are Homeless or at Risk of Becoming Homeless

The Act and the Allocation Principles 1997 do not define ‘homeless’ or ‘at risk of becoming homeless’. However, the Program Manual for the Assistance with Care and Housing for the Aged (ACHA) Program uses this definition of “homeless.”

People who are:
- without any acceptable roof over their head e.g. living on the streets, under bridges, in deserted buildings etc. (absolute homelessness or ‘sleeping rough’);
- moving between various forms of temporary or medium term shelter such as hostels, refuges, boarding houses or friends;
- constrained to living permanently in single rooms in private boarding houses; or
- housed without conditions of home e.g. security, safety, or adequate standards (includes squatting).

ACATs have a responsibility to recognise people who are homeless or at risk of becoming homeless and to ensure that they are able to access an ACAT assessment and any aged care services for which they are approved. Liaison between ACATs and support services for homeless people is particularly important for this group because of their extreme vulnerability.

An assessment of someone who is homeless cannot, by definition, take place in the person’s home. An ACAT Assessor should take particular care to understand the person’s usual living arrangements and the circumstances of their situation.

ACATs should also be aware that homelessness is not grounds to approve a person as eligible for residential or other forms of aged care. The Approval of Care Recipients Principles 1997 sets out the eligibility criteria for all forms of aged care. ACATs should be prepared to make appropriate referrals and work with States and territories and housing and homeless services.

11.7. Care-leavers

Care leavers as defined in the Aged Care Act 1997 means a person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during the 20th century. Care leavers are recognised as people with special needs under the Aged Care Act 1997 and include three distinct groups: Forgotten Australians, Former Child Migrants and Stolen Generations. As children last century, all these people spent time in institutional or out-of-home care, including orphanages and foster care.

ACATs should be particularly sensitive to the effects of care-leavers’ childhood experiences with government officials and other authority figures and in residential institutions. There is a potential for care-leavers to view ACATs in a negative way as they are public servants who hold a delegation to approve people to receive care in an institutional setting. ACATs should emphasise that clients are not obliged to take up any care which may be approved, that care can be provided in a community setting if that is the client’s preference, and that the wishes of the client are taken into account throughout the entire ACAT process.

11.8. Lesbians, Gay, Bisexual, Transgender and Intersex people (LGBTI)

ACATs should not make assumptions about the sexual orientation or gender identity of clients, nor the nature of the relationship between LGBTI clients and members of their support network.
LGBTI people may be more inclined to disclose their sexual orientation or sex/gender identity to ACATs if a non-judgemental, supportive and LGBTI inclusive environment is provided for the client and their support network during assessment. The choice to disclose or not disclose is entirely one for the client. Where a client does disclose this information, the ACAT should emphasise that the information is protected information under the Act. Part J of these Guidelines provides additional information about the protection of information. In the case of transgender and intersex clients, where specific medical history may need to be communicated to service providers, it is important to discuss the way this information will be provided to the providers.

ACATs should also be aware of service providers who provide LGBTI specific services and those that are LGBTI inclusive and be prepared to advocate for LGBTI clients with other service providers as necessary as part of their care coordination activities.

A National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy has been released by the Australian Government. The Strategy informs the way the Australian Government supports the aged care sector to deliver care that is sensitive to and inclusive of the needs of LGBTI people, their families and carers. It is used to guide future funding priorities by assisting the Department in implementing the activities outlined in the Aged Care Reform package.

The Strategy is available on the My Aged Care website.

12. Other Groups with Significant Needs

While younger people with disabilities, people with dementia and people with mental health disorders are not specifically listed as people with special needs under the Act, they also require careful consideration of their circumstances.

12.1. Younger People with Disabilities

States and territories will have developed protocols consistent with the National Guiding Principles for the Referral and Assessment of Younger People with Disability: between state and territory disability services and Aged Care Assessment Teams. The National Guiding Principles were developed between the Commonwealth and the states and territories for the referral of younger people with disability for assessment and coordination of their specialist disability accommodation and support services.

12.1.1 Access to Residential Aged Care by Younger People with Disability

Under the Approval of Care Recipients Principles 1997, Section 5.5(1)(b), a person who is not an aged person is eligible to receive residential care only if they meet the eligibility criteria for aged care services and ‘where there are no other care facilities or care services more appropriate to meet the person’s needs’.

12.1.2 Assessment of Younger People with Disability

The role of ACATs is to comprehensively assess the needs of frail older people to facilitate access to available aged care services appropriate to their needs. ACATs may not have the skills or experience to assess younger people with disability or have an understanding of the range of specialist disability accommodation and support services available.

In accordance with the Act and the Principles, referral of a younger person with disability to an ACAT for assessment and approval of aged care services should only occur where it can be demonstrated by the relevant state and territory disability services that ‘there are no other care facilities or care services more appropriate to meet the person’s needs’.

It is the responsibility of the relevant state or territory disability services agency to assess younger people with disability and ensure they are referred to the most appropriate care service available.
All options for specialist disability accommodation and support services should be fully explored and utilised prior to acceptance by an ACAT of a referral for assessment and approval of aged care services.

Where, following an assessment by a state or territory disability services agency or authorised assessment provider and discussion with the younger person with disability and their family, it is determined through a disability assessment that there are no other care facilities or care services more appropriate to meet the needs of the younger person with disability referral to an ACAT may be considered. There must be documentation from the state or territory disability agency of the assessment and that there are no disability care options appropriate to meet the person’s needs.

The disability assessor should remain involved and provide assistance during the ACAT assessment, including the timely provision of referral documentation. Disability services, with assistance from ACATs where appropriate, should continue to provide support until an appropriate service is accessed.

Where an assessment results in a move to alternate accommodation, the person may require assistance during the transition period. In particular, state or territory disability services should assess and discuss with the younger person (and/or their representative) the appropriateness of providing additional disability services to the person where they enter a residential aged care facility.

12.1.3 Home Care Packages and Younger People

For Home Care Packages, there is not a minimum age requirement for eligibility purposes, but the Home Care Packages Program is targeted at frail older people.

In some cases, younger people with disabilities, dementia or special care needs may be able to access a Home Care Package – If the person has been assessed and approved by an ACAT, and a home care provider is able to offer an appropriate package for the person.

12.1.4 Developing State or Territory Protocols Consistent with National Guiding Principles

In the interests of working together to achieve the best outcome possible for younger people with disability, each state or territory should establish a collaborative, localised protocol between the relevant disability services agency and ACATs. The objectives of such a protocol are to:

- Clarify the respective roles and responsibilities between the disability services agency and the ACAT within each state or territory;
- Identify clear client management procedures between ACATs and the disability services agency including referral processes that are consistent with the following guiding principles; and
- Outline respective roles and responsibilities in relation to younger people with disability who move into residential aged care.

12.1.5 National Guiding Principles Protocols

While state and territory protocols may differ in accordance with the local legislative and regulatory environment, all protocols should be consistent with the following guiding principles:

- Residential aged care services are designed specifically to meet the needs of frail older people, and are not oriented to provide for the needs of younger people with disability.
- The most appropriate outcome for younger people with disability is to access specialist disability accommodation and support services and age appropriate services, rather than aged care services.
- Younger people with disability, living in residential aged care or who are at risk of entering residential aged care, should have access to specialist disability accommodation and support services that are appropriate to their needs.
• Referral of younger people with disability to ACATs for assessment and approval for aged care services from disability services should only occur where it can be demonstrated that all disability service options have been exhausted and no other services more appropriate to meet the person’s needs are available. Detailed documentation should be provided to this effect by the state and territory disability services.

• To minimise duplication in the assessment process, with the client’s consent, any information from the assessment carried out by the disability services assessor must be provided to the ACAT as part of the referral.

• An aged care service provider has the right to determine whether they will accept placement of a younger person with disability, based on their capacity to meet their individual needs.

12.2. Reviews for Younger People with Disability in Residential Aged Care
Wherever possible younger people with disability who remain living in, or enter a residential aged care facility, should receive enhanced specialist disability support services. These services should aim to provide them with opportunities for community access, to maintain family and social relationships and to live a more age appropriate lifestyle.

If a younger person with disability enters a residential aged care facility, a review mechanism should be negotiated between all parties particularly where approvals may be time limited. This should be regular, and involve the younger person with disability, and their family and/or support network.

12.3. People with Dementia
The Australian Government recognises the special needs of people with dementia and their carers. ACATs should develop contacts with dementia specific services, including Dementia Behaviour Management Advisory Services (DBMAS), and where relevant, include this expertise in the assessment process. Fostering links between ACATs and dementia specific services will facilitate an understanding of the needs of ageing people with dementia and their carers and assist improved linkages, integrated care and access.

12.4. People with Psychiatric Disorders
ACATs are encouraged to make links with mental health services which will facilitate an understanding of the needs of older people with mental illness and assist to improve linkages, integrate care and assist these clients to access appropriate care and support services.

In most jurisdictions the majority of people who receive specialist mental health services do so in a community setting. In these circumstances, specialist mental health care is often provided as acute treatment, but individuals who receive treatment are sufficiently stable to be managed in the community.

Involuntary mental health care is governed by separate mental health legislation in each state and territory. It is generally a legislative requirement that people with mental illness receive specialist mental health care in the least restrictive environment possible. Generally people with mental illness with involuntary status are provided with specialist services in a range of community settings, although some people are cared for in mental health residential settings. People who are placed under some form of an involuntary order (eg. to manage their medicines when living in the community) may be eligible for aged care services. ACATs should consider each referral on a case by case basis.

Aged care services usually do not have the capacity to adequately address the support and associated needs of people with a serious uncontrolled mental illness without the support of and treatment by mental health services. Persons who are a danger to themselves or others may not be suitable for entry to an aged care service.
Frail older people with a mental illness however, may require access to a range of supports including Australian Government subsidised aged care services that require ACAT assessment and approval.

ACAT assessment and approval is only appropriate if the intensity, type and model of care is the most appropriate to meet the person’s care needs, including that:

- The person meets the eligibility criteria set out in the Aged Care Act 1997 and Approval of care Recipients Principles 1997.
- The person’s acute treatment has stabilised the condition. For people with a mental illness, their condition should be stable prior to being assessed although it is understood that many may still have significant symptoms.
- Community mental health services will continue to provide collaborative care for those elderly patients who have significant or unstable psychiatric symptoms.

An ACAT assessment is also required to access residential aged care facilities in jurisdictions where Australian Government subsidised residential aged care facilities are part of the aged mental health service system.

It is important to obtain informed consent (either from the person if they have the capacity to do so or if not, a decision maker consistent with state guardianship legislation who is able to make decisions regarding health, accommodation and daily living care) prior to an ACAT assessment.

In some jurisdictions under certain circumstances, mental health legislation empowers the treating psychiatrist to make accommodation decisions in the best interests of a person receiving treatment under an involuntary order. This power is only exercised when a particular accommodation setting is required to facilitate the treatment of a person’s mental illness. It does not replace the need for Guardianship when mental illness is incidental to that person’s need for placement in residential care.

All jurisdictions should develop protocols that reflect relevant state or territory legislation and regulations, to ensure that older people with a mental illness are directed to the responsible agency to assess and recommend services most appropriate to meet their care and support needs. The protocol should outline mutual obligations and responsibility to provide assistance and expertise in the person’s assessment, and care and service coordination. This could take the form of a memorandum of understanding between the ACAT and aged persons mental health services. It is important that protocols ensure that people with mental illness are not discriminated against in accessing aged care services.

The protocol should support good working relationships between ACATs and mental health services to ensure appropriate, responsive and timely service provision to older people with a mental illness.
PART C - RESIDENTIAL CARE

Part C Covers:

- Defining Residential Care
- Eligibility Requirements
- Services Provided in Residential Care
- Low Level Care
- High Level Care
- Borderline Cases
- Residential Respite
- Changes to Residential Care

1. Defining Residential Care

Section 41-3 of the Aged Care Act 1997 (the Act) defines residential care in the following way:

(1) Residential care is personal care or nursing care, or both personal and nursing care, that:
   (a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:
      i. appropriate staffing to meet the nursing and personal care needs of the person; and
      ii. meals and cleaning services; and
      iii. furnishings, furniture and equipment for the provision of that care and accommodation; and
   (b) meets any other requirements specified in the Residential Care Subsidy Principles.

(2) However, residential care does not include any of the following:
   (a) care provided to a person in the person’s private home;
   (b) care provided in a hospital or a psychiatric facility;
   (c) care provided in a facility that primarily provides care to people who are not frail and aged
   (d) care that is specified in the Residential Care Subsidy Principles not to be residential care.

Residential care is for frail older people whose overall care support needs cannot be adequately met in the general community even through a range of Home and Community Care (HACC) services or through a Home Care Package.

Aged Care Assessment Teams (ACATs) can approve people for residential care, depending on their level of disability and support required.
2. Eligibility Requirements

Eligibility requirements for residential care are set out in the Act and the Principles as below. These requirements are the legal criteria which a person must meet before being approved for residential care. ACATs are required to assess people in accordance with these criteria and only approve those who are assessed as requiring this type of care.

Section 21-2 Aged Care Act 1997
Eligibility to receive residential care.

A person is eligible to receive residential care if:
(a) the person has physical, medical, social or psychological needs that require the provision of care; and
(b) those needs cannot be met more appropriately through non-residential care services; and
(c) the person meets the criteria (if any) specified in the Approval of Care Recipient Principles as the criteria that a person must meet in order to be eligible to be approved as a recipient of residential care.

Subsection 21-2(c) above requires that a person also meet the criteria set out in the Approval of Care Recipients Principles 1997 before being approved for residential care.

Section 5.5 Approval of Care Recipients Principles 1997
Residential Care

(1) A person is eligible to receive residential care only if:
   (a) the person is assessed as:
       (i) having a condition of frailty or disability requiring at least low level continuing personal care; and
       (ii) being incapable of living in the community without support; and
       (iii) meeting any other eligibility criteria for the level of care assessed for the person that are set out in the classification level applicable under the Classification Principles 1997; and.
   (b) for a person who is not an aged person—there are no other care facilities more appropriate to meet the person’s needs.

(2) In deciding if the criteria mentioned in subsection (1) are met, the Secretary must consider the person’s medical, physical, psychological and social circumstances, including (if relevant):
   (a) evidence of medical condition, as decided by suitably qualified medical personnel;
   (b) evidence of absence or loss of physical functions, as established by assessment of capacity to perform daily living tasks;
   (c) evidence of absence or loss of cognitive functioning, as established by:
       (i) a medical diagnosis of dementia or other condition; or
       (ii) assessment of capacity to perform daily living tasks; or
       (iii) evidence of behavioural dysfunction;
   (d) evidence of absence or loss of social functioning, as established by:
       (i) using information provided by the person, a carer, family, friends and others; or
       (ii) assessment of capacity to perform daily living tasks;
   (e) evidence that the person’s life or health would be at significant risk if the person did not receive residential care.

It is the balance and mix of function and disability, social support needs and appropriateness of home care services that must be considered when assessing a person’s need for residential aged care.
ACATs should consider both the level of services and the intensity of services required to meet the needs of the person in determining whether a residential aged care facility or a home care service will be able to adequately meet the assessed needs of the person.

Some people may have special needs that may be best met by residential aged care facilities which offer particular kinds of care, such as that provided in dementia specific facilities. If this is the case, then ACATs should include this information at Question 42 on the ACCR.

ACAT members should be familiar with the range of aged care support services and residential facilities available in the region, including specialist facilities and programs such as those for people with dementia. This information should be made available to clients and their carers or advocates as appropriate for the needs of the client.

The ACAT should be able to provide the person with a list of available residential aged care facilities in their area, although the final choice of a facility for a client is made by the person, their family, and the receiving service provider.

The My Aged Care website has services finders available. The ACAT should familiarise themselves with this website and direct people as appropriate.

3. Services Provided in Residential Care

Schedule 1 to the Quality of Care Principles 1997 identifies the care and services that residential aged care providers must provide. Part 1 specifies the hotel services to be provided for all residents and Part 2 specifies the care and services to be provided for all residents. Part 3 specifies the additional care and services to be provided for residents receiving a high level of residential care.

4. Low Level Care

Low level residential care is provided to people assessed as requiring the general accommodation and personal care service provided in residential facilities.

A person receiving low level care might reasonably require daily assistance with bathing, showering and personal hygiene, organising and supervising and administering of medication, toileting and continence management, meals, transfers and mobility, dressing, fitting sensory or communication aids, assessment and referral for appropriate support, communication assistance and provision of special diets and emotional support.

In approving a person for residential care, ACATs limit the approval to either low or high level and record that level of care on the ACCR. An approval for low level permanent residential care lapses after a period of 12 months starting on the day after the approval was given if the person is not provided with that type of care. This will change from 1 July 2014 so that there will be no automatic lapsing of residential care approvals.

Following admission of a client, residential service providers conduct an appraisal using the Aged Care Funding Instrument (ACFI) to determine the level of care being provided to meet the client’s current needs and the related Australian Government subsidy. In normal circumstances, this process has no effect on an ACAT.

However, when an approval is limited to low level care and the initial ACFI appraisal shows that the client needs high level care, the ACAT may be asked to re-assess the client, as this is one of the ways that the service provider can be paid the high level care subsidy. The assessment should be conducted in an independent manner. While the service provider’s input to the assessment should be considered, the ACAT should not be pressured into giving a high level approval if the evidence does not support such an outcome.
5. High Level Care

High level residential care provides functionally very dependent people with 24 hour care either by registered nurses or under the supervision of registered nurses.

The advice provided by medical personnel can be very useful in determining a person’s need for high level care. In general, the person would require complete or almost complete assistance with the majority of the activities of daily living, and would no longer be able to be adequately supported at the low care level.

For those currently living within the community, the person would no longer be able to be adequately cared for by carers or family even with the full range of community supports. Other factors that should be considered when approving a person for high level residential care could include, but would not be limited to, the person’s ability to manage their level of continence, the person’s level of cognitive impairment and the ability or adequacy of low level residential services to meet the needs of the individual successfully.

Approval at the high level by ACATs does not preclude the person receiving care at a low level. A person does not need to be re-approved to receive low level care. Should a high care place not be available, a person with a high care approval may in some cases enter a low care place if the provider and the person agree, and the facility can meet the person’s care needs.

6. Borderline Cases

If an ACAT approves a person for high care in borderline cases, they should indicate this on the ACCR and state for instance that the approval is for high level care due to the progressive deterioration of the person’s condition. In cases where the client is on the borderline between high and low care, the delegate should approve the person for high care to ensure that all of the client’s care needs can be met.

7. Residential Respite Care

Respite care is defined in Schedule 1-Dictionary of the Act, as meaning ‘residential or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short term break from their usual care arrangement.’

Residential respite care may be used on a planned or emergency basis to help with carer stress, illness, holidays, or the unavailability of the carer for any reason.

All people looking to access residential respite care are required to be assessed and approved by an ACAT as being eligible for this type of care. While respite care is not intended for rehabilitation following a post-acute episode and it should not be used as a waiting facility for people seeking a permanent bed, it is not the ACATs role to make a judgement on the use of respite.

From time to time people will no longer be able to care for themselves in the community and request to be placed in respite care until they are able to secure more permanent living arrangements. This type of situation must be considered on a case by case basis and their eligibility for respite care must be determined in with the Act and the Principles. Generally speaking if a person meets the eligibility requirements for residential care they should also be approved for residential respite care.

There are two levels of subsidy for respite care, high and low. The approval of a person for a certain level of care (high or low) not only ensures the person receives care at the appropriate level but also regulates the respite subsidy payable to the residential facility for the care of the person. Service providers require an accurate assessment of the level of care needed to ensure they are able to adequately care for the person and to ensure they receive the correct remuneration.
A respite care approval entitles the client to a maximum of 63 days of respite care in a financial year. This limit is set in section 21.18 (1) of the *Residential Care Subsidy Principles 1997*, based on paragraph 44-12 (2) (c) of the Act. Section 21.18(2) below allows for extensions of 21 days to be added to this maximum.

(2) However, the Secretary may increase the number of days by 21 if the Secretary considers that it is necessary because of any of the following:
   (a) carer stress;
   (b) severity of the care recipient’s condition;
   (c) absence of the carer.

The power to grant an extension is delegated to ACAT Delegates. Delegates should be aware that carer stress, the severity of the care recipient’s condition or the absence of the carer may make an extension appropriate.

Respite care cannot be taken in a residential aged care facility if the person is already admitted to another facility.

ACATs may assess a person as being eligible for respite care (low or high level), or for both respite and permanent residential care simultaneously. For example, this might be necessary where the carer has urgent need for respite, but it is agreed at assessment that ongoing residential care will most likely be required for the person within the foreseeable future.

Further information on the approval for residential respite care is at Part F 7.2 of these Guidelines.

### 8. Changes to Residential Care

From 1 July 2014 the distinction between high care and low care in residential care will be completely removed and a single set of specified care and services for residential care will be introduced. No ACAT residential care approvals will lapse from 1 July 2014.
PART D - HOME CARE

Part D Covers:

- Home Care Packages
- Consumer Directed Care
- Home Care Package Case Management
- ACAT Responsibilities When Approving a Client for Home Care Packages
- Respite Care for Home Care Package Clients

1. Home Care Packages

As part of the Aged Care Reforms, there are four levels of Home Care packages available from 1 August 2013. Home care packages are individually planned and coordinated package of care services including monitoring and review. They are designed to meet the needs of older people who prefer to remain living in the community.

For assessment and approval purposes, Level 1 and Level 2 Homecare packages will be broad-banded, similarly, Level 3 and Level 4 Homecare packages will also be broad banded. This means that ACATs will give approvals for Level 1 and Level 2, or for Level 3 and Level 4 homecare. The actual level of care accessed by the client will be established with the service provider. The ACAT training provides guidance on assessment practices for ACATs in relation to approving people for Home care. The Home Care Packages Program Guidelines are available on the Living Longer Living Better website.

A Dementia Supplement (10% of the value of the package) will be available at all four levels of Home Care to provide appropriate dementia-specific support to clients with dementia. ACATs will not be involved in determining if the dementia supplement should be paid to a service provider. See information on the Living Longer Living Better website.

2. Consumer Directed Care

From August 2013, all Home Care Packages must be offered on a Consumer Directed Care (CDC) basis. Existing packages will be offered on a CDC basis from 1 July 2015. CDC is a way of delivering services that allows consumers and their carers to have greater control over their own lives by allowing them to make choices about the types of care they access and the delivery of those services, including who will deliver the services and when.

The consumer can also decide the level of involvement they wish to have in managing their Home Care Package, which could range from involvement in all aspects of the package, including co-ordination of care and services, to a less active role in decision-making and management of the package.

3. Home Care Package Case Management

The allocation of Home Care packages (HCP) is the responsibility of the HCP service provider, who provides or purchases the appropriate services. Beyond the provision of assessment information in the ACCR, ACATs should not be involved in managing HCPs. However, ACATs should be aware that individual packages will vary according to the particular needs of individual clients. The emphasis for some will be on assistance with activities of daily living, and for others, it may be the management of the social and safety issues that arise.
4. ACAT Responsibilities When Approving a Client for Home Care Packages

ACATs should provide sufficient information on the ACCR to inform the development of a care plan by the HCP provider. This will:

- minimise duplication of assessment of the person;
- allow the service provider to benefit from the ACAT’s professional expertise;
- ensure the best choice of care for a person; and
- facilitate the transition from assessment to provision of service for the client.

The following information describes the individual packages:

- Level 1 Home Care Packages (to support people with basic care needs) will commence on 1 August 2013.
- Level 2 Home Care Packages (low level package) will require an ACAT assessment and approval from 1 August 2013. An ACAT assessment and approval will be required to access these packages. ACATs should be aware of their availability in the local area for referral purposes as appropriate.
- Level 3 Home Care Packages (to support people with intermediate care needs) will commence on 1 August 2013.
- Level 4 Home Care Packages (high level care package) will be a part of the reforms and will continue to require an ACAT assessment and approval. ACATs should be aware of the availability of level 3 and 4 packages in the local area for referral purposes as appropriate. An ACAT assessment and approval will be required to access level 3 and 4 packages.

Approvals for Home Care Packages at any level will not lapse

CACP – Community Care packages will no longer be available from 1 August 2013. EACH – Dementia packages will no longer be available from 1 August 2013.

EACH – Dementia care recipients will transition to a Level 4 Home Care package with a Dementia Supplement from that date.

A person who has an approval for Level 1 and 2 homecare and whose care needs increase must be reassessed by ACAT and approved as eligible for Level 3 or 4 homecare. However an approval for Level 3 or 4 homecare will allow a person to receive care at a lower level; i.e. at level 1 or 2.

5. Respite Care for Home Care Package Clients

People approved for a Home Care package may also be approved for residential respite care in the same way as other people in the community. While the person is receiving alternative care services such as short term residential respite care or is on social leave from a package, service providers are only eligible to receive a home care subsidy for a maximum of 56 days per financial year. A maximum of 28 days of this leave may be social leave. Additional information can be obtained from the Home Care Package Care Guidelines 2013 on the Living Longer Living Better website.
PART E - FLEXIBLE CARE

Part E Covers:

- Flexible Care Under the Act
- Transition Care
- Innovative Care Services

1. Flexible Care Under the Act

Under section 49-3 of the *Aged Care Act 1997* (the Act), Flexible Care means 'care provided in a residential or Home care setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and home care services'.

Flexible Care can take the form of:

- Transition Care
- Aged Care Innovative Care Services
- Multi-Purpose Services (MPSs)

ACATs are not required under the Act to assess or approve people for services provided through MPSs or Aged Care Innovative Care Services.
2. Transition Care

2.1. Definition of Transition Care

Chapter 5, Section 15.28 of the *Flexible Care Subsidy Principles 1997* defines transition care in the following way:

<table>
<thead>
<tr>
<th>15.28 What is transition care?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transition care</strong> is a form of flexible care that is provided to a care recipient:</td>
</tr>
<tr>
<td>(a) at the conclusion of an in-patient hospital episode; and</td>
</tr>
<tr>
<td>(b) in the form of a package of services that includes, at least:</td>
</tr>
<tr>
<td>(i) low intensity therapy; and</td>
</tr>
<tr>
<td>(ii) either:</td>
</tr>
<tr>
<td>(A) nursing support; or</td>
</tr>
<tr>
<td>(B) personal care; and</td>
</tr>
<tr>
<td>(c) as care that can be characterised as:</td>
</tr>
<tr>
<td>(i) goal-oriented; and</td>
</tr>
<tr>
<td>(ii) time-limited; and</td>
</tr>
<tr>
<td>(iii) therapy-focused; and</td>
</tr>
<tr>
<td>(iv) targeted towards older people; and</td>
</tr>
<tr>
<td>(v) necessary to:</td>
</tr>
<tr>
<td>(A) complete the care recipient’s restorative process; and</td>
</tr>
<tr>
<td>(B) optimise the care recipient’s functional capacity; and</td>
</tr>
<tr>
<td>(C) assist the care recipient, and his or her family or carer (if any), to make long-term arrangements for his or her care.</td>
</tr>
</tbody>
</table>

The Australian Government established the Transition Care Program to assist older people after a hospital stay. Transition care has been developed as a jointly funded program by the Australian Government in collaboration with all States and Territory governments.

2.2. Eligibility for Transition Care

Eligibility criteria for Transition Care are set out in the Act and the Principles as below.

<table>
<thead>
<tr>
<th>Section 21-4 Aged Care Act 1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person is eligible to receive flexible care if:</td>
</tr>
<tr>
<td>(a) the person has physical, social or psychological needs that require the provision of care; and</td>
</tr>
<tr>
<td>(b) those needs can be met appropriately through flexible care services; and</td>
</tr>
<tr>
<td>(c) the person meets the criteria (if any) specified in the Approval of Care Recipients Principles as the criteria that a person must meet in order to be eligible to be approved as a recipient of flexible care.</td>
</tr>
</tbody>
</table>

Subsection 21-4(c) above requires that a person meet the criteria set out in the *Approval of Care Recipients Principles 1997* before being approved for flexible care.
Part 2, Section 5.7A of the Approval of Care Recipient Principles 1997

5.7A Flexible care—transition care

A person is eligible to receive flexible care in the form of transition care only if the person:

(a) is assessed under section 22-4 of the Act as satisfying the following requirements:
   (i) the person is in the concluding stage of an in-patient hospital episode;
   (ii) the person is medically stable;
   (iii) the person has the potential to benefit from transition care; and

(b) is in hospital at the time the assessment is undertaken; and

(c) would be assessed, if the person applied for residential care, as eligible to receive residential care at least at a low level of residential care.

2.3. Services Provided by the Transition Care Program

The Transition Care Program provides a package of services that includes low intensity therapy (such as physiotherapy, occupational therapy and social work) and either nursing support or personal care. The services provided as part of the Transition Care Program are designed to meet an older person’s daily care needs and provide additional therapeutic care so that a client can maintain and improve their physical, cognitive and psycho-social functioning thereby improving the person’s capacity for independent living.

Transition care also provides medical support such as GP oversight, case management including establishing community supports and services, and, where required, identification of residential care options.

A non-exhaustive list of the care and services provided under the Transition Care Program is available at Attachment B of the Transition Care Program Guidelines available from the Department of Health’s website.

2.4. Assessing for Transition Care

In considering the appropriateness of transition care for an older person, a number of factors need to be taken into account:

- At the time of assessment, the older person must be an in-patient of a hospital, medically stable and ready for discharge.

- As entry to transition care must immediately follow an older person’s discharge from hospital, the assessment for transition care must only be made in hospital or in a hospital-ausped program, such as Hospital in the Home, where the person is an in-patient of the hospital.

- The intent of transition care is to benefit older persons through a time-limited episode of low intensity therapeutic interventions immediately after a hospital episode, to optimise their functional capacity while assisting them and their family or carer to make long-term care arrangements.

- Older people who have made a final decision about the need to enter residential aged care and are only waiting for a place in an aged care facility without the capacity to benefit from a further therapeutic care program are not eligible and should not be approved for transition care.

- Given the nature of transition care, the ACAT should assess the older person in consultation with the hospital geriatric rehabilitation service or equivalent, or members of the multidisciplinary team treating the person including a registered nurse, the treating physician, occupational therapist, physiotherapist, speech therapist or social worker.
• The ACAT in consultation with the hospital geriatric rehabilitation service or equivalent needs to ensure that the full range of clinical and rehabilitation support to be provided by the hospital has been exhausted before a client enters transition care.

• ACATs should, wherever possible, facilitate liaison between hospital discharge planners and Transition Care Service Providers to ensure that clients are able to access transition care in a timely manner.

2.5. **Lapsing of an Approval for Transition Care**

Section 23-3 (1) of the Act specifies that an approval will lapse if the person is not provided with care within the entry period specified in the Approval of Care Recipients Principles. Section 5.13 of the *Approval of Care Recipients Principles 1997* specifies that the entry period for an approval of a person as a recipient of flexible care in the form of transition care is four weeks beginning on the day after the approval is given.

2.6. **Duration of Care**

Under section 15.34 of the *Flexible Care Subsidy Principles 1997*, the maximum duration of a transition care episode is 84 days. The episode may be extended by up to 42 days, if the person has further transition care needs. The extension process is set out below.

2.7. **Extensions**

A care recipient may require an extension to a transition care episode where their care will need to exceed the 84 day maximum. To apply for an extension, the transition care service provider must complete a Transition Care extension application form with the care recipient (or representative) within the initial 84 day episode of transition care. Once the transition care service provider has completed the form, they must forward it to an ACAT for review. The Transition Care Extension application form is available from the Department of Health’s website.

ACATs should only grant extensions if care recipients have further therapeutic care needs and wish to receive further transition care to achieve a better outcome. In such cases, an assessment for an extension to transition care, which specifies the duration of the extension, may be undertaken. The maximum duration for an extension is 42 days.

Based on the information provided by the transition care service provider, and other sources such as the care recipient and relevant health professionals as appropriate, the ACAT will assess whether or not an extension is required.

It is not necessary for an ACAT to comprehensively re-assess a transition care recipient if the service provider has identified that the person requires an extension and provides the following information:

- reasons why goals were not achieved in 12 weeks;
- physical, cognitive and psychosocial goals that the care recipient would be working on during the extension;
- team action required to achieve care recipient goals and discharge;
- action required by external services to achieve care recipient goals and discharge;
- relevant information from other sources such as the care recipient (or representative) or health professionals; and
- the proposed number of days of extension.
However, the ACAT may undertake a comprehensive re-assessment of the care recipient if they are not satisfied with the information provided by the transition care service provider. The extension form does not need to be signed by the same ACAT delegate who originally approved the person as for eligible for transition care. However, the decision to extend or not extend the transition care episode does need to be made, and the form signed, before the end of the 84 days.

The transition care service provider should allow sufficient time for the ACAT to review the status of the care recipient if it is likely that a more comprehensive re-assessment is required.

While a decision to extend or not extend a care recipient’s episode of transition care is not a ‘reviewable decision’ under the Act, the Department of Social Services offers a right of review to any person whose request for an extension is denied. In the first instance, the decision should be discussed with the ACAT, then a request for a review should be made to the Department of Social Services by writing to the state manager of the NSW Office of the Department of Social Services at the address in Appendix 2. The review would follow the same process as for reviewable decisions under the Act.

2.8. Re-admission to Hospital from Transition Care

If a person is readmitted to hospital during a transition care episode, the episode ceases. If the person is subsequently able to be discharged from hospital within the entry period relevant to his or her transition care approval, he or she is able to enter a new transition care episode without the need for an additional ACAT assessment. The maximum duration of the new transition care episode is 84 days, with the possibility of an additional 42 days, regardless of the duration of the earlier episode.

2.9. Approvals for Transition Care and Longer Term Care Options

When a person is approved for transition care, the ACAT should also give some consideration to the person’s longer term care needs. In some cases, based on the ACAT’s professional judgement and in light of the preferences of the older person and their family, the ACAT may, if appropriate, be able to assess and approve the older person for other long-term care types as part of the initial assessment.

In other cases, it may be more appropriate to undertake a separate assessment towards the end of the transition care episode to establish the person’s long-term care requirements and approve the person to receive appropriate care which takes account of the changes to the person’s care needs following the transition care episode.

3. Innovative Care Services

The Act allows subsidy to be paid for some kinds of flexible care that do not require ACAT approval.

Part of 50-1 Eligibility for flexible care subsidy

(1) An approved provider is eligible for *flexible care subsidy in respect of a day if the Secretary is satisfied that, during that day:
   (a) the approved provider holds an allocation of *places for flexible care subsidy that is in force under Part 2.2 (other than a *provisional allocation); and
   (b) the approved provider provides flexible care to a care recipient who:
      (i) is approved under Part 2.3 in respect of flexible care; or
      (ii) is included in a class of people who, under the Flexible Care Subsidy Principles, do not need approval under Part 2.3 in respect of flexible care; and
   (c) the flexible care is of a kind for which flexible care subsidy may be payable.

Note: * denotes a term defined in the Dictionary in Schedule 1 of the Act. The key point is at 50-1(1)(b)(ii), which refers to care recipients who do not need approval for flexible care under Part 2.3 of the Act.
Section 15.22 of the *Flexible Care Subsidy Principles 1997* specifies a class of people who do not need approval. They are care recipients who are receiving flexible care through an *innovative care service*.

### 15.24 Kinds of care

(1) The following kinds of care are specified for subsection 50-2(1) of the Act:

(a) care that, by its nature, provides alternative care options;

(b) care provided in circumstances that require the delivery of alternative care options;

(c) care provided in a location that, by its nature, requires the delivery of alternative care options;

(d) care provided to a group of people who are in need of alternative care options;

(e) care provided for a limited period to facilitate alternative care options;

(f) other kinds of care that, to the satisfaction of the Secretary:

   (i) are provided in a residential or community setting; and

   (ii) provide alternative care options.

Examples for paragraph (a):

1. The provision of care for older persons with complex conditions.
2. The provision of care for older persons who require coordination and integration of care.

Examples for paragraph (b):

1. Care provided in an emergency such as natural disasters including fire or flood.
2. Initiatives to address access by older persons to, or the viability of, aged care services.
3. Care provided where the care needs of a care recipient are not being adequately met by available residential care services or home care services.
4. Joint initiatives between the Commonwealth and a State or Territory to promote alternative care options for older persons.

Example for paragraph (c), care provided in an area that is not a major city.

Examples for paragraph (d):

1. Care provided to older persons who require coordination and integration of care.
2. Care provided to older persons with complex, chronic conditions.
3. Care provided to older persons who need short term aged care following hospitalisation.

Examples for paragraph (e):

1. Care provided by a pilot service or project.
2. Care provided to care recipients in places that have been allocated for a limited time in an emergency.

(2) In this section:

*alternative care options* means options for providing flexible care to older persons that meets the needs of care recipients in alternative ways to the care provided through residential care services and home care services.
3.1. **Aged Care Innovative Pool**

These provisions in the Act and the Principles allow the Australian Government to develop services that will:

- provide aged care services in new ways;
- provide aged care services to client groups for whom current services are limited or to newly-emerging client groups; and
- provide aged care via new models of partnership and collaboration.

Funding for these services is provided through the Aged Care Innovative Pool. The services are generally time-limited and are evaluated to inform the Government about the innovative application of aged care services.

A wide variety of services have been offered in the past through these arrangements and many of the lessons learned have been brought into mainstream services. The Transition Care Program and consumer directed care are two significant examples.

3.2. **ACATs and Innovative Care Services**

Although care recipients do not require ACAT approval to access innovative care services, ACATs do need to be aware of any innovative care services which are operating in their area and the types of clients the services are attempting to assist. This information should be provided to the ACAT by the local service providers who are operating the services. Detailed information will be included in a Memorandum of Understanding between the Australian Government and the service provider and in the Conditions of Allocation of the flexible care places included in the service. ACATs should refer clients to those services where their needs match the target group for the service, as well as approving the clients for any other types of care for which they are eligible.
PART F - THE APPROVAL PROCESS

Part F Covers:

- Approval as a Care Recipient
- Who Can Complete an ACCR
- Functions and Powers Delegated to ACAT Positions
- Occupants of Delegate Positions
- Types of Care
- Eligibility for Approval as a Care Recipient
- Limitation of approvals
- Date of Effect of Approval
- Approvals Ceasing to have Effect
- Entry Period
- Break in Care
- Revocation
- Reassessment Requirements following the 2013 Legislation Changes

1. Approval as a Care Recipient

The approval of a person as a care recipient is the basis for the ACAP. Approvals are a critical element of the Aged Care Act 1997.

The Act begins by setting out how organisations become Approved Providers of aged care. (Part 2.1) It then sets out how those Approved Providers are allocated places in which to provide aged care. Places can be beds in a residential facility or a Home Care Package delivered in a community setting. (Part 2.2) Once there are places in which Approved Providers can provide care, there needs to be a process for deciding which people can occupy those places. In the language of the Act, this is about “approval as a care recipient” and the purpose of the ACAP is to determine who is eligible for approval as a care recipient and then approve them. (Part 2.3) When an approved care recipient has been admitted to a place which has been allocated to an Approved Provider, the Provider is able to receive funding from the Australian Government for the provision of care.

Within Part 2.3, Division 22 of the Act answers the question “How does a person become approved as a care recipient?” Section 22-1 says that people can be approved as recipients of residential, home care or flexible care and must be approved if they have applied and are eligible. Section 22-2 says that various limits may be placed on approvals. Section 22-3 then deals with applications for approval.

22-3 Applications for approval

1. A person may apply in writing to the Secretary for the person to be approved as a recipient of one or more types of aged care.

2. However, the fact the application is for the approval of a person as a recipient of one or more types of aged care does not stop the Secretary from approving the person as a recipient of one or more other types of aged care.

3. The application must be made in a form approved by the Secretary.
The Aged Care Client Record (ACCR) is the form which has been approved by the Secretary for people to apply for approval as a care recipient.

It may be signed by the person, or by another person on the person’s behalf.

If the person is unable to sign the ACCR there is an order of priority of who should sign on their behalf.

1. In circumstances where a person has already been appointed as legal representative through guardianship, administration or enduring power of attorney it is appropriate for that person to sign. This may depend on the nature of their appointment, however for the purposes of signing the ACCR this is a reasonable indication of their authority to sign.

2. Where there is no legally appointed person in place then the next of kin, other family member or carer should sign on the person’s behalf.

3. If no such person exists then a solicitor, GP or other health professional who does not have a conflict of interest should sign on the person’s behalf.

In all above circumstances, the ACAT assessor must indicate on the ACCR the reason the applicant was unable to sign, the name of the person signing on the applicant’s behalf and their relationship to the applicant.

It is not appropriate for a member of an ACAT to sign the ACCR on the applicant’s behalf. This would be a conflict of interest and contrary to the ACAT role as an independent assessor.

Under subsection 22-3 (2) irrespective of the type of care a person applies for, the person can be approved for any type of care.

2. Who can complete an ACCR?

Information contained on an ACCR is protected information under the Act. This means that the information on the completed form must not be disclosed or distributed without the client’s consent. The points below will assist ACATs and Delegates in their role:

- No blank ACCRs can be given to a non-ACAT member;
- ACAT assessors should collate evidence from a range of multi-discipline health professionals in the assessment process;
- The ACAT assessor must document their own details and sign the Application Form and the ACCR where indicated. This signature represents the ACAT Assessor is taking responsibility for the assessment process;
- All ACAT Delegates must confirm the ACAT Assessor responsible for the assessment process has completed the ACCR and documented and signed the appropriate sections of the ACCR; and
- All non-ACAT members who contribute to the ACAT assessment process will be encouraged to undertake training.
3. Functions and Powers Delegated to ACAT Positions

The Act vests various functions and powers in “the Secretary” (which means the Secretary of the Department of Social Services) and authorises the Secretary to delegate functions and powers to appropriate officers. Subsection 96-2 (5) of the Act states:

(5) The Secretary may, in writing, delegate to a person making an assessment for the purposes of section 22-4:
   (a) all or any of the Secretary’s functions under Part 2.3; and
   (b) all or any of the Secretary’s powers under the Residential Care Subsidy Principles that relate to respite supplement.

The following table sets out the functions under the Act delegated to ACAT positions.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description of Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>22-1 (2)</td>
<td>The Delegate must approve an eligible person who has applied for approval as a recipient of aged care.</td>
</tr>
<tr>
<td>22-2 (1)</td>
<td>The Delegate can limit an approval to a particular kind of aged care, to care for a specified period, to respite care or in other ways specified in the Approval of Care Recipients Principles. Delegates should be aware that approvals are taken to exclude respite care unless respite care is specifically approved. This is why residential respite care must be approved separately from permanent residential care.</td>
</tr>
<tr>
<td>22-2 (3)</td>
<td>The Delegate can limit approval for residential care to low level care and can limit approval for home care to a particular level.</td>
</tr>
<tr>
<td>22-2 (4)</td>
<td>The Delegate can change a limitation at any at any time, e.g. from residential care limited to a low level to residential care limited to a high level, or from home care levels 1 or 2 to home care levels 3 or 4. The Delegate can also vary other types of limitations, for example change a time limit or remove it altogether.</td>
</tr>
<tr>
<td>22-4 (1)</td>
<td>The Delegate may only make an approval after a person has been assessed.</td>
</tr>
<tr>
<td>22-4 (2)</td>
<td>The assessment on which the Delegate relies in making an approval does not have to be part of a larger assessment of the person, but can be exclusively focussed on eligibility for aged care or for a particular level of care.</td>
</tr>
</tbody>
</table>
However, an approval of a person who is provided with care before being approved as a recipient of that type of *aged care is taken to have had effect from the day on which the care started if:

(a) the application for approval is made within 5 business days (or that period as extended under subsection (3)) after the day on which the care started; and

(b) the Secretary is satisfied, in accordance with the Approval of Care Recipients Principles, that the person urgently needed the care when it started, and that it was not practicable to apply for approval beforehand.

The Delegate may be satisfied that a person urgently needed care when it started before being approved as a recipient of that type of care if an emergency existed at that time. If the Approved Provider applies for approval within five business days or such longer time that the Delegate agrees to of the date of entry to care, then the date of effect of the approval is the date the person entered care, rather than the date of the approval. This is the only circumstance in which the date of approval and the date of effect are not the same.

The Secretary must notify, in writing, the person who applied for approval whether that person, or the person on whose behalf the application was made, is approved as a recipient of one or more specified types of *aged care.

The Delegate must give written notice of an approval decision to the person who applied for approval.

The Delegate must give written notice of a limitation on any approval to the approved care recipient.

The Delegate must give written notice of a variation in a limitation on any approval to approved care recipient.

The following table sets out the power under the Residential Care Subsidy Principles 1997 delegated to ACAT Delegates.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description of Power</th>
</tr>
</thead>
</table>
| 21.18 (2) | However, the Secretary may increase the number of days by 21 if the Secretary considers that it is necessary because of any of the following:
(a) carer stress;
(b) severity of the care recipient’s condition;
(c) absence of the carer. |

The Delegate can grant a 21 day extension to the number of days a care recipient can receive residential respite care in a financial year. Such extensions can be made more than once.

### 3.1. Appointment of Delegates

The Secretary does not appoint ACAT Delegates by name. Instead, there is a two-stage process. First, the Secretary delegates functions and powers to positions. Second, state and territory governments nominate individuals to occupy those positions. The occupants of those positions are known as “ACAT Delegates”. These two stages are explained below.

### 3.2. Delegations Round

ACAT Delegations are updated in May and November each year. This update involves the revoking of previous instruments of delegation under the Act and under the Principles, and remaking of a consolidated instrument under the Act and of a consolidated instrument under the Principles. Attached to the instrument of delegation under the Act is a “Schedule A” for each ACAT, which identifies the positions to which the functions under the Act are being delegated. Attached to the instrument of delegation under the Principles is a “Schedule B”, which identifies the positions to which the powers under the Principles are being delegated.
3.3. **Delegate ID**

Positions are identified using a 6 character code, as follows:

<table>
<thead>
<tr>
<th>Character</th>
<th>Format</th>
<th>Variable</th>
<th>Possible Values</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number</td>
<td>State</td>
<td>1, 2, 3, 4, 5, 6, 7, 8</td>
<td>NSW, VIC, QLD, SA, WA, TAS, NT, ACT</td>
</tr>
<tr>
<td>2 and 3</td>
<td>Letter</td>
<td>ACAT ID</td>
<td>Letters in the range A-Z</td>
<td>Identifies the ACAT as coded in the ACAP Data Dictionary. If ACATs have merged or split since the last update of the Data Dictionary, the new ACAT codes will be used</td>
</tr>
<tr>
<td>4</td>
<td>Number</td>
<td>Profession</td>
<td>1, 2, 3, 4, 5, 6, 7</td>
<td>Medical Practitioner, Registered Nurse, Social Worker, Occupational Therapist, Physiotherapist, Other, Psychologist</td>
</tr>
<tr>
<td>5 and 6</td>
<td>Number</td>
<td>Position Number</td>
<td>Numbers in the range 0-9</td>
<td>Sequential numbers from 01 to 99 unique to each delegate position in that ACAT.</td>
</tr>
</tbody>
</table>

For example, the Delegate position 6SR315 indicates that the position is in Tasmania, in the Southern ACAT, can only be occupied by a Social Worker, and is identified by the position number 15 in that ACAT.

### 4. Occupants of Delegate Positions

Once Delegate positions have been created, individual ACAT members can be nominated to occupy those positions by their team manager. This nomination must be endorsed by the relevant state or territory government prior to requesting agreement from the Department. Nominated delegates will only be appointed to ACAT delegate positions if they meet the delegate selection criteria.

#### 4.1. **Principles of Delegation**

The following principles of delegation underpin the delegation framework:

- The exercise of delegated powers is a responsibility which can relate to dramatic changes to a person’s life circumstances and must be enacted with a commensurate responsibility and robust accountability.
- The composition of delegates within any one team should reflect the multidisciplinary approach of the ACAP and should include a mix of disciplines drawn from the core assessment professions.
- Wherever possible the approving delegate should not be the same person as the assessor, even though the assessor may also be a delegate.
In approving a care recipient to receive Australian Government subsidised care, the delegate must be satisfied that the person is not only eligible for the type of care approved, but that this outcome is the optimum for the care recipient. The delegate must be satisfied that the ACAT has:

- conducted the assessment in accordance with relevant legislation and Guidelines.
- conducted an holistic assessment, including assessment of the person’s usual living arrangements.
- ensured that a multidisciplinary approach was taken and involved the disciplines required to assess different aspects of a person’s care needs.
- recommended the care type or types for which the person is eligible and that are most suitable to meet their care needs and wishes.
- involved the client (and/or family as appropriate) in the assessment process.
- collected adequate verbal or written assessment information, sufficient to address any queries the delegate may have.

Where the delegate is not satisfied, the delegate is responsible for obtaining the additional information required to make a fully informed judgment. The delegate should ensure that the ACCR has been completed without errors, contradictions or omissions before signing.

Delegates must comply with all applicable Commonwealth and state or territory laws which include, but are not limited to:


Delegation to positions will be subject to the continued operation of the ACAT according to Commonwealth Guidelines, funding conditions and any directions issued by the Secretary to the Secretary’s delegates.

### 4.2. Delegate Selection Criteria

A review of nominees against the selection criteria assists in the appropriate selection of individuals to occupy delegate positions. ACAT Managers should nominate to their state or territory government new delegates who meet the following criteria:

1. Is employed 0.5 full time equivalent (FTE) or greater on the ACAP.
2. Has been an employee on the ACAP for at least 12 months.
3. Is routinely engaged in the full spectrum of ACAT work including community assessments.
4. Is qualified in one of the core disciplines for the ACATs.
5. Has fulfilled the requirements of the National ACAT Minimum Training Standards.

In some circumstances a new delegate may not fully meet all criteria. This situation may arise in small or rural and remote teams. In these cases, the Department is able to exercise some flexibility, although it must be demonstrated that the person has the necessary skills and knowledge to undertake the role, and that a delegate position is necessary for the effective operation of the team.

These criteria ensure that ACAT members have appropriate levels of experience, knowledge and skills to undertake the delegate role competently. Further, the 0.5 FTE was designed to ensure that delegates have enough time to be able to attend appropriate training, and keep abreast of any communication about changes to the Program. Therefore, any relaxation of these requirements should be treated with a degree of caution.
For Criterion 3, the Delegate needs to maintain their practical assessment experience to complement completion of the theoretical component of the National Delegation Training, in line with the ACAP National Training Strategy and the National Minimum Training Standards. This practical component should include being routinely involved in all aspects of ACAT work, including the clinical assessment of older people in the community and in hospital.

For Criterion 4, the core disciplines are Medical Practitioner, Registered Nurse, Social Worker, Occupational Therapist, Physiotherapist and Psychologist. Outside these disciplines (i.e. where the fourth character in the position number is “6”), delegation will only be granted where there is a demonstrated need for the person to hold the delegation and the need for the profession is agreed with the Australian Government to be critical to the assessment process. Where an outside profession is being considered, it is essential that the prospective occupant holds relevant skills and/or experience and there needs to be clear justification for that profession to be a delegate.

Not all ACAT members need to be delegates. In most instances, no more than 65% of team members should be delegates, although there may be cases, for example in very small teams, where a higher proportion would be necessary.

### 4.3 Nomination Process

The nomination of a new delegate is initiated by the ACAT manager, who must complete a form providing information about each newly recommended delegate. The form indicates whether the proposed delegate meets all of the selection criteria and must be signed by the proposed delegate. The completed form is then sent to the relevant state or territory government for endorsement.

Where all criteria are not met, the ACAT manager should provide sufficient information and justification as to why the ACAT member should become a delegate. This should identify any relevant operational issues, the ACAT member’s relevant skills and experience, and their suitability to perform as a delegate.

If the State or Territory government supports the nomination, the form and recommendation is sent to the Commonwealth Department of Social Services. The Department will discuss and clarify any issues with the State or Territory government as required. If the Department accepts the nomination, the Delegate’s information will be sent to the Department of Human Services.

### 4.4 Changes in Occupation of a Position

When the occupant of a delegate position leaves that position, the ACAT, through the state or territory government, must advise the Department of Social Services. If another person is to take up the position, the nomination process above should be followed.

### 4.5 Conflict of Interest

In accordance with State or Territory government regulations, delegates should disclose, and take reasonable steps to avoid, any conflict of interest (real or apparent). Types of interest and relationships that may need to be disclosed include shareholdings, gifts, employment, voluntary work, company directorships or partnerships that could or could be seen to impact upon the delegate’s decision-making powers.

### 4.6 Liaison with the Department of Human Services

When an ACAT Delegate approves a care recipient, information about the approval is communicated to the DHS. In most ACATs this is through the eACCR process, although some ACATs continue to use a paper-based process which requires the ACCR to be sent by mail to DHS.
The Department of Social Services provides DHS with a list of delegate positions at the end of each Delegation Round. For those ACATs which use the eACCR process, DHS provides each new occupant with an ikey (also known as a shell token/security certificate) which functions as the delegate’s electronic signature. Although changes to delegate positions can only be made during the delegation rounds, changes to the occupant of a delegate position can be made at any time.

4.7. **Roles and Responsibilities of Delegates**

The major roles and responsibilities of the delegate in approving a person for care are:

- ensuring that an assessment was undertaken which meets the requirements of the Act, the Principles and Part B of these Guidelines;
- ensuring that the client is eligible for the types of care for which he or she is being approved;
- ensuring that the care being approved is the optimal outcome of the assessment and approval process for the particular client;
- ensuring that all relevant documentation related to the assessment is retained and is readily accessible should an appeal be lodged;
- ensuring that correct dates are entered at all points of the ACCR, including the date of approval and appropriate time limitation dates on any approvals that the Delegate decides should be time limited;
- ensuring that approval information is provided to DHS using the usual process of the particular ACAT;
- advising the client of the outcome of the assessment using the appropriate template letters provided by the Department of Social Services;
- being available to appear before the Administrative Appeals Tribunal to give evidence in support of the decision, in the event that an appeal against the outcome of the assessment is lodged; and
- ensuring wherever possible that the Delegate is not the same person as the Assessor.

5. **Types of Care**

The Act allows for people to be approved for one or more of the following types of care:

- residential care (including residential respite care);
- home care; and/or
- flexible care.

6. **Eligibility for Approval as a Care Recipient**

Under the Act, to be eligible for a type of care, a person must have care needs that can be appropriately met through the provision of that type of care.

The eligibility criteria for:

- residential aged care are covered in Part C of these Guidelines;
- home care are covered in Part D of these Guidelines; and
- flexible care are covered in Part E of these Guidelines.

ACAT Delegates should only approve people for a particular type of care if the assessment demonstrates that the person meets the eligibility criteria, and the type or types of care being approved are the most appropriate to meet the person’s needs.
7. Limitation of Approvals

Subsection 22-2 of the Act deals with the limitation of approvals. The Secretary’s functions under subsections (1), (3) and (4) are delegated to ACAP Delegates.

Section 22-2 Aged Care Act 1997  Limitation of approvals

(1) The Secretary may limit an approval to one or more of the following:
   (a) care provided by an *aged care service of a particular kind;
   (b) care provided during a specified period starting on the day after the approval was given;
   (c) the provision of *respite care for the period specified in the limitation;
   (d) any other matter or circumstance specified in the Approval of Care Recipients Principles.

The Secretary is taken to have limited an approval to the provision of care other than respite care, unless the approval expressly covers the provision of respite care.

(2) A period specified under paragraph (1)(b) must not exceed the period (if any) specified in the Approval of Care Recipients Principles.

(3) The Secretary may limit the approval to one or more levels of care.

(4) The Secretary may, at any time, vary any limitation under this section of an approval, including any limitation varied under this subsection.

(5) Any limitation of an approval under this section, including any limitation as varied under subsection (4), must be consistent with the care needs of the person to whom the approval relates.

This means that ACAT delegates have the authority to limit an approval to:

- a specific kind of care, for example, under Flexible care, the approval may be limited to transition care;
- a specific time period;
- respite care; and
- a particular level of residential or home care.

However, under subsection 22-2(5) of the Act, the approval must be consistent with the care needs of the recipient.

If an assessment indicates that a person’s care needs require a high level of residential care or home care level 3 or 4, the person should be approved for that level of care. If a person is approved as a recipient of a particular level of care, the limitation of approval to that level does not prevent the person receiving care at a lower level.

7.1. Limitation to Dementia Specific Care

Under Section 22-2(1)(a) of the Act, an ACAT delegate can limit an approval to “care provided by an aged care service of a particular kind.” In practice this allows a delegate, for example, to limit flexible care to Transition Care. However, other kinds of limitations could, in theory, be set. For example, there are facilities with expertise and equipment that allow them to specialise in particular kinds of care such as dementia-specific care, and an approval could be limited to care provided by a such a facility.

In practice, an ACAT would recommend that a person should receive care in such a facility, rather than limit the approval to that care. There are dementia-specific facilities which can provide appropriate care for people with dementia at a low level. If the ACAT recommends that a person with dementia enters such a facility, it is appropriate to approve the person to receive low level permanent residential care.
ACATs should know which local facilities are able to cater for people with moderate to severe dementia. The ACAT must also take into consideration the rights of the existing clients, and the ability of the facility to provide a safe environment for the client, while noting that the final decision about admission rests with the client, the family and the service provider.

If the ACAT assesses that a person with dementia has high level needs but can be cared for in a low level residential facility which is dementia specific, the person should still be approved for high level care. As noted above, approval for high level residential care means a person can receive Commonwealth subsidised care at any level. The availability of a low level dementia specific facility should be recorded on the ACCR. All other relevant information should also be recorded and provided to the aged care provider so that they gain a good understanding of the person’s care needs and can decide if their facility is able to provide the type and level of care required.

Under amendments commencing on 1 August 2013, level 4 Home Care will include not only previous Extended Aged Care at Home (EACH), but also Extended Aged Care at Home – Dementia (EACHD). However a dementia supplement can be provided at any level of Home Care. From 1 August 2013 to 1 July 2014 this and other supplements will be included in a Ministerial Determination made under section 48-1 of the Act. From 1 July 2014 onwards these supplements will be included in the new Subsidy Principles.

### 7.2. Limitation to Residential Respite Care

Approval to receive residential respite care does not lapse, unless it has been limited to a specified period. A person who has been approved for residential respite care is eligible to receive a maximum of 63 days of respite care in each financial year. A delegate can increase this number by 21 days, and this can be done more than once. ACAT approval for residential respite care will be at either the high or low level, with any movement from the low to high level of care requiring re-approval accordingly.

Aged care facilities have an annual allocation of respite bed days and they cannot offer respite care days in excess of that allocation limit. Consequently, a person may need to access respite care in more than one aged care facility to ensure that all facilities remain under their allocation limit.

### 7.3. Additional Residential Respite Care

Under section 21.18 of the Residential Care Subsidy Principles 1997, ACAT delegates have the power to increase by 21 the number of days that a person may access residential respite care beyond the initial 63 days in a financial year. This may occur in circumstances such as carer stress, a temporary or unexpected increase in the severity of a care recipient’s condition, absence of a carer or on account of any other relevant matter where ACATs consider it appropriate for respite to be extended. There is no limit on the number of extensions that may be granted. Each extension is for a period of 21 days.

ACATs must use the “Residential Respite Extension Form – 21 Day Extension” (2670) for respite extensions and submit the form to DHS. A 21 day extension will lapse at the end of June (that is, the end of the financial year), as the person automatically becomes eligible for another 63 days of respite. The 21 day extension form must be completed whenever an extension is required.

There is no provision to backdate a 21 day extension so agreement to extend the respite period must be obtained prior to a person entering the additional respite care. It is the responsibility of the service provider to ensure that the person has a valid approval in place prior to providing care. ACATs are not obliged to keep track of a person’s current number of available respite days.

Any extension for 21 days will be at the person’s approved level of care. If a higher level of care is required, the person must be reassessed and approved by the ACAT for the higher level of care.
7.4. **Varying a limitation**

Under subsection 22-2 (4) of the Act, the Secretary may, at any time, vary any limitation to an approval. This function is also delegated to ACAT delegates under subsection 96-2(5) of the Act.

Variations can include, for example, varying the limitation of low level residential care to high level care, varying any time limitation on the approval for a particular type of care, or varying the kind of care approved within a flexible or Home care approval.

While the Act does not specifically state that a re-assessment is required to vary a limitation, it does state (subsection 22-2(5)) that the variation must be consistent with the care needs of the person. In practice, this means that another assessment should take place to ensure that the person’s care needs can be met through the variation. In other words variation of a limitation should only occur if the person’s care needs change.

The date the variation takes effect, is the date the new ACCR is approved and signed by the delegate. Under paragraph 22-6(3)(b) of the Act, the Secretary must also inform the approved person in writing of the variation to the limitation. This function is specifically delegated to ACAT Delegates.

8. **Date of Effect of Approval**

Under section 22-5(1) of the Act, an approval takes effect on the day on which the Secretary approves the person as a care recipient.

**Section 22-5 Aged Care Act 1997 - Date of effect of approval**

(1) An approval takes effect on the day on which the Secretary approves the person as a care recipient.

Since the function of approving people as care recipients has been delegated to ACAT delegates, the date the delegate makes the decision to approve a person as a care recipient is the date of effect.

**Under the Act, an approval must not be backdated.** The delegate must date the ACCR on the day they sign the form. The delegate may have formed an opinion on an earlier date, but the decision is formalised until the form is signed. The date of effect is the date on which the delegate makes the decision to approve and signs the form.

Under the eACCR process, the default date of the decision (and therefore the default date of effect) is the date the approval is transmitted to DHS. There is scope for the date to be amended to allow for situations such as the unavailability of the electronic system. In all cases where the approval date is amended to a date prior to the date of transmission, the ACAT must hold a paper version of the ACCR which was signed and dated on the earlier date.

Under subsection 22-5(2) of the Act, the date of effect is the date on which care started if the delegate is satisfied that the person urgently needed the care and it was not practicable to apply for approval beforehand. Under section 5.11 of the *Approval of Care Recipients Principles 1997* the delegate can be satisfied that a person urgently needed care when it stated if an emergency existed at that time. There is space for these details to be recorded on the ACCR. See Part G of these Guidelines for more information on what constitutes an emergency and how to apply for approval of emergency care.

There are a number of business rules relating to dates on the ACCR, which are spelled out in the ACCR User Guide. ACAT assessors and delegates should be familiar with these business rules.

9. **Approvals Ceasing to have Effect**

Under Division 23 of the Act, a person’s approval as a recipient of aged care can cease to have effect in one of three ways - it can expire, lapse or be revoked.
9.1. Expire

Under paragraph 22-2(1)(b) of the Act, a delegate can limit an approval to care provided during a specified period. After that period expires, the person no longer has approval under the Act to enter care or continue receiving care under that approval.

9.2. Approvals that lapse

Approvals for the following types of care lapse if care is not received within the entry period, or, in the case of low level permanent residential care, if there is a break in care after the entry period expires:

- Low level permanent residential care; and
- Transition Care
- For low level permanent residential care, an approval does not lapse if care has been received unless there is a break of care of more than 28 days after the entry period ends. For transition care an approval does not lapse unless there is a break of care of more than one day after the entry period ends.

9.3. Approvals that do not Lapse

Approvals for the following types of care do not lapse:

- High level permanent residential care (if the approval date is on, or after, 1 July 2008);
- High level and low level residential respite care (if the approval date is on, or after, 1 July 2008);
- Home Care Packages.

A person with one of these approvals that are not time limited may continue to access that type of care, unless the approval is revoked.

10. Entry Period

Under paragraph 23-3(1)(b) of the Act, the entry period for low level permanent residential care is 12 months, beginning on the day after the approval was given.

Under section 5.13A of the Approval of Care Recipients Principles 1997, the entry period for home care is 2 years and one day beginning on the day after the approval was given.

Under section 5.13 of the Approval of Care Recipients Principles 1997, entry period for Transition Care is 28 days beginning on the day after the approval was given.

An approval for one of these types of care will lapse at the end of the entry period if the person does not receive that type of care within the entry period. If a person enters care and leaves care within the entry period, the approval remains valid and the person may re-enter that type of care at a later point within the entry period. The approval for care will lapse if the person is not receiving that care after the end of the entry period.

Combined with further amendments to the Act and Principles commencing on 1 July 2014, the long entry period for home care means that approvals for Home Care packages at any level will not lapse.

The Act does not indicate that the care must be provided in an Australian Government subsided place. In cases where a person enters care in an unfunded place within a funded service and the care meets the meaning of residential care or home care under the Act, the approval will not lapse at the end of the entry period. The client can transfer to a funded place after the end of the entry period and the service will be eligible to receive funding for the care from the date of the transfer.
11. Break in Care

Section 23-3(3) of the Act and section 5.14(1) of the Approval of Care Recipients Principles 1997 state that an approval for low level permanent residential care lapses if the person is not provided with the care for a period of at least one day prior to the end of the entry period.

There are two points to note about this:

- Under section 23-3(4) of the Act, if a person is on leave from residential care, the leave does not mean that the person has ceased to be provided with care and the approval does not lapse.
- Section 5.14(2) of the Approval of Care Recipients Principles 1997 provides that if a person leaves residential care and enters another residential care service within 28 days, the days the person was not receiving care are to be ignored. This means that the approval does not lapse.

12. Revocation

A person’s approval can be revoked if the Secretary is satisfied that the person has ceased to be eligible to receive a type of aged care for which he or she is approved. This power is NOT delegated to ACATs but to a departmental delegate.

Section 23-4 of the Act sets out the process for revocation of an approval. It outlines the obligations on the departmental delegate to ensure that alternative care arrangements are available for the person. The process includes a requirement for an assessment of the person’s care needs which shows that the person has ceased to be eligible for a type of care that has previously been approved. The person may be receiving the care (for example, by occupying a bed in a residential facility) at the time that the assessment shows that the person has ceased to be eligible. On the rare occasions that revocation is being considered, the departmental delegate will liaise with the ACAT to ensure that the necessary assessment is made.

ACATs should be aware that approving a new ACCR for a client does not revoke any previous approvals.

13. Reassessment Requirements following the 2013 Legislation Changes

The documents below show the circumstances when a reassessment by an Aged Care Assessment Team (ACAT) is, and is not, required. Legislation changes effective 1 August 2013 have meant that the assessment requirements for some types of care have changed.

It is important to note this information is divided into two categories that set out the requirements for people from 1 August 2013 (until 30 June 2014) who:

- have been approved but have NOT received care; or
- have been approved and HAVE received care
<table>
<thead>
<tr>
<th>Have Been Approved but Have Not Received Care</th>
<th>ACAT Approval</th>
<th>Is reassessment required?</th>
<th>Changes from 1 August 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>High level residential care</td>
<td>Yes - If the approval is time limited and care is</td>
<td>required after the specified period expires</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>Low level residential care</td>
<td>Yes - If care is not received within 12 months from the day after approval</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes - If the approval is time limited and care is required after the specified period</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>expires</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes - If high level residential care is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High level residential respite care</td>
<td>Yes - If the approval is time limited and care is</td>
<td>required after the specified period expires</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>Low level residential respite care</td>
<td>Yes - If the approval is time limited and care is required after the specified period</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>expires</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes - If high level residential respite care is</td>
<td>required</td>
<td></td>
</tr>
<tr>
<td>Home Care Level 1 and 2</td>
<td>Yes - If the approval is time limited and care is</td>
<td>required after the specified period expires</td>
<td>Clients may be approved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>expires</td>
<td>for Home Care Packages</td>
</tr>
<tr>
<td></td>
<td>Yes - If Home Care Level 3 or 4 is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Care Level 3 and 4</td>
<td>Yes - If the approval is time limited and care is</td>
<td>required after the specified period expires</td>
<td>Clients may be approved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>expires</td>
<td>for Home Care Packages</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Aged Care Package (CACP)</td>
<td>See requirements for Home Care Level 1 and 2</td>
<td></td>
<td>CACP approvals automatically transition to Home Care Level 2 approval</td>
</tr>
<tr>
<td></td>
<td>N.B: An approval for CACP became an approval for Home Care Level 1 or 2 from 1 August 2013. The original approval, no longer automatically lapses if care is not received within 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible Care in the form of Extended Aged Care at Home (EACH) or Extended Aged Care at Home – Dementia (EACH-D)</td>
<td>See requirements for Home Care Level 3 and 4</td>
<td></td>
<td>EACH and EACH-D approvals automatically transition to Home Care Level 4 approval</td>
</tr>
<tr>
<td>Transition Care</td>
<td>Yes - If care is not provided within 4 weeks from the day after the approval date.</td>
<td></td>
<td>No change</td>
</tr>
</tbody>
</table>
## Have Been Approved and Received Care

<table>
<thead>
<tr>
<th>ACAT Approval</th>
<th>Is reassessment required?</th>
<th>Changes from 1 August 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High level residential care</strong></td>
<td>Yes - If the approval is time limited and care is required after the specified period expires</td>
<td>No change</td>
</tr>
<tr>
<td><strong>Low level residential care</strong></td>
<td>Yes - If the approval is time limited and care is required after the specified period expires&lt;br&gt;Yes – If there is a break in care of more than 28 days (excluding approved leave)&lt;br&gt;Yes – on transfer if the resident has aged in place and wishes to pay an accommodation charge to the new home rather than rolling over an existing bond.&lt;br&gt;Yes – if the first ACFI results in a High Level classification and the provider wishes to claim a high care ACFI subsidy rather than the interim low subsidy&lt;br&gt;No – if the resident has aged in place as follows:&lt;br&gt;• An ACFI reappraisal is conducted that results in a High Level classification (e.g. on expiry of an existing classification, or a voluntary reappraisal following a transfer, or following a major change in care needs) or • a Departmental Review Officer confirms the resident’s ACFI classification during a classification review.</td>
<td>No change</td>
</tr>
<tr>
<td><strong>High level residential respite care</strong></td>
<td>Yes - If the approval is time limited and care is required after the specified period expires</td>
<td>No change</td>
</tr>
<tr>
<td><strong>Low level residential respite care</strong></td>
<td>Yes - If the approval is time limited and care is required after the specified period expires&lt;br&gt;Yes - If high level residential respite care is required</td>
<td>No change</td>
</tr>
<tr>
<td><strong>Community Aged Care Package (CACP) (Home Care Level 1 and 2)</strong></td>
<td>Yes - If the approval is time limited and care is required after the specified period expires&lt;br&gt;Yes – If a Home Care Level 3 or 4 is required</td>
<td>CACP approvals automatically transition to Home Care Level 2 approval</td>
</tr>
<tr>
<td><strong>Flexible Care in the form of Extended Aged Care at Home (EACH) or Extended Aged Care at Home – Dementia (EACH-D)</strong></td>
<td>Yes - If the approval is time limited and care is required after the specified period expires</td>
<td>EACH and EACHD approvals automatically transition to Home Care Level 4 approval</td>
</tr>
<tr>
<td><strong>Transition care</strong></td>
<td>Yes – If there is a break in care of at least one day (excluding an overnight stay in hospital) after the</td>
<td>No change</td>
</tr>
<tr>
<td>ACAT Approval</td>
<td>Is reassessment required?</td>
<td>Changes from 1 August 2013</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>4 week entry period</td>
<td><strong>No</strong> – If the client enters hospital from transition care for longer than an overnight stay, concludes their hospital episode and re-enters transition care (from hospital) within the 4 week entry period.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Yes</strong> – A Transition care episode can be extended from 84 days up to a maximum of 126 days. An ACAT reassessment may be needed if the delegate is not satisfied with information about the care recipient's further transition care needs supplied by the service provider in the Transition Care Extension Form**</td>
<td></td>
</tr>
</tbody>
</table>

** A new approval on an Aged Care Client Record is not required for an extension of transition care.
PART G - APPROVAL IN EMERGENCY CIRCUMSTANCES

Part G Covers

   Emergency Circumstances
   The Assessment and Approval Process in Emergency Circumstances
   Emergencies
   Extension of the Five Business Day Rule
   Example of the Emergency Care Process
   Recipient Dies Prior to ACAT Assessment

1. Emergency Circumstances

Section 22-5 of the Aged Care Act 1997 (the Act) deals with the date of effect of an approval, as mentioned in Part F 8 above.

Section 22-5 Aged Care Act 1997: Date of effect of approval

(1) An approval takes effect on the day on which the Secretary approves the person as a care recipient.

(2) However, an approval of a person who is provided with care before being approved as a recipient of that type of aged care is taken to have had effect from the day on which that care started if:
   (a) the application for approval is made within 5 business days (or the period as extended under subsection (3)) after the day on which the care started; and
   (b) the Secretary is satisfied, in accordance with the Approval of Care Recipients Principles, that the person urgently needed the care when it started, and that it was not practicable to apply for approval beforehand.

(3) A person may apply in writing to the Secretary for an extension of the period referred to in subsection (2). The Secretary must, by written notice given to the person:
   (a) grant an extension of a duration determined by the Secretary; or
   (b) reject the application.

Subsection (1) sets the standard that an approval takes effect on the day the decision is made. Subsection (2) then allows for the possibility of a person needing to commence receiving care prior to having an approval for that care.

A provider will be paid an Australian Government subsidy for a person who enters care prior without an approval if an ACAT assessment agrees that:

   • the recipient urgently needed care; and
   • the recipient was eligible for the type of care they are receiving; and
   • that the provider applied for approval within five business days of the day the care started, or such longer period as agreed by a departmental delegate (see section 4 following).

The ACAT delegate must consider all three of these conditions before signing the ACCR.
2. The Assessment and Approval Process in Emergency Circumstances

There is a range of circumstances in which a person may need to be admitted to aged care without a prior approval. This usually, although not always, involves a sudden change in the person’s existing care arrangements. For example, a carer may become ill, die, or called away, or a home may be damaged. Whatever the details in each case, the person’s plight comes to the attention of an aged care service provider who agrees to admit the person to care despite the fact that the person does not have a valid approval for that type of care.

2.1. Application for Approval

The Act requires that the Application for Approval be made within five business days after the day on which the care started. The approved form for the application is the ACCR. The relevant page of the ACCR, headed AGED CARE CLIENT RECORD [APPLICATION FORM], is available for download from the Department of Health’s website. ACATs may also provide a hard copy to service providers when an emergency occurs.

This page must be signed by the client or by someone else on the client’s behalf and by the service provider. The service provider must also provide the Service Provider Number and the date that care started, and tick the box to say that the person urgently needed the care when it started and it was not practicable to obtain approval beforehand.

2.2. Referral

The Application From must be signed and forwarded to the ACAT within five business days after the day on which the care started. The date it is received should be written on the form by the ACAT member who receives it. This form must be retained by the ACAT as part of the paper file for this referral. The referral date is the date the form is received by the ACAT.

As with all referrals, a priority category must be assigned when there is an emergency admission to care. Since the client is in care and not in danger, it is appropriate to assign the referral as priority category 2 where the client should be seen between 3 and 14 days after the referral is received.

2.3. Assessment and Approval

The ACAT assessment of a person admitted to care in emergency circumstances addresses two elements. As with other assessments, it gathers evidence to assess the client’s eligibility as a recipient of Australian Government subsidised aged care. It must also gather evidence that an emergency existed at the time the client entered care and that it was not practicable to obtain approval beforehand. The delegate is required to exercise the delegated powers both to approve or not approve the person as a recipient of care and to be satisfied that an emergency existed at the time of admission and that it was not practicable to obtain approval beforehand.

3. Emergencies

Assessing if an emergency existed should be undertaken in a face-to-face assessment. The assessor should gather evidence about the situation from as many people as possible, including the client, the carer (if available), the service provider and any other professional who was involved at the time.

There are some situations that are not emergencies and should not be approved as emergency admissions, including:

- a bed becoming available in a residential care aged care facility; and
- moving from an acute setting to another care setting.
If the person is already receiving some form of care and there is no risk of harm then this is not an emergency admission. If delegates are unsure of whether a situation is an emergency, they should contact the Department of Social Services for further assistance.

If a delegate determines that the client is eligible for approval as a care recipient, but an emergency did not exist, then the date of effect of the approval is the date the approval was signed. The service provider will not receive subsidy for the period from the date of admission to the date of approval. The service provider may then charge the care recipient for the cost of care over that period. The provider or the client may also appeal against the delegate’s decision.

4. Extension of the Five Business Day Rule

There are occasions where it is impossible to have the Statement of Application completed and lodged within five business days of the start of care. Subsection 22-5(3) of the Act allows the Secretary to extend this period if an application in writing is received. This power has been delegated to departmental delegates, but has not been delegated to ACAT delegates. The Act states that “A person may apply in writing to the Secretary for an extension”, this can be interpreted to mean that the service provider may write to the Secretary at the Department’s address in Appendix 2 setting out the details of the case and seeking an extension of the five business days rule.

The Secretary must then, by written notice given to the person, either grant the extension for duration of time determined by the Secretary; or reject the application. If the extension is granted, the ACAT can then proceed with the assessment. If the extension is rejected, the provider or the care recipient can seek review of this decision.

5. Example of the Emergency Care Process

The example below is provided to illustrate the operation of this provision. This example deals with a gentleman currently receiving a Home Care Package, who lives with his wife who is his carer. He does not have a residential approval for either permanent or respite care.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday 16 April 2012</td>
<td>Carer suffers a heart attack and is admitted to hospital. Home care provider contacts a residential facility which admits the gentleman to respite since he is unable to care for himself at home.</td>
<td>This is the date that care started.</td>
</tr>
<tr>
<td>Tuesday 17 April 2012</td>
<td>The facility manager signs the Application for Approval, but a family member will not be able to sign until the weekend.</td>
<td>This is the first of the five business days.</td>
</tr>
<tr>
<td>Saturday 21 April 2012</td>
<td>The client’s son is available to sign the Application for Approval. Note that the Application Form can be submitted to the ACAT without the client’s signature. This example illustrates the use of the five business day rule.</td>
<td>This is not a business day and is not counted in the five business days.</td>
</tr>
<tr>
<td>Monday 23 April 2012</td>
<td>The facility manager sends the Application to the ACAT by facsimile. The ACAT marks it as received on 23 April.</td>
<td>This is the fifth business day, so the Application for Approval has been made within the limit set in the Act. This is the referral date for this assessment.</td>
</tr>
<tr>
<td>Monday 23 April 2012</td>
<td>The ACAT assigns the case to priority category 2 because the client is not in any danger and is receiving care.</td>
<td>Referrals in these circumstances should not be assigned to priority category 1.</td>
</tr>
<tr>
<td>Date</td>
<td>Action</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Wednesday 2 May 2012</td>
<td>An ACAT assessor visits the residential facility, conducts a comprehensive assessment of the client and recommends a permanent high level residential respite approval.</td>
<td>This is the first intervention date, the first face-to-face contact date and the end of assessment date.</td>
</tr>
<tr>
<td>Thursday 3 May 2012</td>
<td>An ACAT delegate approves the client for permanent high level residential and residential respite care. The delegate is also satisfied that an emergency existed on Monday 16 April and ticks the check box in Part 6 of the ACCR and enters that date as the date care started.</td>
<td>This is the delegation date for this approval. This date is within 14 days of the referral date, so the ACAT has met the timeframe for priority category 2, even though it is more than 14 days since the date care started. The delegate must not amend the delegation date. The date of effect of the approval is Monday 16 April 2012 and the service provider will receive subsidy from that date.</td>
</tr>
</tbody>
</table>

6. **Recipient Dies Prior to ACAT Assessment**

In a situation when a person enters residential aged care in an emergency, the approved provider commences to provide care and submits the signed application for care to the ACAT within the required 5 business days, but unfortunately the person dies before the ACAT conducts their assessment and subsequent approval for care, the following measures are to be taken.

There is provision in the *Aged Care Act 1997* at section 22-4(3) for the Secretary to approve a person as a recipient of residential and other types of aged care without the person's care needs being assessed, if the Secretary is satisfied that there are exceptional circumstances that justify making the decision without an assessment. The situation where a person enters residential care as an emergency, the approved provider cares for the person but the person dies before the ACAT can conduct the assessment, would likely be an exceptional circumstance.

However, the power under s 22-4(3) to make a decision without an assessment is not a power that is delegated to ACAT delegates. It is only delegated to some officers within the Department of Social Services.

Therefore, in all cases where a person enters residential care in an emergency and dies prior to the ACAT conducting the assessment, it is the Departmental delegate who must make the decision to approve or not approve the person as a recipient of this type of care.

It is likely that the approved provider will contact the ACAT to advise them that the person has died because in most cases it would have been the provider that requested the ACAT to conduct an assessment.

ACATs are to advise the Department when they become aware that a person entered residential care in an emergency, but died prior to completion of an assessment. Any information the ACAT has in relation to the client and contact details for the approved provider should accompany this advice. It is understood in some cases the person may be unknown to the ACAT and the only information the ACAT may have would be the signed application for approval that the approved provider had sent to them.
Contact with the Department can be through email ACAP.Policy.Operations@health.gov.au. Based on all information and evidence the Department receives, the Departmental delegate will make a decision to approve, or not approve, the care and advise DHS-Medicare.

In the cases where the ACAT assessor has completed their assessment and the client dies after the assessment but before the delegate has made their decision, the ACAT delegate can proceed as per usual and make the decision to approve or not approve care. The completed ACCR would be submitted to DHS-Medicare by the ACAT delegate.

If there are any questions about this, enquiries should be sent to ACAP.Policy.Operations@health.gov.au.
PART H - NOTIFICATION OF DECISIONS

Part H Covers

Notifying People of Decisions

1. Notifying People of Decisions

ACAT delegates are under a legal obligation to notify people of the decision to approve or not approve people as recipients of Australian Government subsidised aged care. This obligation is set out at three points in legislation.

Section 22-6 of the Act requires that a person who applied for approval as a care recipient must be notified in writing of the outcome of the application. Section 22-6(3) specifically extends the requirement to cover instances of limiting or varying a limitation under section 22-2.

22-6 Notification of decisions

(1) The Secretary must notify, in writing, the person who applied for approval whether that person, or the person on whose behalf the application was made, is approved as a recipient of one or more specified types of aged care.

(2) If the person is approved, the notice must include statements setting out the following matters:

   (a) the day from which the approval takes effect (see section 22-5);
   (b) any limitations on the approval under subsection 22-2(1);
   (c) whether the approval is limited to a level or level of care (see subsection 22-2(3));
   (d) when the approval will expire (see section 23-2);
   (e) when the approval will lapse (see section 23-3);
   (f) the circumstances in which the approval may be revoked (see section 23-4).

(3) The Secretary must notify, in writing, a person who is already approved as a recipient of one or more types of aged care if the Secretary:

   (a) limits the person’s approval under subsection 22-2(1) or (3); or
   (b) varies a limitation on the person’s approval under subsection 22-2(4).

The requirement to give the notification “in writing” triggers the application of section 25D of the Acts Interpretation Act 1901, which requires that the notification sets out the findings on material questions of fact and refers to the evidence or other material on which the findings were based.

25D Content of statements of reasons for decisions

Where an Act requires a tribunal, body or person making a decision to give written reasons for the decision, whether the expression “reasons”, “grounds” or any other expression is used, the instrument giving the reasons shall also set out the findings on material questions of fact and refer to the evidence or other material on which those findings were based.
In addition, section 85-3 of the Act requires that reasons be given for reviewable decisions.

**85-3 Secretary must give reasons for reviewable decisions**

(1) If this Act requires the Secretary to notify a person of the making of a *reviewable decision, the notice must include reasons for the decision.

(2) Subsection (1) does not affect an obligation, imposed upon the Secretary by any other law, to give reasons for a decision.

The Department has drafted template letters to assist delegates to meet these legal requirements.

When delegates complete the template in accordance with the included directions, the letters satisfy the requirements of the Act and the *Acts Interpretation Act 1901*. Most states and territories have incorporated the templates into their ACAT Client Management Systems (CMS) database systems to support their use by delegates. Many sections of the template are pre-populated from the CMS database depending on the approvals selected by the delegate. Where this feature is not available, delegates should access the template in a word processor and follow the included directions to complete the letter.

Delegates should be aware that the template includes information about the client’s appeal rights. Part I of these Guidelines provide more detail about reviewable decisions and the process for clients to lodge appeals.

Delegates should also be aware of the requirement to provide a printed copy of the client’s ACCR to the client with the notification letter.
PART I - RECONSIDERATION AND REVIEW OF DECISIONS

1. Reconsideration and Review of Decisions

Division 85 of the Act deals with the reconsideration and review of decisions. Decisions under the Act where there is a right of review are known as “reviewable decisions” and are listed in section 85-1. Of these, eight decisions relate to the approval of people as care recipients.

ACAT delegates have the power to make five of these decisions and the power to make the other three decisions is delegated to departmental delegates.

The decisions related to approval as care recipients as listed in section 85-1 are:

<table>
<thead>
<tr>
<th>Item</th>
<th>Decision</th>
<th>Provision under which decision is made</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>To reject an application to approve a person as a care recipient</td>
<td>subsection 22-1(2)</td>
</tr>
<tr>
<td>20</td>
<td>To limit a person’s approval as a care recipient</td>
<td>subsection 22-2(1)</td>
</tr>
<tr>
<td>21</td>
<td>To limit a person’s approval as a care recipient to one or more levels of care</td>
<td>subsection 22-2(3)</td>
</tr>
<tr>
<td>22</td>
<td>To vary a limitation on a person’s approval as a care recipient</td>
<td>subsection 22-2(4)</td>
</tr>
<tr>
<td>23</td>
<td>As to when a person urgently needed care and when it was practicable to apply for approval</td>
<td>paragraph 22-5(2)(b)</td>
</tr>
<tr>
<td>24</td>
<td>To extend the period during which an application for approval as a care recipient can be made</td>
<td>subsection 22-5(3)</td>
</tr>
<tr>
<td>25</td>
<td>To reject an application to extend the period during which an application for approval as a care recipient can be made</td>
<td>subsection 22-5(3)</td>
</tr>
<tr>
<td>26</td>
<td>To revoke an approval of a person as a care recipient</td>
<td>subsection 23-4(1)</td>
</tr>
</tbody>
</table>

Items 19-23 are the matters which may be decided by ACAT delegates.
The reconsideration and review process deals with the eight reviewable matters listed above. Complaints about the operation of an ACAT should be forwarded to the state or territory government as the day-to-day managers of the team. Requests from clients, their carers or families to amend the content of Parts 1 to 5 of an ACCR should be dealt with as set out in the ACCR User Guide. Requests from an ACAT to correct an error in completing Part 6 of an ACCR should also follow the procedure set out in the ACCR User Guide which can be accessed on the Department of Health’s website.

2. Types of Reconsiderations

Reconsiderations and reviews of decisions can be initiated in two ways, as set out below.

2.1. Own Motion Reconsiderations

Section 85-4 of the Act allows for the Secretary to reconsider a decision if satisfied that there is sufficient reason to do so. This power is delegated to departmental delegates but not to ACAT delegates. The Department receives information from time to time which provides sufficient reason to undertake a reconsideration of a decision. The options available to the departmental delegate and the requirements to notify the person to whom the decision relates are broadly similar to those for an on Request reconsideration.

2.2. On Request Reconsiderations

Section 85-5 of the Act allows for a person whose interests are affected by a reviewable decision to request the Secretary to reconsider that decision. This power is delegated to departmental delegates but not to ACAT delegates. The template letter notifying a person who has applied for approval as a care recipient of an approval or non-approval includes information about rights under this section.

The reviews process is managed by the NSW State Office of the Department of Social Services. The template letter notifying clients of the outcome of their assessments includes the address for this office. The contact details are also at Appendix 2 of these Guidelines.

3. Appellants

Under section 85-5(1), any person whose interests are affected by a reviewable decision can request for review by writing to the Secretary of the Department of Social Services (the Department) seeking reconsideration of the decision made by the ACAT. A person whose interests are affected includes aged care service providers, as well as potential and current care recipients and their immediate families, carers or legal guardians.

Where a person is under a Guardianship Order, the appointed guardian would have the authority to lodge the request for review, although a family member can also do so if the decision affects his or her interests. The delegate would consider the Guardianship Order in arriving at a decision in such a case.

A service provider can request a review of an ACAT decision about the approved type or level of care. Australian Government subsidies are paid to service providers for the type of care approved and for care provided in accordance with any limits on the approval.

A service provider may also request review of a decision in relation to emergency circumstances if the ACAT decided that a person did not urgently need care when they entered care. A decision that care was not urgently needed determines that the date of effect of approval was the date of approval by an ACAT delegate rather than the day on which care started.
4. The Review Process

Section 85-5 of the Act sets out the process for an “On Request” reconsideration of a reviewable decision.

The request must be made in writing within 28 days of the date on which the person first received written notice of the decision. There is provision for the departmental delegate to allow an extended period for submitting the request. There is no limit on the delegate’s discretion in allowing an extension. The request must include the reasons for the request. It should be sent to the address provided in the letter notifying the person of the approval or non-approval.

Once a request has been received, the decision must be reconsidered. The reconsideration will involve a review of the documentation supporting the original decision and may include a reassessment by another ACAT. Following the reconsideration, the delegate has three options:

- confirm the decision; or
- vary the decision; or
- set aside the decision and substitute a new decision.

The delegate’s choice from these three options is known as the “decision on review.” The decision on review takes effect either on a day specified in the decision on review, or on the day the decision on review is made if no other day is specified.

The person who has requested the review has the right to further review by the Administrative Appeals Tribunal (AAT).

5. The role of ACATs in the Review Process

As part of a reconsideration, a departmental delegate may request that a reassessment of the client be undertaken. This is usually done by an ACAT that was not involved in the original decision. In some circumstances, such as a client living in a remote setting, this is not possible. In this case, a member of the ACAT who was not involved in the original assessment may conduct a reassessment. The reassessing ACAT can consult the original assessors and delegate and as many relevant parties as possible to ensure a comprehensive reassessment is conducted.

The reassessment results in the production of an ACCR which is provided to the departmental delegate. A paper form can be used, or a form printed from the ACAT’s database system. There are several points to note about a reassessment ACCR including:

- The Application for Approval should not be signed by the client. In this case, the client is not applying for approval, since the request for the assessment has been made by the departmental delegate for the purposes of a reconsideration, so it is not appropriate to obtain the client’s signature on the Application.

  However, the informed consent of the client to the reassessment is still required and should be obtained prior to undertaking the reassessment. This will involve explaining the purpose of the reassessment to the client.

- Part 6 of the ACCR (Approval as a Care Recipient) must not be completed and the ACCR must not be submitted to DHS. The information and recommendations on the ACCR are part of the evidence being gathered by the departmental delegate for the purposes of the reconsideration. The decision on review will be made by the departmental delegate. An ACAT delegate has no role to play in this part of the process.
• The reassessment ACCR should include comprehensive information and recommendations, including any recommendations about limitations on approvals for the client. The departmental delegate will not usually be able to participate in a multi-disciplinary case conference with the ACAT, so the ACCR must be as comprehensive as possible. If necessary, additional information can be provided in an attachment or covering letter when the ACCR is sent to the departmental delegate. The ACAT can also recommend the date on which the type and level of care recommended should take effect.

To enable quick resolution of reviewable decisions/appeals, reassessments should be undertaken as soon as possible.

ACATs must ensure that all information used in making approval decisions, including information gathered to support reviews of reviewable decisions is properly maintained and available for review by the Administrative Appeals Tribunal (AAT) if necessary.

6. Advice on the Outcome of the Review

The person who has sought the review will be advised by the departmental delegate in writing of the outcome of the review, and given reasons for the decision. Where appropriate, the departmental delegate will also advise any other relevant parties of the decision. ACATs must not pre-empt the Secretary’s decision by communicating with the applicant, the client or any other party in any way after completing a reassessment.

The notice of the decision on review must include additional information on further review rights available to the applicant.

7. Administrative Appeals Tribunal (AAT)

If the person who has requested a review is dissatisfied with the outcome, an application may be made to the AAT for a further review of the decision.

The ACAT delegate who made the original decision may be required to appear before the AAT.

8. Ombudsman

If people are dissatisfied with the assessment or review and reconsideration process or outcome, they may apply to the relevant state or territory Ombudsman for review.
PART J - RECORD KEEPING

Part J Covers:

Protection of Information
Using Protected Information
Exceptions to the General Prohibition
Additional Exceptions for People Conducting Assessments
Privacy Principle
Retention of the ACCR and Related Information
Commonwealth Requirements
Destruction of Records
State and Territory Requirements

1. Protection of Information

ACATs access and hold a great deal of information about clients and their families as part of the assessment and approval process. The Act has provisions to protect this information.

Section 86-1 of the Act sets out what information is protected.

86-1 Meaning of protected information

In this Part, protected information is information that:

(a) was acquired under or for the purposes of this Act; and
(b) either:
   (i) is personal information; or
   (ii) relates to the affairs of an approved provider; or
   (iii) relates to the affairs of an applicant for approval under Part 2.1; or
   (iv) relates to the affairs of an applicant for a grant under Chapter 5.

The Dictionary in the Act defines personal information as:

personal information means information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

The information about clients and their families which comes into the possession of ACATs meets this definition and is covered by this section of the Act.

2. Using Protected Information

Section 86-2 of the Act deals with the use of protected information. Subsection (1) makes it an offence to do anything with protected information and sets a penalty of 2 years imprisonment for the offence.
Use of protected information

(1) A person is guilty of an offence if:
   (a) the person makes a record of, discloses or otherwise uses information; and
   (b) the information is protected information; and
   (c) the information was acquired by the person in the course of performing duties or exercising powers or functions under this Act.

Penalty: Imprisonment for 2 years.

Note: Chapter 2 of the Criminal Code sets out the general principles of criminal responsibility.

All ACAT staff need to be aware that information they acquire in the course of their work that is personal information may not be recorded, disclosed or otherwise used apart from the exceptions noted below. For instance, clients may not be discussed with the staff member’s family or friends in any way that would allow a client to be identified, written records of ‘interesting cases’ may not be kept by staff members, and cases may not be referenced in public discussion such as in a Letter to the Editor or in social media.

3. Exceptions to the General Prohibition

Subsection (2) sets some very specific exceptions to the general prohibition on the use of the information.

(2) This section does not apply to:
   (a) conduct that is carried out in the performance of a function or duty under this Act or the exercise of a power under, or in relation to, this Act; or
   (b) the disclosure of information only to the person to whom it relates; or
   (c) conduct carried out by an approved provider; or
   (d) conduct that is authorised by the person to whom the information relates; or
   (e) conduct that is otherwise authorised under this or any other Act.

Note: A defendant bears an evidential burden in relation to the matters in subsection (2) (see subsection 13.3(3) of the Criminal Code).

Paragraph (a) allows the ACAT staff to use protected information to carry out their functions and duties and to exercise their delegated powers (if they are delegates) under the Act.

Paragraph (b) allows them to disclose information about the client only to the client, and information about a family member only to the family member. ACATs should note that this subsection does not allow them to disclose information about the client to a family member.

Paragraph (c) does not apply to ACATs.

Paragraph (d) allows ACAT staff to use protected information in ways that have been authorised by the person to whom the information relates. If the client has given permission, this subsection allows the ACAT to disclose information about the client to a family member. If a family member has given permission, it also allows the ACAT to disclose information about the family member to the client.

Paragraph (e) removes any potential conflict between the Act and any other Act which may authorise some other use of information which is protected under the Aged Care Act 1997.
It is important to understand the penalty and the notes which are included in section 86-2. A person who commits the offence which is established by subsection (1) can face a maximum penalty of imprisonment for 2 years. The note attached to this provision makes it clear that this is a criminal offence and a person found guilty of the offence has a criminal record. The note at the end of subsection (2) means that if a person is charged with the offence created by subsection (1), and wishes to use one of the exemptions in subsection (2) as a defence (eg, claim that what they did was authorised by the person to whom the information relates), the defendant has to produce the evidence that proves, on the balance of probabilities, that the person authorised the action.

These are extremely serious matters, which relate to the daily work of all ACAT staff. All staff should exercise extreme caution in handling the personal information of ACAT clients.

4. Additional Exceptions for People Conducting Assessments

Section 86-4 allows some further exceptions for ACAT staff from the general prohibition on the use of protected information.

**86-4 Disclosure of protected information by people conducting assessments**

A person to whom powers under Part 2.3 have been delegated under subsection 96-2(5), or a person making assessments under section 22-4, may make a record of, disclose or otherwise use protected information, relating to a person and acquired in the course of exercising those powers, or making those assessments, for any one or more of the following purposes:

(a) provision of aged care, or other community, health or social services, to the person;
(b) assessing the needs of the person for aged care, or other community, health or social services;
(c) reporting on, and conducting research into, the level of need for, and access to, aged care, or other community, health or social services.

This section specifically authorises ACAT delegates and assessors to make a record of, disclose and use protected information for assessing people for aged care and other services, the provision of those services and for researching and reporting on the need for and use of those services. However, it does not remove the obligations imposed by section 86-2.

5. Privacy Principle

The Privacy Act 1988 also applies to the collection, retention and use of personal information by ACATs. The Privacy Act 1988 makes provision to protect the privacy of individuals and includes a set of Privacy Principles. Currently, Information Privacy Principle 11 deals with the disclosure of personal information, and sets out when an agency may disclose personal information to someone else, for example another agency. This can only be done in special circumstances, such as with the individual’s consent or for some health and safety or law enforcement reasons.
From 12 March 2014, both use and disclosure of personal information will be covered by new Australian Privacy Principle (APP) 6. AAP 6 provides that:

**Limits on disclosure of personal information**

1. A record-keeper who has possession or control of a record that contains personal information shall not disclose the information to a person, body or agency (other than the individual concerned) unless:
   
   - (a) the individual concerned is reasonably likely to have been aware, or made aware under Principle 2, that information of that kind is usually passed to that person, body or agency;
   
   - (b) the individual concerned has consented to the disclosure;
   
   - (c) the record-keeper believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or of another person;
   
   - (d) the disclosure is required or authorised by or under law; or
   
   - (e) the disclosure is reasonably necessary for the enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue.

2. Where personal information is disclosed for the purposes of enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the purpose of the protection of the public revenue, the record-keeper shall include in the record containing that information a note of the disclosure.

3. A person, body or agency to whom personal information is disclosed under clause 1 of this Principle shall not use or disclose the information for a purpose other than the purpose for which the information was given to the person, body or agency.

The Plain English Guide to the Information Privacy Principles explains Principle 11 in this way:

**Principle 11: Limits on disclosure of personal information**

11.1 An agency must not disclose personal information unless:
   
   - (a) the person the information is about has been told in a valid IPP2 notice, or is otherwise likely to know, that that kind of disclosure is commonly made; or
   
   - (b) the person the information is about has consented; or
   
   - (c) the disclosure is necessary to protect against a serious and imminent threat to a person’s life or health; or
   
   - (d) the disclosure is required or authorised by law; or
   
   - (e) the disclosure is reasonably necessary to enforce the criminal law or a law imposing a pecuniary penalty, or to protect the public revenue.

11.2 An agency that discloses personal information under exception 11.1 (e) must note that disclosure on the record containing the information.

11.3 If an agency discloses any personal information the recipient must only use or disclose it for the purpose for which it was disclosed to them.

ACATs must ensure that they only release information which they have appropriate authority to release. In cases where there is any doubt about the release of information, the ACAT member should discuss the situation with the ACAT manager. The ACAT manager may also consult the state or territory government, the Department or obtain legal advice if any doubt remains, before releasing information.
6. Retention of the ACCR and Related Information

The ACCR is the Secretary’s approved form for a person to apply for approval as a recipient of aged care under section 22-3 of the Act. As such, it is a Commonwealth record. Other documents acquired or created by ACAT members when acting as delegates of the Secretary under the Commonwealth Aged Care Act, including when conducting assessments for aged care approval are also Commonwealth records.

Since ACATs are employed by state and territory governments, and are embedded within their local health networks, the documents they acquire or create may also qualify as state or territory government records. This will depend on the specifics of the relevant legislation in each jurisdiction.

From time to time the Department requires a copy of the record of an assessment for a range of purposes such as dealing with a Freedom of Information request or responding to an appeal. ACATs, in consultation with their state or territory government, must provide a copy of this Commonwealth record to the Department when requested to do so. Since processes such as responding to Freedom of Information requests impose strict deadlines, the records must be readily accessible so that they can be provided within those deadlines.

7. Commonwealth Requirements

As a Commonwealth record, the ACCR and all related information are covered by the Commonwealth Archives Act 1983. Under that Act, the National Archives of Australia and the Department have developed Records Authority 2011/00396196, which is available on the National Archives of Australia website. The ACCR and related documents belong to Class No 51170 in that Records Authority. The requirements for this class of documents are set out below.

<table>
<thead>
<tr>
<th>Class No</th>
<th>Description of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>51170</td>
<td>Records, including case files, relating to the recipients of residential care, community care, or flexible care services. Includes:</td>
<td>Destroy 7 years after the care recipient ceases to receive care</td>
</tr>
<tr>
<td></td>
<td>• advice and other forms of information received or provided to aged care recipients, including about recipient care levels. Includes forms providing detailed information about the level of care required by recipients, correspondence, briefs, phone transcripts and visit reports;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• receipt, assessment, processing and approval of applications for subsidies and financial hardship assistance from care recipients;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• expiration, lapsing or revocation of approvals for recipients of aged care services;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• determinations and notifications, including the notification of decisions to recipients of aged care or other services.</td>
<td></td>
</tr>
</tbody>
</table>
Section 24(5) of the *Archives Act 1983* makes it clear that if the information in an electronic record can no longer be retrieved, then the record is deemed to have been destroyed. Consequently, ACATs and their local data storage areas must ensure that records of their assessments in ACAT CMS databases can be accessed for not less than 7 years after the care recipients cease to receive care. Since there have been instances of clients receiving care for periods of well over 20 years since their first assessment, ACAT CMS databases must be available and accessible for 30 or more years.

The storage of electronic records for that period must also meet the requirements of the *Electronic Transactions Act 1999*. For the purposes of the storage of ACAT information, there are five elements of the *Electronic Transactions Act* that should be observed.

Section 12 (1) provides for information that is required to be recorded in writing to be recorded in electronic form, provided that the information “would be readily accessible so as to be useable for subsequent reference.” The *Aged Care Act 1997* requires ACATs to record the signature of an applicant for approval as a care recipient on the Application for Approval on the first page of the ACCR. This section of the *Electronic Transactions Act 1999* makes it acceptable for an ACAT to scan the Application for Approval and store it electronically as part of the client’s record.

Section 12 (2) provides for paper documents that are required to be retained for a period to be retained in an electronic form if:

- the method of generating the electronic form of the document provides a reliable means of maintaining the integrity of the information in the document; and
- the information “would be readily accessible so as to be useable for subsequent reference.”

This makes it acceptable for ACATs to meet the requirements of Records Authority 2011/00396196 for paper documents by retaining them electronically for a period of 7 years after the care recipient ceases to receive care.

Section 12 (4) provides for electronic communications that are required to be retained for a period to be retained in an electronic form if:

- the information “would be readily accessible so as to be useable for subsequent reference”; and
- the method of retaining the information in an electronic form provides a reliable means of maintaining the integrity of the information; and
- additional information about the origin and destination of the communication, and the time the communication was sent and received must also be retained; and
- the additional information “would [also] be readily accessible so as to be useable for subsequent reference.”

This allows for emails to be stored as emails in an electronic form for a period of 7 years after the care recipient ceases to receive care.

Section 11 (1) provides for a document that is required to be produced, to be produced in an electronic form by means of an electronic communication if:

- the method of generating the electronic form of the document provides a reliable means of maintaining the integrity of the information in the document; and
- the information “would be readily accessible so as to be useable for subsequent reference.”

This makes it acceptable for ACATs to provide electronic versions of assessment records by email when they are required to provide those records.
Where the Electronic Transactions Act refers to maintaining the integrity of a document or the integrity of the information contained in a document, it includes a statement that the integrity is maintained:

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“if, and only if, the information has remained complete and unaltered, apart from:
  (a) the addition of any endorsement; or
  (b) any immaterial change;
which arises in the normal course of communication, storage or display.”
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8. **Destruction of Records**

The destruction of paper records must be by secure waste bins, through a T4 accredited waste management agency. Further information about T4 accreditation can be obtained from the Australian Security Intelligence Organisation website. Briefly, the process uses the shredding method for destruction before sending material away to be pulped and used for recycling goods. ACATs must also maintain a spreadsheet or some other means of identifying what has been destroyed, and provide a copy to the Department on an annual basis.

The destruction of electronic records requires the deletion of all copies of the record from any system which stores the record in such a way that it is impossible to restore the record. This destruction should be included in the spreadsheet which identifies what has been destroyed.

9. **State and Territory Requirements**

If a record of an assessment is a state or territory record as well as being a Commonwealth record, there may be other requirements to retain and store the information under local legislation. ACATs should seek advice from their state or territory government on any local requirements and meet all the requirements set by both levels of government.
APPENDIX 1 - THE AGED CARE ACT 1997 AND THE AGED CARE PRINCIPLES

The Aged Care Act 1997 (the Act) is the legislative basis for the Australian system of aged care. Australian Government subsidised aged care is provided under the Act as either residential, Homecare, or flexible care.

The Act also enables the Minister to make Principles required or permitted under the Act, or necessary or convenient to carry out or give effect to Parts or sections of the Act. (See section 96-1 of the Act)

These Guidelines include a number of quotations from the Act and the Principles. Although the quotations were correct at the time of drafting the Guidelines, the Act and the Principles can be amended by the Parliament and the Minister respectively. Current versions of the Act and the Principles can always be accessed through the ComLaw website maintained by the Office of Parliamentary Counsel.

The Act is available under “Acts” and is simply called the Aged Care Act 1997. The Aged Care Principles are available under “Legislative Instruments”. However, they must be accessed under their individual names. The following is a list of the Aged Care Principles:

Accountability Principles 1998
Accreditation Grant Principles 2011 (until January 2014)
Advocacy Grant Principles 1997 (until January 2014)
Allocation Principles 1997
Approval of Care Recipients Principles 1997
Approved Provider Principles 1997
Certification Principles 1997
Classification Principles 1997
Community Visitors Grant Principles 1997 (until January 2014)
Complaints Principles 2011
Extra Service Principles 1997
Fees and Payments Principles 2013 (until January 2014)
Flexible Care Subsidy Principles 1997 (until January 2014)
Home Care Subsidy Principles 2013 (until January 2014)
Information Principles 1997
Quality of Care Principles 1997
Quality Agency Reporting Principles 2013 (until January 2014)
Records Principles 1997
Residential Care Grant Principles 1997
Residential Care Subsidy Principles 1997
Sanctions Principles 1997
User Rights Principles 1997
APPENDIX 2 - DEPARTMENT OF SOCIAL SERVICES
CONTACT DETAILS

Central Office
Freecall 1800 020 103
Switchboard (02) 6289 1555
Department of Social Services
GPO Box 9848
Canberra ACT 2601

acats@health.gov.au

New South Wales State Office
Freecall 1800 048 998
Switchboard (02) 9263 3555
Department of Social Services
GPO Box 9848
Sydney NSW 2001
APPENDIX 3 - DEPARTMENT OF HUMAN SERVICES CONTACT DETAILS

- Aged Care Online Claiming helpdesk 1800 195 206
- agedcare.support@humanservices.gov.au
## GLOSSARY

<table>
<thead>
<tr>
<th>Item</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>AAT</td>
<td>Administrative Appeals Tribunal. The AAT is an independent body that a person may seek review from if they do not agree with certain decisions that have been made about them by an Australian Government Agency. The AAT can only review a decision where it has been given has jurisdiction to do so under relevant Commonwealth legislation. Section 85-8 of the <em>Aged Care Act 1997</em> (<em>the Act</em>) gives the AAT the jurisdiction to review reviewable decisions under the Act that have been the subject of a reconsideration by the Secretary under sections 85-4 or 85-5 of the Act.</td>
</tr>
<tr>
<td>ACAP</td>
<td>Aged Care Assessment Program</td>
</tr>
<tr>
<td>ACAP MDS V2</td>
<td>Aged Care Assessment Program National Minimum Data Set Version 2. The MDS is an important source of information for the ACAP and the aged care system generally. It contains data on assessments by ACATs, as set out in the ACAP Data Dictionary.</td>
</tr>
<tr>
<td>ACAS</td>
<td>Aged Care Assessment Service (ACATs are known as ACASs in Victoria).</td>
</tr>
<tr>
<td>ACAT(s)</td>
<td>Aged Care Assessment Team(s)</td>
</tr>
<tr>
<td>ACCR</td>
<td>Aged Care Client Record The ACCR is the Secretary’s approved form for a person to apply to be approved as a recipient of aged care under section 22-3(3) of the Act.</td>
</tr>
<tr>
<td>ACFI</td>
<td>Aged Care Funding Instrument. The ACFI is used by residential aged care approved providers to make an appraisal of a client’s care needs. The result of the appraisal determines the level of funding for providing care to the client.</td>
</tr>
<tr>
<td>AGED CARE ACT 1997 (<em>the Act</em>)</td>
<td>The principal legislation that regulates the aged care program. The Act covers residential aged care, flexible care and home care. The Act does not cover Home and Community Care (HACC) services, Carers Allowance and aged care services that are administered under State or Territory legislation (such as Retirement Villages).</td>
</tr>
<tr>
<td>AGED CARE COMPLAINTS SCHEME</td>
<td>The Aged Care Complaints Scheme provides a free service for people to raise their concerns about the quality of care or services being delivered to people receiving aged care services subsidised by the Australian Government, including residential home and flexible aged care as well as Commonwealth funded HACC.</td>
</tr>
<tr>
<td>AGED CARE INNOVATIVE POOL</td>
<td>The Aged Care Innovative Pool of flexible care places was established in 2001-02 to enable the provision of aged care services via new models of partnerships and collaboration with stakeholders, including state and territory governments and approved providers.</td>
</tr>
<tr>
<td>APPROVED PROVIDER</td>
<td>A person or body approved by the Secretary of the Department of Social Services under Part 2.1 of the Act to operate Australian Government subsidised aged care services. In these Guidelines and in the Home Care packages program Guidelines, the term ‘home care provider’ is generally used to refer to the ‘approved provider’ – the corporation that has been approved by the Department of Social Services under part 2.1 of the Act as suitable to prove home care.</td>
</tr>
<tr>
<td>CACP</td>
<td>Community Aged Care Package CACPs were individually planned and coordinated packages of care, designed to meet older people’s daily care needs in the community. On 1 August 2013 these packages transitioned to Home care level 2 packages.</td>
</tr>
<tr>
<td>CARE RECIPIENT</td>
<td>A person approved by an ACAT as having significant care needs which could be met through the provision of residential care, Home care and/or flexible care.</td>
</tr>
<tr>
<td>CARER</td>
<td>A person, who may also be a family member, next of kin, friend or neighbour, who has been identified as providing regular and sustained care and assistance to a person without payment other than a pension or benefit.</td>
</tr>
<tr>
<td>CENTRAL OFFICE</td>
<td>The office of the Department of Social Services in Canberra where the Aged Care Assessment Program is managed and administered nationally.</td>
</tr>
<tr>
<td>DEPARTMENT</td>
<td>The Department of Social Services</td>
</tr>
<tr>
<td>DHS</td>
<td>The Department of Human Services. DHS receives information about approved care recipients from ACATs and makes payments to approved aged care service providers, including home care providers for the care they provide to those care recipients.</td>
</tr>
<tr>
<td>Item</td>
<td>Meaning</td>
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<td>--------------------------</td>
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</tr>
<tr>
<td>EACH</td>
<td>Extended Aged Care at Home (EACH) packages. These were individually planned and coordinated packages of care, designed to meet older people’s daily care needs in the community. On 1 August 2013, these packages become Home Care level 4 packages.</td>
</tr>
<tr>
<td>EACH – DEMENTIA</td>
<td>Extended Aged Care at Home Dementia packages. These were individually planned and co-ordinated packages of care, designed to assist frail older people with dementia and behaviours of concern associated with their dementia, who require management of behaviours and services, because of their complex needs. On 1 August 2013, these packages become Home Care level 4 packages.</td>
</tr>
<tr>
<td>FLEXIBLE CARE</td>
<td>Under the Act, one of three care types, the other being home care and residential care. Flexible care includes Multi Purpose Services and Transition Care. Note, EACH and EACHD packages were formerly known as flexible care before the legislative amendments, effective 1 August 2013.</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GUARDIAN</td>
<td>A person appointed under state or territory legislation to have guardianship of another person’s affairs.</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care. A program of basic maintenance and support services to prevent premature admission to residential care. Services include home nursing, home help, respite care and assistance with meals and transport. Access to HACC services is on the basis of relative care need and the availability of services. ACAT assessment and approval is not required to access HACC.</td>
</tr>
<tr>
<td>Home Care Package Program</td>
<td>The Home Care Packages Program commenced on 1 August 2013, replacing the former community and flexible packaged care programs – Community Aged Care Packages (CACPs) Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACHD) packages. There are now four levels of Home Care packages.</td>
</tr>
<tr>
<td>IPPs</td>
<td>Information Privacy Principles under the Privacy Act 1988</td>
</tr>
<tr>
<td>MINISTER</td>
<td>The Australian Government Minister for Social Services</td>
</tr>
<tr>
<td>MPS</td>
<td>Multi Purpose Service. MPSs are a form of flexible care. The requirements of what constitutes an MPS are contained within section 15.14 of the Flexible Care Subsidy Principles 1997 and include the requirement for MPSs to provide an integrated service that includes residential care and at least one other health or aged care service. The primary objective of MPS is to provide a more flexible, coordinated and cost effective framework for service delivery by pooling State and Australian Government funds for health and aged care services, particularly in rural and remote areas.</td>
</tr>
<tr>
<td>NTFF</td>
<td>National Transaction File Format. The NTFF sets out the requirements for the ACAP data which state and territory governments provide to the Department.</td>
</tr>
</tbody>
</table>
| OLDER PERSON             | 1 Under the Act, there is no definition of an older person or an aged person.  
2 For the purposes of service planning, an older person is someone who is 70 years of age or older, or an indigenous Australian who is 50 years of age or older |
<p>| PLACE                    | A place is the capacity within an aged care service for the provision of one of the three types of aged care for which subsidy is payable under the Act.                                                     |
| RESIDENT                 | A person who has been assessed by an Aged Care Assessment Team as requiring residential care and who resides in an Australian Government funded aged care facility.                        |
| RESIDENTIAL CARE         | Under the Act, one of three care types, the others being flexible care and home care. Residential Care is provided to a person in an aged care facility in which the person is also provided with accommodation that includes appropriate staffing, meals, cleaning services, furnishings and equipment, for the provision of that care and accommodation. |
| RESPITE CARE             | Care given as an alternative care arrangement with the primary purpose of giving the carer or a care recipient a short term break from their usual care arrangement.                               |
| SECRETARY                | The person filling, or temporarily filling, the position of Secretary to the Department of Social Services.                                                                                           |
| PEOPLE WITH SPECIAL      | A group of people that may experience unequal access to services on the basis of their... |</p>
<table>
<thead>
<tr>
<th>Item</th>
<th>Meaning</th>
</tr>
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<tbody>
<tr>
<td>NEEDS</td>
<td>circumstances. People with special needs are identified in the Act and the Principles.</td>
</tr>
<tr>
<td>STATE OFFICE</td>
<td>A state or territory office of the Department of Social Services.</td>
</tr>
<tr>
<td>SUBSIDY</td>
<td>Australian Government funding paid to an approved provider of aged care to subsidise the provision of care in an Australian Government funded aged care place. Providers are paid subsidy for each approved care recipient cared for during the claim period.</td>
</tr>
<tr>
<td>TRANSITION CARE PROGRAM</td>
<td>Transition Care is a form of flexible care that is legislated by the Act and the Principles. Transition care is provided at the conclusion of an in-patient hospital episode. It provides a range of services that includes low intensity therapy (such as physiotherapy, occupational therapy and social work) and either nursing support and/or personal care. Transition Care is goal-oriented, time-limited, therapy-focused and targeted towards older people. It helps older people complete their restorative process; optimise their functional capacity, while assisting them and their family or carer to make long-term care arrangements.</td>
</tr>
</tbody>
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