

Home and Community Care

schedule of co-contribution/charges

Effective Jan 1 2022



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service type** | **LOW co-contribution**  **HACC / CHSP &**  **Medicare gap payment** | **MEDIUM co-contribution** | **FULL COST RECOVERY**  **Home Care Packages**  **Contracted Services-add GST** | **NDIS Charges** |
| Planned Activity Group  Social Support and Community Participation  Allied Health Groups | $8.00 per day – including outings  $5.50 half day (no meal)  (plus cost of meal/transport if from another source)  $8.00 per group | As for low fee range | $24.00  (per hour plus cost of meal/transport if from another source) | Ratio 1:5  $19.07  (per hour plus cost of meal/transport if from another source) |
| Allied Health Services:  Dietetics  Occupational Therapy  Diabetes Education  Podiatry Physiotherapy Speech Therapy  Nail Care | $10.20 per visit  (plus consumables/dressing)  Paediatric services FREE  Health Coach sessions and groups/DVA clients - no co-payment | $15.70 per visit | $120.00 per hour/pro rata  Including travel time of clinician | $193.99 per hour /pro rata  Including travel time  of clinician if more than 10 km |
| Rehabilitation Services /  Restorative Care | No Co-Payment | No Co-Payment | N/A | N/A |
| Counselling services | FREE | FREE | $120.00 per hour | $193.99 per hour |
| Nursing (including district) | $3.90 per visit  (plus consumables/  dressings) | $34.60 per hour | $120.00 per hour | $124.05 |
| Continence Nursing Assessment and advice | $10.20 per visit | N/A | N/A | $124.05 |

* Those identifying as ATSI will not incur a co-payment charge and will be hi priority
* Co-Payment will be waived to ensure this is not a barrier to receive services
* Did Not Arrive/Cancellation within 24 hours- 50% applicable full cost recovery hourly rate for NDIS/Home Care Packages/Contracted Services
* Full cost recovery rate is charged for contracted services/Home Care Packages/ Training
* NDIS charged in accordance with NDIS pricing schedule
* Clinician Travel Time is charged at the Full Cost Recovery Rate for contracted services/HCPackages
* Travel kms may be charged at the ATO rate if more than 10km
* DVA/Workcover/TAC are charged according to their prescribed rates (referred privately)

**INCOME SELF-DECLARATION FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the appropriate box to indicate your gross income level bracket.

\*Child – FREE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Low (HCC/Pension) | Medium | | High |
| Individual | < $38,157 | > $38,157 | < $83,487 | > $83,487 |
| Couple | < $58,438 | > $58,438 | < $111,608 | > $111,608 |
| Family (1 Child) | < $64,644 | > $64,644 | < $114,804 | > $114,804 |
|  | (plus $6,195 per additional child) | | | |

Co-payment fees will be capped each month

Nursing – 13 visits

Allied Health – 5 visits

*\*If experiencing financial difficulty, please speak to a staff member*

*regarding a fee waiver*

**✂………….…………………………………………………………………………………………**

**FEE WAIVER FORM**

To be completed by Colac Area Health to exempt a client from the Government prescribed co-payment. This declaration should be reviewed at appropriate time intervals to determine if circumstances have changed.

|  |
| --- |
| **Client is seeking exemption from the co-payment fee due to current financial difficulties** |
| **Details of waiver:** |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Clinician Name** |  | | | |
| **Client Signature** |  | | **Date** |  |
| **Coordinator/Clinician’s Signature** |  | | **Date** |  |
| **Provide to Reception/Ward Clerk** | | ***TRAK episode to be updated re: No Charge*** | | |