Residential Payments

A guide for administrators
of residential facilities

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Contents

Introduction

This booklet is designed to assist administrators of residential facilities. It outlines the role of the Ministry of Health in the payments process, and includes explanations of the terminology used. It provides examples of paperwork Ministry of Health (Sector Support) requires from facilities before it can make payments, and gives information on the interactions necessary with agencies such as the Ministry of Social Development.

The Role of Ministry of Health (Sector Support) in the Health and Disability Sector

The Ministry of Health and the 21 District Health Boards are responsible for managing New Zealand's health outcomes. This involves contracting many external organisations and individuals to provide services. Ministry of Health (Sector Support) acts as agent between the Ministry of Health and the District Health Boards and these contractors, and administers agreements in accordance with the instructions it receives.

Ministry of Health (Sector Support) provides services to the health sector which include:

- payments to health providers for contracted services
- the establishment and administration of health provider agreements on behalf of health funders
- clinical data collection from health provider claims
- contact centres for claimants, providers and the general public
- the provision of information relating to payment and other health data
- patient eligibility administration
- payments directly to claimants for national travel assistance and carer support.

Ministry of Health (Sector Support)'s two core business functions are as follows.

- **Agreements** – Ministry of Health (Sector Support's) agreements teams process requests from the Ministry of Health and the District Health Boards for all manner of health-related services to be contracted, including (but not limited to):
  - primary health care
  - initiatives for mental health, sexual health and Māori health
  - midwives and general practitioners
  - testing and screening
  - pharmacies and immunisation
  - home-based support, personal care and household management
  - day care, respite care and day activity
  - drug and alcohol rehabilitation
  - community residential rehabilitation and supported accommodation
  - age-related residential care
  - research and development.
- **Payments** – Ministry of Health (Sector Support)'s payment teams make payment against invoices, claims and proposed payment schedules. These are submitted by contracted providers for services in accordance with their agreements. Ministry of Health (Sector Support) does not determine business rules, but incorporates such rules in payment processes.

Notification of Needs Assessment and Service Co-ordinations Forms

District Health Board funded clients

Aged care

Ministry of Health (Sector Support) requires a Notification of Needs Assessment and Service Co-ordination form before it makes any payments for a service user. There must be an active contract in the Client Claims Processing System for the needs assessment information to be entered.

The preferred assessment form for this is the 'NS1004'. This generic four-page form is supplied by the Ministry of Health (Sector Support) to the Needs Assessment Service Co-ordination Organisations for their completion.

Transfer to the same level of care

When a service user is transferring to a different facility where they will receive the same service type/level of care, a Change of Client Details/Residential Care Transfer ('CD1103') form should be used. This form replaces the need for a complete re assessment.

Mental health

The two-page form 'NS0702' is used as a Notification of Needs Assessment and Service Co-ordination form for service users entering residential facilities for the purpose of receiving mental health services.

Electronic loads

Some Needs Assessment Service Co-ordination organisations submit their Notification of Needs Assessment and Service Co-ordination form as part of an electronic load. In these instances, a paper form is not required.

Requirements

All needs assessment forms are checked against certain criteria, which include accuracy and completeness. The following information is compulsory in each form:

- surname and first name (no nicknames)
- National Health Index (NHI) number
- date of service coordination and needs assessment
- funding stream
- service type/level of care
- service start date
- facility/service provider name and address
- a selected primary disability

- ethnicity
- marital status.

Each assessment form **must** be authorised and dated by the relevant assessor.

Non-standard forms cannot be accepted by Ministry of Health (Sector Support). Forms not filled out correctly will be returned to the Needs Assessment Service Co-ordination Organisation for amendment. This is an audit requirement.

Ministry of Health funded clients

Socrates

Service co-ordinations for Ministry of Health funded service users are submitted by Needs Assessment Service Co-ordination organisations as part of an electronic load from a national Needs Assessment Service Co-ordination information system called Socrates. This information relies on active contracts being available in the Client Claims Processing system.

Manual Needs Assessment

The Notification of Needs Assessment and Service Co-ordination form must be completed by the needs assessor in the facility's region. For example, a facility in Tauranga must have its forms completed by an assessor from the needs assessment support co-ordination agency contracted by the funder for Tauranga. Ministry of Health (Sector Support) takes this as proof that the funder has authorised the payment.

Funding Streams and Agreements

The age of a service user does not solely determine the source and type of funding.

A service user's primary impairment or disability determines:

- whether the service user's care can be funded under an agreement with the Ministry of Health or with a District Health Board
- with whom the funder (through the agent) will co-ordinate a package of care
- the type of subsidy the service user may be entitled to, as set out in the table below.

Disability types and their funding streams		
Disability or impairment type	**Funding stream (funder and contractor of Needs Assessment and Service Co-ordination agency)**	**Subsidy type**
Age-related (50–64 and over 65)	District Health Board	Residential care subsidy or top-up subsidy
Mental health/ psychiatric	District Health Board	Residential support subsidy (top-up subsidy cannot apply)
Cognitive/ intellectual/ neurological/ physical/ sensory	Ministry of Health	Residential Support Subsidy (top-up subsidy cannot apply). Ministry of Health default contribution may apply[1]

Providers must be contracted by either a District Health Board or the Ministry of Health, or Ministry of Health (Sector Support) cannot process payments.

[1] Please refer to page 9 for more information about this subsidy.

Work & Income

The payments process for residential services begins with receipt of a Notification of Needs Assessment and Service Co-ordination[2] form from a regional needs assessment service co-ordination organisation.

If a service user is receiving a benefit through Work & Income they must contribute a portion of their benefit towards the cost of their care. The funder pays the difference between the contract rate and the amount the client contributes. The client contribution can be comprised of a Work & Income benefit and a private income.

Each year, benefits, pensions and other allowances paid through Work & Income are reviewed. This may alter a service user's benefit contribution. Ministry of Health (Sector Support) is notified of the outcome of the review prior to 1 April every year. Benefit rates can be found on the Work & Income website at www.workandincome.govt.nz/individuals/a-z-benefits/index.html

[2] Please refer to page 3 for more information on notification of needs assessments.

Types of Residential Subsidies

Service users who have been assessed as requiring long-term supported accommodation due to an illness or a disability may be eligible for one of three subsidies:

- a residential care subsidy (or residential care loan)
- a top-up subsidy
- a residential support subsidy.

A service user's primary disability determines the subsidy he or she is eligible for (refer to the *Funding Streams and Agreements* section).

Types of residential subsidy

Primary disability	
Age-related	**Residential care subsidy** **Residential care loan** **Top up subsidy** Service users with an age-related disability group are subject to a financial means assessment. Service users who have not yet passed an income and asset test or decline to have one are liable for their care costs. There is a statutorily defined maximum contribution from service users for contracted care services.
Intellectual Neurological Physical Psychiatric Sensory Mental health Other non-aged	**Residential support subsidy** Service users in this group are not income and asset tested, but need to contribute towards the cost of their care from any benefit they may be receiving. A certain proportion of their benefit is generally paid directly to the provider, with the service user's consent.

The residential care subsidy

Most service users whose primary disabilities are considered to be age-related are over the age of 65. Needs assessors determine whether a service user is eligible to receive long-term age-related care and, if so, completes the top portion of a Residential Care Subsidy Financial Means Assessment Application form. They then send the form to Work & Income, which is responsible for determining whether a service user is financially eligible for the residential care subsidy. If a service user passes the appropriate financial means assessment then the funding District Health Board is liable for the cost of their contracted care services, less the amount that Work & Income determine the service user is required to contribute. Until the means assessment process is complete, the service user is responsible for the full cost of their care and is classed as a 'private payer'.

Work & Income notifies the Ministry of Health (Sector Support) of a service user's eligibility for the residential care subsidy by letter. An example of such a letter can be found in Appendix 1.

A service user who has been assessed as requiring long-term age-related care and is not financially eligible for the residential care subsidy is responsible for the cost of their contracted care, up to the maximum contribution set by a facility's territorial local authority. If the contracted rate is more than the maximum contribution, the service user is eligible for a top-up subsidy from the funding District Health Board.

There are date restrictions which state that Ministry of Health (Sector Services) is only mandated to pay the facility for a certain period of time prior to the Means Assessment date (up to 90 days of a service user's residential care prior to a financial means assessment application being received by Work & Income (sections 141 (4) and 147(4) of the Social Security Act 1964). If service user or their family does not apply to Work & Income for a financial means assessment within this time, they are deemed to be a private payer and are responsible for costs incurred outside the 90-day period.

Service users may agree to pay for additional services (those that are not contracted care services set out in the District Health Board/provider agreement) this is a private agreement between the service user and the provider. These should be set out in the admission agreement between the service user and the provider.

Residential care loan

If a service user over the age of 65 is not financially eligible to receive the residential care subsidy they may be eligible for a residential care loan. Please refer to page 13 for more information about residential care loans.

Residents aged between 50 and 64

This particular group of service users requiring age-related care is small, but continues to grow. Single people with no dependent children in this group who have been assessed as requiring long-term age-related care are eligible to receive the residential care subsidy. The needs assessors complete the top portion of the Residential Care Subsidy Financial Means Assessment form. They automatically meet the asset test, and Work & Income completes a means assessment of their income to determine how much they must contribute towards the cost of their contracted care services.

People in this group who are married or in a civil union, or have dependent children, are not required to undergo a financial means assessment. The District Health Board will pay for the full contracted cost of their care services.

Residential support subsidy

If a service user's disability is not age-related, the service user is entitled to access the residential support subsidy. There is no asset or income test associated with this subsidy. If a person is receiving Work & Income assistance they are required to contribute a portion of their benefit directly to the provider. Work & Income can pay this

directly to the provider, with the service user's consent. (If the service user does not consent, they are responsible for paying the provider themselves.)

The Ministry of Health (Sector Support) receives information on individual service users' benefit contributions on a weekly spreadsheet Work & Income sends to them.

Top-up subsidy

If a service user in age-related care has been declined or chooses not to apply for the residential care subsidy through a financial means assessment, the service user is then required to pay the lesser of either the cost of contracted care services or the maximum contribution set by the facility's territorial local authority. If the actual cost of the service user's contracted care services is more than the maximum contribution, the service user is eligible for the top-up subsidy through the funding District Health Board.

The client may also choose to pay privately for additional services as part of their admission agreement with the provider.

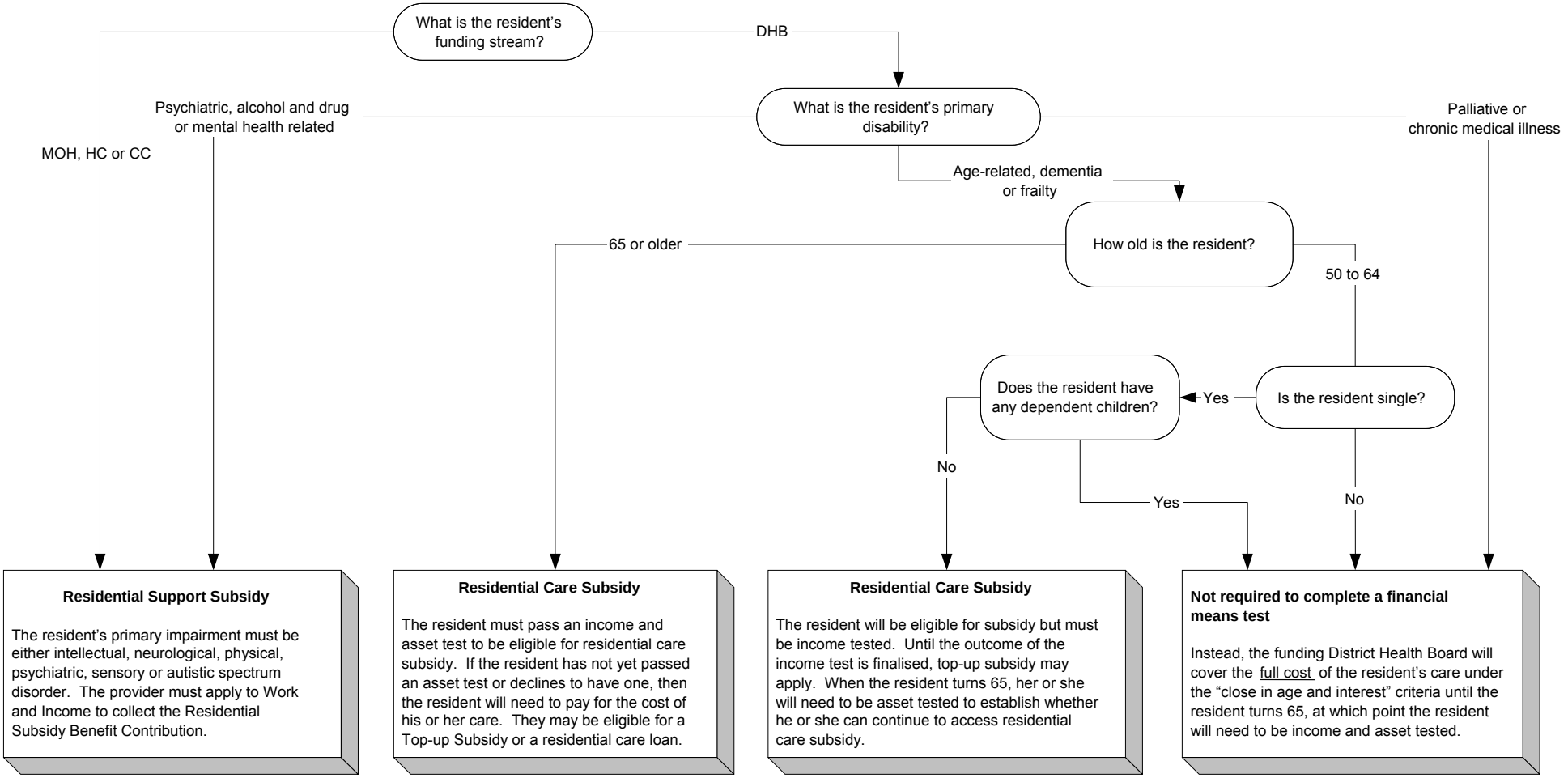
Ministry of Health default contribution

Only Ministry of Health-funded service users are eligible for the Ministry of Health default contribution. This subsidy is applied when an eligibility is received through Socrates for a service user entering a residential care facility whose contract rate requires client contribution (contract will stipulate whether the contract rate is inclusive or exclusive of client contribution), and the service user's benefit contribution has not yet been received by Ministry of Health (Sector Support). The default contribution allows payment to be made without delay. Payments for service users receiving this subsidy will be adjusted accordingly once Ministry of Health (Sector Support) receives the service user's benefit contribution information.

Close in age and interest

This funding stream is determined by the Needs Assessment Service Co-ordination organisation.

Determining a resident's subsidy type



Residential Care Loans

If an aged care service user over the age of 65 does not pass the asset test to qualify for a subsidy and does not have enough cash assets to be able to pay for either the cost of their contracted care services or for the maximum contribution set by the facility's territorial local authority, they may be eligible for an interest-free residential care loan. Eligibility for this is assessed by the Ministry of Social Development.

The loan is secured by a caveat over a service user's house and becomes payable back to the government when the service user dies, the house is sold or the service user is reassessed by the Ministry of Social Development and becomes eligible for a subsidy. If the service user becomes subsidised, then the loan ends. It is possible for qualifying service users to defer their loan to a family member.

For more information about the residential care loan scheme, see the Work & Income website at www.workandincome.govt.nz/individuals/a-z-benefits/residential-care-loan.html or phone Work & Income's Residential Care Subsidy unit on 0800 999 727.

The residential care loan scheme policy statement can be found on the Ministry of Health website at www.moh.govt.nz/assettesting.

All applicable asset thresholds increase by $10,000 on 1 July each year (until 30 June 2026, when the system may be reviewed).

A provider notifies Ministry of Health (Sector Support) of a service user's eligibility for a residential care loan through the form Advice of New Residential Care Loan ('RSU8'). An example of this form can be found in Appendix 1.

Privately Paying Service Users

Any service user who has been assessed as requiring an age-related residential care service in a District Health Board contracted facility is eligible for a top-up subsidy. Ministry of Health-funded service users do not qualify for a top-up subsidy.

Under section 152 of the Social Security Act 1964, the Director-General of Health is required to gazette the maximum contribution for service users of long-term age-related residential care that applies in each region.

This is the maximum weekly amount (inclusive of GST) that a service user is required to pay for contracted care services in the region of their rest home or continuing care hospital.

The maximum contribution is equivalent to the most recent nationally agreed rest home contract price applying to residential care facilities in each territorial local authority. It is the same for all aged-care service users, regardless of the type of contracted care services they receive.

A new maximum contribution only applies when gazetted. New maximum contributions will reflect changes to rest home contract prices that usually result from the annual review of residential care contracts between District Health Boards and residential care providers.

Current maximum contribution amounts and further information about income and asset testing can be found on the Ministry of Health website at www.moh.govt.nz/assettesting.

Proposed Payment Schedules

Each contracted facility will receive a proposed payment schedule and a comments sheet each payment period. (If you do not receive one, please call the Ministry of Health Contact Centre on 0800 281 222.) When you receive your proposed payment schedule, please check the information on it is correct.

Please do not write comments on the proposed payment schedule: all comments must be on the accompanying comments sheet. If you have more than one level of care facility (for example a rest home, a dementia unit and a hospital unit) use a separate comment sheet for each facility.

Use the comments sheet to list the date of arrival of any new service users and any changes to an existing service user's circumstances affecting payments. List all necessary dates and reasons. Examples of relevant changes in circumstances include:

- transfer to another facility (specify)
- transfer to a different level of care
- discharge to own home
- death
- temporary absence to public hospital
- temporary absence for holiday.

Changes to a proposed payment schedule cannot be made through a phone call. All changes must be noted on the proposed payment schedule comments sheet. This is an audit requirement.

Ministry of Health (Sector Support) must receive your proposed payment schedule at least five working days prior to payment. The due date is noted on the top left-hand corner of the proposed payment schedule. If the proposed payment schedule is not received by the due date, you will have to wait a further 10 working days for payment, as set out in the payment clause in your contract (clause B4.3). The Ministry of Health Contact Centre can confirm receipt of the proposed payment schedule.

Public Hospital – Ministry of Health (Sector Support) will automatically stop payment once a service user has exceeded the number of days allocated for a hospital stay, unless it is notified of a return date prior to the allocation being exceeded. (Please refer to your contract for further information on the number of days allocated for a hospital stay.) The same process applies for temporary absences for holidays. It is important that Ministry of Health (Sector Support) knows of the start and end dates for any temporary absence. If necessary, you can request an extension of subsidised funding for a service user's temporary absence from the funder, according to the terms and conditions within your contract. If granted, to the funder must advise Ministry of Health (Sector Support) in writing.

If the proposed payment schedule is not signed, it will not be processed for payment. Please include your phone number, fax number and email address on the comments sheet so that Ministry of Health (Sector Support) can keep the database up to date.

If the person who normally checks and returns the proposed payment schedule is absent, there are two options.

- You can arrange for someone else with the appropriate authority to return the proposed payment schedule with relevant changes.
- Ministry of Health (Sector Support) can process your proposed payment schedule without changes, providing it receives a signed letter requesting this prior to the person's absence. At a later date the usual administrator can send in changes that need to be made.

Sample comments sheet

Family name	First name	Date of birth	National Health Index (NHI) number	Start date	Finish date	Reason
Smith	John	8/1/1920	AAA1111	1/1/2008		Admitted
Smith	John	8/1/1920	AAA1111		4/5/2008	Deceased
Brown	David	1/1/1930	BBB1111	3/4/2008		Transfer to public hospital
Brown	David	1/1/1930	BBB1111		9/6/2008	Returned from public hospital
Wright	Anne	3/5/1925	CCC1111		4/3/2008	Transfer to our hospital level
Donald	Harry	14/3/1920	DDD1111		1/7/2008	Transfer to ABC rest home
Harper	Nancy	20/2/1935	EEE1111		5/8/2008	Discharge to own home

Notice of all absences

Under your contract all dates for absences from facilities must be recorded on the proposed payment schedule comments sheet. Record dates as follows.

Death	Actual date of death – not the day after
Transfer home	Date service user returned to the community
Discharge to public hospital	Date service user was discharged to public hospital
Temporary stay at public hospital	Date service user went to public hospital and date returned

Transfer to other facilities	Date service user left existing facility (specify where they are going)
Holiday	Date service user left for holiday, and return date
Miscellaneous absences	Start date, with a brief explanation of what the absence was for and expected return date

All absences must be reported promptly to Ministry of Health (Sector Support).

Please refer to your contract for day/s after death payments for service users.

Comments to be made by providers on proposed payment schedule comment sheet

Standard comment	Definition
Contribution changed to (new amount) from (date)	Contribution details as stated on the proposed payment schedule have changed. Please specify what the service user's new contribution rate is and what date their contribution changed. Attach a copy of the Ministry of Social Development letter.
New Needs Assessment and Service Co-ordination Agency form from (details, date)	Level of care as stated on the proposed payment schedule has changed. Please specify the date on which the new level of care commenced and brief details of the new assessment.
Permanent transfer to (facility) on (date)	A service user has been transferred to another facility and is not expected to return. Specify the name of the new facility and the date that the service user was transferred.
Temporary transfer to (facility/ hospital or other residence) from (date) to (date)	A service user has been transferred to another facility/hospital or other residence, but is expected to return. Specify the date the service user was transferred and the date they are expected to return.
Deceased (date)	A service user is now deceased. Specify the date of death.
Admitted on (date)	A new service user has been admitted to the facility. Specify the date of admission. (This does not include service users returning from a temporary absence.) Please supply NHI numbers and dates of birth.

Checklist for completing the proposed payment schedule

- Make a buyer created tax invoice for the last payment and proposed payment schedule received.
- Check that all service users are still in your facility.
- Check for deaths/transfers/absences.
- Sign the proposed payment schedule.
- Make any comments on the comments sheet (one per proposed payment schedule).
- Write your contact details (name, phone number and so on) on the comment sheet.
- Sign the comment sheet.
- Return to Ministry of Health (Sector Support) by the due date.

Returning the proposed payment schedule

There are several options available for returning the proposed payment schedule. If you have access to a scanner, email is the most time-effective way to return your paperwork to us. Please include 'Proposed Payment Schedule' in the subject field. When emailed, an auto-reply will confirm receipt. There is a separate email address for each region, as follows:

- Northern region: northernpayments@moh.govt.nz
- Midland region: midlandpayments@moh.govt.nz.
- Central region: centralpayments@moh.govt.nz
- Southern region: southernpayments@moh.govt.nz

If you choose to return your proposed payment schedule by fax, please note the following points to enable timely and accurate processing:

- print legibly – note that small, fine writing does not transmit well
- use a medium black ball pen – red/blue and fine-tips do not transmit well
- leave at least a half-inch border around the page
- make sure the pages being sent are the right way up in the fax
- include a cover sheet stating the number of pages sent
- do not write on the proposed payment schedule: this is not legible when faxed through
- when making queries about a service user, please give their full legal name, date of birth and NHI number if known
- if we frequently do not receive your proposed payment schedule when it is faxed, it is possible an error is occurring with your fax machine. Please make sure your fax machine is regularly maintained.

Your proposed payment schedule can also be returned by post.

Buyer Created Tax Invoices

When you receive your Buyer Created Tax Invoice (BCTI) please check that all the PPS comments have been reflected on your BCTI. This will include payment and/or comments explaining why claims could not be paid. Please add any queries to your next PPS. If you have not received a BCTI for a payment period, please call our Contact Centre on **0800 281 222**.

Do not return any Buyer Created Tax Invoices back to Ministry of Health (Sector Support). These are for Providers' reference only.

Buyer created tax invoice comment sheets

This comment sheet will state the reason why we have or have not processed your requests and will tell you what we require to be able to do so. For an explanation of Ministry of Health (Sector Support) standard comments please see page 18.

Comments made by Ministry of Health (Sector Support) on buyer created tax invoices

Comment	Explanation/required action
No records of this client are held by Ministry of Health (Sector Support)	No details relating to this service user are held on the Ministry of Health (Sector Support) database. Obtain a needs assessment from the needs assessment service organisation.
Needs assessment (eligibility) not yet received for entry	Although Ministry of Health (Sector Support) holds details of this service user, it has not received the necessary Needs Assessment (Eligibility) form for entry to your facility. Contact the needs assessment service organisation that arranged the service user's placement.
Work & Income have not yet advised us that service user is eligible for subsidy	The service user may need to lodge an application with Work & Income.
New contribution details have not been received	Although details of this service user are held by Ministry of Health (Sector Support), the latest contribution details have not been received.
Residential care loan has been stopped due to property settlement – awaiting review of FMA from Work & Income	The property against which the service user's loan was held has been sold. Further subsidy will be subject to another financial means assessment by Work & Income.
Residential Care Transfer Form has not yet been received	A service user has transferred to a new facility, remaining at the same level of care. Send notification of the service user's transfer.
Carer support is paid separately	The details held by Ministry of Health (Sector Support) regarding this service user state that the service user is eligible for carer support. Carer support is paid for through a separate process.
Respite care is paid separately	The details held by Ministry of Health (Sector Support) regarding this service user state that the service user is eligible for respite care. Respite care is paid for through a separate process.
Date of death was notified to Ministry of Health (Sector Support)	Date of death for a service user has been notified by the provider a needs assessment service organisation, Work & Income or Ministry of Health. Please check these details are correct.
Date of transfer notified	This service user has transferred to another facility. Please check these details are correct.

Comment	Explanation/required action
Date of admission notified	This service user has been admitted to a facility. Please check these details are correct.
Date of discharge notified	This service user has been permanently discharged from a facility. Please check these details are correct.

Respite Care and Day Care

If the full-time carer of a service user with an illness or disability living in the community needs some relief from caring for that service user, he or she can use a respite care or day care allocation. Alternatively, if a service user requires day care, an allocation for this service is required. Respite care or day care must be provided by a formal provider who is contracted to provide respite care or day care by the Ministry of Health or District Health Board.

Respite care and day care allocations are co-ordinated by a needs assessment and service co-ordination organisation. The nature of the illness or disability of the person requiring care determines which needs assessment and service co-ordination organisation is authorised to co-ordinate the care package, as well as whether the Ministry of Health or a District Health Board will fund the service.[3]

To enable payment for respite care or day care, a carer needs to submit a tax invoice to Ministry of Health (Sector Support) in accordance with its agreement. Payment should be claimed either using a manual template or as an electronic file. Please refer to your agreement as to which is required. Both templates are available from Ministry of Health (Sector Support). Please refer to page 22 for an example of the manual template.

Listed below are the requirements for respite care and day care invoices submitted to Ministry of Health (Sector Support), including information requirements to meet Inland Revenue Department invoicing rules.

- the invoice must be made out to the District Health Board funder, or the Ministry of Health (for example, Auckland District Health Board or Ministry of Health) as stated in your agreement
- provider name and address
- day care/respite agreement number (for example, 123456-00)
- provider GST number
- invoice date (which must be on or after the service end date)
- a unique invoice number or name
- service user information (full name, NHI number, date of birth)
- service type, start date and end date, number of units, unit cost before GST
- amount of GST added and total invoice amount.

If some or all of these details are not present, the invoice may be returned to you for completion.

[3] Please refer to the section *Funding Streams and Agreements* on page 5 for more information.

For a District Health Board funded service it the invoice must be addressed to the specific District Health Board:

District Health Board
c/- Sector Support
Residential Team
Private Bag 1942
Dunedin.

If Ministry of Health funded please mail to:

Ministry of Health
c/- Sector Support
Residential Team
Private Bag 1942
Dunedin.

If you have access to a scanner, you can scan and email your respite care and day care invoices to the email addresses mentioned in the *Proposed Payment Schedule* section on page 16. Please ensure 'Respite Care Invoice' or 'Day Care Invoice' is entered in the subject field when emailing.

Manual Invoicing Template

Manual tax invoice									
Provider number:	(unique PerOrg number)			**Invoice date:**				**To:** (DHB name or Ministry of Health) **C/- Sector Support** **Residential Team** **Private Bag 1942** **Dunedin**	
Provider name:	(legal entity name)			**Invoice number:**					
Provider address:				**Agreement number:**					
				GST number:	Please include GST #				
Contact phone:				**Due date for payment:**					
NHI	**Date of birth**	**Surname**	**First name**	**Service**	**Service start**	**Service end**	**No. of units**	**Unit cost $ (GST exclusive) (rate)**	**Amount payable (GST exclusive)**
[redacted]								**Net**	
								GST 12.5%	
								Invoice total	
		Signature			**Date**				
		Name							

IMPORTANT: Please ensure that all manual invoices submitted to Sector Support for payment have the following: Provider Name, Invoice Date, Unique Invoice Number/Name, Your Name and Signature, Provider GST Number and Agreement Number. The invoice should also be made out to the Funder of your contract. This is an IRD requirement. If some or all of these details are not present, the invoice may have to be returned to you.

REF: DUN0007

Carer Support

What is carer support?

Carer support is available to people who have a disability, as defined by the Ministry of Health, and have been assessed as requiring carer support. In some cases it may also be available to those who require care for a medical/personal health condition.

Carer support enables the full-time, unpaid caregiver of a person with a disability to have a break. It is seen as one component of a planned programme of care, and is not intended as a one-off crisis intervention.

Types of support carers

- Formal providers: relief carers who provide care in a formal/commercial setting and/or via a formal organisation. These include organisations such as rest homes, private and public hospitals, voluntary organisations and day care centres.
- Informal carers: relief carers who provide care in an informal setting, such as a domestic dwelling. These carers are typically other family members, friends or neighbours.

A person with a disability and/or their full-time carer have a choice over who provides carer support services and for the type and quality of care provided. However, there are some specific restrictions on who can claim as a support carer. The parent or partner of the service user cannot claim, and in most cases a support carer cannot be someone who lives at the same address as the service user/full-time carer.

Payment processes

Support carers (formal and informal) need to lodge an application for payment on a Ministry of Health claim form (as supplied to the full-time carer). This application must be signed by both the support carer and the full-time carer and lodged within 30 days of the care ending.

Payment can be made to either the provider directly or to the full-time carer if they have already paid the provider. Please ensure the name of the provider is the correct legal name.

A carer support claim will be paid within 10 working days from the day the Ministry of Health (Sector Support) receives a correctly completed claim form. Claim forms will be returned **to the full-time carer** if they are incomplete or incorrectly filled in.

Common reasons a form may be rejected include:

- the support carer's address not appearing on the claim
- the support or full-time carer not signing the form
- the number of days or the date range not being supplied.

Bank account details should be written on the form for **each** claim, even if payment has been made to that account number previously. This is so Ministry of Health (Sector Support) can check that the account number on record is still correct. If your bank account changes you should attach bank verification of the new account number to the claim form.

Payment will not be made for any days used beyond those allocated to the service user per year. Payment will not be made prior to the care having been completed.

Payment rates are indicated on the claim form, and may vary between service users and/or regions and/or funders.

These payment rates are GST-inclusive. For further information about additional tax obligations, it is the support carer's responsibility to contact the Inland Revenue Department.

A full day of care refers to claims over eight hours and up to 24 hours. A half-day (in most cases) is between four and eight hours. Smaller amounts of care (such as a single hour) can be accumulated to make up half or full days. A half-day is the minimum payment unit.

Further information

Please contact the Ministry of Health Contact Centre on 0800 281 222.

Please note: Carer support and respite care are separate services to long-term residential care. Therefore, providers cannot claim for carer support or respite care on their proposed payment schedules. Likewise, they cannot claim subsidy for long-term residential care with a provider-generated tax invoice. Please see the *Proposed Payment Schedules* section on page 15 for more information on claiming for long-term service users.

Glossary

BCTI	Buyer created tax invoice
CCPS	Client Claims Processing System
FMA	Financial means assessment
Ministry of Health (Sector Support)	Business unit of the Ministry of Health that processes payments and administers contracts for CCPS contracted services
MSD	Ministry of Social Development
NASC	Needs Assessment Service Co-ordination Organisation
PGTI	Provider generated tax invoice. This is used for submitting manual day care and respite care claims only.
PPS	Proposed payment schedule
RCS	Residential care subsidy
RSS	Residential support subsidy

Appendix 1: Benefit Notification Advices

Advice of residential care subsidy

Work and Income
Te Hiranga Tangata
A service of the Ministry of Social Development

Residential Subsidy Unit

Client and Claims Processing Unit
Ministry of Health
Private Bag 1942
Dunedin 9015

RESIDENTIAL CARE SUBSIDY

Client Name: Client Number:
Date of Birth:
Hospital / Rest Home:
Address:
Referred by:

Date entered care:
Date of financial means assessment:
Assets equal to or less than threshold: Yes
Assets became equal to or less than threshold more than 28 days before date of means assessment: Yes
If no, date assets became equal to or less than threshold: N/A

Benefit type:	New Zealand Superannuation	
Benefit rate:		$
Personal allowance:		$
Contribution from New Zealand Superannuation:		$
Contribution from income:		$
Total client contribution (not to exceed $ 714.18):		$

SAMPLE ONLY

Assessed by

Case Manager

Students | Employers | War Pensions | Service Express | Deaf Fax Number | General Enquiries | NZ Superannuation | Community Services Card

Advice of new residential care loan (RSU8)

15 September 2006

CCPS Team Leader
Residential Payments
HealthPAC
Private Bag 1942
DUNEDIN

Advice of New Residential Care Loan

We advise that a loan agreement has been completed for the client below.
Please note the following details:

1	Client Information	
	Title	
	Surname	
	First name	
	Second name(s)	
	Date of birth	
	MSD Reference (SWN)	
	Hospital/rest home	
	Hospital/rest home physical address	
	TLA of Hospital/rest home	
	Needs assessor	
	Gender	
	Marital status	
	Preferred mailing address	

2	Key Financial Means Assessment (FMA) Information	
	Date cash assets (other than secured property) became equal to or less than the threshold	19.07.2006
	Date entered care	19 July 2006
	Date of new FMA application	7 August 2006

3	Client Contribution Information	
	Benefit type	new zealand superanuation
	Benefit rate	$243.60
	Personal allowance	$31.85
	Amount of benefit/pension contribution	$211.75
	Total (not to exceed the maximum contribution for the applicable TLA)	$211.75

4	MSD Contact Information
	Case Manager
	Legal Executive

5 Person Holding Authority to Act for Client (PHA) *(to be completed by MSD Legal)*

Please attach a copy of the Power of Attorney or Court Order to this form

PHA surname	
PHA first name	
PHA second name(s)	
Solely	
PHA relationship	
PHA phone (day)	
PHA phone (other)	
PHA fax	
PHA email	
PHA mailing address	

Person Holding Authority to Act for Client (PHA)
(which of these Authorities does this person hold?)

Authority held	Enduring Power of Attorney
If Other – specify:	

6 Client's Partner Details

Does the client have a partner?	NO
Partner surname	
Partner first name	
Partner second name/s	
Partner phone (day)	
Partner phone (other)	
Partner fax	
Partner email	
Partner mailing address	

7 Secured Property Details *(to be completed by MSD Legal)*

Physical address of property	
Legal description	
Certificate of title reference	
Ownership type	
What is the value of the property?	
What percentage share of the property does the client have?	

8 Excluded Values *(to be completed by MSD Legal)*

	Personal Exclusion Amount	Property Exclusion Amount
Prior Mortgage		$NIL
Prior Caveat or Personal Loan	$	$
Deferred Rates up until loan application		$
Gifting up until loan application	$	
Other Exclusion 1:	$	$
Other Exclusion 2:	$	$

9 Pre-paid Funeral *(to be completed by MSD Legal)*

Does the client have a pre-paid funeral?	No