

# WA HACC CONFIDENTIAL CLIENT FEE REDUCTION FORM

This form will determine the client's agreed fees for support provided by a HACC service provider.

Client Deta	ails:		
Surname:			
Given Nam	es:		
Age Group:	Less than 15 years:	Complete this form based on parental income	
	16 years or over:	Complete this form based on income	client

If the client has financial difficulty in paying the nominated fees for support services completion of this form will identify the amount the client can pay.

If the additional costs for the client are approximately 10% or more of income (or in accordance with the service provider fee reduction policy), a decision to reduce a fee may apply.

The client may choose not to complete this form, however the maximum fees in the identified income level for support services may be charged.

No client will be refused a service because of financial inability to pay fees.

Service Provider's Details:	
Name:	
Telephone:Facsimile:	
Staff Member's Name:	
Date:	

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# **INCOME DETAILS**

#### What is the client's income source?

(pleas	(please tick)					
	Australian Centrelink Pension Card					
	Australian Health Card					
	Commonwealth Seniors Health Card					
	Tax Assessment Notice					
	Other Income					

### What is the client's income level?

Identify whether single or couple combined	Level 1	Level 2 □	
Single	\$0 - \$50,000	More than \$50,001	
Couple Combined	\$0 - \$80,000	More than \$80,001	
Fees Cap	\$64	\$154	

# **SUMMARY OF FEES PAYABLE BY CLIENT**

Support services included in Fees Cap	Unit of Service	Client's Nominated Fee Contribution (please tick or identify amount in Other)				
	Level 1 -\$8 Level 2 – unit cost	\$6	\$4	\$2	Other	No fee
Domestic assistance	Per hour					
Personal care	Per hour					
Respite care	Per hour					
Social support (one on one)	Per hour					
Social support (group)	Per occasion					
Other food services	Per hour					
Centre based day care (excluding meals and transport)	Per occasion					
Home maintenance	Per hour					
Nursing care	Per occasion					
Allied health	Per occasion					
Total fees to be paid by the client for support services per week						

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Support Services Excluded from Fees Cap	Int of corvice		t's Fee ribution
Home modification	Per job	\$	
Transport	Per one way trip Up to 10 kms 11 kms to 30 kms 31 kms to 60 kms 61 kms to 99 kms	\$ \$ \$	
Meals (no fee reduction applies)	Full cost of meal	\$	
Podiatry (applies to existing separately HACC funded podiatry services only)	Per occasion	\$	

### **ADDITIONAL COSTS**

Please indicate the expenses the client incurs either short term (up to 12 weeks) or long term (a year).

erm (a year).		(1) 11 17 1
Categories	Average Fortnightly Cost	Comments
Health Related Costs		
<ul> <li>Medications</li> <li>Alternative therapies</li> <li>Aids and equipment, including continence products</li> <li>Specialist care, (eg occupational therapy, physiotherapy, extensive podiatry)</li> <li>Special clothing</li> <li>Special foods (eg dietary supplements)</li> <li>Temporary care or respite (Non HACC)</li> <li>Medical supplies</li> </ul>	\$	
Location Related Costs		
<ul> <li>Home modification</li> <li>Specialist care related costs - such as transport or accommodation when travelling to another location to see medical specialist.</li> <li>High accommodation charges</li> </ul>	\$	
Fee Related Costs		
<ul><li>Health or medical insurance</li><li>Fees for other services</li></ul>	\$ \$	
Other Costs		
	\$	
Total Additional Fortnightly Costs	\$	
Actual Fortnightly Income	\$	
Calculate percentage of income (approx 10% or more of income, or in accordance with the service provider fee reduction policy).	%	

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## **CLIENT AGREEMENT**

#### **Fees for Support**

I am unable to pay the maximum fees for the HACC support services I receive and request a Fee Reduction. This is a true and accurate statement of additional costs. I agree to pay the fees as outlined above for my HACC support services on page 2.

Conta	Contacting another HACC Service Provider						
	I give permission to contact another HACC service provider regarding my fees. or						
	<u> </u>						
Are a	dditional cos	ts Short-term □ Long-term □ (up to 12 weeks) (annual review)					
Next I	Review:						
	Client Signat	ure:Date:					
	If you comple	eted this form on behalf of the client, please provide the following details:					
	Surname:						
	Given Name	::					
	Telephone:	Relationship to client:					
	Signed:	Date:					
		To be provided to the Client:  Please tick  □ Copy of completed Confidential Client Fee Reduction Form □ Copy of service provider's WA HACC Fees Policy □ Copy of WA HACC Standard Fees Schedule  Staff Member's Name:					

CLIENT REVIEW					
Annual Review Date	Change in Income/costs?	Completion of new form	Staff Member's initial	Date	
/ /201	Yes / No	Yes / No	<del></del>	/ /201	
/ /201	Yes / No	Yes / No		/ /201	

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