



home and community care

A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM
PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

CONFIDENTIAL

Fee Reduction Form

Agency Details:

Name: _____

Telephone: _____ Facsimile: _____

Assessor's Name: _____ Date: _____

This form will be used to determine whether to reduce a client's fee. No client will be refused a service because of a financial inability to pay a fee.

Client details:

Surname: _____

Given Name: _____

Gender: Male Female Date of Birth: ____/____/____

Age Group:	<i>Less than 15 years:</i>	<i>Complete this form based on parental income</i>
	<i>16 years or over:</i>	<i>Complete this form based on client income</i>

Please indicate, in the categories below, the additional costs the client may incur due to significant changes in additional expenses as a result a functional disability.

Additional Costs	Average Weekly Cost \$	Comments
Health Related Costs		
■ Medications	\$	
■ Alternative therapies	\$	
■ Aids and equipment, including continence products	\$	
■ Specialist care, (e.g., occupational therapy, physiotherapy, extensive podiatry)	\$	
■ Special clothing	\$	
■ Special foods (e.g., dietary supplements)	\$	
■ Temporary care or respite (Non HACC)	\$	
■ Medical supplies	\$	
Location Related Costs (refer policy p13)		
■ Home modification costs	\$	
■ Specialist care related costs - such as transport or accommodation when travelling to another location to see medical specialist.	\$	
■ High accommodation	\$	
Fee Related Costs		
■ Health or medical insurance	\$	
■ Fees for other services	\$	
Other Costs		
■ Total Additional Costs	\$	
■ Calculate percentage of income (eg approx 10% or more of income, or in accordance with the Service Provider fee reduction policy).	%	

GUIDE TO FEE REDUCTION

- If the additional costs are approximately 10% or more of income, or in accordance with the Service Provider fee reduction policy, a decision to reduce a fee from one income level to another may apply. This means fees could move from Level 3 to Level 2, Level 2 to Level 1, and a fee negotiated for Level 1.

<ul style="list-style-type: none"> ■ TOTAL Fees per week (from Fees Income Assessment - Fees Payable) 		\$ _____
<ul style="list-style-type: none"> ■ Calculating Fee Reduction 		<input type="checkbox"/> per week
Level 3	Reduce fee rate to level 2 <input type="checkbox"/>	\$ _____ <input type="checkbox"/> per week
Level 2	Reduce fee rate to level 1 <input type="checkbox"/>	
Level 1	How much can client afford to contribute	
NEW TOTAL for support services		\$ _____ <input type="checkbox"/> per week

CLIENT AGREEMENT

This is a true and accurate statement of additional costs. I agree to pay the contribution as outlined above for my HACC support services.

Signed: _____ Date: _____

If you completed this form on behalf of the client, please provide the following details:

Surname: _____

Given Name: _____

Telephone: _____ Relationship to client: _____

Signed: _____ Date: _____

CLIENT REVIEW

Are additional costs	Short-term <input type="checkbox"/> (up to 12 weeks)	Long-term <input type="checkbox"/> (annual review)
Next Review: ____/____/200__		
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