

Relate

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The journal of developments in social services, policy and legislation in Ireland

Paying for hospital and nursing home care

Introduction

The Nursing Homes Support Scheme (the *Fair Deal*) came into effect on 27 October 2009. It changes the charging arrangements for new residents of public nursing homes and replaces the nursing home subvention scheme for new residents of private nursing homes. It also introduces a distinction between charges for acute care in public hospitals and charges for long-term residential care in acute hospitals.

The new arrangements apply to all new residents of residential care facilities. The majority of people in long-term residential care are older people. However, the rules which are set out here are the same regardless of age. So, younger adults who are in, for example, residential institutions for people with disabilities come under the same rules as older people in nursing homes. A small number of adults and those under the age of 18 are not liable for charges under these new arrangements – see page 2.

The main effects of the new arrangements are as follows:

- You will not be adversely affected by the changes if you were in a nursing home when the new scheme was put into effect, that is, on 27 October 2009. If you are in a public nursing home since before that date or in a contracted bed in a private nursing home, you will continue to be charged under the old arrangements. If you are in a private nursing home, you may retain your present arrangements or you may opt for the new scheme if it would be to your advantage (the new scheme is likely to be better for many such residents).
- State support may be provided to nursing home residents who are assessed as being in need of long-term residential care.
- New residents (from 27 October 2009) of both public and private nursing homes or other long-stay residential facilities are liable to pay 80% of their assessed means towards the costs of their stay; a proportion of the value of assets, including the family home and other property, is taken into account in assessing annual means.
- The period during which the family home is taken into account in the means test is limited to three years. This limit also applies in some cases to farms and businesses.

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- The charges arising from the assessment of assets may be deferred until a specified event occurs such as the sale of the asset or your death or, in the case of the family home, the deaths of certain other family members.
- There is a legal distinction between acute care and long-term residential care. Different charging arrangements apply to each type of care.
- A specified amount of funding is allocated to the scheme each year, so it is possible that not everyone who qualifies will actually receive support.

Long-term residential care services

In acute hospitals

There is now a legal distinction between acute hospital services and residential care services and there are different rules for charging for each service. This means that long-stay patients in acute hospitals may now be charged in the same way as nursing home residents if they are considered not to need acute hospital services.

In nursing homes

Long-term residential care services are defined as maintenance, health or personal care services, or any combination of these, that are provided to you while you are maintained in an approved nursing home or a facility that is publicly designated by the Health Service Executive (HSE) as a facility predominantly for the care of older people. The nursing care in the facility must be provided on a 24-hour basis, for a period of not less than 30 consecutive days, or for periods totalling not less than 30 days within a period of 12 consecutive months. However, if the HSE considers that you are going into the care facility permanently, then charges can apply from the start of your stay rather than beginning after the initial period of 30 days has passed.

Long-term residential care services do not include:

- Medically acute care and treatment in an acute hospital
- Respite care
- Rehabilitative care for less than 12 months or for less than a total of 12 months in a 24-month period
- Out-patient services

Charges for hospital care

If you are getting acute care in a hospital, you are not receiving long-term residential care services. Acute care is free to medical card holders and a number of other groups; others have to pay €75 a day up to a maximum of €750 a year.

If you are getting acute care and you are in hospital for more than 30 days, you may be liable for long-stay charges; the maximum amount of such charges is €153.25 a week.

Acute care is not defined in the legislation so the precise borderline between acute care and long-term residential care may not always be entirely clear. If you are in hospital for more than 30 days, and a doctor certifies that you do not need medical acute care and treatment, you may be charged as if you were receiving long-term residential care services. This means that the cost of your care is considered to be the average cost of care in a public nursing home. You are then liable to pay the cost of your care or 80% of your assessed means whichever is lower; this operates in the same way as nursing home charges and you are eligible for state support in the same way.

Charges for residential care services

The HSE may charge virtually all residents for residential care services which it provides. The maximum charge is the cost of such services. The following are exempted from paying the charges:

- People under 18
- Women in respect of maternity services
- People detained involuntarily under the mental health legislation
- People who contracted Hepatitis C in certain circumstances
- People receiving treatment for certain infectious diseases

Who qualifies for financial support from the state

People who cannot meet the full cost of their care may get state support from the HSE.

In order to get state support under the scheme you must

- Be ordinarily resident in Ireland (this is not defined in legislation but means that you have been living in Ireland for at least a year or you intend to live here for a year) and

- Either have applied for a care needs assessment under the scheme and been deemed to require long-term residential care services (see page 3) or are being provided with care services by or on behalf of the HSE or in an approved nursing home since before 27 October 2009.

Acting on behalf of a person needing care

Another person may act on your behalf in respect of most aspects of the scheme, including applying for financial support and appealing decisions. However, as outlined below, an application for an assessment of need may be submitted only by you or by a *specified person*. Decisions and acts in relation to a nursing home loan may be carried out only by you, by specifically authorised people such as attorneys appointed under an Enduring Power of Attorney or a care representative as described on p7.

Specified person

A specified person may be:

- Your committee if you are a Ward of Court
- An attorney appointed under an Enduring Power of Attorney (provided the attorney is not restricted from doing so)
- A care representative appointed under this scheme (see page 7)
- Your spouse or cohabiting partner
- A relative who is 18 years of age or over
- A "next friend" appointed by a court
- Your lawyer, doctor, nurse or social worker

If an application is made by a specified person, the HSE may refuse to deal with that person if it considers that he/she is not acting in your best interests.

Care needs assessment

If you are applying for state support on or after 27 October 2009, you must have a care needs assessment. Existing nursing home residents are not obliged to have any further assessment of care needs. An application for a care needs assessment may be made by you or by a specified person. Your committee, attorney or care representative have priority over the other possible specified persons but they may consent in writing to having one of the other people apply. The assessment is carried out by or on behalf of the HSE and may involve examinations by one or more of a range of medical professionals including GPs, nurses, occupational therapists and physiotherapists.

The assessment of your care needs involves an evaluation of:

- Your ability to carry out the activities of daily living, including your cognitive ability, extent of orientation, degree of mobility, ability to dress, bathe and eat without assistance, ability to communicate and degree of continence
- The family and community support that is available to you
- The medical, health and personal social services being provided to you or available to you
- Any other matter that affects your ability to care for yourself
- The likelihood of any material change in your circumstances

On the basis of this assessment, the HSE decides whether or not you need residential care services. If you do need care services, the HSE may also decide that it is unlikely that you will ever cease to need those services.

There are no time limits stipulated for the carrying out of the assessment or the length of time to make a decision.

Once the HSE has made a decision, you (or the person who applied on your behalf) must be notified in writing within 10 days. You must be given a copy of the assessment report and told the reasons for the decision. The care needs assessment may identify services which you need but this does not mean that the HSE must provide those services.

If the HSE decides that you do not need care services, you may not make another application for six months after the decision was made unless there has been a material change in your health or circumstances and this is medically verified.

Choice of nursing home

In order to avail of the scheme, you must go into an approved nursing home. You have some choice as regards which nursing home you go to but that choice may be limited by availability and by your particular needs. Public, private and voluntary nursing homes are taking part in the scheme.

Approved nursing homes

An approved nursing home is one which

- Is registered with the Office of the Chief Inspector of Social Services (in the Health Information and Quality Authority) and

- Has an agreement with the National Treatment Purchase Fund to provide services for people who are getting state support and
- Has a tax clearance certificate

HIQA carries out inspections of nursing homes and the inspection reports are available at: www.hiqa.ie.

The means test

If the HSE decides that you do need care services, you may then apply for state support. You and your spouse or partner must provide the HSE with information about your income and assets.

Your weekly assessed means are your combined means assessed under the following headings:

- Income
- Cash assets
- Relevant assets (see below)

The income and assets of each member of a couple are assessed. As well as a married couple who are living together, this includes opposite sex and same-sex cohabiting couples who have been living together for at least three years before applying for support or before the start of the provision of care services. The individual's income is half of the joint assessed income.

Regulations may be made to provide for the relief of undue hardship. This may include provisions that, in exceptional circumstances, the income and assets of the member of the couple who does not need care may not be taken into account. No such regulations have yet been made.

The HSE has the power to access relevant records for the purposes of the scheme. It is required to publish a code of practice for accessing and processing such records.

Income

Income includes income from all sources including pensions. The following amounts are then deducted: income tax, PRSI contributions (these are not payable by people aged 66 and over), income levies (the health levy is not payable by people aged 70 and over but the income levy is payable by everyone), mortgage interest or rent, health expenses, and maintenance payments under a separation agreement. Regulations may be made to provide for other deductions (no such regulations have been made).

Your weekly assessed income is 80% of your total income after deductions and this is generally the amount you must pay towards your stay in the nursing home.

You must be allowed retain 20% of your income or the *minimum retained income threshold*, whichever is greater. The minimum retained income threshold is 20% of the maximum rate of the State Pension (Non-Contributory). A couple must be allowed keep this amount plus the maximum rate of this pension if one of the couple is in care. The effect is that the person going into care must have at least 20% of the pension or their income and the person who is not going into care must have at least the full amount of the same pension or 50% of the couple's income available to live on.

Cash assets

Cash assets means money you own and which is:

- Held in an account or in cash
- Lent to another person and is repayable
- Held in shares, stocks, bonds, securities, and other financial instruments (valued at market value on the date you apply for state support)

It also includes transferred cash assets (see below).

Relevant assets

Relevant assets means any property in which you have an interest, including property abroad and transferred assets. So, it includes the family home, any investment property, farms, shops and other commercial premises. The valuation is the market value on the day you apply for state support. Deductions are allowed for borrowings to buy or maintain the property.

You are considered to have transferred assets if, in the previous five years, you gave away any assets (including cash assets) or sold any assets for less than 75% of their market value. This does not apply if the transfer of assets was done as a result of a maintenance claim by a child or other matrimonial proceedings.

If the asset in question was transferred before 9 October 2008 (the day the Bill to provide for this scheme was published) you may ask that it not be taken into account because including it would involve undue hardship.

The first €36,000 of assets in the case of a single person or €72,000 in the case of a couple is not taken into account.

The rest of the cash and relevant assets that you own are then assessed at 5% of their value. So, if you have cash and relevant assets of €200,000 above the disregarded amount, your means from your assets are assessed as €10,000 a year.

Each of a couple is considered to have half of the combined assessed assets of the couple.

Principal private residence

Your principal private residence is not taken into account when you have been receiving care services for three years; these three years need not be continuous. This means that people who have been in nursing homes for three years before this legislation comes into effect do not have their principal private residence assessed in the means test.

In all other cases it is taken into account for three years of your stay in residential care. So, the maximum imputed value of your house is 15% in the case of a single person and 7.5% in the case of a member of a couple.

Asset value of farm or business

The assessment of the asset value of a farm or business is limited to three years if it is a transferred asset or if the following circumstances apply:

- You have suffered a sudden illness or disability which caused you to need care and
- Before the onset of your illness or disability, a substantial part of your or your partner's working day was regularly and consistently applied to farming or carrying on the business and
- A family successor certifies in writing that he or she will on a consistent and regular basis apply a substantial part of his or her working day to farming or carrying on the business

In effect, the three-year limitation on the assessment of the asset value of your farm, for example, applies if you were an active farmer for whom farming was a significant activity before you became ill or disabled and a member of your family takes over the farm as an active farmer.

Amount of state support

The amount of financial support you get from the state depends on your weekly assessed means (that is, your income and assets as assessed in accordance with the rules described above) and the cost of your nursing home care.

If your weekly assessed means are equal to or greater than the cost of your care, then you get no financial support. If they are less, then you get the difference between your means and the cost of your care.

If you are receiving state support, you or your representative must give notice to the HSE of any material change in circumstances within 10 days of that change.

The HSE may stop paying state support if you do not pay your allocated amount to the care facility. The HSE may also stop paying support if the care services you are receiving are not appropriate for your needs.

Nursing homes and other long-term care facilities will be obliged to inform the HSE within three working days when a person who has been receiving state support dies or leaves the facility. If they propose to discharge a person who is receiving state support they must give at least 10 working days' notice to the HSE.

Ancillary state support/nursing home loan

State support is a payment by the HSE to help you meet the costs of your long-term residential care. *Ancillary state support* is the term used in the Act for the money that the HSE pays on your behalf if you defer payments based on your relevant assets (that is, property) until a *specified event* occurs, such as the sale of the asset or your death or the subsequent death of your partner. Ancillary state support is now being called a *nursing home loan*.

You must apply separately for the nursing home loan. You may apply even if you do not qualify for state support. The loan can be based on relevant assets only; it cannot be based on cash assets. In effect, there has to be a property over which a charge can be taken.

So, for example, if the cost of your care is €1,000 a week and your weekly assessed means are €500 a week and you have no assets, then you have to pay €500 a week and you qualify for state support of €500 a week. If your weekly assessed means includes €100 a week which is based on your assets, then your state support is still €500 a week, you have to pay €400 a week and you can apply for a nursing home loan in respect of the €100 which is attributable to your assets. You may choose to pay that €100 if you can manage to do so. If you apply for, and get, the nursing home loan, then the loan is repayable when a specified event occurs.

If you receive a nursing home loan, the amount of the loan is registered as a charge against your assets. In simple terms, the effect is the same as taking out a mortgage on your house.

When you die, or another specified event occurs, that charge is redeemable. That means that the charge must be paid off before your estate is distributed among your heirs. The charge is a debt that you owe and all debts must be paid before any of your money or assets can be distributed to your heirs. Your personal representatives are obliged to give notice to the HSE of the intention to distribute the estate not less than three months before the actual distribution.

The amount of the charge at that stage is the actual amount of the loan received together with interest (this is based on the consumer price index). If you decide to sell or transfer the asset on which the loan is based, then you must repay the loan amount due when you do this sale or transfer. You must inform the HSE within 10 days if you have sold or transferred the asset in question.

Further postponement of payment

The nursing home loan which you received is, in general, repayable on your death. If the asset on which this support was based is your principal private residence,

then a further postponement of the repayment may be arranged in certain circumstances (further postponement is not possible in the case of other assets such as farms or businesses). If the asset is the principal private residence of your spouse or partner, then he/she may apply for a further postponement until after his/her death. This request must be made within three months of the death (the HSE may allow a later request provided it is not later than six months after the death). Such a request may also be made by a *connected person*. This is a person who has been living in the residence concerned for not less than three years immediately before you applied for the loan (in effect, for three years before you went into a nursing home) and that person does not have any other residence or any interest in other residential property. A connected person may be:

- Your child, or the child of your partner, who is under the age of 21 or who is over that age and whose assets are not more than the asset disregard
- Your sibling, whose assets are not more than the asset disregard
- A relative in receipt of Disability Allowance, Blind Pension, Invalidity Pension or State Pension (Non-Contributory) or the equivalent of one of these from outside Ireland or whose total income is not more than the maximum rate of State Pension (Contributory)
- A relative of the person who is the owner of a building to which the principal residence is attached
- A carer who cared for you for at least six months before you went into a nursing home and who received either the Carer's Allowance, Carer's Benefit or the Respite Care Grant in the previous 12 months

The nursing home loan then becomes repayable when your spouse/partner dies or the house is sold or transferred or the connected person no longer meets the requirements.

The loan may, of course, be repaid at any time before it becomes legally due. It must be repaid within 12 months of your death or six months of the sale of the asset. Interest is applied if the amount is not paid by the due date.

The repayable amount is collected by the Revenue Commissioners. They have the power to do so for 12 years after the amount becomes due.

Care representative

A care representative can be appointed to deal with issues relating to a nursing home loan if you do not have full mental capacity. There is a presumption that everyone does have full mental capacity until the contrary is established.

A care representative has the power to:

- Make an application for ancillary state support
- Consent to the creation of a charge over the asset in question
- Take other necessary actions in relation to the nursing home loan

A care representative may not be appointed in certain cases. These are cases where there is already a person entitled to make the necessary decisions and take the necessary actions. They are:

- Where you are a Ward of Court
- Where there is an attorney appointed under an Enduring Power of Attorney and there are no restrictions on the attorney taking any of the necessary decisions or actions and the power is being implemented
- Where there is another person permitted by law to act on your behalf (for example, a parent is generally entitled to act on behalf of a minor child)

The following may apply to the Circuit Court to be appointed as a care representative (and in the following order of priority):

- A spouse or cohabiting partner
- A parent
- A child
- A brother or sister (including half siblings)
- A niece or nephew
- A grandchild
- A grandparent
- An aunt or uncle
- A person who appears to the court to have a good and sufficient interest in your welfare, other than the owner of a nursing home in which you reside or are likely to reside, or a medical practitioner who examined you and prepared a report for the Court in relation to your capacity.

A person with greater priority may consent in writing to an application by a person with lower priority. So, for example, a spouse could consent to having a child appointed as the care representative.

When deciding on an application to be a care representative, the court must have reports from two doctors who have examined you and certified that you do not have the mental capacity to make the decisions in question. Guidance on the assessment of capacity has been issued by the Department of Health and Children.

You are not considered to have the capacity to make a relevant decision if you are unable to:

- Understand the information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making the decision or
- Communicate your decision

The care representative must be aged 18 or over and must be a fit and proper person to be a care representative. There are certain disqualifications including bankruptcy, convictions for fraud and a conviction for an offence against the person in care. The Court may apply certain conditions to the order.

The care representative is obliged to act in your best interests and to keep proper records and accounts.

Appointment of a care representative

You may apply for the appointment of a care representative to the Circuit Court. If you are making an application for a person, it must be made in the circuit in which the person is living at the time or in the circuit where that person has lived at any time in the previous three years. The President of the Circuit Court has issued a practice direction about such applications. Rules of court will be drawn up later but they are likely to be similar to the procedures set out in the practice direction. It is not necessary to be legally represented when making such an application but it may be advisable.

The application is made by a notice of motion and an affidavit for which the costs are €60 and €11 respectively. There is a standard form for the notice of motion. The affidavit must be sworn before a Commissioner for Oaths (usually a practising solicitor) and must set out the reasons for the application. The notice of motion is assigned a return date before the County Registrar by the Circuit Court office. The notice of motion and the affidavit must be served on the person in respect of whom a care representative is sought to be appointed (this person is then the respondent in the proceedings). They must also be served on every person who has a prior or equal right to apply to be appointed as a care representative and who has not given written consent to the application – this notice must be served at least 14 days before the return date assigned.

The respondent may reply to the application, either personally or through a solicitor. This must be done at least seven days before the return date. If the respondent does not consent to the application, the County Registrar must send a copy of the reply to the applicant. Any such reply must then be served on other possible applicants.

The Citizens Information Board is the statutory body which supports the provision of information, advice and advocacy on a broad range of public and social services. It provides the Citizens Information website and supports the voluntary network of Citizens Information Centres, the Citizens Information Phone Service and the Money Advice and Budgeting Service (MABS).

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People who have a prior or equal right to apply for the appointment of a care representative and who have not given written consent to the application may file an affidavit replying to the application. Such a reply must be given to the applicant and the respondent at least seven days before the return date.

On the return date, the County Registrar may make the appointment if everything is in order. However, if there is any objection to the appointment, the matter must go before a Judge of the Circuit Court.

The necessary forms are all available on the Courts Service website: www.courts.ie

Reviews and appeals

The HSE may review the support being provided at any time. If it does and decides that your means are higher than in the previous assessment or that you qualify for a smaller nursing home loan, that decision may not be implemented for a time – up to a maximum of 40 days. In general, you may look for a review a year after the previous assessment but this can be earlier if there has been a material change in your circumstances.

Appeals

You are entitled to appeal against the following decisions of the HSE:

- A decision, following a care needs assessment, that you do or do not need care and a decision that you are likely to need care for the rest of your life
- A decision to refuse to consider an application for state support for various reasons, for example, because you have not provided enough information
- A decision about state support
- A decision taken after a review of your state support
- A refusal to consider an application not to assess assets which were transferred before 8 October 2008
- A decision on the issue of assessing such transferred assets

You must appeal within 40 days of getting the decision. The HSE must appoint an independent person to hear appeals. The appeals officer may confirm or revoke the decision and/or may substitute another decision or may refer it back to the HSE for re-consideration.

A further appeal may be made to the High Court on a point of law.

Further information

The scheme is operated by the HSE, which has a number of local Nursing Homes Support Offices. Information line: 1850 24 1850
Website: www.hse.ie

Legislation

The scheme is governed by the Nursing Homes Support Scheme Act 2009. As well as a number of Commencement Orders, the following orders also apply:

- Nursing Homes Support Scheme (Assessment of Capacity Report) Regulations 2009; SI 409/2009
- Nursing Homes Support Scheme (Collection and Recovery of Repayable Amounts) Regulations 2009; SI 436/2009
- Nursing Homes Support Scheme (Making and Discharge of Orders) Regulations 2009; SI 437/2009

Links to the legislation and other information are available at: www.dohc.ie

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