Only if Applicable. Information on Fair Deal Contract of Care

(*c*) where appropriate, the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the arrangements for the payment or refund of monies, or

1. **A Nursing Home Support Scheme Information and Application Form is available within this contract**
2. **If you are resident within this centre but have not applied for Nursing Home Support under the Nursing Homes Support Scheme, you will be required to complete the Nursing Homes Support Scheme Application Form**
3. **Part 2 of the Nursing Homes Support Scheme Information and Application Form requests you to apply for an Application for Care Needs Assessment. (page 3 of application form).**
4. **The Care needs assessment is completed by a health care professional and will also be completed by members of the multi disciplinary team. The Care Assessment Needs Assessment used in this area is known as the Common Summary Assessment Record, (Appendix One)**
5. **You or your representatives are required to submit the information requested on the Nursing Homes Support Scheme Application Form and submit by hand or by postage to :**

The Nursing Home Support Office (Louth)
Unit 3
Ardee Business Park
Hale Street Ardee.
Co. Louth.

6. **Once your Nursing Homes Support Scheme and Application form together with your Care needs Assessment has been submitted to the Nursing Home Support Office, a team referred to as the Local Placement Forum will meet and discuss your application. This forum is multidisciplinary and for your protection will examine in detail your current health and social care needs. They will determine whether in their opinion, your situation requires that you are cared for in a Nursing Home.**
7. **If the Local Placement Panel Forum determines that you require nursing home care, you will be informed by letter that on examination of your records and that on Medical Grounds it has been determined that you require nursing home support and care. (Appendix Two)**

8. **Once all your financial information that you would have submitted on the Nursing Homes Support Scheme Application form has been verified, you will then receive what is referred to as a letter of determination, which is a letter stating that it has been determined that you require nursing home placement and that all your details as submitted by you have been checked and verified. (Appendix Three).**
9. **Once you have received the letter of determination you will be required to:**
    a. Please advise this office of your choice of nursing home, if your preferred nursing home is not available, an alternative approved nursing home **must** be chosen. A list of approved nursing homes is available at www.hse.ie or from the Nursing Home Support Office in Ardee.

(b) Please confirm with the proprietor/person in charge of the chosen nursing home that they can meet the applicant's care needs and can offer a place for the above named.

(c) Please contact this office, in writing, within 20 working days of receipt of this letter to confirm the chosen nursing home. This will enable the HSE to calculate the rate of State support and to establish if funding is available for this placement.

(d) The HSE will then make a determination in regard to the application and a formal decision letter will issue regarding approval of State support funding.

Please note that should the applicant's assessed weekly contribution equal or exceed the agreed cost of care in the chosen nursing home then no State support will be payable.

If contact is not made within 20 working days it will be considered that you no longer wish to proceed with the application and your application will be withdrawn. In the event that you wish to reapply for financial support under the Nursing Home Support Scheme you may do so by submitting a new application or by submitting a written request to reactivate the application to the above address.

If you are dissatisfied with the client contribution decision, you have a right of appeal. The appeal must be submitted in writing within 40 working days of notification of this decision. The contact details of the designated Appeals Office are listed below: -

Appeals Office:
HSE Dublin North East,
Bective Street
Kells,
Co. Meath

Phone: **046 9251262**
Fax: **046 9251774**

10. Once you have chosen your choice of Nursing Home, your nursing home will receive a letter outlining that xxxxx is required to contribute €xxxxx per week towards the cost of his/her care from his/her date of admission.

Once the nursing home of your choice as in this centre has determined that we can meet your needs, the nursing home support office will be informed of your date of admission. PLEASE NOTE THAT IT CAN TAKE UP TO THREE MONTHS FOR NURSING HOME SUPPORT FUNDING TO BE RELEASED.

In relation to funding and payments, it will be determined by the Nursing Home Support Office what you are required to contribute to the cost of your care. As an example, if you receive an old age contributory pension of 250.00 euro per week, the nursing home support office may determine as an example only that you contribute 180.00 euro per week. You have two choices here.

1. **You or your representative may hold your pension book, and in this case you will be billed every month for your contribution. Once you receive your bill, we ask that your payment is made by cheque.**
2. **You may ask that the HSE becomes your agent. As an agent the HSE will hold your pension book and cash your pension cheques on a monthly basis. The HSE as your agent, will only take the 180 euro per week, and will lodge your remaining money, as in the example here, 70.00 euro to what is referred to as a Patients Private Property Account or PPP account. This is an account held nationally by the HSE in Tullamore in a Central Account. This is your money, and this money cannot be touched without authorisation from you or your representatives.**
3. **If it is a situation that you or your representative holds your pension book and you pay 180.00 euro per week as an example, you or your representative can also lodge money for your personal use with the HSE. However this Centre does not hold this money. This money is lodged in a local private property account in your name. You can access this money for your own personal use. You will be receipted for all transactions on this account.**

PLEASE TALK TO ANY ONE OF THE ADMINISTRATION STAFF WHO WILL ADVISE YOU OF THESE ARRANGEMENTS.

Appendix One. Common Assessment Record.

COMMON SUMMARY ASSESSMENT REPORT

1. SOURCE OF REFERRAL (PLEASE TICK):

Community Hospital Acute Hospital GP
Mental Health Community Nursing Home
Name of Referring Location: _____ Date of Referral: _____

2. PERSONAL DETAILS:

First Name: _____ Surname(s): _____ Preferred Name: _____
Current Address: Home/Past Address (If relevant): Tel No(s):
_____ _____
_____
_____ _____ Date of Birth (DD/MM/YYYY)
Medical Card No: _____ Hospital Number:_____
_____
PPS No. :
_____
_____

4. ALL APPLICANTS have the right to self-determination and capacity to do so is assumed unless otherwise proven.

His/her preference to stay at home or to be admitted to residential long-term care must be sought and recorded.

Has the person's above preference been discussed with him/her? **Yes No**
If YES - brief outline of outcome
_____
_____
_____
_____

If No - Provide a reason and identify with whom it has been discussed & outline outcome

_____
_____
_____
_____

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____

(PRINT)

Please complete all sections clearly in block capitals. Read guidance notes before completing

I confirm that the assessment process and purpose has been explained to me. I consent that information may be shared as appropriate by relevant health and social care professionals in the processing of this application.

Signature _____ **Applicant/Specified Person Date** _____

(Delete as appropriate)

3. PERSONAL CIRCUMSTANCES:

Marital Status: Single Married Widowed Separated Divorced Other

Living Circumstance: Alone With Spouse With partner With family With carer With Other

Describe Housing situation (See guidance document):

Who is the Principal Carer:

_____

What level of support do they provide?

(Please include contact details):

Assessment of Carer's needs completed? Yes No (Please attach if available)

Identify any family members, neighbours, friends who provide support:

Contact Person/Specified Person/Care Rep: _____ Relationship to applicant?

(Contact details address/phone/mobile): _____
_____

_____

GP: _____ Contact Details:
_____

PHN &/or CMHN: _____ Contact Details Health Centre:
_____

5. RECORD OF CURRENT COMMUNITY/HOME SUPPORT SERVICES (See Guidance Document before completing):

SERVICE Home Day Aids and

(Tick) Help/Support Care Respite Meals Supply Laundry Appliances

Hours/Times p/w or

relevant time or if

refused services

SERVICE PHN/CMHN Family support/ Therapy or Services

(Tick) Private Carer other discipline Day Hospital Refused

Hours/Times p/w or

relevant time or if

refused services

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____

(PRINT)

CSAR Applicant's Name _____ *DOB* _____

6(a). CURRENT DIAGNOSIS AND MEDICAL SUMMARY:

(Please include only relevant conditions)

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____

(PRINT)

6(b). DETAILS OF THE PERSON'S MENTAL HEALTH STATUS:

(Please attach any supporting documentation, if available)

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____

(PRINT)

7. CURRENT MEDICATIONS (See Guidance Notes - Not for Purpose of Dispensing)

Name of Drug Dosage Frequency Name of Drug Dosage Frequency
Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

8: ASSESSMENTS

8 (A): BARTHEL INDEX Please insert Date(s) Undertaken

WEIGHTING SCORE 3 2 1 0 SCORE SCORE
Bowel (Preceding week) Continent Occasional Accident Incontinent (Or needs an enema)
Bladder (Preceding 24-48 hours) Continent Occasional Accident Incontinent (Or Catheterised & Unable to Manage)
Grooming Independent Needs Help
Toilet Use Independent Needs Some Help Dependent
Feeding Independent Needs Some Help Unable
Transfer (From bed to chair & back) Independent Minimal Help Needed Major Help (1-2 persons) Needed Unable (No sitting balance)
Mobility Independent Walks with help of 1 person Wheelchair lindependent Immobile
Dressing Independent (Buttons, zips and laces) Needs Help (But can do half unaided) Dependent
Stairs Independent (Up & down must carry walking aid) Needs Help (Verbal or physical/carrying of aid) Unable
Bathing Independent (Getting in & out unaided & wash self) Dependent
Findings Independent (20) Low Dependency (16-19) Medium Dependency (11-15) High Dependency (6-10) Maximum Dependency (0-5) **TOTAL**
Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

8 (B): COMMUNICATION

Tick Date Signature
No problems
Retains most information and can indicate needs verbally
Difficulty speaking but retains information and indicates needs non-verbally
Can speak but cannot indicate needs or retain information
No effective means of communication

8 (D): OTHER ASSESSMENTS (Specify Tool Used)

Result Date Signature
Pressure Sore Risk
Falls Risk
Nutritional Risk
Wandering Risk
Other - Specify

8 (E): OTHER SIGNIFICANT MEDICAL/SOCIAL/ RISK FACTORS THAT SHOULD BE CONSIDERED AS PART OF THE CARE NEEDS ASSESSMENT:

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

CSAR Applicant's Name _____ *DOB* _____

DATE DATE

8 (C): COGNITIVE SCREENING REPORT - BY DATE ORDER IF MORE THEN ONE AVAILABLE

Cognitive Assessment Date Result Signature Date Result Signature
(Specify Screening Tool)

10(a). HEALTH PROFESSIONAL REPORTS.

(Please attach if relevant. Tick to indicate a report is appended)
Nursing Dietician Occupational Therapy Speech and Language Other
Physiotherapy Psychology Podiatry Social Work

IF LONG TERM CARE IS NOT DETERMINED TO BE APPROPRIATE-THE FOLLOWING SERVICE(S) ARE RECOMMENDED BY LPF

Home Day Meals Aids/
Help/Support Care Respite Supply Laundry Appliances
PHN/CMHN Therapy or other Day Other Other
discipline Hospital (Specify) (Specify)

CSAR Applicant's Name _____ *DOB* _____

9: ADDITIONAL COMMENTS e.g. Employment, Recreational or Social Needs

(Attach supporting documentation):

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

Confirmation of MDT's Recommendation
Name: _____
Role: _____ Date: _____
Signature: _____

Confirmation of MDT's Recommendation
Name: _____
Role: _____ Date: _____
Signature: _____

Service Recommended
Comment(s)

Confirmation of LPF's Determination
Name: _____
Role: _____ Date: _____
Signature: _____

Confirmation of LPF's Determination
Name: _____
Role: _____ Date: _____
Signature: _____

Confirmation of LPF's Determination
Name: _____
Role: _____ Date: _____
Signature: _____

12. LPF DETERMINATION OF CARE NEEDS FOR COMPLETION BY LPF ONLY

It is **the determination** of this LPF that this person's overall care needs are currently best met by:
(Please Tick) Additional Information
Long Term Residential Care Setting
Sheltered Housing
Other (Specify)
At Home with Community Supports
Likelihood of change in personal circumstances Low Risk Medium Risk High Risk

– 4 –

10(b). SPECIALIST ASSESSMENT

(Best practice recommends that all older people should have a Consultant Geriatrician/Old Age Psychiatry assessment prior to a decision being made about their future care needs.)

Geriatric Medicine Completed Date: **Signature:**
Old Age Psychiatry Completed Date: **Signature:**
Rehabilitation Consultant Completed Date: **Signature:**
Neurologist Completed Date: **Signature:**
Other(Specify) Completed Date: **Signature:**
Specialist Comment:
(Or append report)
Completed by: NAME: _____ Specialty: _____ Date: _____ Signature: _____
(PRINT)

11. RECOMMENDATION BY MDT. For Completion by MDT. See Guidance Notes

It is the recommendation of this MDT that this person's overall care needs are currently best met within a Long Term Residential Care Setting (Please Tick):
Yes No
Name & Signature of Professional Co-ordinating completion of this CSAR Form
NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

Appendix Two Medical Determination Letter.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Nursing Home Support Office
Unit 3
Ardee Business Park
Hale Street
Ardee
Co Louth

Tel: 041-6871515/525/529
Fax: 041-6871598

Client ID: xxxxx

DATE

NOK Contact Details
Xxxx
Xxxx
xxxx

Re: Mr/Ms XXXXX – Nursing Homes Support Scheme

Dear Mr/Mrs xxxx,

I refer to the application for a care needs assessment for the above named requested under the Nursing Homes Support Scheme.

It is the view of the Local Placement Forum that the applicant requires long term residential care. I enclose a copy of the Common Summary Assessment Report (CSAR) on which this determination is based. This information is private and confidential to the applicant (the person whose care needs have been assessed).

The care needs assessment is phase one of the application process for the Nursing Homes Support Scheme. This letter **is not** approval of funding under the Scheme; rather it confirms that the outcome of the assessment is that the applicant's care needs are best met by admission to long term residential care. You must now await the outcome of the financial assessment **and** confirmation from the HSE that funding is available to support the cost of care. If the applicant wishes to enter long term residential care without prior approval of financial support, they are free to do so but at their own financial risk, as approval of State Support is subject to the outcome of the financial assessment. We will write to you again to let you know the final outcome of the financial assessment.

If further clarification is required on this matter please do not hesitate to contact this office.

Yours sincerely,

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Lorr
Cha

App

Nursing Home Support Office
Unit 3 Office Unit
Ardee Business Park
Hale Street
Ardee
Co Louth

Tel: 041-6871525/515/529
Fax: 041-6871598

eting.

Date

NOK Contact Details
Xxxx
Xxxx
xxxx

Re: Mr/Mrs XXXX, Nursing Homes Support Scheme

Dear Mr/Mrs XXXX,

I refer to the application received under the Nursing Homes Support Scheme in respect of the above named who has been deemed as requiring long term residential care.

The application for State support has been assessed in accordance with the Nursing Homes Support Scheme Act 2009 and the applicant's assessed contribution has been calculated as follows: -

Contribution to Cost of Care Assessment	**Totals €**
80 % of weekly income (pensions etc)	€xxx
7 ½ % Assessed weekly income from Cash Assets	€xxx
7 ½ % Assessed weekly income from Principal Residence/ Farm / Relevant Business (3 year cap applies)	€xxx
7 ½ % Assessed weekly income from other relevant assets	€xxx
Applicant's assessed total weekly contribution	€xxx

The weekly amount the applicant must pay to the nursing home towards the cost of their care has been assessed as €xxx per week.

This letter is not an approval for funding under the scheme. It confirms the client's contribution towards the cost of their care.

Next steps

1. Please advise this office of your choice of nursing home, if your preferred nursing home is not available, an alternative approved nursing home **must** be chosen. A list of approved nursing homes is available at www.hse.ie or from this office
2. Please confirm with the proprietor/person in charge of the chosen nursing home that they can meet the applicant's care needs and can offer a place for the above named.
3. Please contact this office, in writing, within 20 working days of receipt of this letter to confirm the chosen nursing home. This will enable the HSE to calculate the rate of State support and to establish if funding is available for this placement.
4. The HSE will then make a determination in regard to the application and a formal decision letter will issue regarding approval of State support funding.

Please note that should the applicant's assessed weekly contribution equal or exceed the agreed cost of care in the chosen nursing home then no State support will be payable.

If contact is not made within 20 working days it will be considered that you no longer wish to proceed with the application and your application will be withdrawn. In the event that you wish to reapply for financial support under the Nursing Home Support Scheme you may do so by submitting a new application or by submitting a written request to reactivate the application to the above address.

If you are dissatisfied with the client contribution decision, you have a right of appeal. The appeal must be submitted in writing within 40 working days of notification of this decision. The contact details of the designated Appeals Office are listed below: -

Appeals Office:
HSE Dublin North East,
Bective Street
Kells,
Co. Meath

Phone: **046 9251262**
Fax: **046 9251774**

If further clarification is required on this matter please do not hesitate to contact this office.

Yours sincerely,

_____
Maura Ward,
Area Co-ordinator Services for Older People.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Apl

Nursing Home Support Office
Unit 3
Ardee Business Park
Hale Street
Ardee
Co Louth

Tel: 041-6871515/525/529
Fax: 041-6871598

Client ID xxxxx

Mr Seamus Mc Caul,
Director of Nursing,
Drogheda Services for Older People

The Cottage Hospital,
Scarlet Street,
Drogheda,
Co. Louth.

Re: Mr/Ms XXXX, Client ID xxxxx
Nursing Homes Support Scheme Act 2009.

Dear Mr Mc Caul,

I write to inform you that following the financial assessment under the Nursing Homes Support Scheme the above named is required to contribute €xxxxx per week towards the cost of his/her care from his/her date of admission.

You are obliged to inform this office of the death or discharge of this client within 72 hours. Failure to do so could result in a fine of €1,000.

Payment will only commence when the completed Confirmation of Resident Admission form (attached) is received by this office.

Should you have any queries, please contact the above listed office.

Yours sincerely,

Maura Ward,
Area Co-ordinator Services for Older People.