Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Long Stay Charges

National Guidelines

1. Legislative Framework

The legal basis for levying a charge on a person for long stay in-patient services is:

- Section 53(2)(a) of the Health Act 1970 as amended by the Health (Amendment) Act 2005.
- Health (Charges for In-Patient Services) Regulations 2005 S.I. No. 276 of 2005

Section 53(2)(a) of the Health Act 1970 as amended by the Health (Amendment) Act 2005 provides that the Minister for Health and Children *'shall, with the consent of the Minister for Finance, make regulations providing for the imposition of charges for in-patient services in specified circumstances on persons to whom the in-patient services are provided or on specified classes of such persons'* and Section 53(2)(b) allows for the Ministers *'specifying the amounts of the charges or the limits to the amounts of the charges to be made'*

In-Patient Services is defined at Section 51 of the Health Act 1970 as meaning *'institutional services provided for persons while maintained in a hospital, convalesent home or home for persons suffering from physical or mental disability or in accommodation ancillary thereto'*

Legal opinion received by the HSE advises that the legislation and the regulations apply to all persons who are provided with in-patient services where (a) those persons are residing in a long stay institution and (b) those persons with an intellectual, physical or mental disability that are residing in community type residences.

2. Patients/Clients Charges

Charges

The regulations provide the statutory basis for the imposition of charges for persons in receipt of inpatient services whether or not such persons have full or limited eligibility. The regulations provide for two different classes of person on whom charges can be levied and the maximum charge which can be imposed in respect of each class. With effect from 14th July 2005, charges may be levied on persons who are in receipt of in-patient services in premises where nursing care is provided on a 24 hours basis, and in premises where nursing care is not provided on a 24 hour basis. The Regulations provide for a different level of charge in respect of each class as follows:

Class 1

Class 1 refers to people in receipt of in-patient services on premises where nursing care is provided on a 24 hour basis on those premises. In this case, a weekly charge of €120 can be levied or the total weekly income of that person less €35, whichever is the lesser.

Class 2

Class 2 refers to people in receipt of in-patient services on premises where nursing care is not provided on a 24 hour basis on those premises. In this situation, a weekly charge of €90 can be levied, the total weekly income of that person less €55 or 60% of the weekly income of that person, whichever is the lesser.

Nursing care means, care provided by a fully qualified and state registered nurse. It does not mean care provided by a nurse's aide, care assistant or house parent.

In relation to Class 1, nursing care on those premises means that there is a nurse physically present on a permanent basis, i.e. 24 hours basis, all day, every day. The nurse may only be a bell-ring away, nonetheless, they are on the premises.

In relation to Class 2, nursing care on these premises means that there is a nurse rostered for duty for less than 24 hours a day. Where a nurse is not rostered for duty, these regulations do not apply.

Commencement of Charges

Under Section 4(b)(6) of the Health (Amendment) Act 2005 a person shall be charged where in-patient services have been provided to that person for a period of not less than 30 days or for periods aggregating not less than 30 days within the previous 12 months from the commencement of the regulations i.e. 14th June 2005. As a result, charges can only recommence from 14th July 2005.

Exemptions

Under Section 4(b)(3) of the Health (Amendment) Act 2005 a charge is not payable where in-patient services concerned are provided to:

- A person under 18 years of age
- A woman in respect of motherhood
- A person detained involuntarily under the Mental Health Acts 1945 to 2001
- A person who is in hospital for the care and treatment of patients with acute ailments (including psychiatric ailment) and requires medically acute care and treatment in respect of any such ailment
- A person who in the opinion of the HSE has contracted Hepatitis C directly or indirectly from the use of Human Immunoglobulin Anti-D or the receipt within the State of another blood product or a blood transfusion.

Reduction or Waivering of a Charge

Section 4(b)(4) of the Health (Amendment) Act 2005, provides that the HSE may reduce or waive a charge imposed on a person if it is of the opinion that, having regard to the financial circumstances of that person (including whether or not that person has dependants), it is necessary to do so in order to avoid undue financial hardship in relation to that person.

A person or their representative may make a request to the Authorised Officer as designated by senior management, to reduce or waive the charge for maintenance on financial hardship grounds. Financial Hardship needs to be demonstrated to the satisfaction of the Authorised Officer that the money remaining with the person having taken the charge into account is insufficient to meet their reasonable needs.

Calculation of Charges

All new patients/clients who commenced receiving in-patient services from 14th July 2005, should be financially assessed in order to establish their ability to pay maintenance charges. In this regard an Assessment Form (Appendix A) should be completed and submitted to the Authorised Officer as designated by senior management, for the determination of the relevant charge to be raised.

All patients/clients that were receiving in-patient services as at 14th July 2005, should be identified and their ability to pay charges should be reviewed immediately. Where there is sufficient information on file at anytime from 2004 to carry out this review, patients/clients may not be requested to complete the

Assessment Form. In such cases the HSE may arrange same. In cases, where it is established that the patients/clients sole source of income is a DSFA payment, the current rate of this payment may be used to carry out an assessment regardless of whether the information on file predates 2004. However, where the patient/client has a separate source of income and same needs to be verified, an assessment form should be completed by the patient/client or their next of kin for a decision on the relevant charge. Assessment Forms should be filed on each patient's/client's file. The patient/client or next of kin where appropriate should be advised of the revised charge effective from 14th July 2005.

The following criteria may be used to establish the patient's/client's charge:

a) In the case of a single/widowed person:

   calculate total weekly income
   less
   minimum allowance of €35 (or €55 for Class 2) per week
   less
   allowable expenses (See below).

   Where the amount calculated is greater than €120 (or €90 or 60% of total weekly income for Class 2), the weekly charge will be €120 (or €90 or 60% of total weekly income for Class 2). Where the amount calculated is less than the maximum charge payable, the charge will be the amount calculated. (See Examples at Appendix B)

b) Where a married couple's sole source of income is the Non-Contributory Old Age Pension (NCOAP) or equivalent amount, no charge will be levied.

c) In the case of a married person,

   calculate total weekly income of the patient/client and their spouse
   less
   married couple's rate of the NCOAP including age allowances which includes €35 (Class 2 €55) allowance and normal allowable expenses (See examples at Appendix B)

   Where the amount calculated is greater than €120 (or €90 or 60% of total weekly income for Class 2), the weekly charge will be €120 (or €90 or 60% of total weekly income for Class 2). Where the amount calculated is less than the maximum charge payable, the charge will be the amount calculated. (See examples at Appendix B)

d) Persons with an adult or child dependent whose sole income is either the NCOAP or whose sole income does not exceed an equivalent amount of the NCOAP may not be charged for their maintenance in a long stay institution.

Allowable Expenses

Charges may be reduced or waived in order to avoid undue financial hardship having regard to the patient's/client's financial circumstances. The following expenses may be allowable when calculating the appropriate charge:

- Dependant adult/child
- Life Assurance
- Medical Insurance
- Medical Costs (including prescription costs)
- Rent/Mortgage Allowances
- Loans/Repayments
- Maintenance Payments

- Travel Costs
- Other Outgoings

Dependant adult/child: For the purposes of assessment, the charge may be waived if the person, who has been assessed for a charge, has a dependant. The charge may only be waived if the total income of the patient does not exceed the current Non-Contributory Old Age Pension rate plus the adult dependent allowance for each adult or child dependent (NCOAP €166pw + €109.70pw x No. of Dependents).

When completing the Assessment Form in a case where there is one dependent, adult or child, a personal allowance may be deducted of €275.70 (current NCOAP rate plus adult dependent rate). For each additional dependent, a further allowance of €109.70 per week may be allowed when completing the financial assessment.

It should be noted that as an interim measure for Phase 1 implementation of charges, the adult dependent rate is being allowed in the case of each child dependent. This matter will form part of the overall review of the re-introduction of charges which is due to take place within the next six months.

Please note that where the spouse is aged under 66 years, it is possible that the spouse will qualify for a NCOAP pension when he/she reaches 66 years. The financial assessment may be reviewed at this stage. If a waiver is made on the basis of a child dependent, a review should be carried out as necessary.

The Social Welfare (Consolidation) Act 1993 defined dependants as follows:

> ***'adult dependant'*** means – a spouse of the beneficiary who is being wholly maintained by him/her or a person over the age of 16 years being wholly or mainly maintained by the beneficiary and having the care of one or more qualified child who normally resides with the beneficiary where the beneficiary is –
>
> (a) a single person
>
> (b) a widow
>
> (c) a widower or
>
> (d) a married person who is not living with and is neither wholly nor mainly maintaining nor being wholly or mainly maintained by such married person's spouse
>
> ***'Child dependant'*** means in relation to a beneficiary any child not being an adult dependant who is dependant on that beneficiary for support and who is under the age of 18 years or is over the age of 18 years and is regarded as attending a course of study' *(up to the age of 22 years when pursuing a course of study)*

For the purpose of these guidelines, the above interpretation may be used when deciding whether to reduce or waive a charge due to a person having an adult or child dependent.

Life Assurance: Where the patient has a life insurance policy, then an allowance may be made for the cost of this policy, provided the sum assured represents an

appropriate level of cover to fund the cost of funeral expenses (the contract funeral rate can be used as a guide).

Where the sum assured is for a figure which is in excess of the reasonable cost of funeral expenses, the premium payable may be apportioned to cover the allowable expenses. The allowance under this heading is provided only for the patient/client. No allowance may be provided for other members of the family. Documentary evidence of the premium should be submitted by the person or their representative.

Medical Insurance: Where a person has a current medical insurance policy, allowance may be made for a reduction of the charge where necessary to facilitate the continued payment of premium. Documentary evidence of the premium should be submitted by the person or their representative.

Medical Costs (including prescription costs): An allowance may be made for exceptional medical costs incurred by the patient/client and/or their dependent spouse or children. In cases where the patient/client has full eligibility, allowable expenses may only include public medical costs which are not covered by the medical card scheme. Exceptional medical costs may be allowable to patients/clients who do not have full eligibility, where such costs are incurred as part of treatment provided under the public health system or where costs are being incurred under the drugs payment scheme. Documentary evidence should be sought to support the application.

Rent/Mortgage Allowances: The cost of rent/mortgage of the patient's/client's home is an allowable expense in order to provide for and facilitate the security of tenure on his/her home. However, it is not allowable in cases where there is a person residing in the house who is not a dependent of the patient/client. The Authorised Officer should seek documentary evidence to support the application.

Loans/Repayments: Allowance may be made to reduce the charge imposed where the person has bank/credit union loans/debts which need to be repaid. If savings/assets exist which could be used to reduce or repay the debt, this option should be exercised before any allowance is made. Documentary evidence should be sought to support the application.

Maintenance Payments: Where a court order exists for maintenance payments to a spouse, this may be taken into account when calculating the charge due to ensure undue hardship does not exist. Documentary evidence should be sought to support the application.

Travel Costs: Where the person's dependent spouse or child has to rely on public transport to visit the patient, a claim for an allowance may be considered as an exceptional expense but it is envisaged that this allowance would only be approved in very exceptional cases. Petrol costs are not allowable under this heading. Documentary evidence should be sought to support the application.

Other Outgoings: Other exceptional outgoings may be considered based on its merits. The Authorised Officer may only allow such costs in very exceptional cases. This allowance may form part of the overall review of the process which is due to take place within six months. Documentary evidence should be sought to support the application.

Appeals

In cases where the patient/client or their next of kin as appropriate, are dissatisfied with the Authorised Officer's decision regarding the amount of the charge, they may appeal the decision to the relevant Appeals Officer. The patient/client or the next of kin where appropriate, should be advised of the appeals process on being notified of the charge.

3. Business Process

The business process is as follows:

1. Issue letter (See Appendix C) advising the patient/client or their next of kin where appropriate of the new arrangements and that charges will recommence from the 14th July 2005, following assessment by the HSE/Voluntary Non-Statutory Sector.
2. All new patients/clients who receive in-patient services from the 14th July 2005 and who were not previously assessed to determine their charge, should be financially assessed in order to establish their ability to pay maintenance charges. In this regard an Assessment Form (Appendix A) should be completed and submitted to the Authorised Officer as designated by senior management for determination of the relevant charge to be raised.
3. All patients/clients that were receiving in-patient services as at 14th July 2005 and had been previously assessed, should be identified and their ability to pay charges should be reviewed immediately on the Assessment Form. In order not to impose an administrative burden on people, patients/clients may not be requested to complete the Assessment Form in cases where there is sufficient information on file to carry out this review. In such cases the HSE may arrange same.
4. Assessment Forms should be filed on each patient's/client's file in all cases.
5. All patients/clients or their next of kin where appropriate should be notified of the charge effective from 14th July 2005 (See Appendix D). A copy of the calculation sheet (See Appendix A) giving details in regard to how the charge was calculated should be issued with this notification. Details of allowable expenses should also be advised to the patient/client or their next of kin. Copy of this notification should be placed on the patient's/client's file.
6. In cases where the level of the charge is in dispute with the Authorised Officer, details of the patient's/client's financial circumstances should be submitted to the Authorised Officer on the Assessment Form if not already submitted for a decision. The Assessment Form should be forwarded to the relevant Community Welfare staff/Administrative Officer who should verify the patient's/client's financial circumstances. Based on the patient's/client's income as verified with the Community Welfare/Administrative staff, the patient/client or their next of kin where appropriate should be advised of the revised charge. Where the patient/client or next of kin are not satisfied with the charge determined, they should be advised to make a submission to the Appeals Officer.
7. All decisions should be filed on the patient's/client's file.
8. In cases where the patient/client is non compos mentis and there is no known next of kin, the relevant administrative officer should note same on the file along with filing the Assessment Form on the file.

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