DISTRICT NURSING - CLIENT CONTRIBUTION (HACC/CHSP)

UR Number: _____

Family name: _____

Given names: _____

Date of birth: ____/____/_____ MO: _____

(*Affix patient identification label here if available*)

Client Contribution Agreement Form (HACC & CHSP)

1. Establish eligibility for funding co-contribution

District Nursing provides care to a range of consumers from diverse backgrounds, ages and circumstances. In order to best service your care needs we need to establish what funding source your care comes under, and what (if any), fees you will be required to pay.

The following is to allow us to calculate service provider fees, or consumer contribution fee.

2. Client Contribution

Please tick appropriate category below

	Contribution Level	Determination	✓	Per-visit cost
CHSP	All clients	☐ >65 ☐ >50 Aboriginal or Torres Strait Islander		$6.00
HACC	No Fee	☐ Aboriginal or Torres Strait Islander ☐ Refugees and people seeking asylum ☐ Homeless or at risk of homelessness ☐ Children in Care or child protection ☐ Orange Door Clients		$0.00
HACC	Low Fee	☐ Valid Concession Card ☐ Children of concession card holders		$6.00
HACC	Medium	☐ Meets eligibility criteria but does not qualify for low or no fee groups*		$18.00
HACC	Full cost recovery	☐ Client does not meet HACC eligibly criteria and is seen in a private capacity		*discuss with NUM*

HACC fees current @ 1 November 2025

*HACC Eligibility criteria = People under 65 (or under 50 for Aboriginal or Torres Strait Islander people), have a chronic illness, mental health issue, disability, or other condition that puts their independence at risk, and require support with daily living.

SPECIAL CIRCUMSTANCES

Are there special circumstances which may make it difficult for you to pay the set fee for your service(s)?

Complete "Consideration for fee waiver" ☐ Yes ☐ No

Discuss with DNS CC or NUM Fee waiver approved ☐ No ☐ Yes

NUM/DNS CC Signature _____ Date: _____ Review Date: _____

Fees to be set at: $ per visit + consumables

Monthly fees are capped at $78.00 for CHSP and HACC clients

NOTE: Wound care product costs are additional.
Fees are reviewed annually per Dept Health Services notification.
You will be notified by mail if the fees are increased, or at 12 monthly review.

Client Contribution Agreement

I agree that this information can be used to set fees for the community services I receive, and acknowledge the fee I am charged will be reviewed annually by Northeast Health Wangaratta, District Nursing Service. I am aware that I have the right to request a copy of the NHW Community Fees Policy

Date:	Consumer/Carer	Witness
Name		
Signature		

DO NOT WRITE IN THIS BINDING MARGIN

DISTRICT NURSING-CLIENT CONTRIBUTION UR 200-11

VER 06/26

DISTRICT NURSING - CLIENT CONTRIBUTION (HACC/CHSP)

UR Number: _____

Family name: _____

Given names: _____

Date of birth: ____/____/_____ MO: _____

(*Affix patient identification label here if available*)

Consideration for fee waiver

Identifying factors affecting your ability to pay fees for services:

Do you have any high expenditure in any of the areas below?	Tick if Yes	Is this a short-term or an ongoing cost?
Pharmaceutical or medication costs		
Aids and equipment, including continence products		
Specialist care		
Additional school costs		
Special foods		
Temporary care or respite		
Special clothing		
Utilities (telephone, water, power, gas) where there is higher usage due to disability (for example, people using pumps over night do not get a concession on utilities bill)		
Medical supplies		
Increased property costs where this is related to the additional cost of disability (for example, if you have had to modify your house or move to access services, replacing carpets and bedding)		
Transport (for example, where due to a disability you are not able to use your own car or public transport)		
Specialist care or related costs (eg. accommodation and travel costs to see a specialist at another location)		
Health or medical insurance costs due to disability		
The cost of services other than HACC/ CHSP services		
Other (please specify)		

I agree that this information can be used to set fees for the service/s I receive. I acknowledge that the fee I am charged will be reviewed from time to time at my request or the service provide's request. A review of fees waived will occur on a three monthly basis.

Consumer signature: _____ Date: ____/ ____/ _____

Witness: _____ Fee Waiver Review Date: ____/ ____/ _____