Queensland Government

Metro North Health

TRANSITION CARE PROGRAM AGREEMENT

Service / Site: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Welcome to the Transition Care Program (TCP)

This program seeks to optimise the functioning and independence of older people after a hospital stay. This program provides additional time limited support following your discharge from an acute hospital and helps you transition (move) to your next phase of care. The program includes **low intensity** therapies such as physiotherapy and occupational therapy as well as nursing or personal care support.

The program may include:

1. A short period of additional support and services when you return home **OR**
2. A short inpatient stay at Zillmere Campus with therapy to increase your functional abilities and plan support services prior to returning home **OR**
3. A short inpatient stay at Zillmere Campus while you plan your move to residential care

The steps so far:

1. You have already been referred to the Aged Care Assessment Team (ACAT) for an assessment for eligibility to this program.
2. This agreement is required for admission to the program and is necessary as a daily fee is charged (please see below).

NOTE: Information about the Transition Care Program is available for you and your family from the person coordinating your discharge.

The next steps:

1. Following completion of this agreement, your transfer to the program will be arranged by staff in your current ward.
2. Your admission will be undertaken by a case manager from the program. Your case manager will work with you to develop a written care plan with specific goals and explain the types of services which the program can provide to assist your recovery. Your goals will be reviewed during your time on the program and will be based on your progress with meeting your goals. Discharge planning will be an integral part of this program.
3. Nursing, allied health and support services will then commence for the duration as discussed and agreed with your case manager at your initial assessment.

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Fees and charges

The Commonwealth and State Governments have determined that a nominal client care fee will be payable. The fee is calculated as a daily rate and dependant on the care setting.

The maximum value of the care fee for ***Residential Transition Care*** is 85% of the current single aged pension rate. This fee is $56.87 per day ($398.09 per week).

Please note: In addition to daily care fees, you will also be required to cover the cost of your medication supplied by a nominated private pharmacy.

The maximum value of the care fee for ***Community Transition Care*** is 17.5% of the current single aged pension rate. This fee is currently $11.71 per day ($81.97 per week).

Metro North Transition Care Program will send you a monthly bill.

A fee reduction can be discussed with your case manager/discharge coordinator if there are reasons that this fee will cause financial hardship. This fee reduction must be approved by the Executive Director responsible for the Metro North Transition Care Program. This fee adjustment will not impact on the services which you and your case manager have determined you require to meet your goals.

About this Agreement

The Transition Care Program (TCP) Agreement is made between the Metro North Hospital and Health Service (HHS) and ..... (client) through Metro North Transition Care Program. Fees will commence on the day of your transfer and admission to the Transition Care Program.

I acknowledge that I have read and understood the information above and the additional information provided. I consent to:

- Metro North Transition Care Program using my information in a confidential manner.

☐ I agree to register with the nominated Qld Health Pharmacy provider for the supply of my medication and agree to pay the costs of my prescriptions while I am on the Residential Transition Care Program

☐ I agree to accept a place on the Transition Care Program

☐ I agree to accept a place on the Transition Care Program pending approval of my fee reduction request

Signed: ..... Date: ..... / ..... / .....

Name: .....

Reason why client was unable to sign: .....

If the client is unable to give informed consent, a carer/authorised representative may sign on his/her behalf *(if applicable, provide reason why client is unable to sign)*

Witnessed by:

Name:	Signature:
Designation:	Date:

DO NOT WRITE IN THIS BINDING MARGIN