

TIER 2 APPLICATION FORM

For participation in Tier 2 of the Aged Care On-site Pharmacist Measure

This form is to be used by Residential Aged Care Homes (RACHs) to apply to participate in Tier 2 of the Aged Care On-site Pharmacist (ACOP) Measure. Noting that:

- Tier 2 of the Measure relates to arrangements where a RACH claims and receives payments to engage an ACOP to work at the RACH. Tier 1 of the Measure relates to a community pharmacy providing an on-site pharmacist to work at a RACH
- RACHs are only eligible to participate in Tier 2 of the Measure if they have been unsuccessful in sourcing an ACOP from at least one community pharmacy ([Tier 1](#))
- A separate application must be submitted for each National Approved Provider System Number (NAPS ID), now called Government Provider Management System (GPMS) number. Please note you will need to enter your number in the NAPS ID format e.g. 12345 (i.e. without the PRV-prefix), as the new GPMS format will not be accepted.

A signed version of this document must be uploaded to the PPA Portal by the RACH when applying to participate in the ACOP Measure. Information regarding how to register and apply in the PPA Portal can be found in the [ACOP Measure Tier 2 \(RACH\) Portal User Guide](#). The pharmacist's time on-site under the Measure can only commence once the PPA has reviewed and approved your application in the PPA Portal.

Applicant (Residential Aged Care Home) Details

Name [insert full name of RACH]

NAPS ID [insert NAPS ID]

Address [insert address]

Email [insert email address]

On-site Pharmacist Start Date

Please indicate below the **intended** start date of participation in the Measure, noting that the start date must be:

- **on or before** the first date that a pharmacist funded under the ACOP Measure is intended to work at the RACH; and
- **after** any existing Residential Medication Management Review (RMMR) Program/Quality Use of Medicines (QUM) Program/ACOP providers delivering services to the RACH have been given notice of the RACH's intention to cease the relevant RMMR/QUM/ACOP service relationship.

| | |
|----------------------------|--------------|
| Intended Start Date | <enter date> |
|----------------------------|--------------|

*Note: Days worked can be claimed from **the later of**, the start date entered above, or the date that the RACH's application to participate in the ACOP Measure is approved by the PPA.*

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Confirmation of Notice to other Service Providers

Please tick one of the following boxes according to which applies:

- The RACH was not participating in the RMMR/QUM programs or the ACOP Measure at the time of signing this document.
- The RACH was previously participating in the RMMR/QUM programs or ACOP Measure (Tier 1) and notice has been provided to the RMMR/QUM/ACOP provider of the RACH's intention to cease the relevant RMMR/QUM service agreements or ACOP authorisation.

If the second box (above) was ticked, please provide details of when notice of cessation was provided to the QUM/RMMR/ACOP providers. Please complete for each program the RACH was participating in.

Please note that filling in this form does not constitute notice of termination and termination should be clearly communicated with the existing provider(s) where applicable. Most agreements require at least 30 days' termination notice.

| Program/Measure | Date Notice of Cessation Provided | Effective Termination Date (if notice period is not 30 days) |
|--|-----------------------------------|--|
| Notice of cessation <u>must</u> be provided before signing this application i.e. "notice of cessation" date provided below must not be a future date. | | |
| ACOP | <enter date> | <enter date> |
| QUM | <enter date> | <enter date> |
| RMMR | <enter date> | <enter date> |

Community Pharmacy Contact

Please tick to confirm:

- The RACH has attempted to source an on-site pharmacist through a Community Pharmacy under Tier 1 of the ACOP Measure and was unsuccessful.

Please provide the details of the pharmacy contacted below:

| | | | |
|-----------------------------|--|-----------------|--|
| Pharmacy Name | | | |
| Pharmacy Owner/Manager Name | | Date of Contact | |
| Pharmacy Phone Number | | Pharmacy email | |

Note: The RACH must keep a record of any attempt to access an ACOP through a community pharmacy (Tier 1).

Intended Credentialed Pharmacist Details

Please nominate below at least one credentialed pharmacist that the RACH plans to engage in the ACOP role. *Note: should the pharmacist(s) change, a new application is **not** required.*

| | | | |
|------------------------------|--------------|-------------------|----------------|
| Credentialed Pharmacist Name | <enter name> | Credential Number | <enter number> |
| Credentialed Pharmacist Name | <enter name> | Credential Number | <enter number> |
| Credentialed Pharmacist Name | <enter name> | Credential Number | <enter number> |

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Signatures and Obligations

By signing below the RACH and its representatives confirm the RACH meets all eligibility requirements in relation to the ACOP Measure and that the RACH and the ACOP will comply with the obligations set out in the [Tier 2 ACOP Measure Rules](#).

Please note, if the RACH is part of a broader corporate or not-for-profit group, this document must be signed by both the RACH Facility Manager and a representative from the group head office, where one exists.

Residential Aged Care Home obligations under the ACOP Measure

RACHs participating in the Measure are subject to [PPA's General Terms and Conditions](#) and must adhere to the ACOP Measure Rules. This includes, but is not limited to:

- Ensuring that ACOP Measure funds are not used for any purpose other than the ACOP's pay and on-costs
- Ensuring that funding is paid into the RACH or RACH Head Office bank account
- Ensuring that ACOP work is undertaken on-site at the RACH in full or half day blocks, per a regular working schedule
- Ensuring that the pharmacist/s providing on-site services are credentialed and eligible to do so
- Ensuring the [weekly timesheet and activities summary](#) is completed by the ACOP and a copy is retained by the RACH.

RACH Facility Manager Signature:

NAME

EMAIL ADDRESS

TELEPHONE.....

SIGNATURE

DATE.....

RACH Head Office Signature:

Note – this signature is only provided where the RACH is part of a corporate or not-for-profit group of RACHs.

NAME

POSITION.....

EMAIL ADDRESS

TELEPHONE.....

SIGNATURE

DATE.....