PFLEGESTÜTZPUNKTE
BERLIN
Beratung rund um Pflege und Alter

Information sheet No. 2

Criteria for need for care

People who are limited in their abilities and independence because of a physical, mental or emotional illness are considered to be in need of care. If the need for care is likely to last longer than six months, they can receive support from the nursing care insurance.

How do I apply? How can I get a consultation?

The application form can be obtained at the responsible health / nursing care insurance fund. After the application has been made, the care fund must provide information on free consultation at a care centre or by staff.

When is the decision made?

The care fund decides on the need for care within 5 weeks. Due to reconciliation rules, the deadline for issuing the notification is suspended for applications between 11/01/2016 – 12/31/2017. There are exceptions for urgent cases.
We recommend to contact a care centre in difficult situations.

How is the level of care determined?

After an application is submitted, the care insurance scheme commissions the medical service of the health insurance e. V. (MD) or other assessor. The assessor will contact you for a home visit to determine whether help is needed and to what extent. Friends, family or caregiver should be present during the visit. Documents (e.g. diagnoses, medication schedule, diagnostic findings) should be made available to make it easier for the assessor to identify the level of care. The assessor informs the nursing care insurance about the result of the assessment. The latter then sends the applicant a confirmation or refusal. The decision can be appealed within one month. The determination of the care level can be reviewed with the assessor.

The degree of independence is examined in six areas and evaluated by a points system (see table pg. 2). The subareas include:

1. Mobility
2. Comprehension and communicative skills
3. Behaviour and psychological problems
4. Own ability to self-sufficiency
5. Own management of burden relating to the disease or therapy
6. Structuring of everyday life and social contacts

Criteria included in the area of "mobility" are e.g. position change in bed, holding a stable seated position, changing seat, moving within the living area and climbing stairs.

Points					
0 to 12.4	12.5 to 26.9	27 to 47.4	47.5 to 69.9	70 to 89.9	90 to 100
No PG	PG 1	PG 2	PG 3	PG 4	PG 5

How care level becomes nursing degree ("transitional and acquisitions regulation")

All levels of care before 01.01.2017 are converted automatically. Those in need of care who have physical disabilities are placed in the *next higher* level of care. Example: Care level 1 becomes care level 2. Those having an existing restriction of daily living abilities (limitation of daily life skills) are placed in the *second higher* level of care. Example: Care level 0 becomes care level 2. The so-called "acquisition regulation" stipulates that no person in need of care should be worse off than before a legislative amendment. This means: in the case of a re-assessment, e.g. due to a request for a reassessment for a *higher* degree of care, the person *cannot* be placed in a lower degree for care. However, should it be determined that care is no longer necessary, care benefits will be suspended. The "acquisition regulation" also applies in the case of a change in care home or care insurance. In inpatient facilities, during a transitional phase in nursing level, the possible increase difference must be paid by the long-term care insurance until an adjustment is achieved.

Services:

The person in need of care decides for himself, who should provide support. If only family and friends provide care, cash benefits should be claimed. The care fund transfers a monthly care allowance in accordance with the determined care level. If a nursing service is commissioned, it can settle the amount of the corresponding payment in kind with the nursing care fund. Those in need of care who receive a care allowance must, 2 or 4 times a year (depending on care level), seek professional consultation in their own home. The consultation is to ensure the quality of care as well as provide guidance and practical support. The costs are covered by the long-term care insurance. If the consultation service is refused, the care benefit can be reduced or, in case of recurrence, completely withdrawn. Of course, the person in need of care also has the option of receiving joint assistance from family, friends, neighbours (cash benefits) and nursing services (payment in kind) as a combined service.

Service overview:

Benefit	PG 1	PG 2	PG 3	PG 4	PG 5
Cash benefit outpatient (private)	-	316 €	545 €	728 €	901 €
Benefits in kind outpatient (nursing)	-	724 €	1,363 €	1,693 €	2,095 €
Inpatient (nursing home) (Info. sheet 11)	125 €	770 €	1,262 €	1,775 €	2,005 €
Burden relief amount (Info. sheet 4)	125 €	125 €	125 €	125 €	125 €
Housing adaptation (Info. sheet 16)	4,000 €	4,000 €	4,000 €	4,000 €	4,000 €
Short-term care annually (Info. sheet 8)	-	1,774 €	1,774 €	1,774 €	1,774 €
Respite care annually (Info. sheet 8)	-	1,612 €	1,612 €	1,612 €	1,612 €
Day care (Information sheet 9)	-	689 €	1,298 €	1,612 €	1,995 €
Nursing aids (Information sheet 17)	40 €	40 €	40 €	40 €	40 €
Housing group surcharge (Information sheet 29)	214 €	214 €	214 €	214 €	214 €
Nursing consulting	Yes	Yes	Yes	Yes	Yes
Consulting at home	½ yearly	½ yearly	½ yearly	½ yearly	½ yearly
Nursing courses for caregivers	Yes	Yes	Yes	Yes	Yes

Conversion of benefits

It is possible to convert 40% of the benefits in kind into care and relief services. Here, instead of basic care, care service and domestic assistance can be claimed (see information sheet no. 4).

Co-payment in inpatient facilities

The payable co-payment within an inpatient facility is calculated uniformly per nursing home, regardless of the level of care. In addition there are the costs for accommodation, meals and the investment costs (see information sheet no. 11).

The staff at the Consulting Centre are happy to help you.

Free service number 0800 5950059

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