Information sheet no. 2

Criteria for the need for long-term care - long-term care insurance benefits

If people are physically, mentally or emotionally ill and are therefore impaired in their abilities and independence and require help from others, it is considered that they are in need of long-term care. If the need for assistance is likely to last longer than six months, they may receive support from long-term care insurance benefits.

How can an application be submitted? How do you get a personal advice session?

The application form can be requested from the responsible health/nursing care insurance provider. Once the application has been submitted, the long-term care insurance provider is required to provide information about a free advice session.

When do you receive the notification?

The long-term care insurance provider will decide on the need for long-term care within 5 weeks. There are some exceptions in urgent cases. We therefore recommend that you contact a care support centre if you have a difficult case.

How is the long-term care level assessed?

Once the application has been submitted, the long-term care insurance provider will send instructions to the Medical Service (MD). The MD assessors will make an appointment for a home visit to see whether any help is needed. Friends, family or carers should be present during the assessment if possible. Documents (e.g. diagnoses, medication plan, medical results) should be provided to make it easier for the assessors to identify the level of care.

The level of care depends on the individual's level in terms of restrictions in their everyday life. The degree of independence is assessed in six areas (modules) and evaluated using a points system (see table on p. 3). The sub-areas include:

1. Mobility
2. Cognitive and communicative abilities
3. Patterns of behaviour and psychological problems
4. Ability to take care of themselves
5. Ability to cope and deal independently with requirements and demands related to their illness and treatment
6. Organisation of everyday life and social contacts

Example: The criteria in the area of "mobility" include the ability to change position in bed, maintain a stable sitting position, to move from A to B and around the home and to use stairs

Summary of benefits for 2024

Benefit	Care level 1	Care level 2	Care level 3	Care level 4	Care level 5
Cash benefit outpatient (private), monthly	no benefit	332 €	573 €	765 €	947 €
Benefit for outpatient care (care benefit) monthly	no benefit	761 €	1,432 €	1,778 €	2,200 €
Discharge amount monthly Info sheet 4	€ 125	€ 125	€ 125	€ 125	€ 125
Home adaptation Info sheet 16	€ 4.000	€ 4.000	€ 4.000	€ 4.000	€ 4.000
Short-term care yearly Info sheet 8	no benefit	€ 1,774	€ 1,774	€ 1,774	€ 1,774
Disability care yearly Info sheet 8	no benefit	€ 1,612	€ 1,612	€ 1,612	€ 1,612
Daily care, monthly Info sheet 9	no benefit	€ 689	€ 1,298	€ 1,612	€ 1,995
Care aids consumption, monthly Info sheet 17	€ 40	€ 40	€ 40	€ 40	€ 40
DiPA Digital care applications monthly Info sheet 18	€ 50	€ 50	€ 50	€ 50	€ 50
Housing group allowance, monthly Info sheet 29	€ 214	€ 214	€ 214	€ 214	€ 214
Long-term care advice	yes	yes	yes	yes	yes
Advice service at home	Twice a year voluntary	Twice a year mandatory		4 times a year mandatory	
Long-term nursing courses for caregivers	yes	yes	yes	yes	yes
Inpatient (nursing home), monthly Info sheet 11	€ 125	€ 770	€ 1,262	€ 1,775	€ 2,005

The criteria will be categorised by the assessors using a points system. The points determined in a module are then converted into weighted points. The total number of weighted points will determine the level of care (PG).

Weighted points:

From **0 up to 12.4** points means **no care level**,

from **12.5 up to 26.9** points means **care level 1**,

from **27 up to 47.4** points means **care level 2**,

from **47.5 up to 69.9** points means **care level 3**,

from **70 up to 89.9** points means **care level 4**,

from **90 up to 100** points means **care level 5**.

The Medical Service will send the long-term care insurance provider the result of the assessment. The insurance company will then send the applicant an approval or refusal. Any appeal against the decision must be filed within a month. The report you were sent may be used to check whether the situation has been fully and correctly assessed.

Advice visit at home

Advice visits at home are mandatory for anyone receiving care benefits and must be reported to the care insurance companies every six months for care levels 2 and 3 and every quarter for care levels 4 and 5. This will be carried out by care services and other providers. The purpose of the advice is to ensure the quality of care and provide assistance and practical support. The costs will be covered by the care insurance company. However, if the appointments are missed, the care allowance may be reduced or withdrawn completely if this happens on multiple occasions. If you need addresses for care services, please contact a care support centre.

Services for domestic care

Usually, anyone who is in need of care may decide for themselves who they want to help them. If only friends and family help, the financial benefit should be claimed. The care insurance company will then transfer a monthly care allowance according to the care level determined during the assessment. If a care service has been appointed, it can invoice the care insurance company for the corresponding benefit in kind amount. Of course, anyone who is in need of care also has the option of receiving help from family members, friends, neighbours (cash benefit) and care services (benefit in kind) together (combined benefit).

In addition, a basic package for care home emergency calls will be paid for by the care insurance provider provided that certain conditions have been fulfilled, see also Information sheet 19.

Transfer of benefits

40% of the outpatient benefits for services can be transferred to everyday assistance that has been officially recognised under state law. In this situation, care services and domestic help can be claimed instead of basic care, see also Information sheet 4.

Staff at the care support centre will be happy to provide you with advice

Free service number: 0800 5950059

www.pflegestuetzpunkteberlin.de

The care support centres are operated by the state of Berlin and the care and health insurance companies based in Berlin