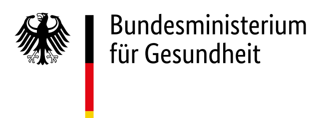


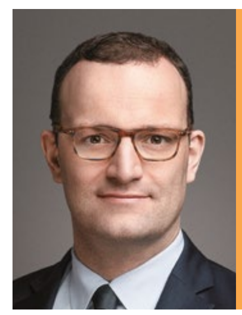
Long-Term Care Guide

Everything you need to know about long-term care

GUIDE

Long-Term Care Guide

Everything you need to know about care



Dear reader,

We are all getting older – every day, the average life expectancy increases by almost five hours. On average, boys born today will live to 78, and girls to 83. And many of us will be active into old age. As a result, our image of ageing has been turned upside down, in a positive sense. The times when older people were described as geriatric, that last stage of life was considered a time of standing still – this is no longer the case at all today. This longer lifespan has now come to include a major stage in life, which senior citizens want to shape in a positive way. This is partly the result of the good healthcare system we have today. Our healthcare system is not perfect. But we

can be quite proud of it in comparison to historical and international standards.

Nevertheless, a longer and more active life does not protect us against the possibility of requiring care. No one is safe from it – it can be the result of illness, very old age, or an accident. This is why long-term care insurance was introduced in 1995; since then people with care needs can count on the support of the community. With a view to the 2020s, when baby boomers will retire, we have initiated a large number of legal improvements in the care sector in recent years and have already achieved a great deal: more recognised people with care needs, significantly higher benefits, more support for caregiving relatives, and a strengthened nursing staff. And we are continuing to make improvements: in home care, in hospital nursing care, and in care for the elderly in care facilities.

I know from many conversations that there is a great need to improve care. At the same time, there is a willingness to do more – among both the young and old. This is precisely why we should use this time to openly debate this issue for the sake of generational equity. After all, care is about community and being together. Let's continue to work on this together.

Sincerely,

Jens Spahn
Federal Minister of Health

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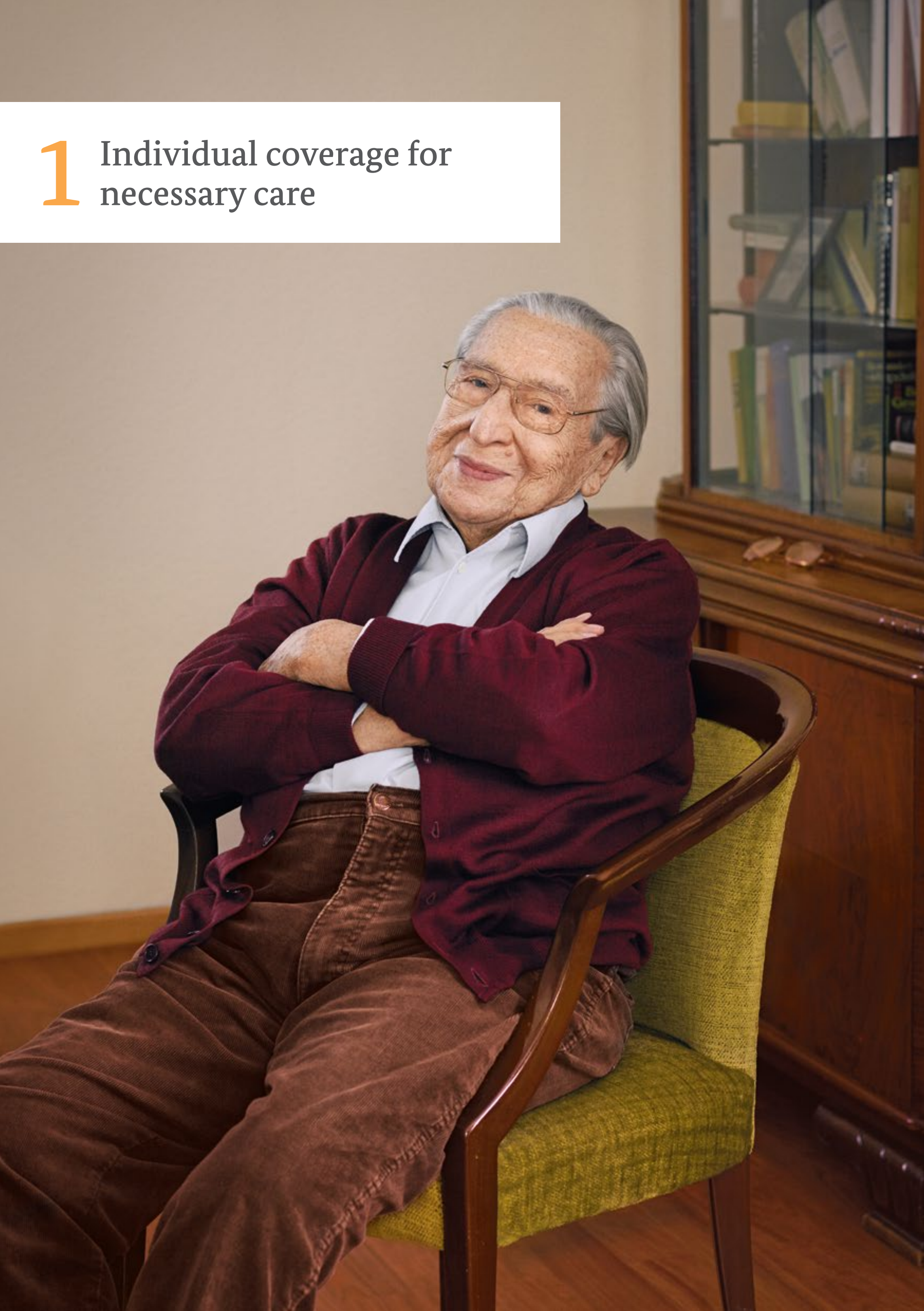
Introduction

The long-term care enhancement laws make the most comprehensive improvements to long-term care since the introduction of long-term care insurance over 20 years ago. These laws make long-term care in Germany more effective, individual, and accurate.

On 1 January 2017, the second long-term care enhancement law fundamentally redefined long-term care needs. Replacing the familiar three care levels are five new care grades with new benefit amounts. Until now, the need for care has mainly been associated with physical conditions, mental and psychological conditions are now given more consideration. To classify insured persons in need of care into one of the five care grades, a fundamentally new assessment tool has been developed.

Another important change in the area of long-term care insurance is the Care Staff Support Act (Pflegepersonal-Stärkungsgesetz – PpSG), which came into effect on 1 January 2019. This act is designed to bring tangible improvements to the everyday working life of care staff through better staffing and better working conditions in nursing care and care for the elderly. The measures contained in this law are important steps towards continuing to improve the care of patients and people with care needs.

This Long-Term Care Guide provides information on the benefits of the long-term care insurance and family members for the support of people with care needs and their caregiving relatives.



1 Individual coverage for necessary care

Every person wants to live as along a life as possible in good health. All the same, anyone could develop a need for long-term care. Long-term care insurance is available in order to ensure that you are covered in this situation. This chapter will show you how financing works, who is entitled to services, and what you have to know if you or a loved one need long-term care.

1.1 What is long-term care insurance?

Long-term care insurance was introduced on 1 January 1995 as an independent branch of the social insurance system. A comprehensive insurance obligation applies for everyone with statutory or private insurance. Those with statutory insurance are automatically enrolled in social long-term care insurance. Privately insured persons must purchase private long-term care insurance.

The services of social long-term care insurance are financed by the contributions that are generally financed equally by employees[1] and employers. When people with care needs receive benefits from the insurance and which benefits they are depends on the duration of the need of long-term care, the long-term care grade and the type of care. Does someone merely need help washing each day and going shopping? Can the person maintain their orientation? Can they live at home or do they need care around the clock in a nursing home? There are different long-term care grades based on the extent of the limitations to independence and capabilities.

1 In order to maintain readability, the female form will be used in some places. Both sexes are usually included in this.

The long-term care insurance gives people with care needs the opportunity to decide how they want to be cared for and by whom. They can choose to hire professional help or receive money to give to family members providing care as financial recognition of their work. The top priority is to enable people needing care to maintain their independence as much as possible. Social insurance, however, may not cover all of the costs of care. The rest is covered by the people with care needs themselves, by immediate family members if necessary, or – in the case of financial need – by social assistance benefits. Long-term care insurance is therefore also referred to as “partial cost insurance”. The Eleventh Book of the Social Code (SGB XI) contains all relevant long-term care insurance regulations.

Why is long-term care insurance necessary?
All industrial nations have one thing in common: Their populations are ageing. Population development projections estimate the number of older people (67 years and older) living in Germany to increase to almost 21.5 million by the year 2040. This is an increase of 6.3 million, or 42 percent, over the number of people over 67 in 2013. A little girl who is seven years old now has good chances of living to see the 22nd century. This positive development, however, has a flip side. Starting at 80 years of age, the statistical probability of having to depend on outside help increases rapidly – to about 32 percent. This means: The older the population, the higher the number of people needing care. A need for long-term care brings with it great physical, psychological, and financial challenges for affected persons and their loved ones, especially since the structure of the family has changed: There are generally few children in the family, and they usually have careers that make it impossible for them to provide as much care to their parents as used to be the case.

How many people are currently dependent on long-term care insurance?
About 3.94 million people use the services of their long-term care insurance each month. Most service recipients, about 2.9 million, receive home care services. About 780,000 people live in nursing homes (Status: End 2018. Source: Business statistics of the long-term care insurance funds and the private mandatory long-term care insurance).

1.2 Who is insured?

Coverage is generally provided through social or private long-term care insurance. This is guaranteed through the regulations described in the following. Everyone generally has their long-term care insurance with the same provider through which they have health insurance. The system in the laws governing statutory health insurance and social long-term care insurance maintain the difference between those who are “mandatorily insured” and “voluntarily insured”, even though everyone is now subject to an obligation to insure.

Those with children pay lower contributions than the childless. There is a difference of 0.25 contribution points.

a. Individuals insured under statutory health insurance
Anyone insured by statutory health insurance is automatically enrolled in social long-term care insurance. So there is no need to submit a special application for coverage under social long-term care insurance. This applies, for example, to workers, employees, students, and retirees. Anyone who is not subject to the obligation to insure, because they have moved their official place of residence abroad for example, can apply to continue coverage under social long-term care insurance (see Chapter 1.2 f. starting page 22).

b. Persons covered by family insurance
Children, spouses, and registered life partners entitled to support whose regular monthly total income does not exceed 455 euros or 450 euros for those employed part-time are covered by family insurance. Registered life partner refers to a life partner of a registered same-sex civil partnership. Those co-insured under the family insurance do not have to pay any contributions to the long-term care insurance.

c. Voluntarily insured individuals
Those who are voluntarily insured under statutory health insurance are also obligated to maintain social long-term care insurance. They can, however, be released from this obligation. The prerequisite for this is: The insured person must decide if they want to be insured under private or statutory long-term care insurance within the first three months of their voluntary insurance status. The insured person must prove that they are covered by corresponding long-term care insurance.

d. Privately insured individuals
Those insured under private insurance must obtain private long-term care insurance (PLCI). The services provided are equivalent to those offered by social long-term care insurance. Cost reimbursement replaces benefits-in-kind, however – as with private health insurance.

e. Insurance obligation for other persons

When it comes to long-term care insurance, the general principle applies “long-term care insurance follows health insurance”. Anyone insured by statutory health insurance is automatically enrolled in social long-term care insurance. Anyone with private health insurance is obligated to purchase private long-term care insurance. In addition to all those with private or statutory health insurance, other persons who do not have private or statutory health insurance, but who are otherwise entitled to coverage in case of illness have also been covered under the long-term care insurance since its introduction in 1995. This includes, for example, persons who are entitled to healing treatment or treatment of illnesses under the Federal War Victims Relief Act (BVG).

f. Continued insurance

Under certain circumstances it may be possible to apply for coverage under the social long-term care insurance on a voluntary basis in order to maintain insurance coverage even after being exempted from the obligation to be insured. In order to qualify, the insured person must have been enrolled in social long-term care insurance for at least 24 months over the past five years or for the past twelve months continuously. Persons who are no longer required to have insurance because they have moved their place of residence or usual place of residence abroad are also qualified to submit an application to continue their insurance.

g. Personal insurance/supplementary insurance

Why is personal supplementary insurance a good idea?

Anyone could develop a need for long-term care. The need for nursing care often comes along unexpectedly and means a big change for the entire family. Most people who suddenly become dependent on third parties want to receive care at home and in a familiar environment for as long as possible. When it comes to making decisions, the desires of the person

needing care should always take top priority and not worries about what kind of care and assistance is financially feasible. Since statutory long-term care insurance only covers basic care and the actual costs of care are quite often higher, it is important to have additional private care insurance.

What kind of elective private long-term care supplementary insurance plans are available?
Many insurance companies offer private long-term care supplementary insurance meant to fully cover or alleviate the risk of having to pay additional fees yourself. There are three ways to purchase this supplementary insurance:

- As long-term care retirement insurance offered as life insurance. If the insured person should need care, the insurance will pay a monthly benefit depending on how much assistance they need. There are different types of contracts available with this type of insurance.

Both the young and the old may need care. Long-term care insurance covers basic care – personal supplementary insurance can help to cover any costs beyond that.

- As long-term care insurance that pays the costs remaining after the mandatory social or private long-term care insurance has paid its share. Here a differentiation should be made between the rates that pay all remaining costs or that pay only part. In any case, it will be necessary to provide proof of expenses.
- As nursing day or nursing month insurance money, with the person needing care receiving a fixed amount of money for each nursing day or each nursing month after providing proof. This amount of money is transferred by the insurer regardless of the actual costs of care.

Which long-term care supplementary insurances are supported by the state?
A care day or care month insurance plan can be supported by an allowance from the state if it meets the following criteria:

- The insured person must pay at least 10 euros toward the plan each month.
- The corresponding long-term care supplementary insurance must cover services under all care grades, with the amount for care grade 5 being at least 600 euros.
- There should not be a health review. Benefit exclusions and additional fees for risk are also not allowed.
- The obligation to contract applies. The insurance company must accept any person who is entitled to government allowances – that is, insured adults with mandatory social or private long-term care insurance who are not currently receiving/have not received long-term care services.

In this case, the allowance amounts to five euros per month or 60 euros per year. It is automatically credited to the insurance contract, the person insured doesn't have to do anything.

1.3 How is long-term care insurance financed?

Social long-term care insurance is generally financed equally by employers and employees.

a. Contribution payment

How high is the contribution payment?

Since 01 January 2019, the contribution payment amount has amounted to 3.05 % of gross income and 3.3 % for those without children.

How will financing for long-term care be strengthened over the long run?

Starting 1 January 2015, the income from 0.1 contribution points, currently around EUR 1.6 billion yearly, are placed in a long-term care provident fund in the form of a special asset managed by the German Federal Bank. The fund is meant to contribute to the reliable financing of long-term care insurance in the future and help stabilize the contribution payment starting in the year 2035. This ensures that it will still be possible to finance care, even once the generations with high birth rates, the "baby boomers" have reached the age where they might need long-term care. Those with children pay lower contributions than the childless.

What is my contribution as an employee?

Employees and employers pay half – i.e. 1.525 % – each, not including the surcharge paid by the childless. In federal states where the number of public holidays existing on 31 December 1993 was not reduced by one public holiday (which always falls on a working day) in order to finance the long-term care insurance (such as in Saxony), employees and employers have to pay the contribution of 1 % alone. Of the 3.05 % long-term care insurance contribution, 2.025 % is covered by the employee (plus 0.25 % in the case of people without children) and 1.025 % by the employer.

Contribution distribution

	Employer	Childless employees	Employers
Federal states that did not abolish a public holiday in the sense described above	2.025 %	2.275 %	1.025 %
Remaining federal states	1.525 %	1.775 %	1.525 %

The contribution made to social long-term care insurance depends on income: The rate of contribution is levied in each case on the income subject to contribution – defined in more detail in the act – up to the income threshold for assessment of contributions (to the income threshold for assessment of contributions see 1.3.c from page 30)

b. Extra contribution for childless persons

Who is required to pay an extra contribution?

In general, all childless members of the social long-term care insurance have been responsible for paying an additional contribution of 0.25 contribution points in additional to the "normal" contribution payment since 1 January 2005. Since 01 January 2019, the contribution payment with additional contribution has amounted to 3.3 percent. Excluded from this requirement are childless members born before 1 January 1940, members 23 years of age or younger, and members receiving unemployment II (ALG II). The reasons for childlessness don't matter.

How is the additional contribution payment made to social long-term care insurance?
The additional contribution payment is made during the usual contribution collection process for the long-term care insurance amount. The entity collecting the contribution (so the the employer from the employee's salary or the care organization of the care contributions) will also withhold the additional contribution proportion amounting to 0.25 contribution payment points and will pay this to the collection office together with the total social insurance payment.

What rules apply to retirees without children?
All childless retirees born before 1 January 1940 are not required to pay the additional contribution amount. Persons receiving retirement benefits (company retirement for example), who were born before 1 January 1940 will not need to pay an increased amount from their retirement benefits.

January 1940, the additional contribution payment will be withheld from retirement payments just as the previous long-term care insurance contributions have been and paid towards long-term care insurance. For childless benefit recipients born starting 1 January 1940, the usual previous contribution process applies to the long-term care insurance contributions of benefit recipients. For benefit recipients that are also receiving retirement payments from government retirement insurance, the offices making the payment will withdraw the contributions from the benefit payment amount and provide it to the responsible financial office. Childless benefit recipients who were born starting in 1940 and who are not receiving retirement from the government retirement insurance must pay the increased amount to the financial office themselves.

All childless retirees born before 1 January 1940 are not required to pay the additional contribution amount

What purpose does the flat rate payment made through the Federal Employment Agency serve?

For certain service beneficiaries of the Federal Employment Agency subject to the mandatory additional payment, additional contribution payments are paid to the long-term care provident fund for social long-term care insurance in one flat fee amounting to 20 million euros per year by the Federal Employment Agency. This is done to simplify administration. The individual members need not pay any additional contributions. This regulation applies for recipients of unemployment money I, subsistence allowance, reduced hours compensation, education benefits, transition money, and – if the Federal Employment Agency is responsible for contribution payment – for recipients of education aid.

Are childless persons with a disability required to make the additional contribution payment?
The additional contribution payments are assessed only for people with disabilities who are independent members of the social long-term care insurance program and who are required to pay contributions. In accordance with the applicable laws, they are insured through their parents' government health insurance and long-term care insurance even after turning 25 without having to pay a contribution, provided that they are unable to support themselves due to a physical, mental, or psychological disability. They are also not required to pay the additional contribution payment if they are childless.

If they are working in workshops for people with disabilities and are have a career or are receiving an education allowance or transition money from the Federal Employment Agency, they do not need to pay an additional contribution payment in the case that they are childless. Beneficiaries of these services are included in the flat rate payment of 20 million euros per year made by the Federal Employment Agency to the social long-term care provident fund.

Is the minimum living wage taken into account when the additional contribution payment is collected?
Despite the additional contribution payment, the minimum living wage for the individual is assured, the additional contribution for childless persons is taken into account when determining social welfare benefits. All persons whose income is not sufficient to live and who must supplement their income with welfare or basic income, will then receive greater welfare services since their entitlement to welfare is determined based solely on their income after the deduction of social insurance contributions, including the additional childless contribution payment. This ensures that the the additional contribution payment for childless persons does not negatively impact the social welfare-related minimum living requirements.

c. Contribution assessment threshold

How high is the contribution assessment threshold for social long-term care insurance?

The same contribution assessment threshold that applies to government health insurance also applies to social long-term care insurance. In the year 2020, this income threshold for contributions to health insurance and long-term care insurance was 56,250.00 euros per year (4,687.50 euros per month).

Calculation units of social insurance and contribution amounts of social long-term care insurance (SPV) and mandatory private long-term care insurance (PPV) since 01 January 2020 in euros

	Year	**Month**
Contribution assessment threshold pension and unemployment insurance – **West**	82,800.00	6,900.00
Contribution assessment threshold pension and unemployment insurance – **East**	77,400.00	6,450.00
Contribution assessment threshold health and long-term care insurance	56,250.00	4,687.50
Pension insurance reference value – **West**	38,220.00	3,185.00
Pension insurance reference value – **East**	36,120.00	3,010.00
Health and long-term care insurance reference value	38,220.00	3,185.00
Insignificance limit[1]		450.00

	Year	Month
Threshold for family insurance without part-time job		455.00
Threshold for family insurance **with** part-time job		450.00
SPV minimum contribution for **voluntary members** [2]		32.38
Highest contribution for long-term care insurance		142.96
SPV contribution for continued insurance abroad [3]		16.19
SPV-contribution for students		22.69
PPV-contribution for students (up to 34 years of age)		16.46
PPV-highest contribution for officials		57.18
PPV-contribution for spouses		214.44

1 Special conditions apply for the payment of contributions to social insurance up to this income.
2 Basis for calculation: 90 part of the monthly reference value.
3 Basis for calculation: 180 part of the monthly reference value.
Contribution payments:
Retirement insurance: 18.6 percent
Unemployment insurance: 2.4 percent
Long-term care insurance:: 3.05 percent

d. Financing of private mandatory long-term care insurance
Those who are insured against illnesses with a private health insurance company must also have mandatory private long-term care insurance. A private insurance contract is concluded for mandatory long-term care insurance. Private long-term care insurances are based on what is called the expectancy of future benefits. This means that old-age reserves must be created to smooth out premium development in old age. With private long-term care insurance, the premium amounts are not determined – as they are with social long-term care insurance – based on the income or capability of the person insured. Employees insured through mandatory private long-term care insurance receive a contribution allowance from their employer amounting to half of the insurance contribution amount – but no more than the possible highest amount of the employer proportion for social long-term care insurance.

How high are the premiums for private mandatory long-term care insurance?
The premiums for mandatory private long-term care insurance are calculated based on individual health risk when purchasing long-term care insurance. This is generally higher for people who purchase insurance at an advanced age; so the premium will be accordingly high for them. In the interest of protecting insured persons, however, lawmakers have established an extensive set of guidelines that must be followed by all private insurance companies when determining their premiums in order to maintain social fairness. So premiums cannot be graded according to gender, pre-existing conditions cannot be excluded, and persons already in need of care cannot be rejected. Children are insured without additional contributions.

In regards to the premium amount, a differentiation is generally made between insured persons (in accordance with § 110 para. 1 SGB XI) who have been insured from the very start – so since private mandatory long-term insurance was

introduced on 1 January 1995 – without interruption and insured persons (in accordance with § 110 para. 3 SGB XI) who obtained private long-term care insurance later on. For those who have been insured from the start, the premium for mandatory private long-term insurance is limited to an amount equivalent to the maximum amount allowed for social long-term care insurance. Married couples or spouses without their own income or with very low income (455 euros or 450 Euro for those with a part-time job) benefit from a premium reduction, meaning that the amount of the combined premium for both spouses cannot exceed 150 percent of the highest amount allowed by social long-term care insurance. New members who come along later cannot benefit from premium limits keeping the maximum amount equal to that of the highest contribution for social long-term care insurance for the first five years and thus these insured persons – depending on age and health– have to pay increased premiums. Other than this, there are no price reductions for spouses. Once the five years have passed, premiums cannot exceed the highest amount allowed for social long-term care insurance, even if the person leaves and enrols again.

Persons receiving special social protection in the base rate for private health insurance are also protected under the more extensive protective conditions of § 110 para. 1 SGB XI in regards to mandatory private long-term care insurance. The more better conditions apply regardless of whether private mandatory long-term care insurance has been maintained since 1 January 1995 or was purchased later.

Is there a base rate for mandatory private long-term care insurance?
No, since mandatory private long-term care insurance is already required to provide insurance services equivalent to those of the social long-term care insurances. In addition to the specifications for socially acceptable provision of long-term care insurance, further social regulations governing the

limitation of contributions for those with lower income have been established for mandatory private long-term care insurance similar to the base rate in private health insurance.

Can ageing reserves be taken along when I switch mandatory private long-term care insurances?
Since 1 January 2009, it has been possible to contractually provide for the portability (ability to transfer) ageing reserves when switching to a different contract. This also includes the ageing reserves for mandatory private long-term care insurance. This applies not only to insured persons who purchase mandatory private long-term care insurance at this point (new cases), but also persons who already had long-term care insurance at this point in time (old cases).

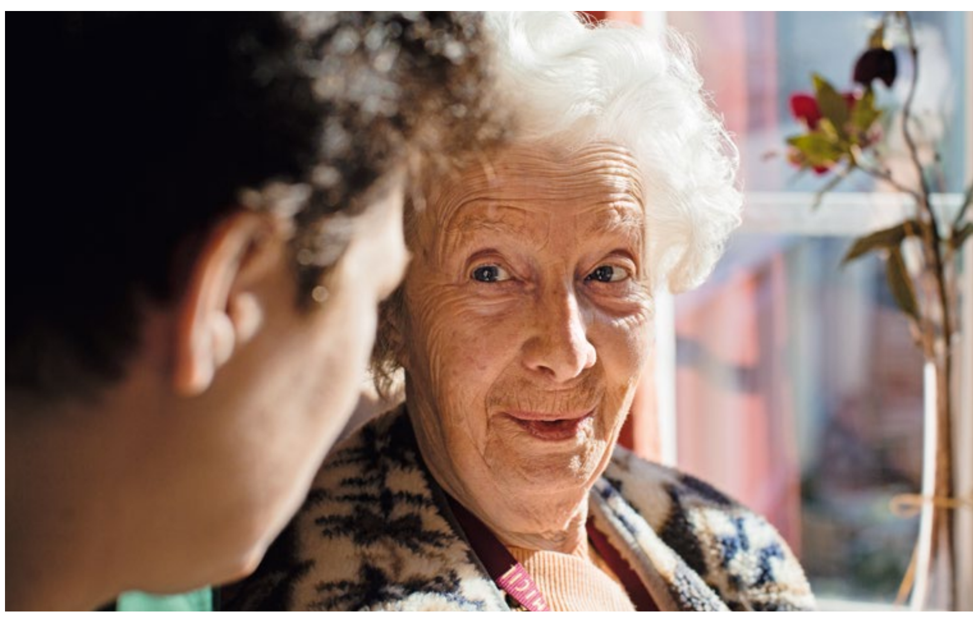
1.4 Who needs long-term care?

a. Need for long-term care

When does someone need long-term care?
The need for long-term care as defined under the law can generally exist in all phases of life. According to the legal definition, this includes people whose independence or capabilities are impaired by (a) health condition(s) such that they are dependent on the help of others. This includes people who are unable to compensate for or manage burdens or demands due to a physical, mental, or psychological disability. There must be a need for care over a long period of time – presumably for at least six months – and that is at least as serious as specified in § 15 SGB XI.

b. Application process

Where do I apply for long-term care services?
In order to take advantage of the services provided under long-term care insurance, an application must be submitted. This can also be done over the phone The long-term care insurance fund is located in the same place as the health insurance fund. Family members, neighbours, or good friends



Persons with impairments caused by health issues that negatively impact independence or ability and therefore require help from others

can also submit the application if they have been legally authorized to do so. As soon as the application is submitted to the long-term care insurance fund, the Medical Advisory Service for the statutory health insurance (MDK) or another independent evaluator will be charged with the assessment of the need for long-term care.

Privately insured persons must submit an application to their private insurance company. An assessment is made by evaluators from the medical service MEDICPROOF.

How quickly will a decision be made on the application?
The legally specified maximum processing period for applications for long-term care services amounts to 25 workdays. If a person is currently hospitalised or living in an in-patient rehabilitation centre, in a hospice, or is currently

receiving palliative care at home, then the MDK or other independent evaluator must complete their assessment within one week if this is necessary in order to ensure continued care or if a caregiver is planning on notifying their or has agreed with their employer that they will need a release as allowed under caregiver leave law (see chapter 3.2 starting page 110). If the applicant is living at home without palliative care and if the caregiver has announced to their employer that they will need a release as specified under caregiver leave law or if the caregiver has negotiated such a release with their employer in accordance with family caregiver leave law, then the evaluation must be completed within two weeks of application submission.

If the long-term care insurance fund does not provide a written decision on the application within 25 workdays of receipt of the application or if the shortened evaluation periods are not adhered to, then the long-term care insurance fund must pay the applicant 70 euros for each week initiated after the period runs out. This does not apply if the delay is caused by something out of the control of the long-term insurance care fund or if the applicant is already receiving live-in care and has already been recognised as being in need of at least serious (at least care grade 2) care.

c. Prerequisites for making claim to services

In order to take full advantage of the long-term care services offered, the insured person must have paid in to the long-term care insurance fund as a member for at least two years within the last ten years before the application is submitted or must have been insured on family insurance.

d. Evaluation by the Medical Advisory Service of the statutory health insurance

How is the need for long-term care determined?

The long-term care insurance fund will have the Medical Advisory Service for the statutory health insurance (MDK),

other independent evaluators, or, for miner's insurance, the Social Medical Service (SMD) carry out an evaluation in order to determine the need for long-term care and the amount of care needed in individual cases. For those insured privately, the evaluation will be carried out by the medical advisory service of MEDICPROOF. With a prior appointment only - there will be no unannounced visits - the respective evaluator (nursing professional or doctor) will visit the residence or nursing care establishment in order to complete their evaluation. Ideally, the family members or caretakers who support the sick person should attend the appointment. Speaking with these individuals will help the evaluator get an idea of how

A decision will be made regarding long-term care services within 25 days of application submission. In order to accomplish this, the MDK or another independent evaluator will carry out an assessment.

independent the applicant still is or which impairments are present.

An **assessment** tool is used to assess the need for long-term care and to identify the correct long-term care grade. This is based on questions such as: What can the person needing care do by themselves each day? What are they still capable of? How independent is the sick person? What do they need help with? **Here the foundation for the evaluation is** the redefinition of long-term care needs, which focuses on individual impairments – regardless of whether they are physical, mental, or psychological.

What's most important is the individual person and the degree to which they are capable of managing their daily lives: The evaluation thus leads to a more individual classification. Persons with dementia, for example, with their special nursing and assistance needs, can thus benefit from this change

In order to determine how independent a person needing care is, the evaluator will take a close look at the following six areas of life:

Module 1 „Mobility“: The evaluator will take a look at bodily movement. For example: Can the affected person stand up alone and move from the bed to the bathroom? Can they move through their residence independently and can they climb stairs?

Module 2 „Mental and communication-related abilities“: This area covers comprehension and talking. For example: Can the person maintain their orientation in time and space? Can they understand facts, recognise risks, and hold conversations with other people?

Module 3 „Behaviour and psychological issues“: This includes restlessness at night or anxiety and aggression that negatively impact the person needing care as well as their family members. If they react to nursing care measures defensively, this is also taken into account here.

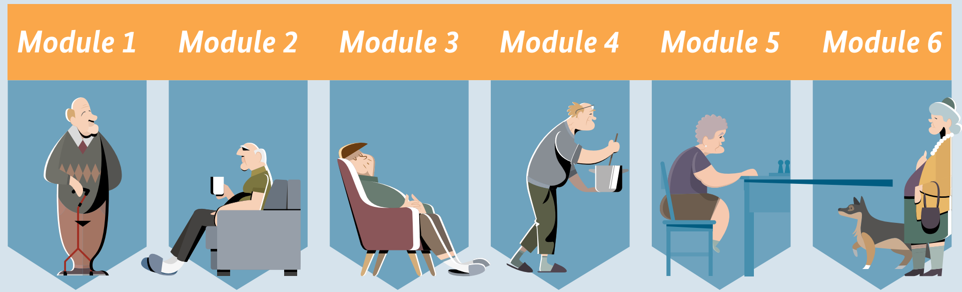
Module 4 “Self care”: Can the applicant wash and dress themselves, go to the bathroom themselves, eat, and drink themselves?

Module 5 „Independent handling of requirements and challenges**associated with illness or therapy – and their management**“**:** The evaluator will check if the affected person can take their medications themselves, for example, if they can independently measure their blood sugar, if they are capable of using aids such as prosthetics or walker, and if they are capable of seeking out a doctor.

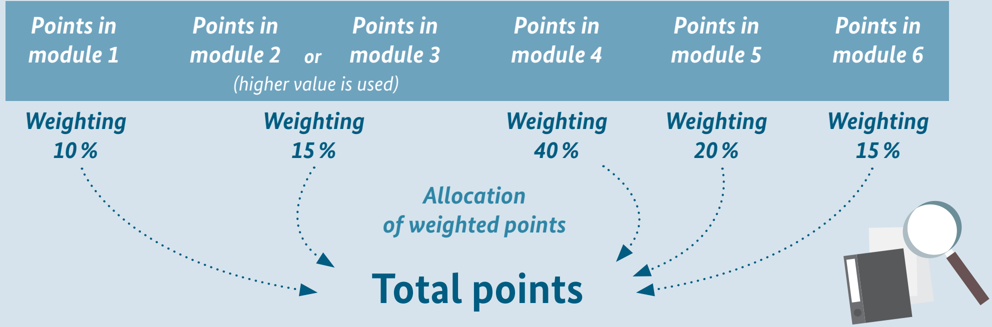
Module 6 "**Everyday life and social contacts“:** Is the affected person capable of planning and going through their day independently? Are they capable of contacting people directly or going out for a game of cards without assistance?

This is how the five long-term care grades are determined

1. RECORDING THE INDEPENDENCE AND CAPABILITIES OF PEOPLE IN SIX AREAS OF LIFE



2. CALCULATION AND WEIGHTING OF POINTS



3. CLASSIFICATION INTO ONE OF THE FIVE LONG-TERM CARE GRADES

12.5 – less than 27	27 – less than 47.5	47.5 – less than 70	70 – less than 90	90 – 100
1	2	3	4	5

For each criteria in the given area of life, the evaluator will determine the degree of independence of the person needing care, generally using a point value between 0 (person can carry out the activity without assistance or perhaps even alone with an aid) and – in general – 3 (person cannot carry out the activity at all, not even part of the activity). This makes the degree of impairment apparent in each area. In the end, the points are assigned various weighting and added up in a total value indicating one of the five care grades.

Furthermore, evaluators also assess **activities outside of the house** and **household maintenance.** The answers gathered in this area are not used to classify the need for care, because the impairments relevant to this are already fully assessed with the questions from the six areas of life. This information does, however, help the care advisor of the long-term care insurance fund if it is determined that the affected person needs care: It allows them to give the person in need of care advice that takes other offers and social services into consideration makes it possible to create a future care plan that is customised to their needs. The information can also help nursing staff put together a better care plan.

In addition, the evaluator checks whether there is an indication for medical rehabilitation service benefits. Rehabilitation may be indicated to improve someone's state of health and to delay or avoid altogether the need for long-term care. It may also be indicated in cases of long-term care needs that cannot be changed, by enabling people to participate in everyday activities again in as self-determined and independent a way as possible despite the need for long-term care. The evaluator submits his or her assessment to the long-term care insurance fund. The long-term care insurance fund passes on the prevention and rehabilitation recommendations of the evaluator to the applicant separately, namely no later than when they are sent the notification regarding the decision relating to the long-term care need (see chapter 2.8 from page 92).

How is the need for long-term care determined for children?
Children are generally assessed by a specially trained appraiser of the Medical Service or other independent appraisers with a qualification as a public health nurse or paediatric nurse or a paediatrician. For children in need of care, the care grade is determined through a comparison of impairments of their independence and abilities with the capabilities of children their own age.

One special condition applies for the evaluation of children under 18 months. Children in this age group naturally lack independence in all areas of daily life. In order to ensure that these children are assigned the medically most appropriate care grade, issues not influenced by age, such as “behaviour and psychological issues” and “handling of demands and burdens associated with illness and therapy” will be included in the evaluation. Furthermore, a determination will be made of whether the child has serious problems ingesting food that require an unusually high amount of assistance.

e. Care grades

How are the care grades arranged?
Five long-term care grades enable the classification of the type and severity of the impairment in question, regardless of whether it is physical, mental, or psychological. The long-term care grades and therefore also the amount of the benefits are based on the severity of the impairments of independence or abilities of the person needing care. The care grade is determined using a nursing care-appropriate assessment instrument. The five care grades are stepped: from minimal impairment of independence or ability (care grade 1) to the most serious impairment of independence or ability, which places special demands on the provision of long-term care (care grade 5). People with care needs with special sets of needs and special nursing care requirements can, for nursing-related reasons, be classified as long-term care grade 5 even if

the required overall score does not permit it. The Spitzenverband Bund der Pflegekassen gives a more concrete description of the professional nursing prerequisites for such special needs constellations in the evaluation guidelines.

f. Additional documents on the notification of benefits

Which documents are sent out along with the notification of benefits?

The decision of the long-term care insurance fund for a certain care grade through the process of defining the need for care should be transparent and understandable to the insured person. For this reason, the long-term care insurance fund will automatically send the evaluation to the applicant unless the applicant has requested that they don't. It is also possible to make a request later for the evaluation to be sent. The insured person will also receive the special prevention and rehabilitation recommendation put together as part of the evaluation. The applicant will at the same time be informed that when they are referred to the responsible rehabilitation provider, an application process for medical rehabilitation services will be initiated if the applicant agrees to receive services.

How is it ensured that the Medical Advisory Services are service-oriented?

The guidelines of theGKV-Spitzenverbands for service orientation in the evaluation process have been in force since July 2013. These are mandatory for all Medical Advisory Services and ensure more transparency and service-orientation throughout the evaluation process. This generally regulates the general guidelines of conduct for evaluators when carrying out evaluations, the individual and extensive explanation of the evaluation instrument to the insured person (also in the languages English, French, Greek, Italian, Croatian, Polish, Russian, Turkish), an insured person survey, and symptom management.

1.5 The need for care exists – what now?

Good to know

A check-list

1. Get in contact with your health/long-term care insurance fund or a care support point in your area. Of course family members, neighbours, or good friends can also do this for you if you authorize them to.

2. The long-term care insurance associations publish comparison online checklists describing the services and prices for approved nursing care establishments as well as offers to assist with everyday life. You can also request this list from the long-term care insurance fund when you submit an application for services.

3. You are also entitled to timely and extensive advising from the care advisor of your long-term care insurance fund. Family members and other persons, such as volunteer caregivers, are also entitled to this if you agree. Immediately after the submission of your application for services, the long-term care insurance fund will offer you a concrete appointment for advising that should take place within two weeks of submission of your application. The long-term care insurance fund will also appoint a care advisor who is personally responsible for you. Alternatively to this, the long-term care insurance fund can also issue you a consultation voucher naming independent and neutral counselling centres that you can also redeem for consultation services from one of these entities within a two-week period at the cost of the long-term care insurance fund.

Good to know

If you would like, the care advisor can come to your home. If there is a care support point in your region, you can also consult them. Further information can be obtained from your long-term care insurance fund.

The mandatory private long-term care insurance offers long-term care advice through the company "COMPASS Private Pflegeberatung (Private Long-Term Care Advising)". The care advisor can advise you at home, at a full-time care institution, at the hospital, or at a rehabilitation establishment.

4. As soon as you apply for services under long-term care insurance, your long-term care insurance fund will order the Medical Advisory Service (MDK) or other independent evaluators to carry out an assessment in the interest of determining your need for long-term care.

5. Please ask your caretaker to be present at the assessment.

6. Try to determine if your family members can provide care long-term at home and if you will need the help of a home care service to supplement their efforts or if you will need to depend fully on a home care service.

7. If it isn't possible to receive care at home – perhaps also by taking advantage of the assistance offerings of a local day or night care establishment – then you can be given information and advice on suitable full-time institutional care establishments.

Good to know

The care advisors of your long-term care insurance fund and the staff of the long-term care support offices in your area can help with any questions you may have. You can also obtain further information by calling the video hotline of the Federal Ministry of Health at www.gebaerdentelefon.de/bmg/. The deaf and hard of hearing can reach the advice service of the Federal Ministry for Health by sending a fax to: 030 3406066-07 or an email to: info.gehoerlos@bmg.bund.de.

8. Privately insured persons can contact the insurance company they are insured with at any time or can also contact the Verband der Privaten Krankenversicherung e.V. Gustav-Heinemann-Ufer 74 c, 50968 Cologne, www.pkv.de.

“COMPASS Private Pflegeberatung (Private Long-Term Care Advising)” can be reached over the phone at 88 1018800.

2 Benefits of long-term care insurance

The services provided by long-term care insurance depend on where and by whom you or a loved one are receiving care and how great the need for support is. In this chapter you can read about exactly which services are involved, when you are entitled to services, and how the services can be combined if necessary.

In principle, citizens have access to various forms of care and nursing facilities. The option chosen by the affected person and their family members depends on the severity of the person's need for care as well as from the personal life circumstances of the persons who will be taking responsibility for care.

The approved long-term care establishments and long-term care services are differentiated by the service type. They range from home care services that support individual caregivers, persons in need of care, and their relatives in the provision of care at home, to new types of residential establishments such as long-term care group homes or offerings for day and night care establishments through to comprehensive care and assistance in full-time institutional care establishments.

Over the past few years, the services provided by long-term care insurance have been added onto – in some instances multiple times. In addition to that, the federal government also reviews the necessity and amount of an adaptation of the services provided by long-term care insurance every three years. The first long-term care enhancement law dynamicised services by four percent as of 1 January 2015. For services that were first introduced in the long-term care reorientation law

of 2012 / 2013, the increase amounted to 2.67 %. Dynamisation aimed to ensure that long-term care services adapt to changes in price. The Second Act to Strengthen Long-Term Care again significantly increased the services of the long-term care insurance on 1 January 2017.

2.1 Care at home – what options are available?

In the case of a need for long-term care, the person in need of care gets to decide: You can choose professional nursing services, such as nursing care from approved home care services that the long-term care insurance fund will cover up to a certain maximum limit, or you can choose monetary benefits such as the nursing allowance, which the long-term care insurance fund or private insurance company pays out to the person in need of care.

Furthermore, you can also, through cost reimbursement, take advantage of certain offerings approved by the state for assistance with daily life.

Home care can be supplemented by semi-residential services of day or night care as well as temporary full-time institutional care services for short-term care (see chapter 2.2 b and c starting on page 73).

a. Home care services (professional long-term care services)
What is home care service?
Home care services assist the person needing care and their family members with care at home. It offers families help and assistance with their everyday lives, so that family members who provide care can better organize career, care, and assistance for example. The services offered for home care services ranges across various areas.

These are mainly:

- Physical care measures such as personal hygiene, nutrition, promotion of ability to move,
- Care-related assistance measures such as help with orientation, assistance in managing everyday life, or support in maintaining social contacts
- Home nursing, in accordance with § 37 SGB V as a service of the statutory health insurance, such as medication administration, dressing changes, injections,
- Advice for the person with care needs and their relatives regarding questions of nursing, help with finding support services such as food delivery or organising (patient) transports.
- Assistance in managing the household, with cooking or cleaning the residence for example.

Home care services allow the affected persons to remain in a familiar environment.

Non-residential care helps people with care needs and their relatives in their day-to-day lives. This helps the caregivers to coordinate their working life and caregiving.

What are home care services and what is their scope?
The long-term care insurance will cover the cost of a home care service for physical care measures, care-related assistance, and help in managing the household up to a legally specified maximum amount for persons needing care that have been assigned at least care grade 2. This is dependent on the care grade:

Long-term care benefits in kind for home care

Care needs	Benefits maximum benefits per month
Care grade 1	*
Long-term care grade 2	689 euros
Care grade 3	1,298 euros
Care grade 4	1,612 euros
Care grade 5	1,995 euros

* Relief amount up to 125 euros per month

Overview of long-term care insurance benefit entitlements of insured persons in 2020 from page 96

Furthermore, the relief amount of up to 125 euros per month can also be used to pay for home care services hired to provide assistance. In care grades 2 to 5, however, the relief amount cannot be used for services related to physical self-care, for help washing each morning for example. The professional services mentioned above are available for this purpose. In care grade 1, however, the relief amount can also be used for home care services related to self-care. Further

information on this can be found in the section “relief amount” in chapter 2.1 f starting on page 60.

What options do persons needing care have?
Persons needing care and their relatives have options to choose from when organizing the service offerings they want for home care services. The care service must inform you in a timely manner of any major change in the form of a cost proposal describing the expected costs of the services you intend to use. This ensures that the options available to the person in need of care as well as the associated costs remain understandable and transparent within the context of their respective care arrangement. It is important to note that care services must be approved by the long-term care insurance funds before their services can be covered. The service and price comparison lists provided by the long-term care insurance funds for free upon request and also available on the internet provide a good overview of the approved care services among other things.

What options are offered by the entitlement to convert?
If the service benefit amount is not used or not fully exhausted for the purpose of obtaining professional home care services, the unused amount can also be used to cover additional costs for services provided within the framework of offerings approved by the state that assist with daily life. A maximum of 40 percent of the respective amount for non-residential benefits in kind can be repurposed in this way. More information is available in the section 'Offers for assistance in everyday life; conversion entitlement' in chapter 2.1 h beginning on page 62.

b. Non-residential care service (non-residential long-term care benefits in kind)
In order to expand the range of care and domestic help services, the law on quicker appointments and better care (the Appointment Service and Care Act, or TSVG) introduced care services as licensed service providers within the system

of long-term social care insurance (§ 71, paragraph 1a, Eleventh Book of the Social Code Book (Social Code Book XI)).

Care services are non-residential services, care at home and help with household chores under the direction of a responsible professional who does not have to be a care worker. The same applies to the staff to be deployed. Qualified skilled professionals with suitable skills with two years of professional experience in their profession, preferably in the health and social sectors, can be employed as responsible specialists.

The range of care services includes personal help, such as support with orientation in and organising everyday life and the household, as well as in maintaining the social contacts and social skills of people with care needs.

Before the introduction of care services, the legislator had these tested in practice and scientifically evaluated in a pilot project by the GKV central association. Scientific support was provided by the IGES Institute Berlin. This pilot project was completed successfully. The results of the pilot project show, among other things, that non-residential care services make an important and valuable contribution to the professionalisation of care in general and non-residential care.

The non-residential care services do not make advisory nursing visits in people's homes (see chapter 4.1 b beginning on page 124). Apart from that, all provisions on the benefits of the long-term care insurance that relate to non-residential care services (such as the relief amount) also apply correspondingly to non-residential care services, provided this relates to the care measures and assistance in the household.

c. Family caretakers (nursing allowance)

Persons in need of care should be able to decide how and by whom they will be cared for. Long-term care insurance therefore also provides assistance when the affected person decides they want to betaken care of by family members, friends, or other volunteers instead of by professional home care service workers. Long-term care insurance will pay out the so-called nursing allowance for this.

When is the nursing care allowance paid out?

In order to receive the nursing allowance, sufficient care must be assured by the beneficiary, through family members or other volunteer caretakers for example,and the person must be assigned at least to care grade 2. The nursing allowance is transferred to the person in need of care by the long-term care insurance fund. The person needing care can use the nursing allowance as they see fit and generally gives the nursing allowance to their caregivers in recognition of their efforts. The nursing allowance can also be combined with professional home care services (see chapter 2.1 d. on page 57).

Nursing allowance for home care

Care needs	Benefits per month
Care grade 2	316 euros
Care grade 3	545 euros
Care grade 4	728 euros
Care grade 5	901 euros

Overview of long-term care insurance benefit entitlements of insured persons in 2020 from page 96

How is the amount of the nursing allowance calculated?
As with professional services, the nursing allowance is graduated according to the degree of need for care:

During respite care (see chapter 2.1 f from page 58), half of the nursing allowance received to this point (proportionate) is paid out for up to six weeks and, in the case of short-term care for up to eight weeks, per calendar year.

Persons in need of care who are being cared for in full-time care facilities for the disabled are entitled to the unabridged nursing allowance proportionate for the days on which they are being cared for at home.

Recipients can use the nursing allowance in any way they like. They usually pass it on to the caregiver as a thank-you.

d. Combined service

Can the nursing allowance and professional home care services be received at the same time?

In order to ensure that care is provided that is optimized to meet the individual needs of the person concerned, it is possible to receive the nursing allowance while also receiving professional home care service. In this case, the amount of the nursing allowance is reduced in proportion to the value of the professional services received.

Calculated

Combination of nursing allowance and non-residential long-term care benefits in kind

A person with care needs of long-term care grade 2 receives benefits in kind by a care service worth 344.50 euros. The maximum amount for non-residential benefits-in-kind they are entitled to is EUR 689 per month. This means that 50 percent of the non-residential benefits in kind have been used. They will also be entitled to 50 percent of their 316-euro nursing allowance, i.e. 158 euros.

e. Individual caretakers

What are individual caretakers?

This refers to independent caretaking staff, such as an elderly care nurse or elderly care assistant.

How are the individual caretakers deployed?

Persons needing care who are assigned care grades 2 to 5 have the option of hiring independent caretaking staff. The long-term care insurance funds should conclude suitable contracts for the care of certain persons needing care with suitable individual caretakers if care provided by such workers would be especially effective and economical or if, for example, it can be done in consideration of the wishes of the person

needing care for how their care should be handled. Persons needing care who have been assigned to care grades 2 to 5 can use the professional home health care benefits to finance individual caretakers. Payment is transacted directly between the approved individual caretaker and the long-term care insurance fund.

f. Stand-in care / Holiday cover

Who will provide care when the caretaker is on vacation or sick?
If the private caretaker goes on vacation or is temporarily unable to provide care due to an illness or other reason, the long-term care insurance will cover the proven costs of a replacement caretaker, the so-called respite care, for no longer than six weeks per calendar year. The caretaker could be temporarily replaced by someone from a professional home care service, individual caretaker, volunteer caretaker, or even close relatives. Benefits for respite care can also be received if replacement care is provided in an establishment. A person will only be entitled to respite care once the caretaker has been caring for the person needing care in their home environment for at least six months. Respite care can also be utilized by the hour.

What is the scope of services provided for respite care?
If respite care is provided by persons not related to or related to by marriage to the person with care needs less than twice removed and do not share a home with the person in need of care, then the benefit covers up to 1,612 euros per calendar year. If the replacement care cannot be professionally ensured by close family members, the expenditures of the long-term insurance fund cannot exceed 1.5 times the amount of the nursing allowance. If, in this case, the replacement caregiver can submit proof of necessary expenditures (such as driving costs or loss of earnings) then the services to be extended to a total of 1,612. The expenses of the long-term care insurance fund cannot exceed a total of 1,612 euros.

Can entitlements to short-term care be used for respite care?
In addition to the service amount for respite care, up to 50 percent of the short-term care amount (that's up to 806 euros in the calendar year) can be used for respite care. The increase amount used for the stand-in care is offset against the benefit amount for short-term care. This means that up to 2,418 euros per calendar year are available for stand-in care. This in particular benefits those eligible persons who require more long-term replacement care and who do not wish to go into a fully residential short-term care facility during this time.

Will the nursing allowance continue to be paid out during the period of respite care?
Yes. During the period of respite care, half of the previously paid nursing allowance will still be paid out for up to six weeks per calendar year.

Calculated

Pro rata nursing allowance in stand-in care

The caregiver is sick for 15 days. During this time, there is an entitlement to stand-in care. Before the stand-in care, a nursing allowance for long-term care grade 4 in the amount of 728 euros was received. The full nursing allowance is paid for the first and last day of the replacement care ($\frac{2}{30}$ 728 euros). For the remaining 13 days, half of the nursing allowance in the amount of 157.73 euros is paid (50 percent of 728 euros = 364 euros x $\frac{13}{30}$ = 157.73 euros). After that, the full nursing allowance is paid again.

g. Relief amount

Who is entitled to relief?

Persons needing care who are being cared for at home are entitled to a relief amount of up to EUR 125 per month (in total EUR 1 500 per year). This also applies to persons needing care who have been assigned to grade 1. The amount is earmarked for quality-checked provisions to ease the workload of caregiving relatives and similar next-of-kin caregivers and to promote the independence and self-determination of people with care needs in the organisation of their everyday life. In the case that the monthly relief amount is not (fully) exhausted in one calendar month, the remaining amount is transferred over to the following calendar months. Service amounts that have not been used by the end of the calendar year can be transferred and used by the end of the subsequent calendar half year.

What offerings can the relief amount be used for?

The relief amount can be used as reimbursement for expenses incurred by the person with care needs in connection with the utilisation of

- Day and night care,
- Short-term care ,
- Services of the approved care services (in long-term care grades 2 to 5 but not services related to self-care) or
- benefits under state law for everyday support.

The services of the home care service where the relief amount is used are in particular nursing care and help with household chores. Only people with care needs of long-term care grade 1 can also use the relief amount for the services of approved care services for body-related self-care. These are certain support services in the area of body-related care measures, such as help with showering or bathing.

Depending on the orientation of the recognised offers under state law, these may include things such as assistance offers (such as day assistance in small groups, individual assistance), offers to relieve caregivers (with a care assistant for example), or offerings to assist with everyday life (in the form of practical help for example). You can find more information about everyday support services in section h.

In order to receive reimbursement for the expenses incurred, receipts must be submitted to the long-term care insurance fund or the private insurance company with which the person in need of care is insured. The documents submitted and the application for reimbursement of costs must indicate in each case which of the above-mentioned services (day or night care services, short-term care services, home care service, and / or everyday support services by recognised care services under state law) were needed by the person in need of care and to what extent the costs incurred in this connection are to be reimbursed from the relief amount. As far as day or night care or short-term care services are concerned, the long-term care insurance funds generally also reimburse from the relief amount any costs for accommodation and meals incurred in connection with these services.

People who utilise support offers are better able to organise their everyday life.

h. Offerings for support in everyday life; conversion entitlement
What are offerings for support in everyday life?
Everyday support services are designed to reduce the workload of caregivers, and they help people with care needs to stay in their home for as long as possible, maintain social contacts and to continue to manage their daily lives as independently as possible. The everyday support services include:

1. Services where volunteers in particular care for people with care needs with general or specific care needs in groups or in people's homes with professional instructions (care services),

2. Offers that serve the targeted relief and advisory support of family members providing care and comparably close caretakers in their capacity as caretakers (offer to relieve caretakers);

3. Offers that serve to support the person in need of care in managing general or care-related challenges in everyday life or in the household, particularly in regards to managing the household or the independent organization of individually necessary assistance services (offers for relief in everyday life).

The services must be recognised by the responsible state authority in accordance with the relevant state law (Landesrecht). Benefits for everyday support specifically refers to support groups for people with dementia, groups of helpers who provide relief for caregiving relatives in the home, day care in small groups or individual care by approved helpers, agencies that organise support and relief services for people with care needs and caregiving relatives and similar next-of-kin caregivers, services that provide relief for families, everyday companions, care companions and service offers for domestic services.

The everyday support services include
- care and general supervision,
- everyday support that helps with or stabilises existing resources and capabilities,
- support services for relatives and other people similarly close to the person in care who, in their capacity as caregivers, need help with coping with everyday care,
- the provision of services, organisational help, or other appropriate measures.

The offerings feature a concept that includes information on quality assurance for the offer as well as an overview of the services that should be offered and the amount of the costs charged to the person in need of care for these services. Furthermore, the concept also provides information on target group and activity-appropriate qualification of the helpers and the presence of basic and emergency knowledge for working with persons in need of care together with information on the suitable training and continuing education of helpers as well as continual professional assistance and support for the work of caretakers, particularly for volunteer helpers. As a rule, the everyday support services are carried out by volunteers.

The relief amount in particular can be used to obtain a reimbursement for recognised everyday support services provided under state law (see chapter 2.1 g from page 60).

Can parts of the benefit amount for non-residential benefits in kind also be used for state law-recognised offerings that provide support in everyday life?
Yes, up to 40 % of the respective benefit amount covering professional home care services can be used to cover offerings for support in everyday life that are recognised by the state as long as this has not be used to obtain home care benefits-in-kind.

In this way, the entitlement to non-residential long-term care benefits in kind can to a certain extent be "converted" into an entitlement to reimbursement of costs for everyday support services under state law. This is why it is called conversion entitlement.

In order to receive a corresponding reimbursement, receipts must be submitted to the long-term care insurance fund or the private insurance company with which the person in need of care is insured and an application for reimbursement must be made which shows which expenses the person in need of care has incurred as a result of the recognised everyday support services under state law and to what extent the costs incurred for this purpose are to be reimbursed by way of the conversion entitlement.

In the context of the combined benefit (see chapter 2.1 d. on page 57), the converted amount is treated as if the amount could (also) have been used for non-residential benefits-in-kind. If you use part of your non-residential benefits in kind for home care service and another part of the non-residential benefits in kind for the conversion entitlement, the amount of the benefit in kind and the conversion amount are added up. If the non-residential long-term care benefits in kind amount is not fully used up, then as part of the combined benefit a proportionate nursing allowance is an option.

With regard to counselling visits in your own home (see also chapter 4.1 b. from page 124) the following continues to apply even of the conversion entitlement is used: People with care needs who receive a nursing allowance but not non-residential long-term care benefits in kind from a care service have to have a counselling visit every six months or every quarter depending on their long-term care grade.

The conversion entitlement applies in addition to the relief amount entitlement. The two entitlements can thus be used independently.

Calculated

Conversion entitlement

Example 1
A person with long-term care needs of grade 3 receives benefits-in-kind in the amount of EUR 908.60 per month from a home care service, which is 70 % of EUR 1 298, the monthly benefit amount for non-residential benefits-in-kind of long-term care grade 3. He will not need further non-residential benefits in kind. However, he wants to take advantage of an everyday support service recognised under state law which offer continuous care support for caregiving relatives. For this, he can use a relief amount of 125 euros per month. In order to give his wife, who cares for and looks after him every day, more relief by means of the voluntary care companion, he also wants to reallocate the unused part of the benefits in kind. He can receive an additional reimbursement of 389.40 euros per month for the care companion. Because this means that he takes full advantage of the long-term care benefits in kind amount, he does not receive an additional pro rate nursing allowance.

Calculated

Conversion entitlement

Example 2
People with long-term care needs of grade 2 do not require non-residential long-term care benefits-in-kind by a care service. They do, however, gladly make use of the care services of volunteer helpers who as a group were given recognition as everyday support service helpers under state law. 40 % of the EUR 689 monthly benefit amount (i.e. EUR 275.60) of long-term care grade 2 primarily intended for non-residential long-term care benefits-in-kind of can thus be converted into a cost reimbursement claim for this recognised day assistance as part of the conversion entitlement.

In the context of the combined benefit, the converted amount is treated as if the person in need of long-term care had received non-residential long-term care benefits-in-kind. In this case, 275.60 euros of the non-residential benefits in kind of long-term care grade 2 of 689 euros monthly were used, i.e. 40 percent of the overall amount. This leaves 60 % of the nursing allowance of long-term care grade 2 (i.e. EUR 316). This equates to EUR 189.60 of pro rata nursing allowance.

The six-monthly counselling visit which must be utilised as a recipient of the nursing allowance must continued to be utilised by the person in need of long-term care when using the conversion entitlement, because although the amount for the non-residential long-term care benefits-in-kind is used, the home care service does not actually visit to provide non-residential benefits-in-kind.

i. Alternative ways of living – long-term care group homes; group home grant; initial grant for new group homes

What are “alternative ways of living”?

Increasingly more people are wanting to live as independently as possible in their old age. New forms of living include, for example, assisted or service living, where in addition to the lease agreement, a service agreement is also concluded with the landlord. This contract includes agreements for certain additional service and help services. Furthermore, living in multi-generation houses where the young and old help each other, or “living for help” where individual residences or rooms are rented to students, for example, are among the alternative forms of living. In such cases, the students pay lower rent, but in return are expected to assist the residents of the house in need of help by doing things such as helping with the household, going shopping, or visits to authorities.

So-called long-term care group homes are another new form of living (long-term caregroup homes). This offers the opportunity to live with people of the same age and receive assistance together – without giving up privacy and independence. The residents of a group home have their own room that they can retreat to at any time. At the same time, they are also able to participate in shared activities in the community rooms.

What alternative forms of living are supported by long-term care insurance?

In order to enable the person needing care to living independently for as long as possible in a home environment, while at the same time without being left to their own devices – long-term caregroup homes that meet certain minimum requirements are favoured by long-term care insurance. Persons needing care who receive the nursing allowance, care benefits-in-kind, and/ or the relief amount and live in an assisted living group home can apply to receive an allowance of 214 euros per month, the so-called group home

Good to know

Setting up a shared care accommodation

If you want to set up a shared care accommodation, you first need to find potential flatmates. You can look for flatmates by putting an ad up at the nearest senior citizens' meeting, for example. You can also ask at a care support base nearby whether any interested parties have come forward. Inquiring with the home care service could also be helpful as they already oversee shared care accommodation.

supplement, in addition to their other services. The group home grant can also be paid to people with care needs of long-term care grade 1 who live in a group home with non-residential care. They do not have to be in receipt of a nursing allowance or non-residential long-term care benefits in kind, the combined benefit, the services of the conversion entitlement or the relief amount in order to receive the group home grant.

The prerequisite for receiving the group home supplement is

- that they must live with at least two and no more than eleven other people in a shared residence for the purpose of receiving shared long-term care and at least two other persons living in the residence must also need care
- that a person (on-site staff) is tasked jointly by the members of the group home, independent of individual nursing care, to carry out general organisational, administrative, care, or other activities that promote community life or assists the group home members with their household chores, and
- that there is no form of assistance, including semi-residential care,which involves the provider of the group home or a third party offering the persons in need of care services that correspond largely to those associated with full-time institutional care.

The group home grant is provided to the group home members in need of care in order to finance the above-mentioned on-site staff member which was appointed jointly by the members of the group home.

What kinds of financial support is available when a new group home is established?

Those who are entitled to the group home supplement can receive start-up financing for age-appropriate or low-barrier reconfiguration of the shared residence when a new group home with home care is established. This supplement is awarded in addition to the grants for measures to improve the living environment (see chapter 2.1 l. starting page 71).

All persons in need of care involved in founding a home care group home can apply for a one-time grant of up to 2,500 euros from their long-term care insurance fund within the context of this start-up financing. This grant is limited, however, to 10,000 euros per group home, so that if more than four persons in the home are entitled to financing, the total amount will be equally distributed among everyone. This grant is available to persons in need of care in all care grades. Group home members must apply for approval of this financing up to one year after establishing the prerequisites for entitlement. More detailed information on the conditions and procedure can be obtained from the long-term care insurance fund.

j. Pooling of services

What is pooling?

Persons needing care can also take advantage of services together with other persons entitled to services – flatmates in a long-term care group home for example. This type of communal service use is called “pooling” and is designed particularly to improve the situation in home care living forms and long-term care group homes and promote their utilization. One approved long-term care service, for example, might take care of multiple persons in need of care in a single residential house or group home. Pooling benefit

entitlements makes it possible to save money through economy. The savings this results in, especially in terms of time and cost savings, must be used exclusively for the benefit of the person needing care.

k. Care aids

What is a care aid?

This refers to devices and tools necessary for home care that facilitate care and contribute to the ability of the person needing care to maintain an independent lifestyle. The long-term care insurance fund differentiates between:

- Technical aids such as a nursing bed, positioning aids or an emergency call system,
- one-time use items such as disposable gloves or bed pads.

When will the long-term care insurance fund cover the costs of care aids?

Persons in need of care can apply for coverage of care aids if these facilitate care, alleviate discomfort, or enable them to live independently. The costs are covered by the long-term care insurance if the health insurance fund is not required to pay. The care aid glossary of the long-term care insurance funds provides information about which care aids can be purchased or rented as part of the long-term care insurance.

The person in need of care must pay a co-pay of ten percent, but no more than 25 euros, towards the cost for technical care aids. Large technical aids are usually available for hire, which means there is no co-payment. The long-term care insurance fund will reimburse up to 40 euros per month of the costs for disposable products. If wheelchairs or walkers are ordered by the doctor, the health insurance fund must bear the costs.

Starting 1 January 2017, the Medical Advisory Service of the health insurance (MDK) or the evaluator hired by the long-term care insurance fund in order to assess the need for care must provide concrete recommendations for care aids and care aid provision. These recommendations are considered to

be an official order for these services as long as the person in need of care agrees. Agreement is communicated to the evaluator during the evaluation and is documented in the evaluation form in writing. The evaluator's recommendation confirms that care aids are necessary in the provision of care or that care with certain, care-relevant aids is required of the statutory health insurance – thus eliminating the need for a review by the responsible long-term care or health insurance fund. This regulation is put in place to simplify the application process o that the insured persons can receive the benefits necessary to maintain independence faster and more easily.

l. Home conversion grants

Will the long-term care insurance fund provide a grant for construction efforts to adapt the residence?

Upon request, the long-term care insurance fund will provide a grant of up to 4,000 euros for persons needing care in care grades 1 to 5 to cover adaptation measures to facilitate and ease care at the residence or restore the independent lifestyle of the person in need of care to the greatest extent possible (measures to improve the living environment). Such measures are also meant to prevent the caretakers from becoming overwhelmed.

If multiple persons entitled to a grant live together, the grant can be applied for up to four times 4,000 euros, so up to a limit of 16,000 euros. If there are more than four persons entitled to the grant living together, the entire amount will be equally distributed among the residents. This is especially beneficial to home care group homes for persons needing care.

What measures does the long-term care insurance fund subsidise?

The long-term care insurance fund will provide a grant for various measures undertaken to adapt the residence. A grant is available for measures that involve major structural

Sometimes minor modifications are enough to make life significantly easier. The long-term care insurance fund also contributes grants – regardless of long-term care grade.

Calculated

Home conversion in shared care accommodation

When eight people with care needs live together, each person receives one eighth of the total amount of 16,000 euros. This makes 2,000 euros per person with care needs.

changes to the building, such as the widening of doors or permanently installed ramps and stair lifts, but also for renovations to the bathroom to make it more conducive to care. Furthermore, the installation and modification of furniture when necessary and in keeping with the requirements of the care situation is also financially supported as is the installation of certain technical aids. Another grant for residence adaptation can also be provided if the care situation changes to such an extent that further measures are necessary.

2.2 Semi-residential day and night care and temporary fully residential short-term care – what options are available?

In addition to the long-term care insurance services described in chapter 2.1 which directly benefit home care, there are additional services that can support care at home.

a. Semi-residential care (day or night care)
When does semi-residential care come into consideration?
Semi-residential care is the intermittent assistance during the course of a day in an establishment. Semi-residential care can be set up as day or night care. Within the limitations of the maximum benefit amounts, the long-term care insurance fund will cover care-related expenses, including expenses for assistance and for establishing necessary services for medical treatment maintenance. The costs for lodging and food as

Semi-residential day and night care

Care needs	Benefits maximum benefits per month
Care grade 1	*
Long-term care grade 2	689 euros
Care grade 3	1,298 euros
Care grade 4	1,612 euros
Care grade 5	1,995 euros

* Relief amount up to 125 euros per month

Overview of long-term care insurance benefit entitlements of insured persons in 2020 from page 96

well as other regular investment costs, however, must be paid privately. Semi-residential care is provided if home care cannot be guaranteed to a sufficient extent or if it is necessary as an addition and to support the home care . As a rule, day care is made use of by people in need of long-term care whose relatives work during the day. The persons in need of care are generally picked up in the morning and returned in the afternoon.

What kinds of services are there?
The benefit amount depends on the care grade. Insured persons assigned care grades 2 to 5 are entitled. Persons in care grade 1 can use their relief amount.

Semi-residential care includes necessary transportation of the person in need of care from their residence to the establishment where day or night care is provided and back again.

In addition, the long-term care insurance in semi-residential care facilities assumes the costs of so-called additional care staff for the additional care and activation of those in need of care there (see chapter 2.3 d. on page 82).

In addition to day and night care, claims to home care services and/or the nursing allowance without abridgement can be claimed to their full extent.

Further information about the financing of day and night care can be found in the section 'relief amount' (see chapter 2.1 g from page 60).

b. Temporary fully residential care (short-term care)
What is the purpose of short-term care?
Many persons needing care are only dependent on full-time institutional care for a short period of time, particularly when managing a crisis situation involving home are or

temporarily after staying at the hospital. These persons can benefit from short-term care in the corresponding approved full-time care establishments. Short-term care can be claimed as a long-term care insurance service from long-term care grade 2 in particular if home care cannot be provided temporarily, not yet or not to the required extent.

The short-term care can also be used in residential prevention or rehabilitation facilities that do not have a licence for nursing care under the Eleventh Book of the Social Code Book (SGB XI) if the caregiver uses a prevention or rehabilitation measure in this facility or nearby. This makes it easier for caregiving relatives to take advantage of a prevention or rehabilitation measure.

If there is no need for long-term care or no care need of long-term care grades 2, 3, 4, or 5 within the meaning of SGB XI has been identified, then under certain conditions short-term care is available as a service of the statutory health insurance (section 39 c SGB V).

What benefits does the short-term care include?
The benefits of the long-term care insurance for short-term care are not differentiated by long-term care grades; rather, they are equally available to all people with care needs with long-term care grades 2 to 5. The amount of the benefit is up to 1,612 euros for up to eight weeks per calendar year. People with care needs with long-term care grade 1 can use the relief amount of 125 euros per month, up to 1,500 euros per year, to take advantage of the short-term care benefits.

Stand-in care funds not used in a calendar year can also be used for the short-term care services. This means the benefit amount of the short-term care can be increased to a total of 3,224 euros per calendar year, i.e. it can be doubled. The increase amount used for the short-term care is offset against the benefit amount for stand-in care.

During the short-term care, half of the previously received (proportional) nursing allowance is granted for up to eight weeks per calendar year.

Further information about the financing of short-term care can be found in the section 'relief amount' (see chapter 2.1 g from page 60).

Is it possible to benefit from short-term care in other suitable facilities in justified individual cases?
Yes. In individual cases, the short-term care can also be used in other suitable facilities that have not entered into a short-term care contract with the long-term care insurance funds; this can include facilities for disabled people or similarly suitable care facilities. The prerequisite is that short-term care in a care facility approved by the long-term care insurance funds is not possible or cannot reasonably be expected.

2.3 Care in a nursing home – what options are available?

a. Full-time institutional care

What services do insured persons receive?

For full-time institutional care, long-term care insurance will pay a fixed allowance for care-related expenses, including expenses for assistance and services related to medical treatment care.

If persons in need of care assigned to care grade 1 choose full-time institutional care, long-term care insurance will provide them with a grant of 125 euros per month.

Fully residential care services

Care needs	**Benefits** per month
Care grade 1	Allowance in the amount of 125 euros
Care grade 2	770 euros
Care grade 3	1,262 euros
Care grade 4	1,775 euros
Care grade 5	2,005 euros

Overview of long-term care insurance benefit entitlements of insured persons in 2020 from page 96

As of 1 January 2017 the co-payment for a fully residential care facility no longer rises as care needs increase, but rather is a standard payment. This means that when there is a new assessment costs do not increase.

The service and price comparison lists provided by the long-term care insurance funds for free upon request and also available on the internet provide a good overview of the approved nursing homes.

What costs associated with residential care are not covered?
If the benefits of long-term care insurance are not enough to cover the expenses incurred by the care, the people with care needs have to make a copayment. On 1 January 2017, this increased disproportionately with an increasing need for care. So persons in need of care with a higher care level had to pay more than persons needing care with a a lower care level. This led to the persons in need of care refusing re-evaluation, even though they needed more care since they feared they would have to pay the higher co-pay. A new regulation remedies this.

Starting 1 January 2017, a unified co-pay was introduced for every full-time institutional care institution for care grades 2 to 5. This means that affected persons in care garde 5 pay just as much fore care as affected persons in care grade 2. Now the co-pay is only different from establishment to establishment.

In addition to care-related co-pay, other costs are also constantly being incurred by persons in need of care in full-time institutional care: This includes costs for lodging and food. Residents of an establishment are also required to cover separately charged investment costs. This involves expenses of the operator for acquisitions, building rent, and similar expenses that can then be passed on to persons in need of care. If the nursing home resident also decides to take advantage of special comfort or additional services, they will also have to pay for these themselves. Generally, the following applies: Since costs for care, lodging, investments, and comfort services can vary considerably between institutions, it is highly recommended that you carefully consider the various nursing homes before choosing one.

During the conversion to the new care grades, the benefit amounts for fully residential care were regraded starting 1 January 2017. In order to avoid the possible penalising persons in need of care as a result of this regradation, the affected people with care needs have acquired rights protection: They will receive a supplement to their normal benefit amount if the co-payment for care they are responsible for increased from December 2016 to 1 January 2017. The supplement should make up the difference.

b. Types of homes

What different types of home are there?

There are three different types of home: the residential home for the elderly, the care home for the elderly and the nursing home.

Living and care options differ in residential homes for the elderly, in care homes for the elderly and in nursing homes. But in all types of homes you have the option of taking meals with other residents.

- In residential homes for the elderly, the residents live relatively independently in small apartments with their own kitchen. They do, however, have the option of taking their meals with the other residents.
- A care home for the elderly provides elderly people who can no longer run the household on their own with nursing care and domestic help. Here, too, the residents will often live in self-contained small flats or apartments.
- The residents of nursing homes generally live in single or double rooms, and often they will have brought their own furniture. Here, the residents are provided with full nursing care and domestic help.

These days, most facilities are a combination of these three traditional types of home, the residential home for the elderly, the care home for the elderly and the nursing home.

Terminal care is provide for the seriously ill and dying in specialised care facilities, the hospices. Hospices specialise in palliative care (see chapter 2.5 from page 85).

c. Medical care for home residents

How is medical care ensured in nursing homes?

Medical care in the nursing home is provided in the same way as for all insured persons, such as for people who live at home. The Associations of Statutory Health Insurance Physicians/Dentists and the Federation of Panel Doctors/ Dentists must provide medical care in nursing homes. Residents in nursing homes have a free choice of doctor.

The availability of general practitioner, specialist medical and dental care for the residents is an important criterion when choosing a nursing home. Residential care facilities are required to enter into cooperation agreements with general general practitioners, specialist doctors and dentists. They are obliged to inform the long-term care insurance funds of how they have organised general practitioner, specialist medical and dental care as well as the supply of pharmaceuticals. In particular they should point to the conclusion of the cooperation contracts and their content and the integration of care facilities in the network of doctors and to the conclusion of agreements with pharmacies for the medical care of residents. This for example includes information about the frequency of general practitioner, specialist doctor and dentist visits as well as about the on-call duties of doctors and dentists and about medical care after 10 p.m. and at weekends. Furthermore, since 1 July 2016 nursing homes have to advise of their cooperation with a hospice and palliative care service.

The long-term care insurance funds must ensure that this information is available at the nursing home, online, and elsewhere, in a way that is understandable, clear, comparable and free of charge.

Additional companion carers go for walks with the people with care needs and reach out to them. They thus contribute to people in inpatient care institutions being able to better participate in community life.

Is it possible for a home to employ a doctor?
Nursing homes can employ a doctor if adequate medical care cannot be guaranteed by the independent doctors in the surrounding area and the nursing home has already made an unsuccessful application to the Associations of Statutory Health Insurance Physicians for a cooperation agreement with an independent doctor. In-house doctors do not make care in the home more expensive. These costs are not included in the care rates.

d. Additional care and activation in residential care facilities
As of 1 January 2017, every person with care needs is entitled to additional care and activation in fully and semi-residential facilities that goes beyond the necessary care. This additional care and activation gives people in residential care more attention, allows them to have more interaction with other people and to participate in community life. The costs of these benefits are borne fully by the long-term care insurance by financing so-called additional support staff. The number

of so-called additional support staff who provide additional care and activation has increased significantly since 2013 due to legal improvements.

2.4 Which benefits are there for people with care needs with long-term care grade 1?

Since the introduction of the new concept of care need in the provisions of the long-term care insurance on 1 January 2017, the new care grade 1 covers people with minor impairments of independence or capabilities. This mostly affects people with minor physical impairments, for example due to spinal or joint diseases. The fact that people with care needs and their carers have access to certain support, advice, and training services even if their level of impairment is minor means there are more options than previously available that allow people to maintain or improve their independence. The introduction of long-term care grade 1 significantly expanded the group of people who can benefit from the services of the long-term care insurance.

For this group of people (due to the relatively low level of impairment in long-term care grade 1), no non-residential benefits-in-kind can be provided through care services or nursing allowances unlike for people in need of long-term care grades 2 to 5. Rather, the benefits of the long-term care insurance for people with care needs with long-term care grade 1 focus on promoting their independence for as long as possible through early assistance and by enabling them to stay in their familiar home environment.

People with care needs with long-term care grade 1 are therefore entitled to comprehensive and personal care counselling which is designed to address to the particular situation of the person affected early on. The people with care needs and their relatives can use the counselling services of

their long-term care insurance fund or their private insurance company or the counselling services in a nearby care support base. In addition, once every six months they are entitled to a counselling session by a licensed care worker – who may be from the home care service – in their own home. Caregiving relatives also have the option of attending a free care course.

People with care needs of long-term care grade 1 are also entitled to be provided with consumable nursing supplies and to grants to convert their living environment (for example installing a disabled-friendly shower). If they live in a non-residential group home within the meaning of the long-term care insurance law they are also entitled to the group home grant and if necessary the initial grant for setting up group homes that receive non-residential care.

In addition, for their home care they are also entitled to a relief amount in the amount of up to 125 euros per month. This can be used for long-term care grade 1 in the same way as for the long-term care grades 2 to 5, with one difference: Unlike in the case of long-term care grades 2 to 5, the relief amount in long-term care grade 1 can also be used for home care service benefits in the area of body-related self-care. This means that for long-term care grade 1, the relief amount can also be used for example for help with showering or bathing provided by a care service.

If people with care needs of long-term care grade 1 choose fully residential care in a nursing home, they receive a grant in the amount of 125 euros a month from the long-term care insurance. In residential facilities they are entitled to additional care and activation like all insured persons. People classified as long-term care grade 1 are also entitled to caregiver leave benefits and short-notice leave benefits.

2. 5 Which specific benefits are available for seriously ill and dying people?

Seriously ill and dying people are entitled to palliative care. Palliative medicine aims to alleviate (palliate) the consequences of a disease when there is no chance of recovery.

How can seriously ill people be cared for?
Palliative care can be provided whenever people are in the last phase of their life – this care can be provided at home, but also in residential care facilities, in hospitals or in residential hospices. Many seriously ill people want to spend the last phase of their life in their home environment. The constant expansion of non-residential palliative care ensures this. Seriously ill and dying people are entitled to specialised non-residential palliative care, which includes both palliative medical as well as palliative nursing care. If the insured person can no longer be cared for in the home or in the family , patients can be cared for in a residential palliative care unit. They can also be cared for in a residential hospice.

How is care for seriously ill people improved?
Dying people need to be certain that they are not alone in the final stages of life and are well looked after and supported in every respect. The Act to Improve Hospice and Palliative Care, which came into force at the end of 2015, therefore promotes the expansion across Germany of palliative care – at home, in the nursing home, in the hospice and in the hospital.

The main reforms include the entitlement to individual advice and support. The statutory health insurance companies now have to support their insured people in the selection and utilisation of the hospice and palliative care benefits. They also have to provide then with information about the possibilities of making personal provisions for their final stage in life, especially regarding living will, power of

attorney and directives in respect of guardianship.

How is good hospice care ensured?
In order to strengthen the financial resources of in-patient hospices for children and adults, the minimum allowance of the health insurers was increased. Hospices that had received below average funding have since then been receiving a higher daily rate per insured person. In addition, the health insurance companies now cover 95 percent instead of 90 percent of the eligible costs. With regard to the allowances for non-residential hospice services, in addition to the staff costs, material costs (such as travel expenses of volunteers) are now also taken into consideration. Furthermore, an appropriate balance of full-time staff and volunteers is now ensured.

How is non-residential care being improved?
Additional reimbursed services were agreed between the medical profession and the health insurers – to improve the quality of palliative care, for additional qualifications of doctors and to promote effective networking with other professional groups and facilities. In addition, palliative nursing care at home can now be prescribed for longer than the previous four weeks. In rural and structurally weak regions, the development of so-called specialist non-residential palliative care (SAPV) is promoted.

In what way has residential care improved?
Terminal care has become an integral part of the benefits provided by the social long-term care insurance. What is more, nursing homes are obligated to enter into cooperation agreements with primary care doctors and specialists for the medical care of the residents.

In addition, the legal basis was created for residential care facilities to offer advice on **care planning in the final stage of life** . This is about giving the nursing home residents the opportunity talk to doctors, qualified non-medical personnel and their next of kin to find out everything they need to

know about how to draw up a living will, for example, and to make detailed decisions about their future personal medical and nursing treatment and care. The goal is to change the structures in such a way that effective forward planning in the clinic and in the practice is paid attention to.

2.6 How are volunteers and self-help groups promoted?

The long-term care insurance makes available funds for the development of care structures and care concepts and for the promotion of voluntary structures as follows

- for the set-up and expansion of everyday support services,
- for the set-up, expansion, and support of volunteer workers and other people with civic commitments and the relevant volunteer structures and
- Pilot projects for the testing of new care concepts and care structures, especially for people with dementia and other groups of people with care needs whose care needs require the current structures to be developed further.

The everyday support services may include things such as voluntary care offers (such as day assistance, individual assistance), offers to relieve caregivers (with a care assistant for example), or offerings to assist with everyday life (in the form of practical help for example). In addition, so-called voluntary initiatives can be supported, i.e. groups of volunteers and other persons willing to do civic work who have set themselves the goal of supporting and providing general care and relief for persons in need of long-term care and their relatives as well as similarly close caregivers and the associated volunteer structures.

Long-term care insurance funds are also available for structured cooperation in regional networks to improve the

Care volunteers are supported by the long-term care insurance funds

care and support of people in need of long-term care and their relatives, as well as similarly close caregivers who are involved in voluntary agreements for the provision of long-term care for people in need of such care. Organised groups of volunteers and other people committed to civic work can get involved in such regional networks in their respective catchment areas.

Valuable help and suggestions for those in need of care and their relatives can also be provided by self-help groups and self-help organisations. Self-help groups are voluntary, neutral, independent, and not-for-profit associations of people who, either because they are affected themselves or because they are relatives or otherwise close to the people affected, pursue the goal of improving the situation of people in need of long-term care as well as their relatives and otherwise close to them by means of personal, mutual support; this can include help from volunteers and other people committed to civic activities. The long-term care insurance funds are obligated to support the set-up and development of self-help groups, organisations, and contact points in the amount of 15 cent per insured person and year,

i.e. a total of around 12 million euros per year. Since 1 January 2019, it has been easier to allocate start-up grants for new self-help groups, organisations, and contact points. There is now also the ability to promote nationwide activities of self-help groups, organisations, and contact points.

In addition, licensed care facilities are entitled to give volunteers who help with the general care and support of people with care needs an expense allowance and to offer training. Any additional expenses are included in the remuneration the long-term care insurance funds pay the facilities.

In addition, people interested in becoming care volunteers can take part in the care courses of the long-term care insurance funds free of charge. This means that care volunteers are supported by the long-term care insurance funds.

2.7 Which care services does the health insurer pay for?

If nursing care at home can prevent or shorten a hospital stay or or if for any reason it is not possible for the person with care needs to stay in a hospital, then the statutory health insurance companies cover the costs for a period of up to four weeks – or longer in duly substantiated exceptional cases. As a rule, nursing care at home includes basic and technical nursing care (such as dressing changes) as well as domestic help as required. Nursing care at home in the form of technical nursing is also provided if it is necessary to ensure the success of the medical treatment. The health insurer can also provide basic care and domestic help and specify scope and duration. Requirement: There are no people living in the household who would be able to provide sufficient care.

When and where is a person entitled to nursing care at home?
Initially, there is an entitlement to at-home nursing care in the home of the insured person. However, the term "household" is broader: Nursing care at home can also be provided in shared accommodation or new forms of living and other appropriate places such as schools, kindergartens and, if there is a greater need for care, also in workshops for people with disabilities. There is no entitlement for the period of stay in facilities where according to legal regulations there is entitlement to technical nursing by the facility. In exceptional cases, medical technical nursing can be prescribed to insured persons in nursing homes who in the long term – foreseeably for at least six months – have an increased need for medical technical nursing. This is the case when the permanent presence of a suitable care worker is required because technical nursing benefits have to be provided during the day and at night and are unforeseeable regarding intensity and frequency or a ventilator must be operated and monitored during the day and at night.

What are the entitlements of people with care needs without care level classification or with long-term care grade 1?
There are cases when when people need care temporarily without there being a need for care within the meaning of the long-term care insurance, for example after an operation or due to an acute serious illness. In the past, such patients were not entitled to legal benefits. This gap was closed by the Hospital Structures Act through the so-called follow-up care after a hospital stay. A new entitlement to short-term care as a health insurance benefit was introduced.

As of 1 January 2016, insured persons are entitled to basic care and help at home for a period of up to four weeks as part of the at-home nursing care as well as to a domestic help. If there are children in the household who at the beginning of the benefit period are younger than twelve years or are disabled and reliant on help, the domestic help can be extended to 26 weeks. If these benefits are not enough, the

person is entitled to be admitted to a short-term care facility for up to eight weeks per calendar year. The health insurer pays a share of the costs for nursing, care and technical nursing up to an annual amount of 1,612 euros. The requirement is that no long-term care need of long-term care grades 2, 3, 4 or 5 within the meaning of the Eleventh Book of the Social Code Book (SGB XI) has been established.

What is the role of care facilities when it comes to hospital discharge?
The care facilities are involved when people with care needs are discharged from hospital. There should be close cooperation between the hospital and the care consultants.

Travel costs to outpatient treatment
People with care needs of long-term care grade 3, if their mobility is permanently restricted, all people with care needs with long-term care grades 4 or 5, and all disabled people with 'aG' (severe walking disability), 'Bl' (blind) or 'H' (helpless) in their disabled pass can now get a taxi to outpatient treatment more easily. They are now considered approved by medical prescription.

2.8 How are rehabilitation and prevention supported?

How important is prevention?
Given the demographic change and the increasing number of elderly and very old people in the population , health promotion and prevention in old age are becoming increasingly important. This is about ensuring that in the future people not only get older, but are healthier into old age. Many diseases that are common in the elderly, such as cardiovascular diseases, diseases of the musculoskeletal system and the metabolism, and dementia, can be counteracted through early prevention. Exercise, a balanced diet, being mentally active and socialising all play a part in healthy ageing, in maintaining independence and in preventing the need for long-term care. The Federal Centre for Health Education (BZgA) information about this on its websites at www.gesund-aktiv-aelter-werden.de and www.aelter-werden-in-balance.de. The responsible use of alcohol and medication as well as not smoking are also important elements of a healthy lifestyle in the elderly.

When using medication, special attention should be paid to

Exercise, a healthy diet, being mentally active and socialising help people be healthier in old age and avoid needing care

strong painkillers as well as sleeping pills and sedatives, which can lead to addiction if used improperly. Combining alcohol with sleeping pills and sedatives or antidepressants is particularly dangerous.

For information about the health of the elderly, visit the BZgA website at: www.bzga.de/infomaterialien/gesundheit-aelterer-menschen/.

Information about substance-related disorders in old age can be found on the website of the German Center for Addiction Issues at: www.unabhaengig-im-alter.de.

You can find information and recommendations about addiction in old age on the website of the Centre for Interdisciplinary Addiction Research (ZIS) of Hamburg University at: www.alter-sucht-pflege.de/.

How are prevention and rehabilitation supported in care?
In many cases there is hope for improvement through rehabilitation and health decline can sometimes be counteracted through prevention. The aim of the principle "rehabilitation before care" is to enable people with care needs to live a self-determined life for as long as possible, to strengthen their self-esteem and improve their quality of life.

The assessment by the Health Insurance Medical Service gives evaluators an impression of the life situation and the lifestyle of elderly person and allows recommendations to be made regarding preventive and rehabilitative measures. With the new assessment tool, which since 1 January 2017 has been used to classify people into the new long-term care grades, this now has an even better foundation. The focus is on the individual situation of the person with care needs. How do they cope day to day? Are there aids that can make their lives easier? Can the living environment be improved? To prevent a disease from deteriorating, rehabilitation and preventative measures can be recommend during the assessment; with the consent of the

person with care needs these can, for example, be classed as an application for aids and directly passed on to the long-term care insurance fund. This makes things considerably easier for the person with care needs.

With the 2016 Prevention Act, the long-term care insurance funds were obliged for the first time to provide specific prevention services in semi- and fully residential care facilities. The "Prevention guideline in residential care facilities" of the National Association of Statutory Health Insurance Funds (GKV central association) mentions the fields of activity diet, physical activity, strengthening of cognitive resources, psychological health and prevention of violence. The long-term care insurance funds are to spend approximately EUR 23 million on this in 2019. Caregiving relatives whose circumstances do not permit them to regularly take part in the prevention offerings from the health insurers now have the opportunity to participate in intensive courses at spa resorts instead. The daily room and board allowance from the healthy insurers for such events was increased to EUR 16 per day.

Growing old together: Often this means caring for one another. Caregiving relatives can take relatives with care needs with them to their own disease prevention courses.

Which residential prevention and rehabilitation measures are caregiving relatives entitled to?
When it comes to the decisions of the health insurers about prevention and rehabilitation, the specific needs of caregiving relatives must be taken into consideration. Relatives who provide care at home should therefore be able to take advantage of prevention or rehabilitation services on their own, for example to take a step back and adopt a new perspective. During this time the person with care needs can be cared for in a licensed short-term care facility.

In addition, caregiving relatives should have the opportunity to take the person with care needs with them to the residential prevention and rehabilitation event. This is because relatives are often prepared to take advantage of such services only if the person with care needs can be nearby. The care for the person with care needs during this time can also be in residential prevention or rehabilitation facilities that do not have a license for nursing care under SGB XI. "Müttergenesungswerk" (an organisation that provides rest for mothers) facilities or other similar facilities can also be included in the care of caregiving relatives and be paid for by the statutory health insurance.

Caregiving relatives are given easier access to medical rehabilitation services. When people with care needs are cared for at the same time in the rehabilitation facility, the health insurers cover the costs. Otherwise, the health insurer and long-term care insurance fund must organise the care.

Long-term care insurance funds and care support bases must provide relatives with advice and, among other things, provide them with information about relief options (such as services for the relief of caregivers, respite care, prevention and rehabilitation services).

Overview of long-term care insurance benefit entitlements of insured persons in

		Care grade 1 low level of impairment of independence or capabilities
Home care	Nursing allowance of € per month[1]	–
	Long-term care benefits in kind of up to € per month[1, 2]	–
Stand-in care[3] provided by close relatives or members of the same household[4]	Care requirement of up to 6 weeks per calendar year of up to € per year	–
by other persons[5]		–
Short-term care[6]	Care requirement of up to 8 weeks per calendar year of up to € per year[7]	–
Semi-residential day and night care	Care requirement of up to € per month	–
Relief amount for non-residential care	Benefit amount of up to € per month	125.00
Additional benefits in group homes with non-residential care	€ per month	214.00

2020

	Care grade 2 significant level of impairment of independence or capabilities	Long-term care grade 3 serious level of impairment of independence or capabilities	Care grade 4 the most severe level of impairment of independence or capabilities	Care grade 5 the most severe level of impairment of independence or capabilities with special long-term care requirements
	316.00	545.00	728.00	901.00
	689.00	1,298.00	1,612.00	1,995.00
	474.00 (1.5 times 316)	817.50 (1.5 times 545)	1,092.00 (1.5 times 728)	1,351.50 (1.5 times 901)
	1,612.00	1,612.00	1,612.00	1,612.00
	1,612.00	1,612.00	1,612.00	1,612.00
	689.00	1,298.00	1,612.00	1,995.00
	125.00	125.00	125.00	125.00
	214.00	214.00	214.00	214.00

Overview of long-term care insurance benefit entitlements of insured persons in

		Care grade 1 low level of impairment of independence or capabilities
Fully residential care	Care requirement of a fixed amount of € per month	125.00
Care of people with disabilities in fully residential institutions or facilities within the meaning of section 43a SGB XI in conjunction with section 71 para. 4 SGB XI[8]	Care requirements in the amount of	–
Consumable nursing supplies	Requirements of up to € per month	40.00
Technical aids and other consumable nursing supplies	Requirement per aid in the amount of	
Measures to improve the living environment	Requirements in the amount of up to	
Payment of pension insurance contributions for caregivers[9]	depending on type of benefit up to € per month (eastern Germany)	–
Payment of unemployment insurance contributions for caregivers[10]	€ per month (eastern Germany)	–

2020

	Care grade 2 significant level of impairment of independence or capabilities	**Long-term care grade 3** serious level of impairment of independence or capabilities	**Care grade 4** the most severe level of impairment of independence or capabilities	**Care grade 5** the most severe level of impairment of independence or capabilities with special long-term care requirements
	770.00	1,262.00	1,775.00	2,005.00
	15% of the remuneration agreed under part 2 chapter 8 of the Ninth Book of the Social Code, up to €266 per month			
	40.00	40.00	40.00	40.00
	100% of costs; however, in certain circumstances a co-payment of 10 % (no more than €25 per nursing supply item) must be made. Technical nursing supplies are mostly made available on loan, i.e. free of charge.			
	€4,000 per measure (up to four times this amount – i.e. a total of €16,000 – when several entitled persons live together)			
	159.95 (151.16)	254.74 (240.74)	414.69 (391.90)	592.41 (559.86)
	38.22 (36.12)	38.22 (36.12)	38.22 (36.12)	38.22 (36.12)

Overview of long-term care insurance benefit entitlements of insured persons in

		Care grade 1 low level of impairment of independence or capabilities
Health and long-term care insurance subsidies for caregivers during caregiver leave	up to € per month Health insurance[11]	166.68
	Long-term care insurance	32.38
Caregiver allowance (gross) for employees during short-term absence from work	up to 10 working days in total	

1 Entitled persons either receive the nursing allowance or non-residential long-term care benefits in kind. These two benefits can also be combined (so-called combined benefit). The nursing allowance in that case decreases in proportion to the value of the non-residential long-term care benefit in kind used in a given month.

2 People with care needs with at least long-term care grade 2, who do not claim their long-term care benefit in kind in a given month, or not in full, can utilise up to 40% of the non-residential long-term care benefit in kind amount for the reimbursement of expenses for benefits under state law for everyday support (conversion entitlement). The combined benefit regulations apply accordingly.

3 During respite care, half of the previously received (proportional) nursing allowance is granted for up to six weeks per calendar year.

4 If proof is provided, close relatives can be reimbursed for the necessary expenses (loss of earnings, travel costs etc.) up to the total benefit amount of €1,612 per calendar year. If the short-term care benefits are claimed (see footnote 5) then this amount can be increased to €2,418 per calendar year.

5 The benefit amount can be increased by up to € 806 from unclaimed short-term care benefits to a total of € 2,418 per calendar year. The increase amount used for the stand-in care is offset against the benefit amount for short-term care.

6 During the short-term care, half of the previously received (proportional) nursing allowance is granted for up to eight weeks per calendar year.

2020

Care grade 2 significant level of impairment of independence or capabilities	Long-term care grade 3 serious level of impairment of independence or capabilities	Care grade 4 the most severe level of impairment of independence or capabilities	Care grade 5 the most severe level of impairment of independence or capabilities with special long-term care requirements
166.68	166.68	166.68	166.68
32.38	32.38	32.38	32.38
90 % (if in receipt of one-off payments subject to contributions in the last 12 calendar months prior to taking time off work, regardless of amount, 100 %) of the net loss of earnings			

7 The benefit amount can be increased by up to € 1,612 from unclaimed respite care benefits to a total of € 3,224 per calendar year. The increase amount used for the short-term care is offset against the benefit amount for stand-in care.

8 If integration assistance benefits are provided in facilities or on premises within the meaning of section 43a SGB XI in conjunction with section 71 paragraph 4 SGB XI, then the integration assistance benefit in accordance with section 103 paragraph 1 of the Ninth Book of the Social Code (SGB IX) also includes the care services in these facilities or on these premises. In these cases, the long-term care insurance contributes to the expenses for nursing care to the extent laid out here.

9 If one or more people with care needs are provided with non-paid care at home and the people with care needs are at least long-term care grade 2 and they are cared for for at least ten hours per week, regularly spread across at least two days a week, if the caregiver is not in employment for more than 30 hours a week and does not receive full old-age pension.

10 One or more people with care needs are provided with non-paid care at home and the people with care needs are at least long-term care grade 2 and they are cared for for at least ten hours per week, regularly spread across at least two days a week, if the caregiver was subject to mandatory insurance immediately prior to providing the care or was entitled to ongoing income replacement benefits.

11 The calculation is based on the general rate of contribution of 14.6 % and the average additional rate of contribution of 0.9 % in the statutory health insurance. This may differ for members of the statutory health insurance because additional rates of contribution that are specific to the health insurer are taken into account.

Overview of other long-term care insurance measures that benefit the insured persons

	To improve care for	
	in the home	residential care
Comprehensive and individual care counselling by qualified care counsellors of the long-term care insurance funds	x	x
• On request, drawing up of a personal care plan that takes into account all required social benefits and appropriate help (case management)	x	
• Early care counselling (once applications for benefits have been received, the long-term care insurance fund offers care counselling, which should take place 2 weeks after submission of application), on request also in the home of the person with care needs;	x	x
• Caregiving relatives may undergo care counselling on their own with the consent of the person with care needs	x	
• Issuance of vouchers for counselling by independent and neutral counselling centres if counselling through the long-term care insurance fund cannot be provided in time	x	x
Care counselling can, on request, be provided by care support bases near the home, provided they are set up in the region	x	x
Sending the expert opinion on the need for long-term care and a separate prevention and rehabilitation recommendation to the insured person	x	x

The long-term care insurance funds publish the following online: • Benefit and price comparison lists of approved care facilities and recognised care facilities for everyday support • Information about self-help organisations and self-help groups • Information about integrated care body / participation in integrated care in the catchment area of the applicant On request, this information is printed out for insured persons	x x x	x x x
Training courses for (informal) carers and care volunteers	x	
Remuneration for additional care and activation in fully and semi-residential care facilities	x	x
Additional remuneration by the health insurance for care facilities (PE) for (additional) specialist posts in connection with the cost for medical technical nursing (care emergency programme); PE with up to 40 residents for half of a care position, with 41 to 80 residents for one care position, with 81 to 120 residents for one and a half, and with more than 120 residents for two additional care positions		x
Promotion of activating and rehabilitative measures through bonus payments for care facilities to significantly improve independence or capabilities		x
Promotion of volunteer structures and self-help	x	x

3 Home care by family members

If you decide to care for a person close to you in the home, the long-term care insurance offers a variety of help and benefits. The following chapter talks about the financial support you are entitled to in this case, which counselling services are available to you and how you can balance caring for a relative with your work.

3.1 What support is given for care in the family?

a. Financial support (nursing allowance)

What is nursing allowance and who gets it?

The nursing allowance is a financial benefit of the long-term care insurance.This is paid when the care itself is guaranteed – for example when it is provided by a relative. The nursing allowance is not paid directly to the caregiver, but rather to the person with care needs. The person with care needs can pass on the money to the caregiving relative as financial recognition (see chapter 2.1 c from page 55).

b. Social security coverage of the caregiver

Who counts as a caregiver?

A caregiver within the meaning of the long-term care insurance law is a person who provides non-paid care for a people with care needs in their home. As of 1 January 2017 the following applies: Someone who provides non-paid care for a person with care needs of long-term care grade 2 to 5 in their home for at least ten hours a week, regularly spread across at least two days a week, is a caregiver within the meaning of the long-term care insurance. These are benefits

relating to pensions and accident and unemployment insurance, which are explained in more detail below.

What are the pension entitlements of a caregiver?
The long-term care insurance pays contributions for caregivers' pension insurance if the caregiver[1] does not regularly work more than 30 hours a week. The contributions are paid until the person receives a full old-age pension and has reached the statutory retirement age of the statutory pension insurance. Contributions can also be paid if the person is in receipt of a partial pension. The amount of the contribution depends on the long-term care grade and the type of benefit (only nursing allowance only non-residential long-term care benefits in kind or combined benefit).

The long-term care insurance fund pays pensions insurance contributions of between 111.97 and 592.41 euros per month (2020 – former West German federal states) or between 105.81 and 559.86 euros per month (2020 – former East German federal states). The caregivers are understood to be in receipt of between EUR 601.97 and 3185.00 of pay per month (2020 – former West German federal states) or between EUR 568.89 and 3010.00 per month (2020 – former East German federal states) . On average, one year of caring means a monthly pension entitlement between 5.89 and 31.15 euros (1 January 2020 – former West German federal states) or between 5.74 and 30.39 euros (1 January 2020 – former East German federal states).

Does the caregiver have accident insurance?
Yes, caregiver[1] who cares for a person close to them in their home is covered by non-contributory statutory accident insurance. This covers the nursing measures that are also part of the long-term care insurance itself as well as help in the household. The caregiver is also covered by accident insurance on the way to and from the place where the care is given if the person with care needs and the caregiver do not live together.

1 This refers to caregivers who are entitled to social security benefits as defined in 'Who counts as a caregiver?' see page 105).

Payment of pension insurance contributions for caregivers since 01 January 2020

Long-term care grade of the person with care needs	Type of benefit received	Contribution amount in euros per month	
		West	East
2	Cash benefit	159.95	151.16
	Combined benefit	135.96	128.49
	fully non-residential benefits-in-kind	111.97	105.81
3	Cash benefit	254.74	240.74
	Combined benefit	216.53	204.63
	fully non-residential benefits-in-kind	178.32	168.52
4	Cash benefit	414.69	391.90
	Combined benefit	352.48	333.12
	fully non-residential benefits-in-kind	290.28	274.33
5	Cash benefit	592.41	559.86
	Combined benefit	503.55	475.88
	fully non-residential benefits-in-kind	414.69	391.90

When is a caregiver covered by unemployment insurance?
Effective 1 January 2017 the long-term care insurance pays unemployment insurance contributions for persons[1] who take time off work to look after relatives with care needs throughout the entire period they act as caregivers. This makes the carers eligible for unemployment benefits and active employment promotion benefits, unless there is a seamless transition to work on completion of their caregiving responsibilities. The same applies to people whose unemployment benefit is interrupted while they provide care.

The contributions are covered by the long-term care insurance. For caregivers who had taken out voluntary unemployment benefit due to their care responsibility under the law applicable until 31 December 2016, as of 1 January 2017 the voluntary insurance is continued as a compulsory insurance (i.e. the contribution is covered by the long-term care insurance only) for as long as they provide care.

c. Holiday and illness cover (stand-in care)
How is the care guaranteed when the caregiver is sick or needs a break?
If the caregiver is unable to care for the relative, for example because they are sick or on holiday, the long-term care insurance fund pays for a necessary replacement for people with long-term care needs of grades 2 to 5 as part of the stand-in care scheme (see chapter 2.1 f from page 58). This only applies if the caregiver has provided care for at least six months . This can be claimed for up to six weeks a year Other rest or respite options for caregivers are the semi-residential day and night care and short-term care (see chapter 2.2 b. and 2.2.2 c. from page 73). For up to six weeks per calendar year in the case of stand-in care and up to eight weeks per calendar year in the case of short-term care, half of the previously nursing allowance will be paid.

1 This refers to caregivers who are entitled to social security benefits as defined in 'Who counts as a caregiver?' see page 105).

Caregivers also need holidays. They should not ignore their limits.

Are the pension fund and unemployment contributions paid during the holiday?
Yes, the long-term care insurance fund pays the pension and unemployment insurance contributions of the caregiver for the duration of the holiday. This means that the pension entitlement continues undiminished for the holiday period and the carer continues to enjoy unemployment insurance protection.

d. Training courses for (informal) carers for relatives
Is professional guidance available for care at home?
The long-term care insurance funds must provide free training courses for people who care for a relative or who are volunteer carers. These courses are partly offered in partnership with the non-governmental welfare organisations, with adult education centres, the neighbourhood assistance services or the education associations. They offer practical guidance and information as well as advice and support on many different topics. These courses also give caregiving relatives the opportunity to exchange experiences with others and to socialise. On request, the training course can also be offered in the home of the person with care needs.

In addition, counselling consultations are provided in the home of the people in receipt of the nursing allowance. People with care needs who only receive the nursing allowance must use this advice regularly (see chapter 4.1 b from page 124). People with care needs who receive nursing care from a home care service are also entitled to a counselling visit every six months. In addition, people with care needs with long-term care grade 1 are also entitled to such a counselling visit every six months.

3.2 How is the reconciliation of work and care promoted?

a. Leave of absence under the Caregiver Leave Act
What is caregiver leave?
Employees who care for a close relative at home are entitled to caregiver leave. There is an entitlement to leave of absence for the home or out-of-home care of underage relatives in need of care and for the accompaniment of close relatives in their final phase of life. This applies to all long-term care grades. This is a full or partial leave from work for a period of up to six months covered by the social insurance and not paid for by the employer. This only applies to employers with more than 15 employees. The following in particular count as close relatives: grandparents, parents, parents-in-law, spouses, life partners, partners in a marriage-like relationship, partners in a life partner-like relationship, siblings, spouses of siblings and siblings of spouses, children, parents, adopted children and foster children (including the spouse's or life partner's), children-in-law, and grandchildren.

What must be taken into account when taking caregiver leave?
If part-time caregiver leave is to be taken, the parties to the employment contract will have to enter into an agreement. The employer must be notified of the caregiver leave in writing ten days before it starts. This written notice also

includes information about the time period of the caregiver leave and its scope. In the case of part-time leave, the desired distribution of working hours must also be specified. The employer must meet the wishes of the employees, unless there are urgent operational reasons to the contrary. The long-term care need of the close relative must be demonstrated to the employer by providing a certificate from the long-term care insurance fund or the Health Insurance Medical Service.

Is it possible to terminate caregiver leave early?
Generally, the following applies: caregiver leave can only be terminated early with the consent of the employer. Exceptions: Caregiver leave terminates early, with a transitional period of four weeks, if the person in need of care dies, has to be admitted to a residential care facility or it becomes impossible or unreasonable to provide home care for the close relative for other reasons.

Entitlement to caregiver leave applies to all long-term care grades. This leave from work for up to six months is covered by the social insurance

Can caregiver leave be combined with filial leave?
All types of leave within the meaning of the Caregiver Leave Act and the Family Care-giver Leave Act (see chapter 3.2 b from page 114) can be combined. However, they have to follow one another without a gap in between. Their overall duration must not exceed 24 months. The notice periods and the different requirements, which depend on the size of the employer, must be observed.

Are you protected against dismissal during caregiver leave?
Employees are protected against dismissal from the time they give notice – but for no longer than twelve weeks before the announced starting date – until the end of the caregiver leave. Notice of termination can only be given in special exceptional cases. Whether an exceptional case exists is decided by the competent highest state authority for employment protection or a body designated by it.

Are caregivers covered by social insurance during the caregiver leave?
As a rule, they continue to be covered by health insurance and long-term care insurance during the caregiver leave, because during this time they are covered by family insurance. If this is not possible, the caregiver has to take out voluntary health insurance , for which generally the minimum contribution has to be paid. Once you are covered by health insurance you are automatically also covered by long-term care insurance. On request, the long-term care insurance reimburses the health and long-term care insurance for all long-term care grades up to the minimum contribution. The necessary contributions are covered by the long-term care insurance fund. Private health and compulsory long-term care insurance continues during caregiver leave. On request, the long-term care insurance fund or the private long-term care insurance company of the person with care needs, whatever their long-term care grade, covers the health and long-term care insurance up to the minimum contribution as is the case for people with social insurance.

During caregiver leave, the caregiver is covered by pension insurance if they care for one or more people with care needs with long-term care grade 2 to 5 for at least ten hours per week, regularly spread across at least two days a week and if they are not in employment for more than 30 hours a week. If the working hours are merely reduced during caregiver leave, the employer continues to pay the pension insurance contributions based on the reduced pay.

During caregiver leave, the caregiver is also covered by unemployment insurance if they care for a person with care needs with at least long-term care grade 2 for at least ten hours a week , regularly spread across at least two days a week. This is under the condition that the caregiver was covered by unemployment insurance immediately before providing the care or was entitled to unemployment benefit.

During caregiver leave, as is the case for all caregivers who care for one or more people with care needs of long-term care grade 2 to 5 for at least ten hours per week, regularly spread across at least two days a week, the caregiver is covered by non-contributory statutory accident insurance.

What support can caregiving relatives receive during caregiver leave?
Employees who, under the caregiver Leave Act, decide to take up to six months of part-time or full-time leave are entitled to an interest-free loan; this also applies when filial leave is taken (see below). The loan is designed to help with cost of living and can be applied for with the Federal Office of Family Affairs and Civil Society Functions (www.bafza.de). It is paid in monthly instalments and covers half of the net salary that was reduced as a result of the cutting of working hours.

A lower monthly loan instalment can also be applied for (minimum: 50 euros). When full-time leave under the Caregiver Leave Act is taken, then the loan instalment is limited to the amount which is to be granted when the carer works an average of 15 number of hours per week during filial leave.

In smaller companies where there is no entitlement to leave, voluntary leave can be agreed with the employer. In this case the carer is entitled to an interest-free loan.

b. Leave of absence under the Family Care-giver Leave Act
What is filial leave?
Employees are legally entitled to filial leave; this means that for a period of up to 24 months with minimum working hours of 15 a week on average over a year home carers can take part-time leave to care for a close relative with care needs (long-term care grades 1 to 5). People who care for underage close relatives in need of care out of the home are also entitled to part-time leave.

This legal entitlement only applies if the employer has more than 25 employees, not including apprentices. The notice period for the leave is eight weeks. At the same time an explanation has to be given regarding time period and scope of the leave from work . The desired distribution of the working hours must also be indicated. Employer and employee must enter into a written agreement regarding the reduction and distribution of the working hours. The employer must meet the wishes of the wishes of employees, unless their are urgent operational reasons to the contrary.

Are civil servants entitled to caregiver leave and filial leave?
For civil servants, the federal regulations of the federal and state governments apply. In the "Act on Improving Compatibility of Family, Care Giving and Work Commitments for civil servants of the federation as well as soldiers and for the change of other public sector

Employees are entitled to filial leave of up to 24 months to care for a family member

employment provisions“, which came into force on 28 October 2016, the above regulations which apply for the private sector and for salaried employees were largely duplicated for civil servants and soldiers. A legal entitlement to filial leave and caregiver leave was introduced and at the same time they are also entitled to an advance payment in order to help them with cost of living during the (part-time) leave.

Are you protected against dismissal during filial leave?
Employees are protected against dismissal from the time they give notice – but no longer than twelve weeks before the announced starting date – until the end of the leave under the family Care-giver Leave Act. Notice of termination can only be given in special exceptional cases. Whether an exceptional case exists is decided by the competent highest

state authority for employment protection or a body designated by it.

Are caregivers covered by social insurance during filial leave?
During filial leave the employer continues to pay the pension insurance contributions on the basis of the reduced pay. In addition, the long-term care insurance fund transfers to the pension insurance during the filial leave contributions for the care provided, provided that the care for one or more people with care needs with long-term care grades 2 to 5 is at least ten hours per week, regularly spread across at least two days a week, and the carer is not in employment for more than 30 hours per week. The pension entitlements rise with the long-term care grade of the person with care needs, such that, overall, depending on the long-term care grade, this can be on the same level as full-time employment. Information about how the filial leave affects the amount of pension in individual cases are provided by the competent pension insurance fund. During filial leave, as is the case for all caregivers who care for one or more people with care needs of long-term care grade 2 to 5 for at least ten hours per week, regularly spread across at least two days a week, the caregiver is covered by non-contributory statutory accident insurance.

In what way do caregivers have financial security during filial leave?
During leave under the Family Care-giver Leave Act employees are entitled to an interest-free loan from the Federal Office of Family Affairs and Civil Society (www.bafza.de). A loan in the amount of half the difference between the estimated net pay before and during the leave is granted. Employees may choose a smaller amount, but for administrative reasons the monthly loan instalment has to be at least 50 euros. If voluntary leave is agreed, a loan may also be given. The filial leave calculator and other information and application forms are available online at www.wege-zur-pflege.de.

c. Short-term absence from work and caregiver allowance
What does "short-term absence from work" mean?
If the close relative of an employee becomes acutely in need of care, he or she has the right to take time off work for up to ten working days if this is necessary in order to organise appropriate care or nursing care . This helps relatives to organise care quickly, for example following a stroke. Employees are obliged to inform the employer without delay of their inability to work and of the expected duration of their inability to work. At the request of the employer a medical certificate must be submitted about the likely care need of the relative and the need to take time off work. All employees are entitled to short-term absence from work – regardless of the number of staff the employer has. Health insurance, care, pension and unemployment insurance cover continues during this time.

Good to know

Combination of leave of absence under the caregiver Leave Act and under the Family Care-giver Leave Act

Caregiving relatives can combine leave under the Caregiver Leave Act and the Family Care-giver Leave Act. The total permissible leave is 24 months. Close relatives may take leave at the same time or separately and share the care as partners.

Filial leave can be split: Several close relatives may divide the overall entitlement of 24 months amongst themselves and use it either at the same time or separately

What is the caregiver allowance?
As compensation for loss of earnings in the event of 'short-term absence from work' within the meaning of section c above employees are entitled to a so-called caregiver allowance for up to ten working days per person in need of care. This applies to the care of people with care needs whatever their long-term care grade. This is an income replacement benefit. The gross caregiver allowance is 90 percent (100 percent if in receipt of one-off payments in the last twelve months) of the lost net earnings. If several employees take short-term leave from work to benefit the same close relative in need of care, then their entitlement to caregiver allowance together is limited to ten working days.

The caregiver allowance must be applied for immediately – i.e. without undue delay – with the long-term care insurance fund or the private long-term care insurance company of the person with care needs. If such an application is made, the medical certificate about the (likely) care need of the relative also has to be submitted to the long-term care insurance fund or the private long-term care insurance company (as well as to the employer if applicable). The employer is obliged to continue to pay the remuneration only if such an obligation arises from other statutory provisions or from an agreement.

4 Advising in long-term care cases

Whether residential or at home: The long-term care insurance provides many different benefits for the care, assistance and support of a person with care needs. They should therefore seek advice on what they are entitled to. This chapter is about where you can find the right advice and what counselling you are entitled to.

4.1 What counselling options are there?

a. Care consultants

Who is entitled to care counselling?

Insured persons in receipt of long-term care insurance benefits are legally entitled to receive care counselling from the long-term care insurance fund or the private insurance company that provides the private compulsory long-term care insurance. The same applies to insured persons who are not in receipt of long-term care insurance benefits but have applied for them and clearly are in need of help and counselling. Caregiving relatives and other persons, such as volunteer carers, are also entitled to care counselling. This requires the consent of the person with care needs.

What do the care consultants provide?

The care consultants have comprehensive expertise, such as about social law and social security law, and they have a special qualification in care counselling. As soon as you have submitted an application for benefits to the long-term care insurance fund you receive from the care insurance

- either, by providing the details of a contact person, an offer for a specific counselling appointment, which must take place within two weeks of receipt of the application,
- or a counselling voucher that mentions independent and impartial counselling centres where, at the expense of the long-term care insurance fund, they can be redeemed within two weeks.

The care consultants, which on request provide the counselling in the home and at a later date, listen to the concerns and questions of those in need of help and care and of their relatives, determine their specific need for help, provide comprehensive advice on the available offers and support the care situation. If necessary and on request, they also draw up a personal care plan that includes the help the person with care needs requires.

It is also the responsibility of the long-term care insurance funds to inform people that they are entitled to be provided with the expert report and the separate rehabilitation recommendation which the Health Insurance Medical Service or another expert have created on behalf of the long-term care insurance fund.

The care consultants must, if applicable, also provide information about offers and services of the long-term care insurance that provide relieve and support for caregivers, and in particular caregiving relatives.

Information about care is also available from the care support bases and from the service and counselling centres of the federal states. The long-term care insurance funds provide information about the nearest care support bases. Care consultants can also be found in the care support bases.

What are the qualifications of the care consultants?
The complex care counselling work has to be performed by qualified staff. They may have an initial qualification as a social insurance clerk or a qualification under the Act on Professionals Engaged in the Care of the Elderly the the Act on the Professions in the Field of Nursing. Another possibility is a qualification as a social worker. Other suitable professions or degrees are also possible.

In addition to the basic qualifications gained during their vocational training or degree course, care consultants also have to have undergone further training and completed a care internship to gain the necessary skills and knowledge.

The care counsellors provide information about all types of support the long-term care insurance provides. They also determine the need for care and may draw up a personal care plan.

The same requirements apply to the staff of independent and neutral counselling centres.

What happens when there are problems?
Undergoing care counselling is voluntary. The long-term care insurance fund appoints a personal care consultant to those seeking advice, who are there to answer all his or her questions. Of course a specific care counsellor cannot be forced on someone.

What are care support bases?
A care support base pools all nursing, medical and social services and the advice they provide. The care support bases are the umbrella under which the staff of the long-term care insurance funds and health insurers, of the elderly care facilities and the social assistance agencies coordinate with each other and explain what social benefits are available to those seeking advice and help. People entitled to care counselling can also use this service in a care support base.

b. Counselling in your own home

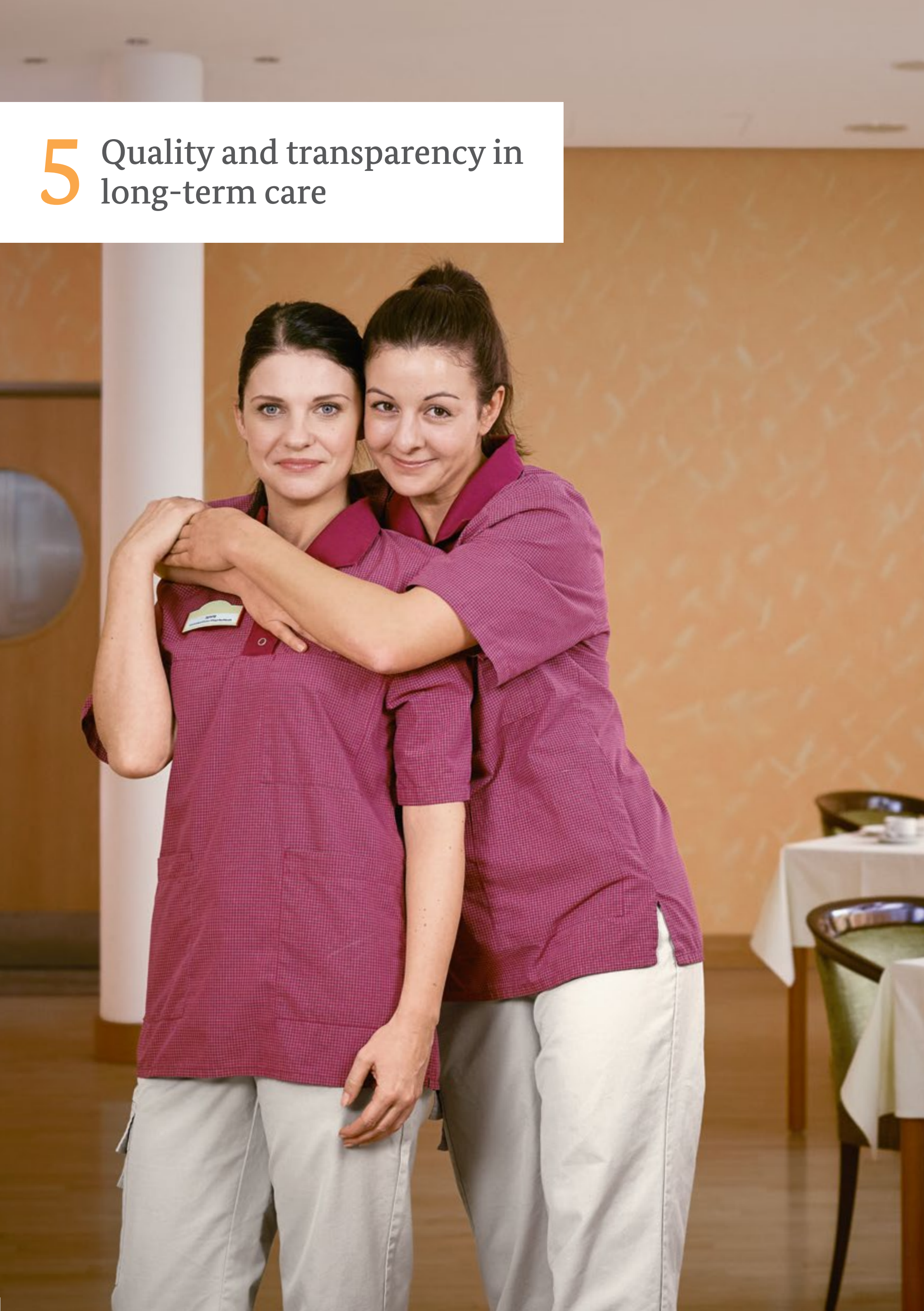
Who must and who can undergo care-related counselling consultations?
People with care needs who receive only a nursing allowance must attend a consultation in their home every six months if they are long-term care grade 2 and 3 and quarterly if they are long-term care grade 4 and 5. This also applies if the benefit amount intended for non-residential long-term care benefits-in-kind by care services is used only for recognised everyday support service under state law (as part of the conversion entitlement). The counselling visit in a person's own home ensures the quality of the home care and provides regular and practical nursing support for home caregivers.

People with care needs with long-term care grade 1 are entitled to a counselling visit once every six months. People with care needs who obtain non-residential long-term care benefits in kind are also entitled to a counselling visit once every six months.

The counselling visits can be carried out by the following bodies:

- approved care services,
- Neutral and independent counselling centres with nursing qualifications which are approved by the regional statutory long-term care insurance associations,
- Care workers who are tasked by the long-term care insurance fund but are not employed by it,
- The care consultants of the long-term care insurance funds,
- Counsellors of the communal local authorities with the required nursing competence.

What counselling is available in the palliative care of seriously ill people?
The statutory health insurance companies must assist the people they insure in the selection and use of the services of palliative and hospice care. For this reason, as of 1 January 2016, people are entitled to personal advice and assistance under the Act to Improve Hospice and Palliative Care. The health insurers should also provide general information about the available options regarding making personal provisions in the final stage of life, specifically regarding living will, power of attorney and directives in respect of guardianship.



5 Quality and transparency in long-term care

People with care needs are entitled to good care – and good care must be recognisable as such. This chapter explains which measures contribute to improving the quality and transparency of care and how existing shortcomings are remedied.

5.1 How is good-quality care ensured?

a. Expert standards

How are the quality standards for nursing homes and care services determined?

In order to improve the quality of care for people with care needs and their relatives, so-called expert standards are being developed using sound scientific and professional processes (including trials). The latest findings in medical nursing are summarised in individual topics. The following expert standards are currently in place: Decubitus prophylaxis in care; discharge management in care; pain management in care for acute pain; pain management in care for chronic pain; fall prevention in care; promoting urinary continence in care; caring for people with chronic wounds; nutrition management to safeguard and promote oral nutrition in care; forming relationships when caring for people with dementia. The expert standard "forming relationships when caring for people with dementia" requires carers to adjust to the changes associated with dementia (communication behaviours, sense of orientation, judgement, social behaviours) and to place those affected and their emotional and social needs at the centre of their work. The expert

standard "maintaining and promoting mobility" is currently being revised and scientifically tested. For user-friendly descriptions of the expert standards "decubitus prophylaxis in care" (measures to prevent bedsores / pressure sores) and "fall prevention in care", please follow the link below: www.biva.de/publikationen.

b. Quality inspections

What is checked during the quality inspections?

The focus of the inspection of nursing homes and home care services is the quality of the results; however, how the benefits are claimed for is also checked. This means: The auditors of the Health Insurance Medical Service (MDK) and the Service of the German Association of Private Health Insurers (auditing service of the PKV) not only assess the documents and files, they also very much focus on how people are cared for.

They carefully look at whether the care measures have an effect and, if so, in what way and whether there are any care deficits – such as pressure sores or malnutrition. When assessing the home they also take into account how satisfied the people with care needs are.

Are the inspection dates announced in advance?

All nursing homes and home care services are regularly audited once a year (regular inspection) by the MDK, the auditing service of the PKV or an expert.

In deviation from this, as of 1 January 2021 an inspection in an approved fully residential care facility can take place regularly at intervals not exceeding two years if the facility in question ensures a high level of quality.

Unannounced annual inspections ensure that the care standards are maintained. The files are checked during an inspection and how people are cared for is assessed.

All inspections of residential care facilities until 31 October 2019 are generally carried out unannounced. Quality inspections in non-residential care facilities must be announced one day in advance. As 1 November 2019, the latter also applies to residential care facilities, if they meet their new legal requirements for the regular and systematic collection and transmission of quality data.

Are there additional inspections in the event of complaints?
When there are specific indications of poor quality in non-residential or residential care facilities (such as if a person with care needs or relatives have complained or provided specific information to the long-term care insurance fund), then the long-term care insurance fund can instruct the Health Insurance Medical Service or the auditing service of the PKV to carry out unannounced inspections.

In addition, the regional statutory long-term care insurance associations, provided there are factual indications of incorrect invoicing, can either carry out an audit themselves or appoint a professional auditor to do this.

c. Auditing bodies

What is the Health Insurance Medical Service (MDK)?
The Health Insurance Medical Service is the social medical advisory and appraisal service of the statutory health insurance companies and the long-term care insurance. On behalf of the regional statutory long-term care insurance associations, the MDK also checks the quality of non-residential and residential care facilities.

What is the Auditing Service of the German Association of Private Health Insurers (PKV)?
The German Association of Private Health Insurers represents the general interests of the private health insurance, the private long-term care insurance and its member companies. The auditing service of the PKV performs the same tasks as the MDK and has the same powers in order to check there and then whether the licensed care facilities meet the quality requirements under the Social Code (SGB XI).

What role does the MDK and the auditing service of the PKV play when it comes to quality inspections?
The MDK and the auditing service of the PKV, on behalf of the regional statutory long-term care insurance associations, check the quality of nursing homes and home care services. Each year, the regional statutory long-term care insurance associations allocate 10% of the total auditing jobs to the Auditing Service of the German Association of Private Health Insurers (auditing service of the PKV).

However, the MDK and the auditing service of the PKV do not assess the quality of results. It is their job to advise facilities on questions of quality and to give recommendations on how to avoid poor quality care.

What is the role of the inspectorate of homes?
The residential care facilities are not inspected or advised by the MDK or the auditing service of the PKV. The care facilities are monitored and advises by the inspectorate of homes

authorities in the federal states as part of regular or one-off inspections. The content and the implementation of these inspections is regulated by law in the different federal states.

d. Publishing inspection results

What are the transparency reports for?

When you choose a home care service or a non-residential care facility you have access to the quality inspections of the care facility in question. By law they are published in a user-friendly way and they are published free of charge, such as online or in a care support base. The transparency reports should be visibly displayed in the care facilities, for example near the entrance; the report must include the date of the most recent inspection by the Health Insurance Medical Service (MDK) or the Service of the German Association of Private Health Insurers (auditing service of the PKV), together with a summary of the results and a grading of the results.

What are the care scores and what is assessed during the inspection?

The inspections of the MDK and the PKV inspection service are divided into different topics. The result consists of so-called care scores, which include several sub-scores and one overall score.

In nursing homes, the following your sub-areas are inspected:

1. Nursing and medical care for the insured persons,
2. Dealing with residents with dementia,
3. Care and daily activities,
4. Housing, meals, home economics and hygiene.

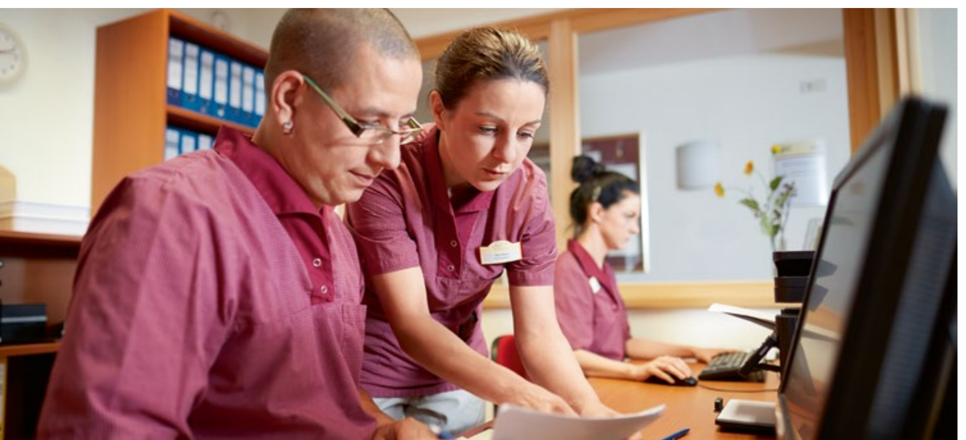
Home care services are rated in three categories:

1. Quality of nursing care,
2. Nursing services prescribed by a doctor,
3. Service and organisation.

The inspection results also include surveys of the home residents or customers. The scores are given separately. In addition, information about general practitioner, specialist and dental care in a residential care facility as well as the supply of pharmaceuticals is also published and made available free of charge.

The scores can be viewed on the following websites:

- www.aok-pflegeheimnavigator.de (AOK)
- www.bkk-pflegefinder.de (BKK)
- www.der-pflegekompass.de (miner's insurance, LSV, IKK)
- Www.pflegelotse.de (vdek – association of substitute funds)



Transparency reports of the results are published in a user-friendly way such as online or in a care support base, and they can be accessed free of charge

Further information is also available at:

- www.weisse-liste.de/de/pflege/pflegeheimsuche
- www.heimverzeichnis.de

What is happening with the quality inspections and transparency agreements?
The main yardstick for a good care facility is high-quality care that is provided in accordance with the latest nursing findings. This is precisely what is not very well reflected by the current care scores. For this reason, the Second Act to Strengthen Long-Term Care is about fundamentally revising the care scores with the support of science.

An important element here is the commitment of the self-administration partners to develop and introduce a new scientific procedure for measuring and presenting quality – giving particular consideration to the quality of results. On the other hand, the decision-making structures are to be substantially revised. To this end, a care quality committee was set up that is supported by a scientifically qualified national office.

The new methods for measuring and presenting quality will take effect in 2019. Under the Care Staff Support Act, which came into effect on 1 January 2019, the new quality assessment and presentation system in fully residential care will be mandatory as of 1 October 2019.

e. What is done in the event of poor quality
What possible sanctions are there?
Where a quality report reveals shortcomings, several options are available for sanctioning the offending facilities. A multi-tiered mechanism is in place: The regional statutory long-term care insurance associations decide on the audit report drafted by the Health Insurance Medical Service (MDK) or the Auditing Service of the German Association of Private Health Insurers (auditing service of the PKV) and after hearing the

facility in question, if and what measures must be taken to remove identified deficiencies. For this purpose, the long-term care insurance funds serve a “deficiency letter“ on the facility’s operator, at the same time stipulating a deadline for corrective measures to be completed. If a care facility does not provide services of the quality required, it violates its statutory and contractual duties. In this case, the negotiated fee rates are to be reduced commensurately for the duration of the violation.

Can nursing homes be suspended?

If the facility no longer meets the requirements for the conclusion of a service agreement, the regional statutory long-term care insurance associations in consultation with the competent social assistance agencies can terminate the service agreement in full or in part. More details about the contractual requirements and their fulfilment will in future be part of the respective federal state master agreements. A condition for a termination is that the regional statutory long-term care insurance associations and the competent social assistance agencies are convinced that the care facility is not able to meet the requirements in the long term. In particularly serious cases the service agreement can be terminated immediately without notice of termination. This requires the breach of duty of the care facility to be so severe that the regional statutory long-term care insurance associations and the competent social assistance agencies cannot reasonably maintain the service agreement.

f. Claims checks

In order to prevent false claims fraud more effectively, the Second Act to Strengthen Long-Term Care gave the long-term care insurance funds more control options. Under the act, the Health Insurance Medical Service (MDK) and the Auditing Service of the German Association of Private Health Insurers (PKV auditing service) are permitted to carry out unannounced home care inspections. In addition, the MDK

and the auditing service of the PKV have to perform mandatory audits of the claims. With the Third Act to Strengthen Long-Term Care the statutory health insurance was granted a systematic right of audit for care services that exclusively provide at-home nursing care on behalf of the health insurers. The quality spot checks of care services also include people who only receive at-home nursing care.

The authorities for combating misconduct in the health care system play a central role in exposing false claims fraud; they were set up following the enactment of the modernisation act of the statutory health insurances (GKV) from 2003 by the health insurers, long-term care insurance funds and Associations of Statutory Health Insurance Physicians.

It is their job to look into matters that suggest anomalies or the unlawful or improper use of financial resources in connection with the relevant long-term care insurance fund or association. Anyone can contact these authorities – including anonymously. These authorities must investigate such matters, provided they seem credible given the details provided or the overall circumstances. If necessary, they must notify the competent public prosecutor's office. With the entry into force of the act to combat misconduct in the health care system on 4 June 2016, these authorities are also required to regularly exchange experiences with each other as well as with the professional chambers and the public prosecutor's offices.

5.2 Care facilities: more staff – less red tape

a. Additional companion carers

How was residential care improved?

Residential care quality has been enhanced thanks to an improved staff-to-resident ratio in the form of additional companion carers who take the residents out for a walk, have

As of 1 January 2017, every person with care needs in a fully and semi-residential care facility is entitled to additional care and activation by additional companion carers. The costs are fully covered by the long-term care insurance.

conversations with them, or read to them; this means that insured persons in receipt of fully or semi-residential care receive more attention and are able to participate better in community life. The First Act to Strengthen Long-Term Care increased the carer-to-resident ratio from 1 to 24 to a current 1 to 20. As a result, the number of additional companion carers in fully and semi-residential care facilities has increased significantly; a nursing home with 100 residents with care needs can now have five additional staff for this task. Insured persons of all long-term care grades are entitled to this additional care and activation. The costs for the additional care staff are fully covered by the long-term care insurance funds.

b. Cutting red tape

How is the care documentation simplified?

The care documentation is important for quality assurance. However, carers and relatives have been complaining about the huge amount of red tape for some time. The introduction of a new care documentation concept has improved the situation. In future, care facilities can avoid unnecessary red tape and thus reduce the workload of carers. This in turn gives them more time to provide care.

To cut down on the red tape involved in the care documentation the so-called structural model was developed together with practitioners. The model significantly reduces the need for records without compromising on quality or raising liability issues. A new Structured Information Collection (SIS) documents the wishes of people with care needs, the assessment of the nursing and care needs by the care worker and the individual care-relevant risks. Instead of schematic and routine documentation the new concept focuses on the professional competence of the caregivers and on reducing the amount of information that is written down, for example by noting down anomalies rather than standards.

The structural model has proven its worth in a comprehensive practical trial, and it was introduced throughout Germany at the beginning of 2015. The project is being implemented by the care commissioner of the federal government, state secretary Karl-Josef Laumann, together with the central associations of the facility and funding agencies and the municipalities, the Health Insurance Medical Service, the Auditing Service of the German Association of Private Health Insurers, the association of the caring professions and the federal states. By November 2017, almost half (47.3 percent) of care facilities had joined the project to cut down on red tape. Since November 2017, the reduction of red tape involved in the care records has been continued under the auspices of the service provider associations.

c. The contracts between the nursing homes and the long-term care insurance funds

What options do the nursing homes have when it comes to contract design?

As care rates are negotiated between a long-term care facility and the third-party payers, the necessary facility-specific human resources must be agreed in addition to type, contents and scope of the benefits to be provided. It is not only the amount of the care rate (including the facility-specific co-payment rate) that is jointly determined between the parties, but also the benefits to be provided and their quality.

In addition, the agencies of the care facilities can enter into a full care contract for the local facilities that are connected with each other – such as a care service, a day care facility and a nursing home; the contract enables them, among other things, to deploy staff more flexibly during the set-up phase of a new facility or during peak periods or to ensure that support is available close to where people live between the different care areas.

d. Remuneration of carers

How is an appropriate remuneration of carers ensured?

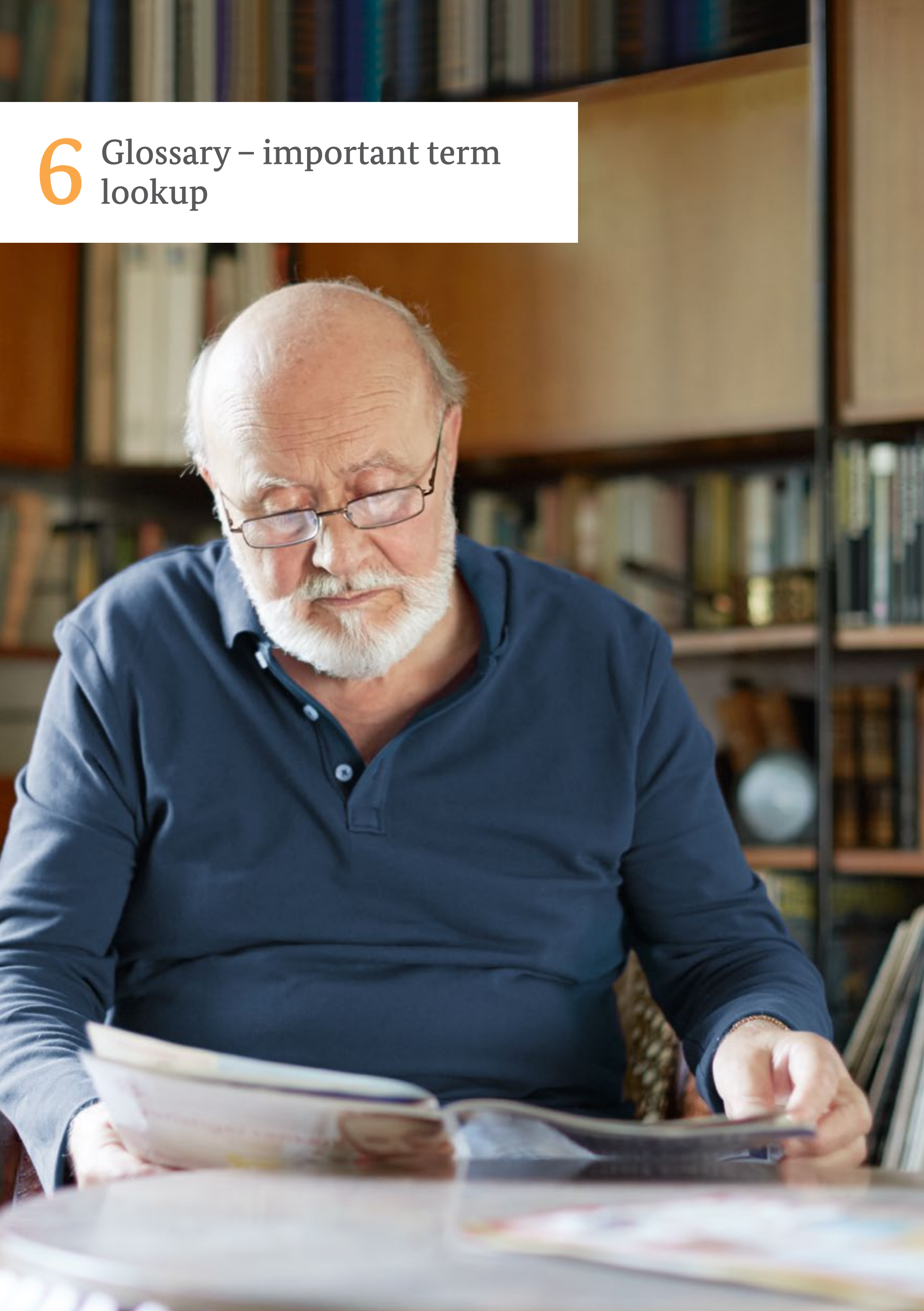
Providing people with care needs with good care is one of the most important tasks of a society. To achieve this calls for motivated carers who, in addition to social recognition, also have appropriate working conditions and salaries. This also helps make the caring professions more attractive.

However, when it comes to long-term care and non-residential nursing care, as in other professions, it is the collective bargaining parties who are responsible for negotiating pay. The federal government has put an appropriate legal framework in place that promotes collectively negotiated wages and prevents wage dumping: The minimum wage for long-term care agreed by the fourth care commission on 28 January 2020 for employees in long-term care and non-residential nursing care:

- From 1 July 2020, the minimum wage for nursing assistants in the west and east are to be increased in four steps to a €12.55 per hour. The adjustment of the different regional minimum wages will be completed by 1 September 2021. This applies to the additional companion carers, provided they spend at least 25 percent of the agreed working time with the recipients of the care services in a day-structuring, activating, caring or nursing capacity.
- As of 1 April 2021, a minimum wage of 12.20 euros per hour will be introduced in the east and 12.50 euros per hour in the west for qualified nursing assistants (at least one year's training and relevant work experience). By 1 September 2021 the minimum wage will be 12.50 euros across Germany. From 1 April 2022, this is to be increased to 13.30 euros per hour.
- On July 1, 2021, a uniform minimum wage of 15.00 euros per hour is to be introduced for care workers, which is to increase to 15.40 euros from 1 April 2022.

If the employer of a carer is a private household or a shared accommodation, then the general minimum wage applies. By law, a care facility, if efficiently managed, has to be able to cover its costs. Paying collectively agreed wages and the relevant pay under church employment law cannot be rejected as inefficient. Since 1 January 2017 it has been easier for non-tariff-bound facilities to negotiate tariff-level pay. Long-term care insurance funds and social assistance agencies have to recognise them in future as efficient and appropriately fund them. On the other hand, the funding agencies have the right to know that the employees do in fact receive the negotiated remuneration .

6 Glossary – important term lookup



From A for non-residential long-term care benefits in kind to Z for additional companion carers: The following pages provide an overview of the main terms related to care.

Non-residential long-term care benefits in kind
People with care needs who continue to live at home can hire a licensed professional care service and receive what is called a long-term care benefit in kind. This is also called home care support. These include:

- Physical care measures, such as help with personal hygiene, eating, mobility and positioning,
- nursing care, such as help with managing and organising everyday life (help with orientation, structuring the day, communication, needs-based everyday activities, etc.),
- helps in the household, such as cleaning the home, or everyday shopping needs.

The non-residential long-term care benefits in kind can be tailored to the individual care situation.

The non-residential benefits in kind of the ↗ **long-term care insurance** for the use of a care service at home are, as of 1 January 2017, for long-term care grade 2, up to 689 euros per month, for long-term care grade 3 up to 1,298 euros, for long-term care grade 4 up to 1,612 euros and for long-term care grade 5 up to 1,995 euros per month.

People with care needs of long-term care grade 1 can use their entitlement to the ↗ **relief** amount of up to EUR 125 per month instead for ↗ **home care services** within the meaning of the above-mentioned non-residential benefits-in-kind including the so-called self-care services. Self-care services refer to certain physical care measures, especially with regard to nutrition and body care, such as help with showering or washing.

Home care service
The home care service helps people with care needs and their families with ↗ **care at home.** It provides help and support in their daily lives so that ↗ **caregiving relatives** can, for example, better organise work and care. The care service staff visit the people with care needs in their home and provide professional help with their daily care routine. The care at home allows people with care needs to stay in their familiar surroundings despite their ↗ **need for care**.

The range of home care services covers different areas. It mainly comprises the following services:

- Physical care measures, such as help with personal hygiene, eating, mobility and positioning,
- nursing care, such as help with managing and organising everyday life (help with orientation, structuring the day, communication, needs-based everyday activities, etc.),
- help in the household, such as cleaning the home, or everyday shopping needs,
- Advice for the person with care needs and their relatives regarding questions of nursing.

  Home care services also help with arranging support services such as food delivery or organising (patient) transports.

If the required conditions are met, the home care service also provides ↗ **at-home nursing care** according to § 37 SGB V as a benefit of the statutory health insurance. At-home nursing

care includes drug administration, dressing changes and injections.

The service and price comparison lists, which the long-term care insurance funds provide free of charge, provide an overview of the approved care services.

Everyday support services
Everyday support services are designed to reduce the workload of caregivers, and they help people with care needs to stay in their home for as long as possible, maintain social contacts and to continue to manage their daily lives as independently as possible. The support staff are usually volunteers. The everyday support services include:

1. Services where volunteers in particular care for people with care needs with general or specific care needs in groups or in people's homes with professional instructions (care services),
2. Offers that serve the targeted relief **and advisory support of family members providing care and comparably close caretakers in their capacity as** caretakers (offer to relieve caretakers);
3. Offers that serve to support the person in need of care in managing general or care-related challenges in everyday life or in the household, particularly in regards to managing the household
or the independent organization of individually necessary assistance services (offers for relief in everyday life).

The everyday support services require approval under state law by the competent state authority.

Benefits for everyday support specifically refers to support groups for people with dementia, groups of helpers who provide relief for caregiving relatives in the home, day care in small groups or individual care by approved helpers, agencies that organise support and relief services for people with care needs and caregiving relatives and similar next-of-kin

caregivers, services that provide relief for families, everyday companions, care companions and service offers for domestic services.

To finance the everyday support services approved under state law, the **relief amount**, and where applicable the **conversion entitlement**, can be used.

Initial grant for group homes with non-residential care
When a home group with non-residential care is set up, the home group may be eligible for an initial grant. This is a benefit by the long-term care insurance – in addition to the **group home grant** in the amount of EUR 214 per month, which the people with care needs receive from the **long-term care insurance** if they appoint a person in a group home with non-residential care for general organisational, administrative, care, or other activities that promote community life or assist the group home members with their household chores. The initial grant is up to 2,500 euros for each person with care needs, with a maximum of 10,000 euros per group home, and it is designed to help set up a group home with a non-residential carer and for the age-appropriate and wheelchair accessible conversion of the group home. More details are available from the long-term care insurance funds.

Assessment (long-term care insurance)
The **need for long-term care** as defined under the law can generally exist in all phases of life. An application has to be made to the long-term care insurance fund for the benefits of the **long-term care insurance**. As soon as **the application has been made, the long-term care insurance fund tasks the** Health Insurance Medical Service (**MDK**) or other independent appraisers with the assessment for determining a long-term care need.

On behalf of the long-term care insurance funds the MDK or another independent appraiser assesses whether the long-

term care need conditions are met and which long-term care grade the person is classified as. For people with miners' insurance the assessment is drawn up by the social medical service (SMD). The assessment of privately insured persons is performed by MEDICPROOF. The assessment, for which notice is given, is generally performed in the applicant's home by an appraiser (care worker or doctor).

As part of the assessment the MDK or other appraisers examine the extent to which the insured person is restricted in their independence or capabilities in six areas (mobility, cognitive and communicative skills, behaviours and psychological problem areas, self-sufficiency, ability to independently cope with needs and stresses due to illness or therapy, organising everyday life and social contacts) and estimates for how the person is likely to be in need of care.

In the case of children with care needs, the long-term care grade is determined by comparing their level of independence and capabilities with other children who developed in accordance with their age. Children up to the age of 18 months are assessed differently. Children in this age group naturally lack independence in all areas of daily life. In order to ensure that these children are assigned the medically most appropriate care grade, issues not influenced by age, such as “behaviour and psychological issues” and “handling of demands and burdens associated with illness and therapy” will be included in the evaluation. Furthermore, a determination will be made of whether the child has serious problems ingesting food that require an unusually high amount of assistance. Children are generally assessed by a specially trained appraiser of the Medical Service or other independent appraisers with a qualification as a public health nurse or paediatric nurse or a paediatrician.

The legally specified maximum processing period for applications for long-term care services amounts to 25 workdays. If the person to be assessed is in hospital or in a

non-residential rehabilitation facility, in a hospice or is receiving non-residential palliative care, the MDK or another independent appraiser must perform the assessment within one week if this is necessary in order to guarantee continued care or the employer was notified of leave under the caregiver Leave Act or Family Care-giver Leave Act.

If the applicant is at home and does not receive palliative care, and the employer was notified of leave under the caregiver Leave Act or Family Care-giver Leave Act , a processing period of two weeks applies.

In addition, the long-term care insurance fund is obligated to give the applicant a choice of at least three independent appraisers if no assessment has taken place within 20 working days.

If the long-term care insurance fund does not provide a written decision on the application within 25 workdays of receipt of the application or if the shortened evaluation periods are not adhered to, then the long-term care insurance fund must pay the applicant 70 euros for each week initiated after the period runs out. This does not apply if the delay is not the responsibility of the long-term care insurance fund or if the applicant is in residential care and had already been significantly restricted in their independence or capabilities (long-term care grade 2).

The long-term care insurance fund sends the assessment to the applicant provided they do not oppose this. It is also possible to make a request later for the evaluation to be sent.

Contribution payments:
As of 1 January 2019 the contribution rate for the social **long-term care insurance** is 3.05 percent of the gross income, and 3.3 percent for people without children.

Counselling in their own home
People with care needs in receipt of ↗ **nursing allowance** must attend a consultation in their home, every six months if they are long-term care grade 2 and 3 and quarterly if they are long-term care grade 4 and 5 . People with care needs who use the ↗ **non-residential long-term care benefits-in-kind** of a care service, and people with care needs with long-term care grade 1 are entitled to these counselling visits once every six months. The counselling visit ensures the quality of the home care and provides regular and practical nursing support for home caregivers.

The counselling consultations are provided in the home of the person with care needs. Depending on the care situation, this can be their own household, the household of the caregiver, or a household that has taken in the person with care needs.

The counselling visits can be carried out by the following bodies:

- Approved care services,
- Neutral and independent counselling centres with nursing qualifications which are approved by the regional statutory long-term care insurance associations,
- Care workers who are tasked by the long-term care insurance fund but are not employed by it,
- ↗ **The care consultants** of the long-term care insurance funds,
- Counsellors of the communal local authorities with the required nursing competence.

Care services
With the Act to Reorient Long-Term Care Insurance, legislators have introduced a model project to test in practice and scientifically evaluate home care services by providing care services exclusively for care at home – especially for people with care needs who have dementia – and for

domestic help. The aim was to use the scientific support to gain important insights about the extent to which home care and domestic help can be expanded professionally and about the number of staff.

The central association of long-term care insurance funds (the National Association of Statutory Health Insurance Funds) was tasked with implementing this model project. Scientific support was provided by the IGES Institute Berlin.

This pilot project was completed successfully. The results show, among other things, that non-residential care services make an important and valuable contribution to the professionalisation of care in general and non-residential care.

In order to develop and expand the range of care and domestic help services, the law on quicker appointments and better care (the Appointment Service and Care Act, or TSVG) introduced care services as licensed service providers within the system of long-term social care insurance (§ 71, paragraph 1a, Eleventh Book of the Social Code Book (Social Code Book XI)] The statutory regulations on care services came into force on 11 May 2019.

Under the new Act, the regional statutory long-term care insurance associations are obliged to conclude contracts with service providers that offer quality-assured nursing care and help in the household. The provisions of the Social Code Book XI that apply to care services are also to be applied accordingly to care services, provided there is no regulation deviating from this (§ 71, paragraph 1a, Social Code Book XI).

Dementia
“Departing from the mind” or “without mind” – this is the literal translation of the Latin word “dementia”. It refers to the main symptom of dementia, namely the loss of mental capacity.

The disease starts with an impaired short-term memory and an impaired ability to remember things; later, people are no longer able to retain information in their long-term memory either, which means that sufferers increasingly lose the abilities and skills they acquired over the course of their lives. But dementia is more than “simple” memory impairment. It affects a person’s entire being: their perception, behaviour and experience.

Dementia can have a number of causes. A distinction is made between primary and secondary forms of dementia. The latter are caused by other underlying diseases, usually located outside of the brain, such as metabolic diseases, vitamin deficiencies and chronic toxicity from alcohol or medication. These underlying diseases are treatable and sometimes even curable. This means that the symptoms of dementia can often be alleviated.

However, only about ten percent of all cases of dementia are secondary , 90 percent of cases are primary and generally irreversible. Among these, Alzheimer's is the most common type and makes up around two thirds of all dementias. This is followed by the so-called vascular dementia with around 20%; researchers believe that mixed forms of dementia are also not uncommon, with around 15 percent of patients suffering from them.

Volunteer work

The long-term care insurance supports volunteer care activities with a variety of measures. Because as the number of people with care needs rises, so does the need for qualified caregivers and for people who do volunteer work. The **long-term care insurance** therefore promotes (in accordance with § 45c SGB XI) the set-up and development and the support of volunteer groups and other people willing to do volunteer work as well as the relevant volunteer structures.

Citizen volunteers and self-help groups and organisations are integrated into the local support networks. This includes, for example, everyday support services on a municipal level such as support groups for people with dementia, easing the workload of caregivers by supporting and caring for people with care needs on an hourly basis in their home or working with citizen volunteers or members of self-help groups at the **care support bases** to advise people with care needs and their relatives.

Citizens interested in doing volunteer work in licensed **care facilities** to help with the care and support of people with care needs or, for example, want to help people with **dementia** who find it difficult to cope with everyday life, can attend training courses organised by the care facilities. They can also attend the free **training courses for (informal) carers** provided by the long-term care insurance funds.In addition, licensed care facilities can pay volunteers who provide general care services an expense allowance.

In addition, financial support is given to the set-up and expansion of care-related self-help groups, organisations and contact points (according to section 45d SGB XI). Long-term care insurance makes available additional funds in the amount of EUR 0.15 per insured person and year for this, which is a total of approximately EUR 12 million per year. Since 1 January 2019, the funding of start-up grants for new self-help groups, organisations, and contact points has also been simplified and, for the first time, the funding of nationwide self-help activities of self-help groups, organisations, and contact points has been made possible.

Individual carers
Individual carers are generally carers, such as carers for the elderly, who have become self-employed. People with care needs can use self-employed carers to provide home care. The long-term care insurance funds must enter into contractual

agreements with appropriate caregivers, provided there are no specific reasons to the contrary.

The aim here is to enable people with care needs to live a largely self-determined life or to meet their special support requirements. If care is provided by individual carers, these carers have to enter into a care agreement with the person with care needs, which details the type and the scope of the services including the agreed remuneration. The the carer bills the long-term care insurance fund directly.

Cutting down on the red tape involved in the care documentation

Both caregivers and people with care needs increasingly feel that the red tape involved is at the expense of providing actual care. In an effort to cut down on red tape in care, the care documentation, both for non-residential and residential care, has been made more efficient. A practical structural model was developed for this purpose, which was introduced between 2015 and 2017 as part of a project.

The new basic structure of the care documentation reduces the written documentation of the care process to four steps. The core of the model is structured information collection (SIS), which is done at the start of the care process on the basis of defined topics, and this is done jointly by the person with care needs and the care worker to assess the individual situation.

The additional clearly structured capture of nursing risks and phenomena at the start of the care process in SIS and the planning of measures on this basis as well as the specification of evaluation data safeguards the quality of nursing care.

To systematically take into account the personal perspective of the person with care needs is a central aspect of the structural model. At the same time, the professional

competence of the care workers is paid closer attention to again: Routine documentation and individual proof of recurring basic care and support services on the report sheet is no longer required, and instead more trust is placed in the professional evaluation of the care worker. By law, the time saving must not mean less pay , but more time to provide care. This strengthens the carer's motivation and frees resources for the care itself.

The authorised representative of the federal government for care, state secretary Karl-Josef Laumann, initiated this project at the beginning of 2015 to introduce the structural model across Germany and implement it jointly with the central associations of the funding and facility agencies and representatives of the relevant associations and the federal states. By November 2017, almost half (47.3 percent) of care facilities had joined the project to cut down on red tape. Since November 2017, the reduction of red tape involved in the care records has been continued with the so-called "structural model" under the auspices of the service provider associations.

Interested **care facilities** can find out more at www.Ein-STEP.de.

Relief amount
Persons needing care who are being cared for at home are entitled to a relief amount of up to 125 euros per month. The amount is earmarked for quality-checked provisions to ease the workload of caregiving relatives and similar next-of-kin caregivers and to promote the independence and self-determination of people with care needs in the organisation of their everyday life. It serves to reimburse insured persons for the following expenses:

1. **Day and night care**services,
2. **Short-term care**
3. **Home care within the meaning of § 36** SGB XI (long-term care grades 2 to 5, but not self-sustainment) services,
4. **Everyday support services** approved under state law within the meaning of section 45a SGB XI.

The services of the home care service within the meaning of section 36 SGB XI are relief amounts used in particular for nursing care and help with household chores. Only people with care needs of long-term care grade 1 can also use the relief amount for the services of approved care services relating to body-related self-care (these are certain support services in the area of body-related care measures, such as help with showering or bathing).

Depending on the orientation of the recognised offers under state law within the meaning of section 45a SGB XI, these may include things such as assistance offers (such as day assistance in small groups, individual assistance), offers to relieve caregivers (with a care assistant for example), or offerings to assist with everyday life (in the form of practical help, help in the household, organisational help, etc.).

In the case that the monthly service amount is not (fully) exhausted in one calendar month, the remaining amount is transferred over to the following calendar months. Service amounts that have not been used by the end of the calendar year can be transferred and used by the end of the subsequent calendar half year. Benefit amounts not used until then can no longer be used.

Case management
A very wide range of care benefits is available. The long-term care insurance funds are therefore obligated to promptly offer the people with care needs insured with them care counselling in the form of individual care management. As a rule, the care counselling is provided by the long-term care insurance fund staff, who have comprehensive knowledge, especially of social law and social insurance law. It is their job to assess the personal need and the situation of the individual person with care needs, to help the people with care needs and their relatives organise the care and to support them in their care situation. This in particular includes:

- Advising the people affected and their relatives about benefits;
- Preparing applications and dealing with other formalities;
- Providing information about the entitlement to access the expert report by the Health Insurance Medical Service or other experts commissioned by the long-term care insurance fund as well as separate rehabilitation recommendations;
- on request, drawing up a personal care plan together with the person with care needs and all others involved in the care;
- Initiating all measures under the care plan and supporting its implementation as well as making suggestions for adjusting it to changed needs.

Filial leave
As of 1 January 2015 employees are legally entitled to filial leave, i.e. to partial leave for providing home care for a close relative for up to 24 months with weekly minimum working hours of 15. If a reduction of weekly working hours was applied for for a shorter period of time , then with the consent of the employer leave can be extended to up to 24 months. If there is an important reason why the carer cannot be changed, employees are entitled to their employer to extend the filial leave.

In order to be able to care for underage relatives with care needs both in their own home and out of the home, employees are also entitled to leave under the Family Care-giver Leave Act (partial leave of up to 24 months with a minimum of 15 weekly working hours) or the Caregiver Leave Act (full or partial leave of up to six months).

The entitlements to partial leave under the Family Care-giver Leave Act do not apply if the employer usually has 25 or fewer employees

To help with the cost of living, employees who take leave under the Family Care-giver Leave Act are entitled to an interest-free loan from the government. You can apply for the interest-free loan with the Federal Office of Family Affairs and Civil Society Functions (BAFzA).

Leave under the Caregiver Leave Act and the Family Care-giver Leave Act

As a result of the new regulations of the Family Care-giver Leave Act and the Caregiver Leave Act, the reconciling of family, caregiving and work commitments has significantly improved. As of 1 January 2015, employees benefit from greater time flexibility and security when providing home care to close relatives.

Employees who need time to organise an acute care emergency of a close relative can take time off work for up to ten days. Since 1 January 2015, they have been eligible for **caregiver allowance as wage replacement benefit** for a total of up to ten working days per close relative in need of care. On application **this is paid by the long-term care insurance fund or** the private compulsory care insurance of the person in need of long-term care.

Employees who care for a close relative in the home can, under certain conditions,take full-time or part-time leave for up to six months(**caregiver leave**). People with an underage close relative are entitled to leave even if they are cared for outside the home. In addition, employees may request full-time or part-time leave from work of up to three months to care for a close relative in the last phase of their life. In this case, too, employees must provide proof of the relative's illness by furnishing the employer with a medical certificate. Employees working for employers with more than 15 employees are entitled to the above leave.

In addition, as of 1 January 2015, employees of companies with usually 25 or more staff employed as trainees are entitled to filial leave, **, i.e. part-time leave to care for a close relative** in need for care in the home for a period of up to 24 months and weekly minimum working hours of 15.

To help with the cost of living, employees who take leave under the Caregiver Leave Act or the Family Care-giver Leave Act are entitled to an interest-free loan from the government.

At-home nursing care

If nursing care at home can prevent or shorten a hospital stay or or if for any reason it is not possible for the person with care needs to stay in a hospital, then the statutory health insurance companies cover the costs for a period of up to four weeks – or longer in duly substantiated exceptional cases. As a rule, nursing care at home includes basic and technical nursing care (such as dressing changes) as well as domestic help as required.

Nursing care at home in the form of technical nursing is also provided if it is necessary to ensure the success of the medical treatment. Requirement: There are no people living in the household who would be able to provide sufficient care. The health insurer can also provide basic care and domestic help

and specify scope and duration. However, these additional benefits can no longer be covered by the health insurers once a person is in need of care **from long-term care grade 2** within the meaning of the **long-term care insurance** , because then it falls within the responsibility of the statutory long-term care insurance.

Initially, there is an entitlement to at-home nursing care in the home of the insured person. The health care reform of 2007 broadened the term “household”: Nursing care at home can also be provided in shared accommodation or new forms of living and other appropriate places such as schools, kindergartens and, if there is a greater need for care, also in workshops for people with disabilities.

There is no entitlement for the period of stay in facilities where according to legal regulations there is entitlement to technical nursing by the facility. In exceptional cases, medical technical nursing can be prescribed to insured persons in nursing homes who in the long term – foreseeably for at least six months – have an increased need for medical technical nursing care.

This is the case when the permanent presence of a suitable care worker is required because technical nursing services have to be performed during the day and night and are unforeseeable regarding intensity and frequency or a ventilator must be operated and monitored during the day and at night.

When you are discharged from the hospital: At-home nursing care can be prescribed by registered contract doctors or by the hospital doctor; since the latter is the patient’s most recent attending doctor, he or she will have the most detailed information. They can prescribe at-home nursing care for up to three days to discharged patients and provide them with medication to take home. The responsible hospital doctor

must notify the responsible registered contract doctor of this. This new regulation significantly lightens the administrative burden for **home care services** .

On being discharged from the hospital, people with care needs are often faced with a new situation and feel helpless. For this reason, a staff member at the clinic must look after the person with care needs while he or she is still in the hospital. The so-called discharge management scheme is designed for hospitals to ensure a smooth transition from hospital treatment to non-residential care, rehabilitation or nursing care.

Aids

The statutory health insurance companies pay for aids that may be required to safeguard the success of the hospital treatment, to prevent a possible disability or to help with an existing disability. The entitlement may also concern medical provision, such as when an aid is required to prevent a person from **needing care**.

Aids include a wide range of products: including incontinence aids, compression stockings, shoe inlays, prostheses and orthoses, wheelchairs and hearing aids.

The aid has to be approved by the health insurer before it is made available, unless the health insurer has waived this requirement (for example for certain aids or up to a specific value). This also applies if the aid was prescribed by a doctor.

Compare with glossary entry for **consumable nursing supplies** .

Combined benefit
Within home care nursing allowance and ↗ **non-residential** long-term care benefits in kind can be combined (this is called "combined benefit"). The ↗ **nursing allowance** in that case decreases in proportion to the extent to which in any given month the non-residential long-term care benefits in kind is claimed.

Community participation in care
The Second and Third Act to Strengthen Long-Term Care strengthen the regional cooperation when it comes to caring for people with care needs locally; this specifically relates to the following measures:

The long-term care insurance funds can join self-organised networks for a structured care cooperation. They can contribute, either individually or jointly, to the costs of the network with up to 20,000 euros per calendar year at the district / district-free city level.

The cooperation between the various local counselling services is being improved. The regional statutory long-term care insurance associations enter into federal state master agreements with the competent bodies of the federal states regarding cooperation in counselling.

The service and price comparison lists for the licensed non-residential and ↗**residential care facilities** now also include the everyday support services recognised by the federal states. Other support services for people with care needs can also be included in the service and price comparison lists. This creates transparency about the services available locally.

The ↗ **Third Act to Strengthen Long-term Care (PSG III)** strengthens the role of municipalities in care. The municipalities are granted a right of initiative to set up ↗ care support bases. In addition, they can redeem counselling vouchers in the future and provide compulsory counselling

when ↗ **nursing allowance** is claimed. As part of the municipal care counselling model projects, up to 60 districts or district-free cities can provide counselling and care counselling from a single source. The participation of the federal states and the municipalities in funding the development of care structures and volunteer work is being simplified. The municipalities can request the long-term care insurance funds to conclude local counselling cooperation agreements.

Short-term absence from work

In an acute care emergency, employees have the right to stay off work for up to ten working days to give them time to provide or organise proper care for a close relative. Close relatives may share these ten days. As of 1 January 2015, ↗ **caregiver allowance** can be granted for up to ten working days. This is an income replacement benefit of the long-term care insurance fund. If several employees claim this entitlement to short-term absence from work to care for a relative in need of care, then their entitlement to the caregiver allowance is limited to up to ten working days. Under the Caregiver Leave Act all employees have the right to short-term absence from work to cope when an acute "care situation" has to be organised for a close relative. An acute care situation under the Caregiver Leave Act exists when the situation occurs suddenly and unexpectedly. If a person is already ↗ **in need of care,** and this continues unchanged, then this does not apply. As a rule, an acute care emergency only occurs once per relative with care needs, which means that this right can only be exercised once for each case. However, if a close relative does experience an acute care emergency more than once, then the right to short-term absence from work may be exercised again.

It is important that

1. the person with care needs is a close relative (parent, grandparent, spouse, partner, sibling, child etc.);

2. the relative with care needs is expected to be classified as long-term care grade 1 to 5;

3. employees are obligated to immediately notify their employer of their inability to work, including how long this is expected to be the case.

At the request of the employer a medical certificate must be submitted about the likely care need of the close relative and the need for short-term absence from work. If there is no entitlement to continued remuneration from the employer during the short-term absence from work, an application for caregiver allowance can be made to the long-term care insurance fund or the long-term care insurance of the close relative in need of care. The application must be accompanied by a medical certificate.

If short-term absence from work is required to care for a child, there is no entitlement to caregiver allowance if sickness or injury benefit (if the child is sick or had an accident) is also claimed simultaneously.

It is important that the employee submits the application for the caregiver allowance to the long-term care insurance fund or the long-term care insurance company of the close relative to be cared for as soon as possible. Any documents, such as a certificate from the attending doctor of the person with care needs or proof of salary can be submitted at a later date.

Short-term care
Some people with care needs require **fully** residential care for a limited period, for example because there is a home care crisis or a transitional period following a hospital stay has to be organised. Fully residential facilities are available for such short-term care. Short-term care can be claimed as a long-term care insurance service from long-term care grade 2 in particular if home care cannot be provided temporarily, not yet or not to the required extent.

The short-term care can also be used in residential prevention or rehabilitation facilities that do not have a licence for nursing care under SGB XI if the **caregiving relative** uses a prevention or rehabilitation measure in this facility or nearby. This makes it easier for caregiving relatives to take part in prevention and rehabilitation measures.

The benefits of the long-term care insurance for short-term care are not divided into long-term care grades; the same amount is paid out to all people with care needs with long-term care grades 2 to 5. The amount of the benefit is up to 1,612 euros a year for up to eight weeks per calendar year.

People **with long-term care grade 1** can use the relief amount of 125 euros per month to take advantage of the short-term care services.

Stand-in care funds not used in a calendar year can also be used for the benefits of short-term care. This means the benefit amount of the short-term care can be increased to a total of 3,224 euros per calendar year, i.e. it can be doubled. The increase amount used for the short-term care is offset against the benefit amount for stand-in care.

During the short-term care, half of the previously received (proportional) **nursing allowance** is granted for up to eight weeks per calendar year.

In addition, since 1 January 2016 there has been an entitlement to short-term care as a benefit of the statutory health insurance (GKV) for people who are not classified as needing care according to long-term care grades 2, 3, 4, or 5 within the meaning of the law on long-term care insurance. If non-residential support in the form of **at-home nursing care** and / or domestic help is not sufficient, insured persons are entitled to short-term care, a benefit of the GKV in a suitable facility. The scope of the benefits are equivalent to the social

long-term care insurance, i.e. expenses currently up to the amount of 1,612 euros are covered.

Long-term care insurance benefits
Citizens generally have access to a wide variety of advising formats and establishments. Which option the people with care needs and their relatives go for depends on the amount of **care required** and on the particular circumstances of the potential caregivers. The licensed **care facilities** and services are differentiated by **type of benefit, and include home care servicesand** individual carers who support the people with care needs and their relatives by providing **care at home** , new forms of living such as **shared care accommodation** and **comprehensive nursing care in nursing homes.**

Health Insurance Medical Service (MDK)
The MDK is the social medical advisory and appraisal service of the statutory health insurance companies and the **long-term care insurance.** The MDK plays an important role when it comes to assessing **care needs** and quality assurance.

Minimum wage
When it comes to nursing care, the minimum remuneration is either based on the special minimum wage in the caring professions under the Act on the Posting of Workers („fourth regulation on mandatory working conditions for the care sector – 4th PflegeArbbV", the recommendations are to come into force on 1 May 2020 and cease to be in force on 30 April 2022) or the general legal minimum wage under the minimum wage law.

Palliative care and hospice services
Non-residential hospice services and residential hospices which rely on volunteer work make a valuable contribution to providing dignified support for people who are dying and their relatives.

The statutory health insurance companies give financial assistance to non-residential, semi-residential and residential hospice services.

The medical and nursing care of dying people is part of the standard care of the statutory health insurance. In addition, seriously ill people and dying people are entitled to specialist residential palliative care from the statutory health insurance under certain conditions (SAPV). This benefit aims to meet the wishes of seriously ill people to die with dignity in their own home. The benefit is for palliative patients who suffer from an incurable disease that has advanced to such an extent that it limits their life expectancy and requires particularly time-consuming care. The insured people are cared for by non-residential teams of doctors and nursing staff. They work closely together with hospice services. This benefit requires a prescription by a registered contract doctor or a hospital doctor.

Care needs
People with care needs are restricted in their independence or capability due to health problems and therefore need help. People with care needs must have physical, cognitive or psychological impairments or stresses that they are unable to compensate for or cope with independently. The need for care must exist permanently – foreseeably for at least six months – and their impairment must be at least as serious as laid down in § 15 SGB XI .

Care counsellors – "care counselling under § 7a SGB XI"
The long-term care insurance supports people with care needs and their relatives by providing personal and free care counselling.

If you apply for ↗ **long-term care insurance** benefits the long-term care insurance fund offers you a care counselling appointment which has to take place within two weeks of the application. The long-term care insurance funds appoint a

specific contact person for the local care counselling. This person is the long-term care insurance funds' point of contact for all queries related to the long-term care insurance. With the approval of the person with care needs, relatives can also undergo care counselling.

The counsellor is a specially trained care consultant with expert knowledge, especially in social law and social insurance law. Most of the care consultants are employees of the long-term care insurance funds. The municipalities also make counsellors available. Some of the counsellors of the long-term care insurance funds and the municipalities will also be available at the local ↗ **care support bases**; however, they are not available in all regions. Care counselling is also available at the care support bases. The long-term care insurance funds provide information about the nearest care support bases. The service and counselling centres of the municipalities and the welfare organisations also provide information about care. A small number of long-term care insurance funds do not themselves offer care counselling , but rather issue care counselling vouchers, which can be redeemed at independent counselling centres.

↗**The mandatory private long-term care insurance offers long-term care advice through the company** "COMPASS Private Pflegeberatung (Private Long-Term Care Advising)". They can be contacted on free phone number 0800 1018800. Overviews of the benefits, costs, and the quality of ↗**care facilities** are published online by the regional statutory long-term care insurance associations. There you can also find information about the long-term care benefits in kind available in your region. If you apply for care benefits, you can request a printout of the service and price comparison list for your region from the long-term care insurance fund.

The care counselling of the long-term care insurance should work together with the counselling centres of the districts and towns, and especially with the counselling centres of the

social welfare offices and other non-commercial counselling centres, in order to ensure that the services of the different local counselling centres are well coordinated. The details are to be laid down in the framework agreements on a national level.

The qualification of the care consultants: They may have an initial qualification as a social insurance clerk or a qualification under the Act on Professionals Engaged in the Care of the Elderly or the Act on the Professions in the Field of Nursing. Other suitable professions or degrees are also possible.

In addition to the basic qualifications gained during their vocational training or degree course, care consultants also have to have undergone further training and completed a care internship to gain the necessary skills and knowledge. The central association of the long-term care insurance funds has issued recommendations on the qualification of care consultants.

The same requirements apply to the staff of independent and neutral counselling centres.

Care facilities
To support care at home, approved non-residential care facilities can be used – i.e. home care services.

If home care cannot be provided to a sufficient extent or if home care needs to be supplemented or strengthened, there are a number of other ways to ensure proper care for a relative. Care in a semi-residential care facility that provides day or night care is an important element. This is generally made use of when ↗ **caregiving** relatives work during the day. The people with care needs can be picked up in the morning and taken back home in the afternoon.

If these services are also no longer enough, the person with care needs can be cared for in a fully residential care facility, i.e. in a ↗ **nursing home**.

However, more and more people also want to live a self-determined life in old age in other living arrangements. New forms of living, including shared accommodation for the elderly and shared care accommodation offer women and men the opportunity to share a living environment – without giving up their privacy or independence. The residents of shared accommodation (SA) live in their own rooms, but at the same time they have the option of engaging in joint activities , such as cooking.

Quite often, residential homes for the elderly and care homes for the elderly give people the opportunity to live an independent life in apartments without giving up the necessary nursing care they need.

Need for long-term care

The need for long-term care can occur any stage of life, with immense implications not only for the people affected themselves, but also for their relatives. The Eleventh Social Code Book covers people with care needs who are restricted in their independence or capability due to health problems and therefore need help. People with care needs must have physical, cognitive or psychological impairments or stresses that they are unable to compensate for or cope with independently. The ↗ **need for long-term care** must be permanent, and foreseeably for at least six months.

People with care needs and their relatives are given help, advice and a comparison list of the services and remunerations of the licensed **care facilities** from the competent long-term care insurance funds, **insurance companies or a local** care support base. **The necessary applications for** the benefits of the long-term care insurance can also be made there. In addition, the people with care needs are also entitled to receive prompt and comprehensive advice from the **care consultants** of the competent long-term care insurance fund.

When an application for care benefits is made for the first time, as soon as the application is received the long-term care insurance fund must offer a specific counselling appointment to be held within two weeks. Alternatively, the long-term care insurance fund can also issue a counselling voucher for independent and neutral counselling centres, which have to be redeemed within two weeks at the expense of the long-term care insurance fund. On request, the care counselling appointment can be held at home. **The mandatory private long-term care insurance offers long-term care advice through the company "**COMPASS Private Pflegeberatung (Private Long-Term Care Advising)". The care advisor can advise you at home, at a full-time care institution, at the hospital, or at a rehabilitation establishment.

As soon as you apply for **services under long-term care insurance**, your long-term care insurance fund will order the Medical Advisory Service (MDK) or other independent evaluators to carry out an assessment in the interest of determining your need for long-term care.

The insured person's own caregiver should also attend this assessment appointment. If possible, the assessment should determine whether in the longer term the care can be provided by relatives or other caregivers **and whether the help of a** ↗ residential care service is also or exclusively needed. If it is not possible to receive ↗ **care at home** – perhaps also by taking advantage of the assistance offerings of a local day or night care establishment – then you can be given information and advice on suitable full-time institutional care establishments.

The care consultants of the long-term care insurance funds and the staff at the local care support bases will also answer any questions you may have. Information is available via the citizens helpline of the Federal Ministry of Health on 030 3406066-02.

Privately insured persons can contact the insurance company they are insured with at any time or can also contact the Verband der Privaten Krankenversicherung e.V. Gustav-Heinemann-Ufer 74 c, 50968 Cologne, www.pkv.de.

Nursing allowance
As some people want to chose their own caregiver, they can instead receive the nursing allowance. To receive the nursing allowance, home care must be guaranteed, for example by a relative or a volunteer. The mandatory regular nursing advice is designed to ensure the quality of home care and to support the caregivers.

The nursing allowance is transferred by the long-term care insurance fund. The nursing allowance can generally be freely disposed of, and it is usually passed on to the caregiver as a thank-you. To ensure optimal care tailored to individual needs, it is possible to combine the nursing allowance with the ↗ **non-residential long-term care benefits in kind** (help by the care services). In that case, the nursing allowance decreases in proportion to the value of the benefits in kind.

The nursing allowance per calendar month is as follows:

- 316 euros for people with care needs of long-term care grade 2,
- 545 euros for people with care needs of long-term care grade 3,
- 728 euros for people with care needs of long-term care grade 4,
- 901 euros for people with care needs of long-term care grade 5.

Long-term care grades and the new definition of long-term care
On 1 January 2017, five care grades replaced the previous three care levels. They enable the classification of the type and severity of the impairment in question, regardless of whether it is physical, mental, or psychological.

The long-term care grades and therefore also the amount of the **benefits are based on the severity of the impairments** of independence or abilities of the person needing care. The care grade is determined using a nursing care-appropriate assessment instrument. The five care grades are stepped: from minimal impairment of independence or ability (**long-term care grade 1**) to the most serious impairment of independence or ability, which place special demands on the provision of long-term care (long-term care grade 5). People with care needs with special sets of needs and special nursing care requirements can, for nursing-related reasons, be classified as long-term care grade 5 even if the required overall score does not permit it.

Care grade 1
The benefits of the **long-term care insurance** are designed for people with care needs with long-term care grades 2 to 5. For the purpose of maintaining or restoring independence and to avoid a severe **need for long-term care**, people with a low level of impairment classified as long-term care grade 1 can receive certain long-term care insurance benefits. These are mainly benefits that help the insured persons who do not have full access to the **benefits of the long-term care insurance** to remain at home. They are entitled to the following benefits:

- **Care counselling**,
- **Counselling in your own home** once every six months,
- the **group home grant**,
- **Initial grant for setting up group homes that receive non-residential care**,
- provision of **consumable nursing supplies,**
- **grants to improve their individual or shared living environment**,
- additional benefits **for caregiver leave** and **short-term absence from work**,
- **additional care care and activation in residential** care facilities,
- die **training courses** for (informal) carers and care volunteers
- the **relief amount** of up to EUR 125 per month or
- a **fully residential care** grant of EUR 125 per month as well as additional care and activation in the residential care facility.

Nursing home
The residents of nursing homes generally live in single or double rooms, and often they will have brought their own furniture. Here, the residents are provided with full nursing care and domestic help. People with care needs in fully residential nursing homes receive **fully residential care** benefits from the long-term care insurance. In addition, the insured persons with care needs in the fully residential nursing homes are entitled to additional care and activation by **additional companion carers.** The costs for the additional care staff are fully covered by the long-term care insurance.

Consumable nursing supplies
Consumable nursing supplies are devices and materials that help with home care, alleviate the symptoms of people with care needs, or help the people with care needs to live an independent life. People with care needs are entitled to consumable nursing supplies as part of their long-term care insurance, provided the nursing supplies do not have to be provided by the health insurance company or other care funders due to illness or disability. The long-term care insurance fund differentiates between:

- Technical aids such as a nursing bed, positioning aids or an emergency call system,
- Consumable nursing supplies such as disposable gloves or bed pads.

The consumable nursing supplies register lists the consumable nursing supplies that are made available (including for hire).

People with care needs from the age of 18 must pay a co-payment for consumable nursing supplies of ten percent up to a maximum of 25 euros per consumable nursing supply. Large technical aids are usually available for hire, which means there is no co-payment.

Up to 40 euros per month of the costs of consumable aids are reimbursed by the long-term care insurance fund.

Compare with glossary entry for **aids** .

Training courses for (informal) carers
If you care for a relative or care for people with care needs as a volunteer, you can take part in a free course organised by your long-term care insurance fund. The long-term care insurance fund is obligated to offer such courses.

These courses are partly offered in partnership with the non-governmental welfare organisations, with adult education centres, the neighbourhood assistance services or the education associations. They offer practical guidance and information as well as advice and support on many different topics. These courses also give **caregiving relatives** the opportunity to exchange experiences with others and to socialise. On request, the training course can also be offered in the home of the person with care needs.

Caregiving relatives and their social security
Many people with care needs want to be cared for in their own home, and many relatives want to care for their relatives with care needs without giving up social security benefits.

Caregivers are entitled to social security benefits. As of 1 January 2017 the following applies: Someone who provides non-paid care for a person with care needs of long-term care grade 2 to 5 in their home for at least ten hours a week, regularly spread across at least two days a week, is a caregiver within the meaning of the **long-term care insurance**.

If the caregiver is not in employment for more than 30 hours a week , the long-term care insurance pays the pension insurance contributions. The amount depends on the long-term care grade and the type of benefit (only **the nursing allowance,** **combined benefit** or **non-residential long-term care benefits-in-kind** in full).

If the caregiver meets all the requirements described above for the receipt of social security benefits, the caregiver is also covered by non-contributory statutory accident insurance during the care activities and when helping the person with care needs in the household. The caregiver is also covered by accident insurance on the way to and from the place where the care is given if the person with care needs and the caregiver do not live together.

As of 1 January 2017, the long-term care insurance pays unemployment insurance contributions for persons who take time off work to look after relatives with care needs throughout the entire period they act as caregivers. This makes the carers eligible for unemployment benefits and active employment promotion benefits, unless there is a seamless transition to work on completion of their caregiving responsibilities.

Providing care in the home
Care at home allows people with care needs to be cared for in their familiar environment. The **long-term care insurance** provides a variety of assistance – from paying for non-residential carers to help for **caregiving relatives** – to meet the wish of many people with care needs to be cared for at home. The benefits of the **long-term care insurance** help them implement this wish. The amount of the benefit depends on the person's long-term care grade. The important benefits are as follows:

People with care needs with long-term care grades 2 to 5 are entitled to **non-residential long-term care benefits in kind (care services)** or nursing allowance **or a combination of the two (the so-called** combined benefit).

Approved **home care services** and **individual carers** provide help in the home in the form of a non-residential long-term care benefits in kind.

People with care needs with long-term care grades 2 to 5 are entitled to nursing allowance instead of non-residential long-term care benefits in kind. They have free disposal of the nursing allowance and can, for example, pass it on to the person who cares for them as a thank-you. This can provide caregiving relatives with financial support.

In addition, all people with care needs who receive home care are entitled to a **relief amount** of 125 euros, for example for everyday support benefits.

The long-term care insurance provides various services, assistance and securities to make it easier for caregiving relatives to provide home care. Caregiving relatives who work are also entitled to **caregiver leave** and **filial leave**.

If the caregiving relative goes on holiday or is sick and is therefore temporarily unable to provide care, the long-term care insurance covers the proven costs of a replacement carer for up to six weeks per calendar year; this is the so-called stand-in care, which as a rule is in the amount of 1,612 euros for no longer than six weeks per calendar year if the person with care needs is at last classified as long-term care grade 2.

In addition, people with care needs with long-term care grades 2 to 5 are entitled to fully residential short-term care for up to eight weeks per calendar year in a crisis situation or for a transitional period following **residential treatment**. Short-term care and stand-in care can also be combined.

When people with care needs are cared for at home, it can be helpful to adapt the living environment to the specific needs of the people with care needs. The legislator supports the insured persons with home conversion **grants when there is a long-term care need.** The long-term care insurance also covers the costs of **consumable nursing supplies** .

Care quality

Social Code Book XI (SGB XI) contains the statutory framework conditions to ensure that the quality of the services provided by the residential and community-based long-term care providers is maintained and improved, the quality know-how and the internal quality management strengthened and greater transparency of results secured for the benefit of all parties involved.

The main elements are:

- Agreements concluded by the self-administration structure on the federal level about the standards and principles for quality and quality assurance in residential and community care settings as well as for the development of in-house quality management systems that is geared towards constantly ensuring and enhancing long-term care quality (§ 113 SGB XI)
- Developing and updating evidence-based and technically coordinated expert standards on quality assurance and advancement in long-term care (§ 113a SGB XI);
- regular inspection (at least once a year) of all approved **care facilities** as part of the quality inspections of the **Health Insurance Medical Service** (MDK) or the **Auditing Service of the German Association of Private Health Insurers (PKV auditing service)** (sections 114 ff. SGB XI);

- Publishing the results of quality audits of the MDK and the PKV auditing service, especially in terms of outcome quality and quality of life, in a format that is straightforward, comparable and easily understandable for the persons cared for and their relatives (§ 115 (1a) SGB XI).

The licensed long-term care facilities are required to implement quality assurance as well as quality management measures as set out in § 113, to apply expert standards pursuant to § 113a and to co-operate in quality audits pursuant to § 114 (§ 112 SGB XI).

The self-administration partners are required to develop and introduce a new scientific procedure for measuring and presenting quality – giving particular consideration to the quality of results.. The new quality assessment and presentation system developed by the self-governing body will be mandatory in fully residential care of the elderly as of 1 October 2019.

Act to Strengthen Long-term Care I

At the end of 2017, around 3.4 million people in Germany were in need of long-term care (social and private ↗ **long-term care insurance**). The First Act to Strengthen Long-Term Care (PSG I), which has been in effect since 1 January 2015, provides them and their relatives with significant additional support. Almost all benefit amounts of the long-term care insurance were increased. The benefits of ↗ **short-term care** and ↗ **stand-in care** were expanded and they can now be combined better. Entitlement to low-threshold care benefits in non-residential care was expanded. Furthermore, financial assistance for ↗ **conversion measures** – such as the installation of a disabled-friendly shower – was increased to 4,000 euros per measure, which allows people with care needs to stay in their familiar environment for longer.

The benefits for people with **dementia** were also improved. As of 1 January 2015, the First Act to Strengthen Long-Term Care entitles people with dementia with care level 0 (valid until 31 December 2016) to semi-residential day or night care and to short-term care benefits. The act also entitles them to additional benefits for residents of group homes who receive non-residential care and grants for newly set up group homes. On 1 January 2017, people with care needs with so-called care level 0 were automatically classified under the new long-term care grade 2.

The improvements of the First Act to Strengthen Long-Term Care were taken over when the new definition of long-term care and the five new long-term care grades combined with the new benefit amounts were introduced on 1 January 2017 and expanded again.

Act to Strengthen Long-term Care II

The Second Act to Strengthen Long-Term Care (PSG II), which has been in effect since 2017, introduced fundamental changes and improvements for people with care needs, relatives and carers. The act's cornerstone is the introduction of a new definition of long-term care, which is more focused on the needs of each individual, his or her personal circumstances and personal impairments and capabilities.

That is the basis on which, since 2017, all persons with care needs have had equal access to **long-term care insurance** benefits, irrespective of whether their impairments are physical, psychological or cognitive. Thanks to the new assessment tool, the personal circumstances and individual care needs of those filing an application for long-term care insurance benefits can be better captured. This makes it possible for services to be better matched to the individual person with care needs and to enhance their independence in the long term. A special priority is the improved assessment of people with **dementia.**

The new benefit law systematically implements the objectives of the new definition of long-term care needs: it makes specific help available to maintain and strengthen the independence and capabilities of people with care needs. To finance these measures, the contribution rate for long-term care insurance was raised again by 0.2 percentage points as of 1 January 2017.

A statutory advisory committee was set up to support the implementation of the Second Act to Strengthen Long-Term Care, and the new definition of long-term care in particular as well as the new assessment tool; the advisory committee includes representatives from the long-term care insurance funds, the care providers' associations, self-help organisations of people with care needs and people with disabilities, representatives of the nursing professions, the federal states and municipalities and representative of the scientific community.

The second Act to Strengthen Long-term Care also focused on the following:

- Improvements in counselling
- Staff requirements in residential facilities: By the year 2020 the self-governing body must develop and test a scientifically substantiated standard process for assessing staff requirements in ↗ **care facilities**
- **Developing the quality assurance regulations:** Quality assurance, quality measurement and quality representation are developed on a scientific basis; this accelerates the decision-making processes of the self-governing body

Act to Strengthen Long-term Care III

The Third Act to Strengthen Long-Term Care (PSG III) implemented the recommendations agreed by a federal-state working group on the strengthening of the role of care at the municipal level between the federal and state governments and municipal central associations. These concern the following areas:

- Ensuring access to care,
- Counselling,
- Low-threshold services (now: everyday support services),
- Living adapted to the needs of the elderly.

The Third Act to Strengthen Long-term Care also contains a set of measures for improving the prevention, detection and combating of false claims fraud. The law includes regulations both for the statutory health insurance (SGB V) and the long-term care insurance (SGB XI). The coordinated regulations of the SGB V and SGB XI aim to close existing gaps in quality and claims inspections. One of the most important regulations is the introduction of a systematic audit right in Social Code Book (SGB) V: Care services that exclusively provide at-home nursing care on behalf of the health insurers are also subject to regular quality and claims audits by the Health Insurance Medical Service (MDK). In addition, existing quality assurance tools in the area of long-term care insurance were developed further: For example, the inspections of the MDK at the care services were extended by including new groups of people (the sample now includes people who are only in receipt of technical nursing), and claims audits are now carried out independently of the quality audits of the MDK.

The relationship between care and integration assistance is made more precise. The “equal status” is retained. However, when there is a co-occurrence of identical benefits by different funds, social welfare offices and long-term care insurance funds are to agree on how the provision of benefits relative to the claimant, provided they agree, is to be provided from a single source and how cost reimbursement between the funds is to be dealt with.

Furthermore, the Third Act to Strengthen Long-Term Care introduces a new long-term care definition within social welfare law. Since the insurance benefits according to SGB XI are limited to statutory maximum amounts (system that provides limited cover), with the introduction of the new definition of long-term care in the SGB XI and the significant improvement to the benefits of the long-term care insurance, there may be additional need for care. If there is a financial need, this is covered by the assistance for care within social welfare and the social right to compensation (Federal War Victims Benefits' Law– BVG). Compared with the SGB XI , according to applicable law, the term is broader in that the need for care does not have to be expected to exist for six months. The main changes in the law of assistance for care are:

- Switch from care levels to long-term care grades,
- Benefits in the long-term care grades,
- additional care-related support services within the assistance for care.

In addition, the Third Act to Strengthen Long-Term Care also aims to recognise the economic viability of compensation up to the **tariff level in the care compensation negotiations of the** ↗ care facilities.

Finally, insured persons in residential facilities of assistance for disabled people within the meaning of § 43a SGB XI receive treatment benefits as **at-home nursing care** according to § 37 para. 2 clause 1 SGB V. The requirement here is that the need for treatment requires constant monitoring and care by a qualified care worker.

Care support bases

Care support bases are set up by the health insurance and long-term care insurance funds on the initiative of a federal state and they offer advice and support to those seeking help. When individuals seeking help are themselves in need of care or have relatives in need of care, then the care support bases provide them with all important information, application forms and practical assistance. The care support bases are also where you find the **care consultants** of the long-term care insurance funds.

For example, if people with care needs or their relatives want to convert a home to suit the elderly, the staff at the care support bases inform them about possible grants from the long-term care insurance fund. The advisory staff know all about suitable nursing homes and are are able to help. An overview of voluntary services in the community can also be provided by the care support bases.

On request of the individual, the care support base will coordinate the entire range of benefits for people in need of long-term care. Care support bases can therefore also help relatives who provide care with the preparation and organisation of the care. They enable all services for people with care needs to be efficiently interlinked locally as well as in the region, and they are designed to help overcome the boundaries between the social benefit agencies.

Caregiver allowance as wage replacement benefit
Employees who need time to organise an acute care emergency of a close relative can stay off work for up to ten working days (this is called **short-term absence from work**). This regulation serves to improve the reconciliation of work and care. According to section 44a of Social Code Book (SGB) XI, relatives are eligible for caregiver allowance as wage replacement benefit for up to ten working days per close relative in need of care. On application this is paid by the long-term care insurance fund or the private compulsory care insurance of the person in need of long-term care. If several employees claim this entitlement to short-term absence from work to care for a relative in need of care, then their entitlement to the caregiver allowance is limited to up to ten working days.

In order for the caregiver allowance to be granted, an application must be made to the long-term care insurance fund or the insurance company of the relative in need of care. This application must be made as soon as the acute care emergency occurs and submitted together with the relevant medical certificate. The benefit recipient is given a certificate by the long-term care insurance fund or the insurance company about being in receipt of the caregiver allowance, which in turn must be immediately presented to the employer.

Long-term care insurance
On 1 January 1995, in view of the demographic change and an increasingly ageing population in Germany, the last major social care gap was closed. Since then, long-term care insurance has been the fifth social insurance pillar alongside health insurance, unemployment insurance, pension insurance and the statutory accident insurance. Since anyone

can potentially be in need of care, the long-term care insurance is compulsory for all people with statutory and private insurance. This means: Everyone who has statutory health insurance is automatically insured with the social long-term care insurance, and everyone who has private health insurance must take out **private compulsory long-term care insurance**.

The long-term care insurance gives people with care needs the opportunity to decide how they want to be cared for and by whom.

People in need of long-term care can thus decide whether to get help from professionals or whether they would rather be in receipt of a **nursing allowance**, which they can pass on to their relatives who provide care as financial recognition. The main priority is to enable people with care needs to lead a self-determined life as much as possible. The top priority is to enable people needing care to maintain their independence as much as possible.

The benefits of the social long-term care insurance are funded through contributions from employer and employees, who pay half each. Insured persons without children also pay what is called the childless surcharge.

The social long-term care insurance does not cover all care costs; the people in need of long-term care or their relatives must cover part of the costs themselves. The long-term care insurance is therefore also called “partial cost insurance” or core protection system. The complete financing of all care benefits would require a significantly higher rate of contribution.

The Eleventh Book of the Social Code (SGB XI) contains all relevant long-term care insurance regulations.

Long-term care provident fund
The increasing life expectancy of citizens and the decline in birth rates in the past decades poses a challenge for the long-term care insurance. More people will be in need of care in the coming years, while at the same time fewer employees will pay into the long- term care insurance fund. For this reason, under the **First Act to Strengthen Long-Term Care** a long-term care provident fund was created by the Bundesbank.

A share of 0.1 percentage points of the long-term care insurance contributions is invested each year in this long-term care provident fund. Currently, this is around 1.6 billion euros per year. Over a period of 20 years, enough money will be saved up to be able to absorb to an extent the expected contribution rate increases.

The savings period of 20 years results from the fact that the 1959 to 1967 age groups (the so-called baby boomers) is much more numerous with 1.24 million to 1.36 million people than either the age groups before them or the age groups after them. In 2034 the first age group will be 75, after which the likelihood of needing care rises significantly. Around 20 years later, the much less numerous age groups born after 1967 will be of an age where they are likely to be in need of care.

This means that after 2034, there will be a particularly high number of people with care needs. The long-term care provident fund is designed to cushion possible contribution rate increases during this period in particular.

Promoting care provision
Because the statutory **long-term care insurance** pays the costs of basic care, citizens should make their own provisions in case they need care. The central aim of the state-funded care provision is thus to promote individual responsibility.

To enable everyone, including those on a low income, to take out a supplementary care insurance, the government supports the private care provision with an allowance of 60 euros per year. One option – which is often advisable – is to enter into a contract with dynamised benefits in order to offset any loss of purchasing power. If there is a benefit entitlement, the insured person can freely dispose of the money.

With the introduction of the five long-term care grades on 1 January 2017, § 127 para. 2 no. 4 SGB XI stipulated that for supported additional care tariffs, benefits in all five long-term care grades are provided for. For long-term care grade 5, a monthly care allowance payment of at least 600 euros must made. For insured persons with a government subsidised supplementary long-term care insurance, this means that the insurance conditions of the existing contract were adjusted accordingly on 1 January 2017.

The main statutory eligibility conditions that must be met for a private supplementary care insurance in order to count as eligible and for the insured persons to receive the state allowance of five euros per months:

- The insurer has a legal obligation to accept the contract. This means they have to offer an insurance contract to all adult applicants insured with the statutory (i.e in the social or private) long-term care insurance and have not yet received the benefits of the statutory long-term care insurance (this includes the suspension of these benefits because of receipt of benefits from another social insurance).
- Medical check-ups, risk premiums and benefit exclusions are not permitted. The amount of the insurance premium therefore exclusively depends on the age of the policyholder when the contract is concluded and on the contractually agreed scope of the benefits.

- The insurance benefits are cash benefits (monthly care allowance or daily care allowance), that are paid out for every long-term care grade. There must be benefits for each long-term care grade, and for long-term care grade 5 at least 600 euros. The contractually agreed benefits must not be greater than the benefits which are granted by the social long-term care insurance.
- When it comes to assessing the benefit entitlement, the insurance companies must follow the assessments of the competent long-term care insurance fund. If there is a benefit entitlement, the insured person can freely dispose of the money.
- The waiting period until the beginning of the insurer's benefit obligation must not be greater than five years.
- The minimum monthly amount policyholders have to pay themselves in order to receive the state allowance of five euros is ten euros.
- People who need financial assistance must have the option of terminating or suspending the contract retroactively to when the need for financial assistance started.
- The costs of entering into the contract and administrative costs must not exceed the legally prescribed limits. With two monthly contributions or ten percent of the gross premium these limits are well below the market average for contract and administrative costs for private insurance contracts.

Further mandatory specifications, such as regarding the minimum scope of benefits , are defined in the standard industry model terms by the German Association of Private Health Insurers. As of 1 January 2017, according to these terms, in long-term care grade 1 at least ten percent, in long-term care grade 2 at least 20 percent, in long-term care grade 3 at least 30 percent, and in long-term care grade 4 at least 40 percent of the cash benefit provided for in long-term care grade 5 must be covered by insurance. The state allowance is five euros a month or 60 euros a year, and it is the same for all

eligible contracts. Per person, only one contract is eligible. Policyholders receive the allowance automatically. You do not have to make an application.

The insurance company deals with this and the associated formalities. The state allowance for the past year is paid by a central agency of the German Pension Fund and credited to the eligible contract only on request of the insurance company. This way the allowance can be processed without too much red tape.

Shared care accommodation
Most people want to live a self-determined life for as long as possible and live in their own home. New forms of living, including shared accommodation for the elderly and shared care accommodation offer women and men the opportunity to share a living environment and to receive support – without giving up their privacy or independence.

The residents of shared accommodation (SA) live in their own rooms, which they can go to at any time, but at the same time they have the option of engaging in joint activities, such as cooking and eating, playing chess or exercising. **This also reduces the risk of isolation and loneliness, which unfortunately often** goes hand in hand with a need for care.

Long-term care insurance gives people with care needs in so-called group homes with non-residential care additional benefits under certain conditions, such as the **group home grant** or – in the case of new homes – the **initial grant for group homes with non-residential care** for the age-appropriate and wheelchair accessible conversion of the group home.

Caregiver leave / leave under the Caregiver Leave Act
According to the caregiver Leave Act (PflegeZG), employees working for employers with generally more than 15

employees, if they have a relative with care needs or they care for a close relative at home, have the option of taking caregiver leave. Caregiver leave can be taken for up to six months. During this time, employees can take full-time or part-time leave. To take leave, employees must produce proof of their close relative's ↗ **need for care** by producing a certificate from the long-term care insurance fund or the ↗ **Health Insurance Medical Service** (**MDK**). People with care needs insured with the ↗ **private nursing care** insurance also have to produce the relevant proof.

People with an underage close relative are entitled to leave even if they are cared for outside the home.

If more short-term leave was applied for, with the approval of the employer it can be extended up to a maximum of six months. If there is an important reason why it is not possible for a new person to take on the role of carer, employees are entitled to have the caregiver leave extended up to the maximum.

In addition, employees may request full-time or part-time leave from work of up to three months to care for a close relative in the last phase of their life. In this case, too, employees must provide proof of the relative's illness by furnishing the employer with a medical certificate.

To help with the cost of living, employees on caregiver leave or on leave to care for a close relative in the last phase of their life are entitled to an interest-free loan, which can be applied for from the Federal Office of Family Affairs and Civil Society Functions (BAFzA).

Prevention/Rehabilitation
Preventing ↗ **the need for care** is a central social challenge. Prevention and medical rehabilitation therefore take precedence over care. The long-term care insurance funds must ensure that the competent care funders (, such as the

health insurance funds) provide all appropriate benefits for the prevention, medical treatment and medical rehabilitation early in order to prevent the need for care. The rigorous implementation of the principle of 'prevention before rehabilitation before care', which is enshrined in law, is designed to enable many people to live an independent life without outside help.

This starts with the assessment. The new assessment tool, which has been used since 1 January 2017 to classify people into the new long-term care grades, provides a better foundation for assessing which forms of prevention and rehabilitation are necessary. Each assessment is accompanied by recommendations on how to promote and preserve independence and capabilities in addition to the care that was provided previously. It includes recommendations on, for example, therapeutic measures, **aids** and **technical aids**, home improvement measures, and above all preventive and rehabilitation measures.

The long-term care insurance fund will provide the applicant with a separate prevention and rehabilitation recommendation (which was submitted as part of the assessment). At the same time, the long-term care insurance fund informs the applicant that an application will be submitted to the competent rehabilitation agency for medical rehabilitation services, provided the applicant agrees.

Long-term care insurance funds should also provide prevention benefits in partial or fully residential **care facilities** . The long-term care insurance funds are to spend approximately EUR 23 million on this in 2019. **Caregiving relatives** whose circumstances do not permit them to regularly take part in prevention offerings have the opportunity to participate in intensive courses in spa resorts instead. The daily room and board allowance from the healthy insurers for such events was increased to EUR 16 per day.

The health insurers should enter into contracts with rehabilitation clinics to ensure that caregiving relatives receive the kind of rehabilitation that meets their specific needs. Caregiving relatives can take relatives with care needs with them to certain rehabilitation clinics. In these cases, they are entitled to the benefits of the ↗ **long-term care** insurance for ↗ **short-term care** in these institutions.

When it comes to the decisions of the health insurers about prevention and rehabilitation , the specific needs of caregiving relatives must be taken into consideration. Caregiving relatives work enormously hard, quite often seven days a week, 24 hours a day, as they try to meet the needs of a partner, child or other relative with care needs. They are often exposed to high levels of psychological and physical stress for many years. They should therefore be able to receive prevention and rehabilitation benefits.

If they do this on their own to take a step back and adopt a new perspective, then during this time the person with care needs can be looked after in a licensed short-term care facility. Similarly, people with care needs can also benefit from ↗ **short-term care** in a residential prevention or rehabilitation facility (without a license) to receive nursing care under SGB XI, provided the caregiver takes part in a rehabilitation measures there at the same time (§ 42 SGB XI). There are facilities that specialise in such services.

Long-term care insurance funds and ↗ **care support bases** must provide relatives with advice and, among other things, provide them with information about relief options (such as services for the relief of caregivers, ↗ **respite care**, prevention and rehabilitation services).

Private compulsory long-term care insurance
In the ↗ long-term care insurance the principle of "long-term care insurance before health insurance" applies. This means: Anyone insured by statutory health insurance is enrolled in

social long-term care insurance. Anyone with private health insurance is obligated to purchase private long-term care insurance.

This means that people insured with a private health insurance company have to take out compulsory long-term care insurance either with this same company or another private insurance company.

Private long-term care insurances are based on what is called the expectancy of future benefits. This means that old-age reserves must be created to smooth out premium development in old age. This is why the insurance premium is not (as with the social long-term care insurance) based on the insured person's current income or current financial standing, but rather, among other things, on the their age and state of health, i.e. insurance risk at the time the insurance is taken out. In addition, private insurance companies must observe a number of legal regulations when it comes to pricing premiums. So premiums cannot be graded according to gender, pre-existing conditions cannot be excluded, and persons already in need of care cannot be rejected. Children are insured without additional contributions.

In the case of insured persons who have been continuously privately long-term care insured since the introduction of the private compulsory long-term care insurance, the premium for the private compulsory long-term care insurance was limited to the maximum contribution of the social long-term care insurance. For spouses without an income or a low income (EUR 455 or, for people in marginal employment, EUR 450) membership in the private compulsory long-term care insurance is discounted: Both spouses together pay no more than 150 percent of the maximum contribution of the social long-term care insurance.

For new members, there is no premium limit for a period of five years. You may have to pay higher premiums – depending

on your age and state of health. There is also no spouse discount either. After five years, the premium must not exceed the maximum contribution of the social long-term care insurance.

For insured persons who have private health insurance at the basic rate, the above discounts apply regardless of whether they have had the private compulsory long-term care insurance since 1 January 1995 or took it out later.

Employees insured with a private compulsory long-term care insurance receive a contribution allowance from their employer. The allowance is based on the employer's share in the social long-term care insurance and is at most half of the total contribution.

Auditing Service of the German Association of Private Health Insurers (auditing service of the PKV)
When it comes to quality audits, the auditing service of the PKV has the same tasks as the Health Insurance Medical Service (MDK) and it has the same powers, namely to make sure there and then that the licensed care facilities meet the quality requirements under the Eleventh Book of the Social Code Book (SGB XI).

Day and night care (semi-residential care)
Day and night care (semi-residential care) means care from time to time throughout the day in a relevant facility. The long-term care insurance fund covers care-related expenses, including expenses for assistance and for establishing necessary services for medical treatment maintenance for people with care needs with long-term care grades 2 to 5. This includes the costs of the facilities' morning and evening pick-up and drop-off services. The remaining costs (such as for meals, investment costs) must be paid for privately.

Semi-residential care is provided if home care cannot be guaranteed to a sufficient extent or if it is necessary as an

addition and to support the home care. As a rule, day care is made use of by people in need of long-term care whose relatives work during the day. Furthermore, it often gives **caregiving relatives** of people with dementia an important relief option. The persons in need of care are generally picked up in the morning and returned in the afternoon.

The monthly rate of the **long-term care insurance benefit** for the semi-residential day and night care of people with care needs is:

- for long-term care grade 2 up to EUR 689,
- for long-term care grade 3 up to EUR 1,298,
- for long-term care grade 4 up to EUR 1,612,
- for long-term care grade 5 up to EUR 1,995.

In addition, the insured persons with care needs in semi-residential day and night care facilities are entitled to additional care and activation by **additional companion carers.** The costs for the additional care staff are fully covered by the long-term care insurance.

The benefits of the day and night care can be combined with **out-patient long-term care benefits in kind** and / or the **nursing allowance without being offset against each other.**

Conversion entitlement
People with care needs in home care of at least long-term care grade 2 can receive a reimbursement for benefits under state law for **everyday support** offset against their entitlement to non-residential long-term care benefits in kind, provided that for the benefit amount in question in that calendar month no **non-residential long-term care benefits** in kind were received from the care service. In this way, part of the entitlement to non-residential long-term care benefits in kind can be "converted" into an entitlement to reimbursement of costs for everyday support services

under state law. Per calendar month, the amount must not exceed 40 percent of the maximum amount of the care benefit for non-residential long-term care benefits in kind for the long-term care grade in question.

The conversion entitlement and the **relief amount** can be used independently.

Stand-in care/Holiday cover
If the private caregiver goes on holiday or is sick and is therefore temporarily unable to provide care, the **long-term care insurance** covers the proven costs of a replacement carer for up to six weeks per calendar year; this is the so-called stand-in care if the person with care needs is at last classified as long-term care grade 2.

A carer is entitled to stand-in care only once they have cared for the person with care needs at home for at least six months.

If replacement care in the context of the respite care is provided by persons not related to or related to by marriage to the person with care needs less than twice removed and do not share a home with the person in need of care, then the benefit amount covers up to 1,612 euros per calendar year. This is the case, for example, when the replacement care is provided by a gainfully employed person, a home care service or another care facility, or if it is provided by more distant relatives (relative or relative by marriage less than twice removed), or if it is provided by a neighbour.

If the replacement care is provided by a close relative or relative by marriage (up to twice removed) or by a person who shares a home with the person with care needs, then the benefit is based on the amount of the **nursing allowance** of the respective long-term care grade: The costs of the long-term care insurance fund must not exceed the amount of the nursing allowance times 1.5 of the person's long-term care

grade. Something else only applies if the replacement caregiver either provides the replacement care as an employee or if the replacement caregiver can prove necessary expenses (e.g. travel expenses or loss of earnings) in excess of the corresponding nursing allowance amount. In such cases, the benefit amount can also be up to a maximum of 1,612 euros, depending on the case.

In addition to the benefit amount for the stand-in care, up to 50 % of the short-term care amount (up to EUR 806 per calendar year) can be used for the stand-in care. This means that instead of up to 1,612 euros, up to 2,418 euros will be available for the stand-in care per calendar year. This in particular benefits those eligible persons who require more long-term replacement care and who do not wish to go into a fully residential short-term care facility during this time. The increase amount used for the stand-in care is offset against the benefit amount for **short-term care**.

Fully residential care

In the case of fully residential care in a nursing home, the long-term care insurance for people with long-term care grades 2 to 5 covers the care-related expenses including expenses for assistance and expenses for services for medical treatment maintenance in the nursing home as part of fixed benefits in kind. The monthly amount of the benefit depends on the respective long-term care grade as follows:

- long-term care grade 2: 770 euros,
- long-term care grade 3: 1,262 euros,
- long-term care grade 4: 1,775 euros,
- long-term care grade 5: 2,005 euros.

People with care needs classified as long-term care grade 1 receive an allowance in the amount of 125 euros per month.

For those in fully residential care, what matters to the residents is not the benefit rates but the co-payment rates they have to pay out of their own pocket. In the past, the care-related co-payment increased with increasing **careneeds**. As of 1 January 2017 this is no longer the case, which eases the strain on many care recipients. All nursing home residents in long-term care grades 2 to 5 pay the same care-related co-payment. This rate varies from one home to another. People with care needs also have to pay for meals, accommodation and investments. This also varies from one nursing home home to another.

For an overview of licensed nursing homes and their care rates and other calculable costs, consult the benefit and price comparison lists which the long-term care insurance funds make available free of charge.

Group home grant

Persons needing care who receive the nursing allowance, care benefits-in-kind, and/ or the relief amount and live in an assisted living group home can apply to receive an allowance of EUR 214 per month, the so-called group home supplement, in addition to their other services. The group home grant can also be paid to people with care needs of long-term care grade 1 who live in a group home with non-residential care. They do not have to be in receipt of a nursing allowance or non-residential long-term care benefits in kind, the combined benefit, the services of the conversion entitlement or the relief amount in order to receive the group home grant.

The prerequisite for receiving the group home supplement is

- that they must live with at least two and no more than eleven other people in a shared residence for the purpose of receiving shared long-term care and at least two other persons living in the residence must also need care
- that a person (on-site staff) is tasked jointly by the members of the group home, independent of individual nursing care, to carry out general organisational, administrative, care, or other activities that promote community life or assists the group home members with their household chores, and
- that there is no form of assistance, including semi-residential care, that involves the provider of the group home or a third party offering the persons in need of care services that correspond largely to those associated with full-time institutional care.

The group home grant is provided to the group home members in need of care in order to finance the above-mentioned on-site staff member which was appointed jointly by the members of the group home.

Home conversion grant when there is a long-term care need / conversion work

When people with care needs are cared for and looked after at home, it can be helpful to adapt the living environment to the specific needs of the people with care needs. For example, the bathroom can be made disabled-friendly, the kitchen appliances and other furnishings can be adapted and thresholds and other obstructions can be removed.

On application, the long-term care insurance fund can provide a grant of up to 4,000 euros for measures that improve the individual living environment , provided that the conversions enable home care or – especially especially also for carers – make it significantly easier, or enable the person in need of care to live an independent life as much as possible.

Once the application has been made, it is advisable to wait for the long-term care insurance fund's notification before starting to convert the living environment. The approved grant is generally paid out once the conversion has been completed and proof of the costs incurred can be provided.

When the care situation has changed to such an extent that new conversion measures are needed, additional grants can be authorised.

If several people with care needs live together, the grant can also be used to improve the joint living environment. The upper limit for these grants is 16,000 euros. This means that four people with care needs can each receive the full funding of up to 4,000 euros to convert the joint home. If more than four people entitled to the grant live together, then the total amount may be transferred proportionately to the insurance carriers.

These grants to improve the joint living environment can be paid to people with care needs in group homes – in addition to the flat-rate grant for the home group members in the amount of 214 euros per month and where applicable the ↗ **initial grant** for new group homes for the age-appropriate and wheelchair accessible conversion of the joint home in the (one-off) amount of 2,500 euros per person with care needs,

limited to a maximum of 10,000 euros per group home.

Additional companion carers / Additional care and activation in residential care facilities

People with care needs in residential **care facilities** are entitled to additional care and activation that goes beyond the care based on what kind of care is required and how much.

The facilities receive a remuneration allowance for this, which is to be covered by the long-term care insurance fund or the private insurance company. These costs are not to be borne by the eligible persons or the social assistance agencies.

This regulation applies to all residential facilities, i.e. fully residential and semi-residential facilities. It also applies to all people with care needs in these facilities, i.e. including people with care needs of **long-term care grade 1.**

Ultimately, this aims to make additional staff available for this type of care in the facilities. The regular care services that must be provided under §§ 41 to 43 SGB XI ("social support" until recently) remain unaffected and are not transferred to the additional companion carers.

The principles of the work and tasks of the additional companion carers in residential care facilities are laid down in the guidelines on the qualification and responsibilities of additional companion carers in residential care facilities (carerguideline) according to § 53c SGB XI. These are resolved by the GKV central association and approved by the Federal Ministry of Health.

More information

Information and service offerings

"Im Dialog" magazine
"Im Dialog" is the magazine of the Federal Ministry of Health. It provides information on all important topics and events related to health and care. Here you can find information about useful services and our events as well as explanations of the current campaigns. Even difficult specialist topics are explained clearly in editorial and using graphic illustrations.

If you would like to order an issue or subscribe to the magazine, please send an email to: ImDialog@bmg.bund.de

Internet offers
For up-to-date information by the Federal Ministry of Health on the topics of care, go to:
www.bundesgesundheitsministerium.de/pflege

Care Benefit Helper (Pflegeleistungs-Helfer)
The Pflegeleistungs-Helfer is an interactive application on the website of the Federal Ministry of Health. It shows you which care benefits you are entitled to based on your personal situation. It is available at: www.pflegeleistungs-helfer.de

Other publications

Order publications free of charge at:

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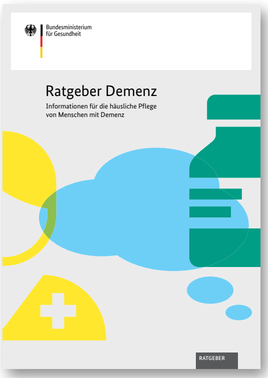
Fax: 030 18102722721
By post: Publication correspondence of the federal government, Postfach 48 10 09, 18132 Rostock
Website: For online orders and current list of publications go to: www.bundesgesundheitsministerium.de/publikationen

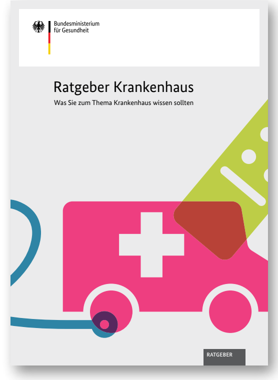
Brochure
"Pflegeleistungen zum Nachschlagen" (care benefits - a reference resource)

This brochure provides a summary of the long-term care insurance benefits. The reference work is aimed at people in need of care as well as their relatives who provide care.
Order number: BMG-P-11025



Brochure:
“Dementia advice. Information about home care for people with dementia” (Ratgeber Demenz. Informationen für die häusliche Pflege von Menschen mit Demenz)

This brochure provides information about caring for people with dementia, gives answers to frequently asked questions and introduces the benefits of the long-term care insurance.
Order number: BMG-P-11021



Brochure:
“Hospital advice. What you should know about hospitals” (Ratgeber Krankenhaus. Was Sie zum Thema Krankenhaus wissen sollten)

This brochure introduces the hospital landscape in Germany and provides comprehensive information about the important processes and benefits before, during and after hospital care.
Order number: BMG-G-11074

Brochure
"Ratgeber Krankenversicherung. Alles, was Sie zum Thema Krankenversicherung wissen sollten" (Health insurance guide. Everything you need to know about health insurance)

This guide helps you find your way around the health care system. From which health insurer to choose to visiting the pharmacy – this brochure shows you the most important provisions at a glance.

Please note: This guide is currently being updated. You may pre-order it.
Order number: BMG-P-07031

Citizens helpline

The citizens helpline of the Federal Ministry of Health is open from Monday to Thursday from 8 a.m. to 6 p.m., and on Friday from 8 a.m. to noon; the numbers are as follows:

Citizens helpline for health insurance
030 3406066-01

Citizens helpline for long-term care insurance
030 3406066-02

Citizens helpline for disease prevention
030 3406066-03

Advice service for the deaf and hearing impaired

Fax:
030 3406066-07

Video telephony:
www.gebaerdentelefon.de/bmg/

Email:
info.gehoerlos@bmg.bund.de

The staff of the citizens helpline in Rostock are there to answer your questions. The citizens helpline is run by Telemark Rostock, which collects, processes and uses personal data only within the framework of the General Data Protection Regulation and the German Federal Data Protection Act.

For more information, please visit the following website: www.bundesgesundheitsministerium.de/service/buergertelefon

Hotlines of the Federal Centre for Health Education (BZgA)

BZgA hotline for addiction prevention[1]
0221 892031

Addiction & drugs hotline[2]
01805 313031

BZgA smoking cessation telephone advice[1]
0800 8313131

1 Monday to Thursday from 10 a.m. to 10 p.m., Friday to Sunday from 10 a.m. to 6 p.m.
2 Monday to Sunday around the clock

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