

# Service Authorisation

## For participation under Tier 1 of the Aged Care On-site Pharmacist (ACOP) Measure

This document evidences the authorisation provided by the Residential Aged Care Home (RACH) identified below, to the pharmacy identified below, to provide an on-site pharmacist under Tier 1 of the Aged Care On-site Pharmacist (ACOP) Measure.

A signed version of this document must be uploaded to the PPA Portal by the Pharmacy when registering their relationship with the RACH under the Measure. Claims and payments cannot be made in respect of pharmacist time on-site at the nominated RACH prior to the Service Authorisation being approved by PPA.

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

### Details

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#### Residential Aged Care Home (RACH) and s90 Pharmacy

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<b>Residential Aged Care Home</b>	Name	.....
	NAPS ID	.....
	Address	.....
	Email	.....

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<b>Pharmacy</b>	Name	.....
	PBS Approval Number	.....
	Address	.....

#### Service Authorisation Start Date

Please indicate below the intended start date of this Service Authorisation, noting that the Start Date must be:

- on or before the first date that a pharmacist funded under the ACOP Measure is intended to work at the RACH; and
- after any existing RMMR/QUM/ACOP providers delivering services to the RACH have been given notice of the RACH's intention to cease the relevant RMMR/QUM/ACOP service relationship and commence participation in the ACOP Measure via the Pharmacy named above.

<b>Intended Start Date</b>	
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*Note: Services can be claimed from the later of, the Start Date entered above, or the date that the ACOP relationship between the pharmacy and RACH is approved by the PPA.*

### Confirmation of Notice to other Service Providers

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

- The RACH was not participating in the RMMR/QUM programs or the ACOP Measure at the time of signing this service authorisation.
- The RACH was previously participating in the RMMR/QUM programs or ACOP Measure (Tier 1) and notice has been provided to the RMMR/QUM/ACOP provider and the PPA of the RACH's intention to cease the relevant RMMR/QUM service agreements or ACOP authorisation.
- The RACH was previously participating in Tier 2 of the ACOP Measure and notice of cessation of the ACOP(s) engagement has been provided.

If the second or third box (above) was ticked, please provide details of relevant service relationships below.

Program/Measure	Date Notice of Cessation Provided
ACOP	
QUM	
RMMR	

## Signatures and Obligations

By signing this Service Authorisation, each party is confirming that they meet all eligibility requirements in relation to Tier 1 of the ACOP Measure and that they will comply with the obligations set out below.

### Residential Aged Care Home (RACH) obligations under the ACOP Measure

RACHs participating in the Measure are subject to [PPA's General Terms and Conditions](#) and must adhere to the [ACOP Measure Rules](#).

### Pharmacy obligations under the ACOP Measure

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

- Ensuring that the RACH is not charged a fee for any pharmacists provided under the ACOP Measure
- Ensuring that on-site work is undertaken at the RACH in full or half day blocks
- Ensuring that on-site work is undertaken at the RACH as per a regular schedule agreed with the RACH
- Ensuring that the pharmacist/s providing on-site services are credentialed and eligible to do so.
- Ensure that ACOP Measure funds are not used for any other purpose.

**Pharmacy Owner Signature:**

NAME .....

SIGNATURE .....

DATE.....

**RACH Manager Signature:**

NAME .....

EMAIL ADDRESS .....

TELEPHONE.....

SIGNATURE .....

DATE.....

**RACH Head Office Signature:**

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

NAME .....

POSITION.....

EMAIL ADDRESS .....

TELEPHONE.....

SIGNATURE .....

DATE.....