2023
Regulations governing the Personal Budget for Nursing and Care

Zorg en Zekerheid
Beter in jouw buurt

2023 Regulations governing the Personal Budget for Nursing and Care (*Reglement persoonsgebonden budget verpleging en verzorging 2023*);

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Definitions

Care contractor
We use the term ‘care contractor’ to refer to a party with which you have entered into a contract for the provision of care. This can also be your formal or informal care provider.

Care provider
We use the term ‘care provider’ to refer to the person who actually provides the care services for you.

Conscious choice call
A conversation between you and us, conducted by telephone or in a personal meeting. If you are represented by another person, we will (also) have this conversation with your representative. During the call, you have an opportunity to explain the details of your application. Our staff member will tell you what the choice for a personal budget pursuant to the Healthcare Insurance Act (‘Personal Budget’ below) will mean for you, and will assess whether you meet the conditions for a Personal Budget and have the requisite personal budget skills. They will ask questions about yourself, your care needs and the care to be purchased. Of course you can also ask us any questions you may have.

Contracted care
In the case of contracted care, the care contractor provides the care and performs the associated administrative work. We have contracted that care contractor.

General Database Code (AGB code)
Unique code assigned to each care provider or care contractor and included in the AGB register.

Home address
Your address as stated in the Key Register of Persons (BRP).

Legal representative
A legal representative of a person under age 18 is one of that person's parents with parental authority, or a guardian. A legal representative of a person aged 18 or older is a court-appointed curator, mentor or administrator.

Nursing and care
This is the care as described in Section 2.10 of the Healthcare Insurance Decree (*Besluit zorgverzekering*, Bzv). Nursing and care comprise the care typically provided by nurses, on the understanding that the care:
- relates to the need for the medical care referred to in Section 2.4 or a high risk of such a need;
- is not accompanied by a stay as referred to in Section 2.12, and;
- is not maternity care as referred to in Section 2.11.

Partner
Your spouse, registered partner or other life companion with whom you run a joint household on a long-term basis.

Reassessment of indication
Zorg en Zekerheid may decide to have your care needs reassessed. In that case, we will ask you to make an appointment with a second, independent district nurse who works for a home care organisation designated by us, for a reassessment of the existing indication.

Representative

A representative is a person you have designated as your representative from among your family members (blood relatives and relatives by marriage up to and including the second degree) or who is your spouse, registered partner or other life companion, and who does not meet the definition of the legal representative. We will assess whether this representative will enable you to assume the tasks and responsibilities associated with the Personal Budget in a responsible manner.

Individuals who will not be accepted as representatives are those who:

a. on previous occasions when acting as assistants or representatives in connection with a Personal Budget, failed to guarantee fulfilment of the associated obligations;
b. have no valid home address;
c. have been deprived of their liberty;
d. have been declared subject to a debt rescheduling arrangement or who are the subject of a request to that effect submitted to the court;
e. come under the debt rescheduling arrangement for natural persons or is the subject of a request for that arrangement being declared applicable submitted to the court or has been declared bankrupt;
f. is otherwise unable to sufficiently safeguard compliance with the obligations imposed on the budget holder under the Personal Budget regulations.

Individuals or organisations that manage your Personal Budget for a fee will not be accepted as representatives either.

Restricted activities

Restricted activities are medical procedures that involve unacceptable risks for a patient's health if not carried out by an expert. Those authorised to perform these procedures are identified in Sections 35-39 of the Individual Healthcare Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*, BIG).

Second opinion of indication

Your care needs can be reassessed. If you wish, you can have your care needs reassessed by a different district nurse registered under the BIG (Individual Healthcare Professions Act) and trained at higher professional education level. Your basic insurance will reimburse the second opinion, but only if we gave our permission beforehand. You have the option of asking us to designate a different nurse.

Article 1 Introduction

Why do we need these regulations?

Your entitlements are stated in the policy conditions of your healthcare insurance, but not in detail. Subject to specific conditions, you can apply for a Personal Budget for District Nursing covering nursing and care, so that you can purchase the care yourself. These Regulations tell you more about the Personal Budget, the conditions for eligibility, how to apply for the budget, how to claim the costs and how your claims are assessed. These Regulations form part of your policy conditions.

1.1 What is the basis for these Regulations?

If you have taken out healthcare insurance with Zorg en Zekerheid, the Personal Budget Regulations apply. You are entitled to nursing and care in accordance with the relevant provisions in the policy conditions of your healthcare insurance. Section 13a of the Healthcare Insurance Act (*Zorgverzekeringswet*, Zvw) serves as the legal basis is for awarding a Personal Budget. Should Section 13a of the Zvw and the associated lower-tier legislation be amended effective 1 January 2023 or beyond, we may modify these Regulations accordingly by effecting changes resulting directly from those amendments. We may also effect any interim amendments to these Regulations resulting from changes in laws and regulations, government measures or other matters as yet to be determined. In such a case, we will inform you accordingly.

1.2 Administrative arrangements regarding the Personal Budget

The conditions and arrangements included in the Regulations are derived in part from the most recent administrative arrangements regarding the points of departure and content of the Personal Budget as agreed between the Ministry of Health, Welfare and Sport, Zorgverzekeraars Nederland, Dutch Nurses' Association V&VN and Per Saldo.

Article 2 Target group for the Personal Budget

1. You qualify for a Personal Budget if you require nursing and care as typically provided by nurses, on condition that the care relates to the need for, or a high risk of the need for, medical care, is not accompanied by a stay at an institution and does not qualify as maternity care.

   The care as identified in Article 2.1 does not include care procedures for minors that are aimed at removing a lack of ability to care for themselves in daily activities.

2. In addition, in order to qualify you must:
   a. depend on the nursing and/or care for a prolonged period of time, i.e. for more than 1 year, or:
   b. depend on palliative terminal care. This is the case when, according to your attending physician, your estimated life expectancy is less than 3 months.

Article 3 Conditions governing access to the Personal Budget

You must satisfy all of the following conditions: if, in the healthcare insurer's opinion, you do not satisfy all the conditions below, the healthcare insurer will not make a Personal Budget available to you or will impose additional requirements that you will have to satisfy in order to qualify, or re-qualify, for a Personal Budget;

1. you have an indication for nursing and care as specified in Article 2.1 of these Regulations. The indication may not have been issued more than 3 months prior to the moment the healthcare insurer receives the application;
2. in the healthcare insurer's opinion, the Personal Budget will enable you to effectively obtain sufficient care or other high-quality services. In this connection, you must in any case:
   a. have at least 2 care providers if you receive care on 7 days a week and/or if you need care more than 3 times a day; and
   b. select a care provider within a reasonable distance from your location. In the case of unscheduled care, only a travel time of 20 minutes or less will be deemed to be reasonable.

3. be able, in the healthcare insurer's opinion, to assume the tasks and responsibilities associated with the Personal Budget in a responsible manner, either independently or with assistance from a (legal) representative. We will include the following aspects in our assessment:
   a. you or your (legal) representative has spoken and written command of the Dutch language;
   b. you are able to supply all the information for the various procedures accurately and in full;
   c. you satisfy the 10 Personal Budget skills as described in Step 1 on our website **www.zorgenzekerheid.nl/zorg-regelen/pgb/aanvragen.htm**;
   d. in connection with a previous Personal Budget awarded to you under the AWBZ, ZVW, WLZ, WMO or Youth Act you failed to fulfil the associated obligations;
   e. within a period of 5 years preceding the submission of your Personal Budget application, you were involved in deliberate deception in connection with a healthcare insurance policy taken out by you or on your behalf;
   f. you are the subject of an ongoing investigation into potentially unlawful acts in connection with a Personal Budget awarded to you under the ZVW, WMO, Youth Act, WLZ and/or AWBZ;
   g. at any point over the past 12 months, you have run into arrears in the payment of your health insurance contributions for 4 months or more;
   h. you are the subject of a debt rescheduling arrangement for natural persons (*Schuldsaneringsregeling natuurlijke personen*, Wsnp) or a request for such an arrangement to be declared applicable has been submitted to the court;
   i. you have applied for a suspension of payments, are bankrupt or have been declared bankrupt;
4. in the healthcare insurer's opinion, you are able to instruct your chosen care providers and coordinate their work, independently or with assistance from a (legal) representative, in such a manner that the care you receive or will receive qualifies as responsible care;
5. in the healthcare insurer's opinion, you are able to explain, either independently or with assistance from a (legal) representative, that you qualify for and wish to receive care with a Personal Budget.

Article 4 Grounds for refusal

You will not receive a Personal Budget if one of the following grounds for refusal applies:

1. you do not meet the conditions of Articles 2, 3 or 8;
2. in connection with a previous Personal Budget awarded to you, you were unable to fulfil the tasks and obligations associated with the Personal Budget, either independently or with assistance from a (legal) representative;
3. according to the Key Register of Persons (BRP), you have no home address;
4. you have been deprived of your liberty at law;
5. you fail to cooperate or to continue cooperating with the 'conscious choice call' and/or any home visit organised by the healthcare insurer;
6. it emerges from your application form or from the conscious choice call and/or home visit that you intend to use your Personal Budget exclusively for purchasing care or other services from care providers that the healthcare insurer has contracted for the provision of care or other services;
7. your (legal) representative (in the event that you need his or her assistance to satisfy the eligibility conditions mentioned in Article 3):
   a. failed to guarantee fulfilment of the conditions associated with one or more previous Personal Budgets in which he or she served as assistant or (legal) representative;
   b. has no home address, according to the Key Register of Persons (BRP);
   c. has been deprived of his or her liberty at law;
   d. you are the subject of a debt rescheduling arrangement for natural persons (*Schuldsaneringsregeling natuurlijke personen*, Wsnp) or a request for such an arrangement to be declared applicable has been submitted to the court;
   e. has applied for a suspension of payments, is bankrupt or has been declared bankrupt;
   f. is otherwise unable to sufficiently safeguard your compliance with the obligations imposed on you under the Personal Budget Regulations;
   g. provides the care against payment;
8. you have been issued multiple indications for the care described in Article 2.1. Your entire care need with respect to the care described in Article 2.1 must be formulated in a single indication;
9. No Personal Budget will be awarded for care that is already reimbursed under different types of care, such as medical specialist care (from a DTP). This is in order to prevent double funding and unjustified reimbursement of the costs of care.

Article 5 Applying for the Personal Budget

1. Your application for a Personal Budget will be assessed on the basis of the fully completed set of Personal Budget Application Forms including appendices (Part I: the nursing section and Part II: the insured person section). A conscious choice call is part of the application procedure unless we decide to refrain from such a call. If this information shows that you comply with the conditions stated in Articles 2 and 3, you will receive a statement of approval of your Personal Budget application. You can find the Personal Budget Application Form on our website, **www.zorgenzekerheid.nl/brochures**. You can also ask us to send you the Personal Budget Application Form by email:

   Please note that we can only process your application if you have completely filled in the set of forms. This also applies in the event that any of the required appendices for your application are missing.

2. a. if your application concerns adults aged 18 or older, you must have an indication issued at least by a nurse registered under the BIG (Individual Healthcare Professions) Act and trained at higher professional education (HBO) level, who has drawn up the indication in your presence and in accordance with the home nursing and care indication and organisation standards;
   b. if your application concerns children under age 18, you must have an indication issued at least by a nurse registered under the BIG (Individual Healthcare Professions) Act and trained at higher professional education (HBO) level and/or a nursing specialist specialised as a paediatric nurse. The person issuing the indication must be employed at a care provider that is affiliated with the Sector Association for Integrated Paediatric Care (BINKZ). This indication must meet the standards for performing care needs assessments and organising nursing and care in the patient's own environment, and must have been drawn up in your presence (child) and in the presence of your legal representative (parent(s), curator, administrator, mentor).
3. In performing the care needs assessment, the assessor is required to use the Quality Standard for the Use of Interpreters for Non-Dutch Speaking Patients so as to decide whether it is necessary to engage an interpreter;
4. In the event of restricted or high-risk procedures, you must be able to demonstrate that those procedures are performed on the instructions of a physician or nursing specialist.
   a. In the case of high-risk procedures, the nature, scope and content of the care must have been set out in the care plan.
   b. In the case of restricted procedures performed by an informal care provider, your care provider must have the requisite authorisation and competence to perform those procedures. You must be able to produce, at our request, a physician's performance request for the procedures concerned and to demonstrate that the procedures are carried out in accordance with the 'Manual for restricted procedures in (district) nursing and care'
   (Actiz, 2019).
   c. In the case of a restricted procedure performed by an informal care provider, you must be able to demonstrate, at our request, that the physician considers the care provider to be sufficiently aware and competent to be able to perform the procedure in a responsible manner.
5. If you depend on palliative terminal care, you must include a statement by your attending physician to the effect that your estimated life expectancy is less than 3 months. To extend an application for palliative terminal care, you must send a new statement from your attending physician as soon as possible stating that your estimated life expectancy is less than 3 months;
6. The care needs assessment must be drawn up in an independent manner. This means, at any rate, that it may on no account be issued by a district nurse who:
   a. is your legal representative and/or your blood relative or relative by marriage up to and including the 2nd degree, and/or
   b. is to provide care for you himself or herself, and/or
   c. is employed by or collaborates with a care provider that is going to provide part of the care to you, unless this is a care provider contracted by us for contracted care.
7. Following the care needs assessment, the district nurse is required to identify, with due regard for the V&VN Dutch Nurses' Association's 'Guide to the home nursing and care indication and organisation standards framework', the elements of care that the insured party or his/her network can arrange themselves. This means, among other things, that the district nurse should first map out the insured person's network and then consider which elements of care that network can be expected to be able and willing to provide. Of the care the network can be expected to be able and willing to provide, the part actually provided by the network cannot be included

in the indication for district nursing. This means you will not qualify for a Personal Budget for that care. The indication should specify the grounds considered by the district nurse in arriving at his or her decision.
When preparing the indication, the district nurse will consider how the care need can be met or the intervention be performed, with due regard for the full context of the care applicant's situation. This should be based on the notion that the care applicant should perform the intervention himself or herself, if possible, with due regard for the facilities available. If this arrangement is impossible or insufficient, the district nurse, with due regard for the V&VN Dutch Nurses' Association's 'Guide to the home nursing and care indication and organisation standards framework', will consider:

- treatment by other care professionals (rehabilitation, physiotherapy, remedial therapy, speech therapy, medical specialist etc.);
- use of healthcare technology, aids or home modifications that would remove the need for the care or enable the care applicant to perform it himself or herself;
- possibilities from other domains (WMO, WLZ etc.);
- the care applicant's network and the possibility to mobilise volunteers before engaging a healthcare professional (from district nursing or a healthcare professional from a different discipline).

8. It may be the case that an indication for care has been issued which, in our opinion, does not fall under the nursing and care entitlement or is ineffective, or that the care needs assessment does not satisfy the V&VN Dutch Nurses' Association's 'Home nursing and care indication and organisation standards' (the standards framework). In that case, we will contact the district nurse who has drawn up the indication and ask him/her to explain the indication in more detail. If, after that contact, we conclude that the care does not fall under the nursing and care entitlement or is ineffective, or that the indication was not produced in accordance with the standards framework, we will not award a Personal Budget. As a result, the award may be smaller than the number of hours stated in the indication. If so, we will motivate our decision to deviate from the indication.
   In such a situation, we may also ask for the indication to be reassessed; We will finalise the submitted application.based on the reassessment by the district nurse. If you choose not to have your indication reassessed, we will not be able to process your application any further;
9. If you state in the application form that you are going to engage only 1 care provider, you must also let us know how and with assistance from which other care provider or providers you intend to meet your care needs in the event of the sudden absence of your contracted care provider due to illness, holiday or otherwise;
10. If you stayed in an institution on medical grounds in connection with medical care as referred to in the Healthcare Insurance Act (ZVW), or in an institution for in-patient primary care (ELV), you can use your valid indication again as soon as you return home. In that case, you do not have to resubmit a full application, unless there have been changes in the nature, scope or duration of your care needs. You do have to submit a new application if you are admitted to an institution for long-term care or to a hospital for more than 60 days or use the services of an institution for short-term care for more than 60 days as referred to in Article 27 of your policy conditions;
11. in Part II of the application form (the insured person section), you should specify the care contractor or contractors you want to go to, based on the number of hours stated in your nursing and care indication. In this part you should also specify the care contractor or contractors you want to go to for contracted care, and those you wish to contract yourself based on the Personal Budget. The nurse should draw up a single indication for this purpose that includes both the contracted care and the care from the Personal Budget. The care contractors we have contracted only provide contracted care (*Zorg in Natura)*; they do not provide care funded from the Personal Budget. You are also required to provide this information to the nurse who draws up the indication, the institution providing the contracted care and the party providing care under your Personal Budget. If we have not approved the reimbursement for contracted care combined with Personal Budget care, this will affect the level of that reimbursement.

Article 6 Award certificate

1. The Personal Budget comes into effect on the date we receive your application, fully completed and duly signed. We can however postpone the effective date of your Personal Budget if you wish;
2. Once your award certificate has expired, you can only retain your Personal Budget by applying for a new one. In that case, your new Personal Budget will only come into effect, at the earliest, on the date we receive your fully completed application form. So make sure to ask your district nurse to fill in the application form with you before the expiry date of your current award certificate. Please submit the fully completed and signed application forms plus any appendices at least 6 weeks before expiry of your current award certificate.

3. If a reassessment is issued in the interim, you can only retain your Personal Budget by applying for a new budget. In that case, your new Personal Budget will only come into effect, at the earliest, on the date we receive your fully completed application form.
4. The written award certificate that we will send you will also state the term of validity of your Personal Budget. The maximum term of your Personal Budget is 2 years from the moment it was awarded to you, and provided you have a valid indication. If you wish to continue to qualify for a Personal Budget after this period, you can submit a new Personal Budget application to us, in accordance with Article 5.
5. We will calculate the amount of your Personal Budget on the basis of the number of requested hours compared with the number of hours for nursing and care in the nurse's indication;
6. The budget is calculated per calendar year and will end, at the latest, on 31 December of the calendar year for which it was awarded;
7. If your healthcare insurance or Personal Budget ends before the end of the calendar year, your Personal Budget will be reduced proportionally. Following such a reduction, your Personal Budget will be: (the original Personal Budget) times (the number of days on which your Personal Budget and healthcare insurance applied during the calendar year in question), divided by (365). If the care you have claimed exceeds the proportionally reduced Personal Budget, you will be charged for the excess amount; In the event of an interim reassessment, your Personal Budget will be reduced or raised proportionally. Following a reduction, your Personal Budget will be: (the original Personal Budget) times (the number of days on which your Personal Budget and healthcare insurance applied during the calendar year in question), divided by (365). If the care you have claimed exceeds the proportionally reduced Personal Budget, you will be charged for the excess amount;
8. If your award certificate for the Personal Budget is granted, terminated or withdrawn, we will inform you accordingly in writing;
9. If you submit an application for a Personal Budget in connection with a condition for which you already receive contracted care, or if you are already entitled to reimbursement of the costs of the care applied for, you will have to end that care yourself. You must do so before the effective date of the Personal Budget as stated in the award certificate. This does not apply, however, if you informed us in your application form that you will continue purchasing your care from that/those care provider/providers.

Article 7 Claiming the costs of care

7.1 Conditions for claiming costs

1. You can claim invoices from the effective date of the Personal Budget stated in your award certificate;
2. To ensure the smooth and effective settlement of your claims, please use our standard claim form. You can find it on our website**, www.zorgenzekerheid.nl/brochures** (Personal Budget Claim Form). You can also ask us for a paper copy of the claim form by telephone or email:
3. Please check the invoices from the care providers that you have contracted under your Personal Budget and submit them to us. You can only claim the costs of care that is in line with the award certificate we have issued.
4. You can only claim the costs of care after it has been provided. By submitting the invoices, you confirm that the amounts in them and the hours of care provided are correct.
5. It is not permitted to claim fixed monthly wages. You can only claim the costs of the care actually provided, in hours and minutes, rounded to 5-minute units.
6. Please make sure to submit the invoices of the amounts claimed no later than 3 months after the care was delivered. This deadline is necessary to ensure an up-to-date picture of withdrawals from your Personal Budget.
7. There is no reimbursement in the Personal Budget for the costs of a needs assessment and evaluation of care needs as described in Article 2.1, case management and day care nursing and accommodation for intensive paediatric care. Depending on your healthcare policy, these types of care will be provided in the form of contracted care or as non-contracted care under regular district nursing arrangements.

7.2 Amount and scope of the claim

1. The following maximum rates apply to formal care providers:
   a. personal care: €40.08 per hour (€3.34 per 5 minutes);
   b. nursing: €56.76 per hour (€4.73 per 5 minutes).

2. The following are eligible for the formal rate:
   Care providers that hold:
   a. an AGB code from one of the following categories:
      - 41 independent district nurses / providers of care under the Personal Budget / managing foundations
      - 42 nursing homes
      - 75 home care agencies
      - 91 nurses
      - 98 claimants / service agencies / healthcare insurers; and
   b. who are independent or work on behalf of the agency referred to under a. as a specialist district nurse, district nurse, nurse with an MBO nursing diploma or a 3IG or Level 3 care-giver and are able to demonstrate compliance with the quality requirements regarding work experience and expertise. We may ask you for the diploma of your formal care provider so as to verify that he or she is qualified to provide nursing and care based on the formal rate. If the actual care is provided by a care provider other than the care contractor, the AGB codes and diplomas must be enclosed with the application form.

      A blood relative and relative by marriage up to and including the 2nd degree or your spouse, registered partner or life companion will never be eligible for the formal rate.

      Your claim cannot exceed the amount based on the rates for informal care providers mentioned in Article 7.2(1). To claim this amount, you must state your care provider's General Database Code (AGB code) in your application for the Personal Budget and in each claim;

      Care contractors included in the External Reference Register (EVR) or who are seriously suspected of having committed fraud may be excluded, following an investigation, from payment under the Personal Budget.
3. The maximum amount you can claim for care delivered by informal care providers is €23.52 per hour for personal care and nursing.
4. Informal care providers are understood to at least include care providers who:
   a. are a parent, care-giver, partner (such as a spouse, registered partner or other life companion), blood relative or relative by marriage up to and including the 2nd degree (these individuals will not under any circumstances qualify as your formal care providers), and/or
   b. are a care assistant or nursing assistant up to level 3, and/or:
   c. are not listed as a nurse in the register referred to in Section 3 of the BIG (Individual Healthcare Professions) Act for professions involving the provision of care, and/or
   d. are not included in the Trade Register, or not registered in the Trade Register under SBI codes 86, 87 or 88 as a care organisation.
   These will never qualify for the formal rate.
5. Both the formal and informal rates are ‘all-in’ rates. This means that you cannot claim any other costs not covered by these rates, such as employer's social security contributions, travel expenses, holiday pay and care aids.

7.3 Other provisions regarding claims

1. You yourself are responsible for the timely payment of the care providers you have contracted. In the event that you fail to fulfil your contractual payment obligations in time, any additional costs (such as collection costs and statutory interest) cannot be paid from the Personal Budget;
2. We have the right to perform checks in order to verify that the care being claimed has actually been provided by the care providers you have contracted, and that the care is in line with the award certificate we have issued. In addition, we may decide to assess the effectiveness and legitimacy of the care provided. If applicable, we may advise you on how the care can be provided more effectively;
3. Any part of your Personal Budget that remains unclaimed cannot be carried over to a subsequent period;
4. We will no longer reimburse any invoices from your Personal Budget once you have reached the maximum amount of the awarded annual budget or the maximum number of hours under your Personal Budget, or we pay a proportional reimbursement in the case of premature termination of the Personal Budget. In the event of an overpayment of claims, we will recover the excess amount directly from you;
5. The submission of claims and payment of care costs are subject to the general policy terms and conditions of your healthcare insurance, as well as to the provisions of these regulations; We only reimburse invoices that comply with the policy conditions and these Regulations.

6. If you temporarily live abroad and wish to engage one or more foreign care providers during that period, you must inform us of your intention in writing in advance. You can only claim the invoices from such foreign care providers after we have granted permission in writing;
7. a. the costs of transport to and from a medical day nursery, if medically necessary in connection with intensive paediatric care, cannot be claimed under your Personal Budget;
   b. in the event of your temporary stay in hospital or in a mental healthcare institution or institution for in-patient primary care (ELV), rehabilitation or geriatric rehabilitation (GRZ), you cannot purchase and claim care under your Personal Budget during this period;
   c. the costs of a care needs assessment are not covered by the Personal Budget;
   d. we only pay invoices by crediting the amount due to your (the policyholder's) account number known to us. In other words, we do not pay invoices directly to the care contractor or other parties. This does not apply, however, if you have outsourced your Personal Budget payroll records tasks to the Social Insurance Bank (SVB).

Article 8 Obligations

1. You are obliged to record the agreements with your care providers in writing, in the form of care agreements. The care agreement must at least include:
   a. name and address details of the insured person;
   b. name and address details of the care provider;
   c. the relationship between the insured person and the care provider;
   d. the term of the agreement;
   e. the type of care to be provided;
   f. the number of hours of care to be provided, and when the care will be provided;
   g. the rate you are going to pay for the care concerned;
   h. the AGB code in the case of a formal care provider;
   i. the signatures of the insured person or his/her (legal) representative and the care provider.

   An example of such a care agreement is available on **www.zorgenzekerheid.nl/brochures** and on www.svb.nl.

2. As the insured person, you are required to ensure that the partner and blood relatives and relatives by marriage up to and including the 2nd degree with whom you enter into an agreement and who are not subject to the Working Hours Decree (*Arbeidstijdenbesluit*) do not perform any work in excess of 40 hours within a single week. Once the blood relative or relative by marriage up to and including the 2nd degree has an employment relationship governed by the Working Hours Decree, the working week should not be longer than 40 hours, including the hours funded from the Personal Budget. Also note that the care provider may not be younger than 18;
3. You are obliged to cooperate in the evaluation of your care needs if the district nurse who established your care needs asks you to do so. If it emerges from this evaluation that your care needs have increased or decreased, you are obliged to complete and submit another Personal Budget Application Form in cooperation with the district nurse;
4. You are obliged to cooperate in multidisciplinary consultation sessions (MDO) organised by the district nurse;
5. For a care needs assessment funded by the Personal Budget, the nursing process shall serve as the basis;
6. As the insured person, you are responsible for the quality and effectiveness of the care that you purchase. Your healthcare insurer is not liable for errors committed by care providers you have contracted.
7. a. if there is any change in the nature, scope or duration of your care needs, the nurse will have to draw up a new care needs assessment. This applies both in the case of a deterioration and an improvement of your health. In such a case, you must apply for a new indication and submit a new Personal Budget application immediately;
   b. at least once a year, the nurse who drew up your indication may, on their own initiative, test whether the indication still reflects your care needs, i.e. is still correct. If that test results in a new indication, you will have to submit a new Personal Budget application.
   Monitoring and evaluation are part of the care needs assessment process; any changes in your care needs (as detected in the assessment) can mean that the amount of your Personal Budget is adapted;
   c. if your care needs are found to exceed 24 hours per week, the nurse may decide to organise a multidisciplinary consultation session (MDO) before issuing an indication, allowing various different professionals to be involved in determining the care;
   d. the nurse's role ends if he or she decides that his/her medical expertise is no longer required in view of the insured person's medical situation or believes that his/her interventions no longer serve any nursing

objective for the insured person. If the nursing expertise is no longer required, the remaining care needs (if any) can be transferred to the network or to a different domain. In such a case, the current indication will lapse;

e. in the event of any changes in the combination and ratio of contracted care and care under the Personal Budget, you will have to submit a new Personal Budget application. If applicable, the costs will then be settled based on the new application. The old Personal Budget will be (re)calculated in the manner described in Article 6.7 of the 2023 Personal Budget Regulations with effect from the date of the new application.
f. If you go to a different care provider, you must notify us using the change notification form available at **www.zorgenzekerheid.nl/brochures**.

8. It is your own responsibility to ensure that your budget and/or hours are spent in accordance with the award certificate we have issued;
9. You are obliged the manage a (preferably digital) dossier and keep it for at least 5 years after the end of the Personal Budget. That dossier should include, as a minimum:
   a. a court decision if you have a legal representative, unless you are a legal representative by operation of law;
   b. the full set of Personal Budget Application Forms plus appendices and care agreements;
   c. invoices and hour sheets in the names of the care providers concerned, stating hourly wages, units, type of care and an explanation of the care received;
   d. proof of bank transfers (proof of cash payments will not be accepted) or wage statements issued by the Social Insurance Bank (SVB);
   e. copies of invoices from care providers and claims submitted;
   f. your care plan and records concerning its objectives and evaluation moments;
   g. the award certificate for your Personal Budget issued by Zorg en Zekerheid.
10. In addition, at our request you must provide us with information from this dossier as soon as possible. You are required to manage this dossier yourself, even if the Social Insurance Bank (SVB) pays your care providers' invoices;
11. Under the privacy regulations (GDPR/Healthcare Insurance Regulations), we are entitled to contact the nurse who filled in the application with you so as to inspect your (medical) data regarding the Personal Budget application and the care needs assessment for nursing and care, whenever this is necessary to ensure a proper assessment. This will take place under the responsibility of our medical adviser. If, for the purposes of a proper assessment, we need further (medical) information from your general practitioner or medical specialist, our medical adviser or nursing consultant may contact your general practitioner or medical specialist, provided that you have expressly agreed to this;
12. You are obliged to cooperate in a conscious choice call or home visit (announced or unannounced) if and when we believe this is necessary, for example for verification purposes. At our request, you yourself and your (legal) representative, if applicable, must attend such a call or visit;
13. We may decide to ask a third party to perform the home visit our behalf. We will carefully select this third party. The third party is authorised to ask for, view and inspect your personal and medical data on our behalf. They will do so with the utmost care and in accordance with our privacy statement, which is available on our website;
14. Are you switching to a different healthcare insurer and is your award certificate still valid? If so, your new healthcare insurer will take over the valid award certificate (up until the end date of the indication stated on it; you should contact your new healthcare insurer about this) for the stated number of hours for nursing and care. Note however that the level of reimbursement for those hours may be different, as each healthcare insurer has its own rates. We advise you to keep the award certificate for as long as it remains valid and to send a copy to your new healthcare insurer;
15. If you only purchase care from informal care providers and the weekly number of nursing and care hours is higher than 24 (especially in the case of complex care needs), the healthcare insurer may require that part of the care be delivered by a formal care provider to ensure the required level of quality of the care.
    This condition will be discussed during the conscious choice call, the guiding principle being that the care should always be tailored to your needs. In exceptional situations, the healthcare insurer may demand that part of the care be delivered by a formal care provider and/or that the care be evaluated in the interim even if you purchase less than 24 hours of nursing and care per week. If your care needs involve less than 24 nursing and care hours per week, deviation from this rule must be substantiated through consultation between the healthcare insurer, the nurse and the budget holder.

Article 9 Review or withdrawal

Your Personal Budget may be reviewed or withdrawn with retroactive effect from the date it was awarded if:

a. you no longer satisfy the conditions attached to the award;
b. you meet one of the grounds for refusal;
c. you fail to fulfil the obligations laid down in these Regulations;
d. you are entitled to care under the Long-term Care Act (*Wet langdurige zorg*);
e. you are staying in an institution for more than 2 months in connection with care insured under your basic insurance;
f. with effect from the date of your award certificate, if the award certificate is based on incorrect or incomplete information provided by you and correct or complete information would have resulted in a different decision;
g. you fail to provide us with the information requested or to do so in time;
h. you fail to cooperate in an investigation of your dossier;
i. an investigation of your dossier has revealed irregularities under the applicable laws and regulations;
j. you fail to comply with the Regulations;
k. during the term of your Personal Budget, you designate a new (legal) representative or engage a (legal) representative for the first time and your healthcare insurer is of the opinion that you cannot be deemed to be able to assume the tasks and responsibilities associated with the Personal Budget in a responsible manner with that representative. You must notify us immediately of any change of (legal) representative using the Personal Budget Change Notification Form, which is available on **www.zorgenzekerheid.nl/brochures**;
l. if you receive contracted care from one or more care providers that you did not mention in your application form;
m. you submit a formal expense claim for informal care.

Article 10 Termination of the Personal Budget

10.1 Your entitlement to a Personal Budget ends automatically with effect from the day on which:

a. you are no longer part of the specific target group referred to in Article 2;
b. the care you need can be funded by virtue of a statutory act or provision other than the Healthcare Insurance Act, such as the Long-Term Care Act or the Social Support Act (*Wet maatschappelijke ondersteuning*);
c. you have been declared bankrupt or declared subject to the Statutory Debt Rescheduling Arrangement (*wettelijke schuldsaneringsregeling*, Wsnp);
d. you no longer have a home address, according to the Key Register of Persons (BRP);
e. you have been deprived of your liberty at law;
f. you use your Personal Budget to purchase care exclusively from care providers that the healthcare insurer has contracted for the provision of care;
g. you ask for the Personal Budget to be terminated;
h. your award certificate has expired;
i. your healthcare insurance ends.

10.2 The healthcare insurer may also terminate your entitlement to the Personal Budget:

a. from the day you are no longer capable of independently satisfying the eligibility conditions mentioned in Article 3.1 and you have no representative to assist you;
b. from the day your (legal) representative (in the event that you need his or her assistance to satisfy the eligibility conditions mentioned in Article 3.1):
    1. is no longer you curator, administrator, mentor, guardian, partner or blood relative or relative by marriage up to and including the 2nd degree;
    2. failed to guarantee fulfilment of the conditions associated with previous Personal Budgets in which he or she served as assistant or representative;
    3. no longer has a home address, according to the Key Register of Persons (BRP);
    4. has been deprived of his or her liberty at law;
    5. has been declared bankrupt or declared subject to the statutory debt restructuring scheme (WSNP);
    6. is otherwise unable to sufficiently safeguard continued compliance with the obligations imposed on you under the Personal Budget Regulations;
    7. your care provider is not also your blood relative or relative by marriage up to and including the 2nd degree.
c. with effect from the day you fail to fulfil (or no longer fulfil) the obligations associated with the Personal Budget;

d. with effect from the day the Personal Budget can no longer be deemed to sufficiently ensure high-quality and/or efficient care. Care will in any case not be deemed to be of high quality if you incur health risks due to the way in which the care is provided; Effective care is understood to mean the extent to which the Personal Budget will help to improve, maintain, or limit the deterioration of, your health. This serves to test whether the way you propose to use your care budget is effective in view of your care needs.
e. with effect from the day the continuity of the care can no longer be deemed to be sufficiently guaranteed in situations in which your care provider is unable to provide the required care due to illness, holiday or otherwise;
f. with effect from the date of your award certificate, if the award certificate is based on incorrect or incomplete information provided by you and correct or complete information would have resulted in a different decision;
g. with effect from the day one of the situations described in Article 4 of the Personal Budget Regulations materialises.

Article 11 Recovery of amounts paid

If you spend funds from the Personal Budget in violation of the provisions of these Regulations, the healthcare insurer may recover any or all funds paid out to you from the Personal Budget.

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