2026 Regulations governing the Personal Budget for Nursing and Care

Zorg en Zekerheid
Beter in jouw buurt

Contents

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Definitions

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

Conscious choice conversation
This is a conversation between you and us. During this conversation, your ability, or your representative's ability, to manage the Personal Budget is assessed on the basis of the current version of the Personal Budget Regulations and the ten Personal Budget skills. Your care needs and the obligations associated with a Personal Budget are also discussed during this conversation.

Doelmatigheid
Onder doelmatige zorg wordt verstaan in hoeverre met het Zvw-pgb zal worden gewerkt aan de verbetering, het behoud of beperking van achteruitgang van uw gezondheid. Daarmee wordt getoetst of de wijze waarop u uw zorg wil inzetten, gezien uw zorgvraag, effectief is;

Reassessment of care needs
Zorg en Zekerheid may decide to have your care needs reassessed. In that case, we will ask an independent nurse trained at higher professional education (HBO) level who provides care needs assessments to draw up a new care needs assessment. He or she will make an appointment with you for this purpose.

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

Second opinion regarding care needs assessment
Your care needs can be reassessed. You can have your care needs reassessed by another nurse or paediatric nurse, registered under the Individual Healthcare Professions Act (BIG Act) and trained at higher professional education (HBO) level and/or a nursing specialist trained as a paediatric nurse. The second opinion is covered by basic insurance, but only if we gave our permission beforehand. You have the option of asking us to designate a different nurse.

Award with an extended term of validity
If we have previously granted a Personal Budget, then in some customised situations it is possible to award a Personal Budget with a term of validity of up to five years in accordance with the Guide to Award of a Personal Budget with an Extended Term of Validity (Handreiking verlengde toekenning Zvw-pgb).

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.

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

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. failed to guarantee fulfilment of the conditions associated with any previous Personal Budgets in which he or she served as an assistant or the representative;
b. have no valid home address;
c. have been deprived of their liberty;
d. have been declared subject to a debt rescheduling scheme arrangement or who are the subject of a request to that effect submitted to the court;
e. are the subject of a debt rescheduling arrangement for natural persons, or are the subject of a request for such an arrangement to be declared applicable that has been submitted to the court, or have been declared bankrupt;
f. are otherwise unable to sufficiently safeguard compliance with the obligations associated with the Personal Budget that the budget holder must fulfil;

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

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.

Home address

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

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 nursing and care (district nursing), 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. In the event of any amendments to Section 13a of the Zvw and the associated lower- tier legislation that are effective from 1 January 2026 or a later date, we may modify these Regulations by effecting changes that result 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, V&VN Dutch Nurses' Association 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 one year, or
   b. Depend on palliative terminal care. This is the case if, according to your attending physician, your estimated life expectancy is less than three months.

Article 3 Conditions governing access to the Personal Budget

You must satisfy all of the following conditions. If, in Zorg en Zekerheid opinion, you are not able to satisfy all the conditions below, Zorg en Zekerheid 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 care needs assessment covering nursing and care as specified in Article 2.1 of these Regulations. The care needs assessment must not have been issued more than three months prior to the moment Zorg en Zekerheid receives the application.

2. In Zorg en Zekerheid opinion, you are able to use the Personal Budget to effectively obtain sufficient care or other high-quality services. Zorg en Zekerheid takes into account factors such as, among other things, the travel distance between you and your care provider (or you and your care providers), the quantity of care sessions, study load and whether a second care provider is required. A second care provider is always required for a formal care provider.
3. In Zorg en Zekerheid opinion, you are able to perform the tasks and responsibilities associated with the Personal Budget in a responsible manner, either independently or with assistance from a representative or legal representative. We will include the following aspects in our assessment:
    a. in connection with a previous Personal Budget under the AWBZ, Zvw, Wlz, Wmo or Youth Act (Jeugdwet), you failed to fulfil the associated obligations;
    b. within a period of five 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;
    c. 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 (Jeugdwet), Wlz and/or AWBZ;
    d. you have incurred payment arrears amounting to at least four monthly premium payments at any point in the past year and/or an invoice for the excess and/or your personal contribution has been outstanding for more than one year;
    e. 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;
    f. you have applied for a suspension of payments, are bankrupt or have been declared bankrupt;
    g. you, or your representative or legal representative, has a good command of Dutch, both spoken and written;
    h. you are able to supply all the information for the various procedures accurately and in full;
    i. you satisfy the ten Personal Budget skills as described on www.zorgenzekerheid.nl/zorg-regelen/pgb/pgb-aanvragen.
4. In Zorg en Zekerheid opinion, you are able to instruct your chosen care providers and coordinate their work, either independently or with assistance from a representative or legal representative, in such a manner that the care you receive or will receive qualifies as responsible care.
5. In Zorg en Zekerheid opinion, you are able to explain, either independently or with assistance from a representative or legal representative, that you qualify for and wish to receive care funded from 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 satisfy the conditions set out in Articles 2, 3 and/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 or other 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 in, or no longer cooperate in, a conscious choice conversation and/or any home visit organised by Zorg en Zekerheid.
6. It is evident from your application form or from the conscious choice conversation and/or home visit that you intend to use your Personal Budget exclusively for purchasing care or other services from care providers that Zorg en Zekerheid has contracted for the provision of care or other services
7. Your representative or 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 any previous Personal Budgets in which he or she served as an assistant or as the representative 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. is the subject of a debt rescheduling arrangement for natural persons (Schuldsaneringsregeling natuurlijke personen, Wsnp), or is the subject of a request for such an arrangement to be declared applicable that 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 compliance with the obligations associated with the Personal Budget that you must fulfil;
    g. the representative provides assistance with managing the Personal Budget in exchange for payment.
8. You have care needs assessments 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 care needs assessment.
9. The care is already reimbursed under different types of care, such as medical specialist care (under a DTP). This is in order to prevent double funding and therefore 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 relevant Personal Budget Application Forms including the required appendices (Part I: the nursing section and Part II: the insured person section). A conscious choice conversation forms part of the application procedure. If it is evident from this that you meet the conditions referred to in Article 2 and Article 3, you will receive a statement of approval for a Personal Budget. The Personal Budget Application Form

can be found at www.zorgenzekerheid.nl/brochures. You can also ask us to send you the Personal Budget Application Form by email.
If an application form, including the required appendices, is incomplete or has been incorrectly completed, it will not be processed.

2. a. if the application concerns adults aged 18 or older, you must have a care needs assessment issued at least by a nurse registered under the Individual Healthcare Professions Act (BIG Act) and trained at higher professional education (HBO) level, who has drawn up the care needs assessment in your presence and in accordance with the home nursing and care needs assessment and organisation standards (the V&VN Dutch Nurses' Association's standards framework).
   b. For children under the age of 18, you have a care needs assessment issued at least by a paediatric nurse registered under the Individual Healthcare Professions Act (BIG Act) and trained at higher professional education (HBO) level and/or a nursing specialist trained as a paediatric nurse, who has also followed the mandatory training on the Paediatric Care Needs Assessment Process Guideline (Handreiking Indicatieproces Kindzorg, HIK) and can prove this with a valid certificate. The person issuing the care needs assessment must be employed at a care provider that is affiliated with the Sector Association for Integrated Paediatric Care (BINKZ). The care needs assessment must be drawn up in accordance with the V&VN Dutch Nurses' Association's standards framework and the Paediatric Care Needs Assessment Process Guideline (Handreiking Indicatieprocess Kindzorg, HIK) in the home situation in the presence of yourself (the child) and your legal representative (parent/parents, court- appointed curator, administrator or mentor).
3. When performing the care needs assessment, the assessor must use the Quality Standard for the Use of Interpreters for Non-Dutch Speaking Patients in Healthcare Settings (Kwaliteitsnorm tolkgebruik voor anderstaligen in de zorg) when determining 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.
   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 a formal care provider, your care provider must have the required authorisation and competence to perform those procedures. If we so request, you must be able to produce a request from a physician for the procedures in question to be performed and also demonstrate that the procedures are performed in accordance with the 'Manual for restricted procedures in nursing (including district nursing) and care' ('Handleiding voorbehouden handelingen in de (wijk)verpleging & verzorging') (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 three 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 three months;
6. The care needs assessment must be drawn up in an independent manner. This means, in any event, that it must on no account be issued by a district nurse who:
   a. is your representative or legal representative and/or your blood relative or relative by marriage up to and including the second degree, and/or
   b. will provide care for you in person, and/or
   c. is employed by, or collaborates with, a care provider that will provide part of the care to you, unless this is a care provider we have contracted to provide 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 'Home nursing and care needs assessment and organisation standards framework', the elements of care that you and your network are able and willing to arrange. This means, among other things, that the district nurse must first map out your network and then consider which elements of care that network is able to provide, based on the care burden and the network's capabilities. The elements of care that the network are able and willing to provide are not included in the care needs assessment for district nursing purposes. The considerations that the district nurse took into account in this context must be included in the care needs assessment.
   According to the conceptual framework of the V&VN Dutch Nurses' Association, a network is defined as 'relatives and informal caregivers', such as the insured person's partner, children, housemates, family members and friends. When drawing up the care needs assessment, the district nurse will consider how the care needs can be met, or the nursing care treatments can be performed, with due regard for the full context of the care applicant's situation. This must be based on the starting point that the care applicant is to perform the nursing care treatments himself or herself wherever possible, with due regard for the facilities available. If this 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 needs assessment and organisation standards framework', will consider:
   - treatment by other care professionals (rehabilitation, physiotherapy, remedial therapy, speech therapy, medical specialist, etc.);
   - the use of healthcare technology, aids or home modifications that could remove the need for the nursing care treatments or enable the care applicant to perform the nursing care treatments himself or herself;
   - possibilities in other areas (WMO, WLZ, etc.);
   - the care applicant's network and the possibility of using volunteers before engaging a healthcare professional (under district nursing arrangements, or a healthcare professional from a different discipline).

8. It may be the case that a care needs assessment has been issued for care 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 needs assessment and organisation standards framework' (the standards framework). In that case, we will contact the district nurse who has drawn up the care needs assessment and ask him/her to explain the care needs assessment 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 care needs assessment 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 care needs assessment. If so, we will explain the reasons for our decision to deviate from the care needs assessment. In such a situation, we may also ask for a reassessment of the care needs assessment. We will then handle the submitted application on the basis of the reassessment by a nurse trained at higher professional education (HBO) level,
a paediatric nurse trained at higher professional education (HBO) level and/or a nursing specialist trained as a paediatric nurse. If you choose not to undergo a reassessment, we will not be able to process your request any further and will therefore have no option but to reject the application.
9. If you state in the application form that you are going to engage only one 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 any other reason. You must also enter into a care agreement with a substitute care provider.
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 care needs assessment 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 the policy conditions.
11. In Part II of the application form (the insured person section), you must specify the care provider or providers you want to make use of, based on the hours of nursing and care specified in your care needs assessment. In this part you must also specify the care contractor or contractors you want to make use of for contracted care, and those you wish to contract yourself based on the Personal Budget. The nurse must draw up a single care needs assessment for this purpose that includes both the contracted care and the care funded from the Personal Budget. The care providers 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 care needs assessment, 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 completed and signed application. 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. You therefore need to ask your district nurse to fill in the application form with you before the expiry date of your current award certificate. Please send us the fully completed and signed application forms, including the required appendices, well before your current award certificate expires.
3. If a care needs 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. If the nurse issuing the care needs assessment has established that you require less care, we will adjust our authorisation accordingly, where necessary with retroactive effect, from the date of the care needs assessment. This is because the old care needs assessment will lapse on account of the new care needs assessment.
4. The written award certificate that we will send you will also state the term of validity of your Personal Budget.
    a. The maximum term of validity of your Personal Budget is two years from the moment it was awarded to you, and only so long as you have a valid care needs assessment. If you wish to continue to qualify for a Personal Budget after the this period, you can request a new care needs assessment from your district nurse and then submit a new Personal Budget application to us, in accordance with Article 5.
    b. If we have previously granted a Personal Budget, then in some customised situations it is possible to award a Personal Budget with a term of validity of up to five years, in accordance with the Guide to Award of a Personal Budget with an Extended Term of Validity (Handreiking verlengde toekenning Zvw- pgb).
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 specified in the nurse's care needs assessment.
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 originalPersonal 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 a care needs reassessment issued in the interim, your Personal Budget will be reduced or raised 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.

8. If your award certificate for the Personal Budget is granted, terminated or withdrawn, we will notify in writing.
9. If you already receive contracted care for the care for which you requested a Personal Budget, or if you are already entitled to reimbursement of the costs of this care when you apply for the Personal Budget, you will be required to terminate 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 to purchase your care from that care provider / those care providers.

Article 7 Claiming the costs of care

7.1 Conditions for claiming costs

1. You can submit claims for invoices from the effective date of the Personal Budget stated in your award certificate.
2. Only you or your legal representative can submit claims for invoices under a Personal Budget.
3. Please use our standard claim form to ensure your claims are processed properly and quickly. You can find it on our website at www.zorgenzekerheid.nl/brochures (‘Personal Budget Claim Form’). You can also contact us by phone or email and ask us to send you a paper copy of the claim form.

   Please check and submit the invoices you recieve from the care providers that you have contracted under your Personal Budget. You can only claim the costs of care that is in line with the award certificate we have issued.

   If the invoice number and invoice date are not stated on the claim form, we cannot process the claim.
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. Claiming the costs of fixed monthly wages is not permitted. You can only claim the costs of the care actually provided, in hours and minutes, rounded to five-minute units.
6. Please make sure you submit the invoices for the amounts claimed no later than three months after the care was delivered. This is necessary to ensure an up-to-date picture of withdrawals from your Personal Budget.
7. The costs of a care needs assessment and evaluation as described in Article 2.1, case management and daycare nursing and accommodation for intensive paediatric care are not reimbursed from the Personal Budget. 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 in the case of formal care providers:
   a. Personal care: € 43.56 per hour
   b. Nursing: € 58.68 per hour
2. The following are eligible for the formal rate: Care providers that have:
   a. an AGB code for 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 a VET nursing diploma or a 3IG caregiver or level 3 caregiver and are able to demonstrate compliance with the quality requirements regarding work experience and expertise. We may ask you for your formal care provider’s diploma in order to verify that he or she is qualified to provide nursing and care based on the formal rate. A blood relative, or relative by marriage, up to and including the second degree or your spouse, registered partner or life companion is never 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 In order to claim this amount, you must state your care provider's AGB code in your application for the Personal Budget and in each claim.
3. The maximum amount you can claim for care delivered by informal care providers is €24.22 per hour for personal care and nursing.
4. Informal care providers include in any event care providers who:
   a. are a parent, caregiver, partner (such as a spouse, registered partner or other life companion), blood relative or relative by marriage up to and including the second degree (these individuals will not qualify as your formal care providers under any circumstances), and/or
   b. are a care assistant or a nursing assistant person up to level 3, because they do not meet the nursing and care training requirements under the Healthcare Insurance Act (Zvw), and/or
   c. are not registered as a nurse in the register referred to in Article 3 of the Individual Healthcare Professions Act (BIG Act) for professions involving the provision of care, and/or
   d. are not registered in the Trade Register, or not registered in the Trade Register as a care organisation under SBI codes 86, 87 or 88.
      These will never be eligible for the formal rate.

5. Both the formal rate and the informal rate are ‘all-in’ rates. This means that, besides this rate, you cannot claim any other costs, such as employer's social security contributions, travel expenses, holiday pay, holiday entitlement and care aids.
6. You can still make use of a Personal Budget if the cost of the care in question is higher than the reimbursement from the Personal Budget, provided you pay the difference yourself.

7.3 Other provisions regarding claims

1. You are personally responsible for ensuring the care providers you have contracted are paid on time. 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. These maximums will be proportional in the event that the Personal Budget is terminated early. 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 this article. We only reimburse invoices that comply with the conditions in these Regulations.
6. You cannot use your Personal Budget to pay for support with your duties as an employer or client of a care provider and/or to pay for support with payment transactions.
7. If you wish to hire one or more other care providers (for example, a foreign care provider) other than those for which we have granted permission, you must notify us in writing in advance. This allows us to assess, among other things, whether your healthcare provider is qualified. You can only submit claims for invoices from these care providers (including foreign care providers) once we have granted permission in writing.
8. a. The costs of transport to and from a medical day nursery, if this is medically necessary in connection with intensive paediatric care, cannot be claimed under your Personal Budget.
   b. If you have a 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 that 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 account number (i.e. the policyholder's account number) as known to us. In other words, we do not pay invoices directly to the care provider 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 have an obligation to record the agreements with your care providers in writing, in the form of care agreements. The care agreement must at least include:
   a. the name and address of the insured person;
   b. the name and address of the care provider;
   c. the relationship between the insured person and the care provider;
   d. the term of validity 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 or her representative or legal representative and the care provider.

   An example of such a care agreement is available at www.zorgenzekerheid.nl/brochures and at www.svb.nl.
2. As the insured person, you are required that the informal caregiver with whom you enter into agreements 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. If the informal caregiver with whom you have an employment relationship governed by the Working Hours Decree, the working week must not exceed 40 hours, including the hours funded from the Personal Budget. Furthermore, the care provider must not be under the age of 18.
3. a. You have an obligation 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 is evident from this evaluation that your care needs have increased or decreased, you must complete and submit another Personal Budget Application Form in collaboration with the district nurse.
   b. You have an obligation to cooperate in multidisciplinary consultation sessions (MDO) organised by the district nurse.
   c. The nursing process serves as the basis for any care needs assessment for care funded from a Personal Budget.
4. As the insured person, you are responsible for the quality and effectiveness of the care that you purchase. Zorg en Zekerheid is not liable for mistakes made by the care providers who are contracted by you.

5. 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 may concern a deterioration or an improvement of your health. In that case, you must apply for a new care needs assessment and submit a new Personal Budget application immediately.
   b. At least once a year, the nurse who drew up your care needs assessment may, on their own initiative, review whether the care needs assessment still reflects your care needs, i.e. is still correct. If that review results in a new care needs assessment, you will have to submit a new Personal Budget application. Monitoring and evaluation form part of the care needs assessment process; any changes in your care needs (as detected in the assessment) may result in a change in the amount of your Personal Budget.
   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 care needs assessment, so that multiple professionals can be involved in determining your care.
   d. The district 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 if he or she believes that his/her nursing care treatments 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 that case, the current care needs assessment will lapse.
   e. If there is a change in the combination or ratio of contracted care and care funded from the Personal Budget, you must submit a new Personal Budget application. If applicable, settlement will then take place on the basis of the new application. The old Personal Budget will be calculated/recalculated in the manner described in Article 6.7 of the Personal Budget Regulations with effect from the date of the new application.
   f. If you change your care provider, you must notify us using the change notification form available at www.zorgenzekerheid.nl/brochures.
6. It is your own responsibility to ensure that your budget and/or hours are spent in accordance with the award certificate we have issued.
7. You are obliged to manage a (preferably digital) dossier and keep it for at least five 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. proofs of payment (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 reports;
   g. the award certificate for your Personal Budget issued by Zorg en Zekerheid.
8. 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.
9. Under the privacy regulations (GDPR/General Data Protection Regulation (Implementation Act)/Healthcare Insurance Act Regulations/Healthcare Insurance Regulations), we are entitled to contact the nurse who filled in the application with you so as to receive 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 may contact your general practitioner or medical specialist, provided that you have expressly agreed to this.
10. a. 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.
    b. We may decide to ask a third party to perform the home visit on 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.
11. 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.
12. 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), Zorg en Zekerheid 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, Zorg en Zekerheid 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 Zorg en Zekerheid, 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 satisfy 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), Social Support Act (Wet maatschappelijke ondersteuning) and/or Youth Act (Jeugdwet);
e. you ask for the Personal Budget to be terminated;
f. you are staying in an institution for more than two months in connection with care insured under your basic insurance;
g. with effect from the date of your award certificate, if the award certificate is based on incorrect or incomplete information provided by you and the provision of correct or complete information would have resulted in a different decision;
h. you fail to provide us with the information we request or fail to do so on time;
i. you fail to cooperate in an investigation of your dossier;
j. an investigation of your dossier has revealed irregularities under the applicable laws and regulations;
k. you fail to comply with the Regulations;
l. during the term of validity of your Personal Budget you designate a new representative or legal representative, or engage a representative or legal representative for the first time, and Zorg en Zekerheid is of the opinion that you cannot be deemed to be able to perform 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 representative or legal representative using the Personal Budget Change Notification Form, which is available on www.zorgenzekerheid.nl/brochures;
m. you receive contracted care from one or more care providers you failed to mention in your application form;
n. you submit a claim for the cost of formal care when informal care was provided.

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 Zorg en Zekerheid 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 Zorg en Zekerheid may also terminate your entitlement to the Personal Budget:

a. from the day you are no longer capable of independently satisfying all the eligibility conditions mentioned in Article 3.1 and you have no representative to assist you;
b. from the day your representative or 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 your court-appointed curator, administrator, mentor, guardian, partner or blood relative or relative by marriage up to and including the second degree;
    2. failed to guarantee fulfilment of the conditions associated with any previous Personal Budgets in which he or she served as an assistant or the 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 must also not be your blood relative or relative by marriage up to and including the second 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 assumed 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 make use of care 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 any other reason;

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, Zorg en Zekerheid may recover all or part of the funds paid out to you from the Personal Budget.

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