Australian Government
Department of Health and Aged Care

Support at Home program

Program manual for 1 July 2025

Version 1.0

March 2025

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Disclaimer

The *Aged Care Act 2024* (the Act) governs the delivery of funded aged care services by registered providers (providers). The 'Support at Home program' refers to delivery of home support, assistive technology and home modifications under the Act and related rules.

The information in this Manual is intended as a general guide to providers on the policy intent of the Support at Home program. It is not intended as legal or professional advice on interpretation of the legislation or how it applies in individual circumstances.

Providers are responsible for complying with all relevant legislation when delivering funded aged are services. In addition to legislation referred to in this program manual, other Australian Government portfolios and state and territory jurisdictions may have separate legislation relevant to providers' operations as a registered provider. It is the registered provider's responsibility to understand and meet their obligations as they relate to all applicable legislation.

Providers should consider obtaining their own legal or professional advice relevant to their circumstances, especially in relation to requirements and obligations for delivering funded aged care services that may be new or different under the Act and related rules.

The department will review and update the information in the Manual as needed. The most up-to-date version of the Manual will be published on the department's website.

Please refer to the online version of the Manual to ensure that you have the most recent version. The footer on the front page includes the issue date.

If you are reading a printed copy of this Manual, please make sure it is the same as the most up-to-date version published on the department's website. The revisions and summary of changes made to the Manual are outlined at the beginning of the document in the version history.

The department does not guarantee the accuracy or completeness of information in the Manual. The department also does not accept liability for any loss or damage resulting from reliance on the Manual or the information it contains.

Additional information and resources that may further support providers understand their responsibilities and obligations will be available through the following Australian Government resources:

- Department of Health and Aged Care https://www.health.gov.au
- My Aged Care www.myagedcare.gov.au
- Aged Care Quality and Safety Commission www.agedcarequality.gov.au
- Services Australia http://www.servicesaustralia.gov.au

- Australian Competition and Consumer Commission www.accc.gov.au
- Australian Taxation Office www.ato.gov.au

Version history

Date	Summary of changes
March 2025	Support at Home program manual (v1.0) first issued.

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Part A: Introduction

This section covers:

- purpose of this program manual
- audience of this program manual
- scope of this program manual
- how to use this program manual
- how this manual is updated
- where to find more information
- training

1.0 Purpose

The Department of Health and Aged Care (the department) has prepared the Support at Home program manual 2025-2027 (program manual) for Support at Home registered providers (providers). The program manual outlines how the Support at Home program should be delivered.

Providers delivering Support at Home must be registered under the *Aged Care Act 2024* (the Act). Registered providers must comply with key obligations, including the conditions attached to their registration, when delivering funded aged care services. Civil penalties or offences may apply for failure to meet these obligations.

More information on governance for Support at Home and provider obligations is in Part B.

1.1 Audience

This program manual is intended for providers delivering services under the Support at Home program. This program manual serves as an operational guide to assist providers to understand and comply with the Support at Home program rules, procedures and provider obligations, supporting providers to deliver high-quality and consistent care that meets the needs of participants.

1.2 Scope

This program manual explains the government's policy, legislative context, operational requirements and guidelines for the delivery of Support at Home. It also outlines the responsibilities of providers under the Act.

Information included in this program manual relates to Support at Home and covers:

- governance of the program including the person-centred legislative framework, aged care system governance, program assurance and the Supported Decision-Making framework
- an overview of the Support at Home program
- entry into the program including assessment and accessing a provider
- care management
- participant budgets and contributions
- service delivery for ongoing services
- the self-management approach
- exits, changing providers and temporarily stopping services
- short-term pathways for restorative care, end-of-life support and assistive technology and home modifications
- provider claiming and payment arrangements

- program linkages including interactions with the Commonwealth Home Support Program.

Whilst high-level information may be provided, this program manual does not include detailed information on:

- legislation from the Commonwealth, states or territories
- provider registration and deeming
- the strengthened Aged Care Quality Standards (strengthened Quality Standards)
- program assurance
- provider reporting requirements
- other governance requirements, for example, Serious Incident Response Scheme and worker screening
- technical specifications for Commonwealth or provider-specific systems
- provider-specific operational processes and procedures.

1.3 How to use this manual

The table below provides a structural **overview of the Support at Home program manual**, which is organised into 7 parts (parts A to G). Each part focuses on a specific aspect of the program, detailing important information for providers including relevant legislative provisions and strengthened Quality Standards.

Part	Description
Part A: Introduction	• Purpose and scope of the program manual • How to use the program manual • Where to find more information • Additional assistance
Part B: Governance for Support at Home	• Overview of the key themes of the Act including the Statement of Rights and Statement of Principles • Information regarding aged care system governance • Program assurance for Support at Home
Part C: Service delivery for Support at Home	• Key operational information for providers as it relates to the legislation and/or strengthened Aged Care Quality Standards • Program overview • Assessment and accessibility, including service agreements • Care management • Participant budgets and contributions

Part	Description
	• The Support at home service list and key information for service delivery • Self-management • Exits, changing providers and temporarily stopping services
Part D: Short-term pathways and services	• The Assistive Technology and Home Modifications (AT-HM) Scheme • The Restorative Care Pathway • The End-of-Life Pathway
Part E: Provider payment arrangements	• Provider claiming and payment processes • Monthly statements
Part F: Program linkages	• Interactions with other national and state-based programs including the Commonwealth Home Support Programme (CHSP), Transition Care Program (TCP) and residential aged care • Business and Workforce Advisory Service • Rural, remote and Aboriginal and Torres Strait Islander funded aged care services
Part G: Glossary	• Terms and meanings used throughout this program manual.

1.3.1 Transitioned participants and grandfathering arrangements

This icon is used throughout the program manual to highlight arrangements that relate to transitioned HCP recipients and grandfathered HCP recipients. All previous home care package recipients are transitioned participants, with a subset having grandfathered provisions applied.

- **Transitioned HCP recipient:** A Home Care Package recipient who transitioned to Support at Home on 1 July 2025. This also includes older people who were on the National Priority System prior to 1 July 2025 but had not received a Home Care Package.
- **Grandfathered HCP recipient*:** A Home Care Package recipient who, on 12 September 2024, was either receiving a package, on the National Priority System, or assessed as eligible for a package.

*Grandfathering arrangements only apply to participant contributions and primary supplements.

More information on grandfathering arrangements is in section 8.4.1.

1.3.2 Appendices

Appendices to this program manual are available via the department's website Support at Home program manual a guide for registered providers.

1.3.3 Information subject to finalisation

This icon is used throughout the program manual to highlight additional information and supplementary resources that are being finalised, as well as information that is subject to consultation of the subordinate legislation (the Rules).

Consultation on the Rules is scheduled through to April 2025. This program manual will be updated with additional content once the Rules have been finalised.

1.4 How the program manual is updated

Support at Home and the broader aged care system continue to operate in an environment of change. The department will update the manual, as required, to ensure its currency.

Please refer to the online version of the Support at Home program manual to ensure you have the most recent version. The footer on the front page includes the issue date of the manual. Revisions made to this program manual are outlined in the version history.

1.5 Where to find more information

1.5.1 The Department of Health and Aged Care

More information about Support at Home, including a copy of this program manual, is available on the department's website health.gov.au/our-work/support-at-home.

Providers, peak bodies and advocacy agencies can access additional information and operational support through the Support at Home Community of Practice (website to be available for 1 July 2025).

1.5.2 Federal Register of Legislation

Legislative information including the *Aged Care Act 2024*, the *Aged Care (Consequential and Transitional Provisions) Act 2024* and the *subordinate legislation*

(Rules) can be found on the Federal Register of Legislation. As the Register is frequently updated, this program manual does not include links to the legislation.

The subordinate legislation is subject to consultation and parliamentary processes and is not yet available via the Federal Register of Legislation.

1.5.3 My Aged Care

Support at Home providers, aged care needs assessors, Care Finders, and the Elder Care Support workforce can access a range of resources for participants via the My Aged Care website or can request resources from myagedcare.gov.au/resources.

For technical assistance providers and assessors can contact the My Aged Care Service Provider and Assessor helpline on 1800 836 799.

1.5.4 The Aged Care Quality and Safety Commission

The Aged Care Quality and Safety Commission (the Commission) is the national regulator of aged care services. The Commission regulates aged care providers and workers to make sure that they meet their obligations to:

- provide safe and quality care
- treat the older people receiving their services with dignity and respect.

Registered providers are responsible for their delivery of care and services at all times. The Commission expects providers to work with older people to identify where they can improve and deliver the high-quality care that older people deserve. For more information regarding the Commission's regulatory approach, including its monitoring, compliance and enforcement regulatory powers and functions, refer to the Regulatory Strategy 2024–25.

More information on the obligations of registered providers is at section 3.1.

Support at Home providers can also access a range of information and resources regarding their obligations and responsibilities for delivering safe, quality aged care from the Aged Care Quality and Safety Commission (the Commission).

1.5.5 State and territory offices

The department has local network offices in each state and territory. These offices can assist providers with program management enquiries.

State or territory	Contact
Western Australia	WAPlaces@health.gov.au
New South Wales Australian Capital Territory	NSWPlaces@health.gov.au

Victoria	vic.office@health.gov.au
Queensland	engagement.QLD@health.gov.au
South Australia	SAPlaces@health.gov.au
Tasmania	TAS.Office@health.gov.au
Northern Territory	NTPlaces@health.gov.au

1.5.6 Peak organisations

Peak bodies may be a further source of information and support for delivering funded aged care services.

Peak body	Website	Phone number
Ageing Australia	www.ageingaustralia.asn.au	1300 222 721
Council on the Ageing (COTA) Australia	www.cota.org.au	(02) 6154 9740
Partners in Culturally Appropriate Care (PICAC)	www.picacalliance.org	
National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC)	www.natsiaacc.org.au	
National Seniors	www.nationalseniors.com.au	1300 765 050
Older Persons Advocacy Network (OPAN)	www.opan.org.au	1800 700 600
National Aboriginal Community Controlled Health Organisation (NACCHO) Affiliates	www.naccho.org.au	(02) 6246 9300
Palliative Care Australia	www.palliativecare.org.au	(02) 6232 0700

1.6 Training

The department is developing self-paced learning packages to help providers transition to the Support at Home program. These packages will include detailed information on the Support at Home program.

Learning packages will be available from April 2025 and will complement existing resources including this program manual and the Support at Home Program Provider Transition Guide.

For updates, visit the department's website for Engagements for reforming in-home aged care.

1.7 Grants

Providers can register on Grant Connect to receive updates on current and future opportunities, including updates for the Support at Home Thin Market Grants.

Part B: Governance for Support at Home

This section covers:

- legislative framework
- aged care system governance
- program assurance

2.0 Legislative framework

The following laws govern the Support at Home program:

- The *Aged Care (Consequential and Transitional Provisions) Act 2024* - This provides transitional arrangements related to the *Aged Care Act 2024,* ensuring a smooth transition to the new aged care system.
- The *Aged Care Act 2024* (the Act) – This is the overarching principal legislation effective from 1 July 2025.
- The *subordinate* legislation (the Rules) – This is the subordinate legislation made with powers provided by the Act. The subordinate legislation provides more details on how the Support at Home program operates.

The subordinate legislation is subject to consultation and parliamentary processes and is not yet available via the Federal Register of Legislation.

This section of the program manual outlines key themes under the principal legislation, the Act.

Operational information, as it relates to the Rules, is included throughout this program manual from Part C.

2.1 Aged Care Act 2024

The Act establishes a modern rights-based legislative framework that focuses on the safety, health, and wellbeing of older people and places their needs at the centre of the aged care system. The Act is structured in a way to give effect to the human rights conventions that form a part of the legal basis for the Act.

The objectives of the Act set up key concepts and considerations that must be considered when executing powers and functions under the Act.

In summary these objectives include:

- obligations under the *Convention on the Rights of Persons with Disabilities*, the *International Covenant on Economic, Social and Cultural Rights*, and other relevant instruments
- obligations to assist older people to live active, self-determined and meaningful lives
- equitable access to, and flexible delivery of, funded aged care services that considers the individual needs of older people, including people of diverse backgrounds and needs, and vulnerable people
- obligations to assist older people accessing funded aged care services to effectively participate in society on an equal basis with others, which will help promote positive community attitudes to ageing

- older people accessing funded aged care services can choose who will deliver their services, and when and how they do so
- people accessing funded aged care services are free from mistreatment, neglect and harm from unmet strengthened Quality Standards or unsafe care
- education and advocacy arrangements that can assist older people to access funded aged care services, understand their rights, make decisions, and provide feedback on the delivery of their services without reprisal
- promotion of innovation in aged care based on research, and supports continuous improvement.

The objectives of the Act give registered providers and regulators a high-level person-centred framework for engaging in decision making in the context of delivering aged care services and regulating the aged care sector.

A summary of the Act and key concepts is outlined in the New Aged Care Act Policy Manual (resource to be available prior to 1 July 2025).

2.2 Registered providers under the Act

Under the Act, registered providers are organisations that deliver Commonwealth-funded services to older people who need help in their own home or who can no longer live at home.

Funded aged care services are provided to older people in their home or an approved residential care home, through:

- Support at Home program
- Commonwealth Home Support Programme (CHSP)
- Residential Aged Care
- Transition Care program (TCP)
- Multi-Purpose Services (MPS)
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC).

Providers of in-home funded aged care services must be registered, at the provider level, under one or more of the six registration categories. Registration categories group together service types of similar complexity and risk, allowing regulatory obligations to be applied proportionately to all providers delivering a service.

More information on registration categories is on the department's website at The new aged care regulatory model.

2.3 The Statement of Rights and Principles

The Statement of Rights and the Statement of Principles support the person-centred aged care system, ensuring older people receive equitable, safe and quality care.

The Statement of Rights and the Statement of Principles are a reference point for the standard of conduct, duties and obligations for when registered providers, care workers and/or supporters deliver funded aged care services.

2.3.1 The Statement of Rights

The Statement of Rights (section 23 of the Act) is a fundamental part of the person-centred Act and promotes the older person's right to an adequate standard of living in the aged care system. It is a reference point for providers and workers to consider when delivering funded aged care services under the Act.

The Statement of Rights includes the right for every older person to have:

- independence, autonomy, empowerment and freedom of choice
- equitable access to care
- quality and safe funded aged care services
- respect for privacy and information
- person-centred communication and ability to raise issues without reprisal
- access and support from advocates, significant persons and social connections.

Providers and their aged care workforce delivering funded aged care services must take all reasonable and proportionate steps to deliver services that are compatible with the rights.

A summary of the Statement of Rights is outlined in the New Aged Care Act Policy Manual (resource to be available prior to 1 July 2025).

2.3.2 The Statement of Principles

The Statement of Principles (section 25 of the Act) provide guidance on how the aged care system should operate. It should be used to guide the decisions, actions and behaviours of everyone operating in the aged care system, including providers, aged care workers, supporters and government agencies.

The Statement of Principles includes:

- putting older people first
- treating older people as unique individuals
- recognising the rights of participants under the Statement of Rights.

The Statement of Principles also aims to guide the actions of government agencies and bodies to ensure that the whole aged care system is directed towards the safety,

health, wellbeing, and quality of life of individuals accessing funded aged care services.

More information, including a list of the Statement of Principles, is in the New Aged Care Act Policy Manual (resource to be available prior to 1 July 2025).

2.4 Supported Decision-Making Framework

The Act (Chapter 1, Part 4) establishes a framework for supported decision-making across the aged care system. Supported decision-making emphasises a person's autonomy and ability to make decisions. Under this framework, the department will have a role in registering supporters.

A supporter is an individual who, with the consent of the older person, may do any of the following:

- request, access or receive information or documents
- communicate information, including the will, preferences and decisions of the older person.

The supporter's role is to assist the older person, only to the extent necessary, so the older person can make their own decisions.

Some supporters can make decisions on behalf of an older person if the older person cannot or does not want to make the decision themselves. This is because the framework recognises people appointed under state and territory arrangements for supported and substitute decision-making. This includes a Guardian or Enduring Power of Attorney. The framework does not create a substitute decision maker for aged care. These supporters can only make decisions by virtue of, and in accordance with, their state or territory legal arrangement.

More information is on the department's website at Supported Decision-Making Framework (resource to be available prior to 1 July 2025).

3.0 Aged care system governance

The aged care system is governed by the Secretary of the Department of Health and Aged Care (referred to as the System Governor), the Aged Care Quality and Safety Commissioner and by the Complaints Commissioner.

The aged care governance arrangements also includes the:

- Inspector-General of Aged Care
- Aged Care Quality and Safety Advisory Council
- First Nations Aged Care Commissioner

- Independent Health and Aged Care Pricing Authority.

Collectively, the administration of the aged care system – including facilitating equitable access to funded aged care services, provider registration functions, investigation of systemic issues within the system, and handling of complaints – is critical in ensuring that a person-centred aged care system is maintained.

This system is designed to ensure providers maintain a level of care and safety required to protect older people and their right to safe and consistent care.

3.1 Provider obligations

The Act establishes a framework for registration of aged care providers which strengthens the link between delivery of aged care services and the rights of the individual.

The Act requires providers to be registered into one or more registration categories and to be approved by the Aged Care Quality and Safety Commissioner (Commissioner) before they can commence delivering government-funded aged care services.

Registration of providers includes registration conditions and statutory duties that the provider must meet. A registered provider must comply with obligations, including conditions of registration. Obligations refers to the obligation of providers to deliver safe and quality services and the rights of an individual to receive safe and quality services from their provider. For more information on provider registration, see the department's resources on how the new aged care regulatory model will work.

It is a condition of registration that all providers, can demonstrate they understand the rights of individuals under the Statement of Rights and have practices in place to ensure the provider acts in compatibility with these Rights. In addition, failure by a provider to meet certain conditions of registration and obligations gives the Commissioner the power to undertake regulatory action. This may include suspending or revoking a provider's registration or civil penalties for breaches of certain provisions of the provider obligation framework.

Separate obligations are also placed on responsible persons and aged care workers of registered providers, including to comply with the Aged Care Code of Conduct.

More information on provider obligations is in the New Aged Care Act Policy Manual (resource to be available prior to 1 July 2025).

3.2 Strengthened Aged Care Quality Standards

Section 15 of the Act establishes a framework that links Aged Care Quality Standards to the regulation of a registered provider. The strengthened Quality Standards explain what safe quality care should look like and supports providers to deliver the funded aged care services that older people need and expect. The strengthened Quality Standards are relevant throughout this program manual as a whole. The diagram below outlines the **7 strengthened Quality Standards**.

The strengthened Quality Standards were developed as a suite of interrelated Standards. Standard 1 - The Individual, is relevant to all standards and underpins the expectations for all other strengthened Quality Standards by requiring providers and aged care workers to deliver person-centred care.

Providers must meet the strengthened Quality Standards that apply to their registration category and the services they deliver. The Aged Care Quality and

Safety Commission (Commission) will monitor and regulate providers by auditing their ability to comply with all legislative provider obligations, including the requirements of the strengthened Quality Standards.

More information is on the department's website at Strengthened Aged Care Quality Standards.

The Commission has developed a suite of draft guidance resources for providers on the strengthened Quality Standards.

More information, including guides and training resources on the Strengthened Quality Standards, is on the Commission's website at Strengthened Quality Standards.

3.3 Code of Conduct

The Act incorporates an Aged Care Code of Conduct (the Code) that registered providers, their responsible persons and aged care workers (including volunteers) must adhere to when delivering aged care services. The Code describes how they must behave and treat people receiving funded aged care services.

The Code:

- supports a person's right to personal choice, dignity and respect
- promotes kind, honest and respectful behaviour
- keeps people receiving care safe from harm.

The Commission monitors and enforces compliance with the Code. Where a provider, responsible person or aged care worker fails to comply with the Code, they may be subject to enforcement action by the Commissioner.

More information and resources on the Code is in section 14 of the Act, Chapter 1 of the Rules and on the Commission's website at Code of Conduct for Aged Care.

3.4 Serious Incident Response Scheme

The Serious Incident Response Scheme (SIRS) aims to reduce abuse and neglect of older people receiving government funded aged care services.

SIRS establishes responsibilities for all providers to:

- prevent and manage incidents (focusing on the safety and wellbeing of older people)
- use incident data to drive quality improvement
- report serious incidents.

Providers must use the My Aged Care Service and Support Portal to notify the Commission if a reportable incident occurs.

Providers must comply with the incident management and reporting requirements under sections 164 and 166 of the Act and any related Rules.

More information, including resources and guidelines on SIRS, is in Chapter 5, Part 2, Division 1, Subdivision G of the Rules and the Commission's website at The Serious Incident Response Scheme.

Providers with questions about SIRS can contact the Commission by:

- calling 1800 081 549
- emailing sirs@agedcarequality.gov.au.

3.5 Worker screening

Section 152 of the Act requires registered providers to:

- comply with the worker screening requirements prescribed by the Rules
- ensure that aged care workers and responsible persons of the provider comply with the worker screening requirements prescribed by the Rules.

All aged care workers and responsible persons must have:

- a police certificate that is not older than 3 years and does not record certain convictions or offences, or
- a NDIS check for aged care workers or responsible persons that are also working (or have worked) in the NDIS sector.

The government is working with the states and territories to expand NDIS checks to the aged care sector. This future screening process will not start before 2026. Information on when the future screening process will start, and obligations on registered providers, will be communicated to the aged care sector to support a transitional process.

More information on worker screening requirements is in Chapter 4 of the Rules and on the department's website at Screening requirements for the aged care workforce.

3.6 Continuity of care

The Rules establish that providers must ensure there are appropriate continuity of care arrangements in place for people receiving funded aged care services. Continuity of care was previously known as Security of Tenure.

Information on Continuity of Care is subject to finalisation of the Rules and further information will be available prior to 1 July 2025.

4.0 Program assurance

The role of the department, as the System Governor, includes protecting the integrity of, and the government's investment in, the aged care system. Section 508 of the Act provides for the System Governor to conduct assurance activities.

Assurance activities could include how providers:

- use subsidy or grants and charge for services, including justification for costs charged
- structure their financial accounting for delivery of services
- deliver funded aged care services
- work with participants
- keep records and information
- apply and document procedures.

In undertaking its program assurance activities, the department can seek provider participation, for example requiring documents and information. The department may publish reports on program assurance activities.

To support assurance activities, the department has created a Program Assurance Framework and Program Assurance Plan.

More information on program assurance will be available on the department's website prior to 1 July 2025.

Part C: Service delivery for Support at Home

This section covers:

- program overview
- assessment and access to aged care services
- care management
- participant budgets and contributions
- service list and delivery of services
- self-management
- temporarily stopping services, transfers and exiting Support at Home.

5.0 Support at Home program overview

This chapter covers:

5.1 Overview of Support at Home
5.2 Staged implementation
5.3 Context of Support at Home in the aged care system
5.4 Wellness and reablement
5.5 Support for diverse needs
5.6 Dignity of risk
5.7 Continuity of care

Provider responsibilities

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference. This is not an exhaustive list of all provider obligations and responsibilities.

The Aged Care Act 2024:

- Section 23 and 25

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

Providers of Support at Home services must comply with the strengthened Quality Standards based on the service type they offer and the category or categories under which they are registered.

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

- On 1 July 2025, Support at Home replaces the Home Care Packages (HCP) Program and the Short-Term Restorative Care (STRC) Programme.
- The Commonwealth Home Support Programme (CHSP) will transition to Support at Home from no earlier than 1 July 2027.
- Support at Home has 8 funding classifications for ongoing services and 3 short-term funding classifications: the Restorative Care Pathway, the End-of-Life Pathway and the Assistive Technology and Home Modifications (AT-HM) Scheme.

Key points to remember
• Providers must be guided by the aged care rights and principles (Section 23 and 25 of the Act) that underpin the Support at Home program and apply wellness and reablement approaches.

5.1 Overview

This chapter provides an overview of the Support at Home program, its context in the broader aged care reforms and the underlying principles of the program.

The Home Care Packages (HCP) Program and the Short-Term Restorative Care (STRC) Programme are replaced by the Support at Home program on 1 July 2025

Support at Home is a coordinated package of care and services to meet the assessed ageing related care needs of eligible older people. The program includes:

- **8 ongoing classifications** with increasing levels of funding to provide varying levels of care to a broad spectrum of older people with assessed needs.
    - Additionally, there are 4 classifications for transitioned Home Care Package (HCP) recipients who have not been reassessed under Support at Home. These classifications reflect the level of funding previously provided under the HCP program.
- **3 short-term support classifications:**
    - the **Restorative Care Pathway** to regain or maintain independence
    - the **End-of-Life Pathway** to support older people who have 3 months or less to live and wish to remain at home.
    - the **Assistive Technology and Home Modifications (AT-HM) Scheme** for older people with an assessed need for equipment, products and/or home modifications.

More information on Support at Home classifications is in section 6.7.

For ongoing and short-term classifications, funded aged care services are grouped into three categories:

- **clinical supports** – such as nursing care, occupational therapy and physiotherapy.
- **independence** – such as personal care, social support, respite care, community engagement and transport.
- **everyday living** – such as domestic assistance, home maintenance and repairs, and meals.

More information on the Support at Home service list and delivering services is in chapter 9.0.

5.2 Context of Support at Home in the aged care system

Australia's aged care system is made up of several programs with different services and eligibility requirements to meet a wide range of support needs for older people.

In addition to Support at Home, the Commonwealth aged care system also includes:

- **Residential aged care** which provides a range of care options and accommodation (including short-term and emergency care) for older people who cannot live independently in their own home.
- **Commonwealth Home Support Program (CHSP)** which provides entry-level support for older people living at home. CHSP is not designed for people with intensive or complex care needs. People with higher needs are supported through the Support at Home program and residential aged care. More information on CHSP, including reforms and the CHSP manual are on the department's website at Commonwealth Home Support Programme (CHSP).

  CHSP will transition to the Support at Home program no earlier than 1 July 2027. **Transition Care Programme (TCP)** which provides short-term, goal oriented and therapy-focused care for older people following hospital stays. It can be offered in a person's home, a community setting or a residential aged care setting. More information on TCP is on the department's website at Transition Care Programme.
- **Multi-Purpose Services (MPS) program** which is a joint initiative of the Australian Government and state and territory governments. It provides integrated health and aged care services for small, rural and remote communities. More information on the MPS program is on the department's website at Multi-Purpose Services (MPS) Program.
- **National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) Program** which provides culturally appropriate aged care services to older Aboriginal and Torres Strait Islander people. These services are offered close to home and community and are mainly located in rural and remote areas. More information on the NATSIFAC program is on the department's website at National Aboriginal and Torres Strait Islander Flexible Aged Care Program

More information on how the Support at Home program interacts with other Commonwealth aged care programs is in chapter 17.0

5.3 Wellness and reablement

Wellness and reablement are person-centred, holistic approaches to service delivery. They build on people's strengths, capacity and goals to promote greater independence and autonomy. Wellness and reablement approaches are based on the premise that, even for individuals who experience frailty, older people want to improve their physical, social and emotional wellbeing, and remain living at home, connected to their community.

Under the Statement of Principles, providers have a responsibility to support participants to maintain or improve their physical, mental, cognitive and communication capabilities, and remain at home, where possible. Providers must also ensure that the delivery of aged care services puts older people first and treats them as individual participants.

Wellness and reablement approaches support providers to ensure that service delivery aligns with the core principles of Support at Home. Providers should support participants to maximise their wellbeing, independence, autonomy and capacity through person-centred wellness and reablement approaches. These approaches should focus on individual participant strengths and goals and recognise the importance of partnering with the individual.

The strengthened Quality Standards require providers of funded aged care services to ensure individuals receive care that meets their needs, goals and preferences and optimises their quality of life, reablement and maintenance of function (Outcome 3.2).

Additionally, clinical care delivered by providers must encompass clinical assessment, prevention, planning, treatment, management and review, to minimise harm and optimise quality of life, reablement and maintenance of function (Outcome 5.4).

5.3.1 Wellness approach

Wellness is a philosophy that informs how providers are expected to work with participants by building on their strengths, abilities and goals to promote greater independence and autonomy.

A wellness approach avoids 'doing for' when 'doing with' can support a participant to undertake an activity with less assistance, acknowledging the abilities of the participant and building on their strengths and skills.

A wellness approach also aims to empower participants to take charge of, and participate in, informed decision-making about the care and services they receive. It's about listening to what the participant wants to do, looking at what they can do, and focusing on regaining or retaining their level of function so that they can continue to manage their day-to-day life.

A wellness approach underpins all service delivery under the Support at Home program.

5.3.2 Reablement approach

Reablement offers time-limited interventions that focus on achieving a participant's specific goal or desired outcome. It involves maintaining or regaining skills, improving functional capacity, improving confidence and enhancing capability so a participant can resume everyday activities.

Providers under Support at Home should identify opportunities for reablement as part of their ongoing support of participants.

A reablement approach underpins the Support at Home Restorative Care Pathway, aiming to restore capability and keep people as independent as possible.

5.3.3 Wellness and reablement provider responsibilities

In applying wellness and reablement approaches, Support at Home providers are required to partner with participants and:

- ensure services focus on working with participants to achieve the goals outlined in their support plan, and as agreed in their care plan or goal plan
- apply a 'doing with' approach to service delivery
- offer time-limited interventions, where appropriate
- regularly review and monitor changes to a participant's needs and goals
- have an implementation plan outlining their approach to embedding wellness and reablement in service delivery
- comply with wellness and reablement reporting requirements.

5.3.4 Embedding wellness and reablement

The table below outlines the **key components and actions providers need to implement in order to embed a wellness and reablement approach**.

Key component	Provider action
Promote independence	People value their independence. Providers should actively promote participant independence and connection to community so they can live fulfilled, autonomous and confident lives.
Identify the participant's goals	Service delivery should focus on working with the participant to plan and actively work towards their goals (as identified in their aged care assessment), as well as improve independence wherever possible.

Key component	Provider action
Consider physical and psychosocial needs	Independence is not limited to physical function, it includes both social and psychological function. Support should be tailored to meeting the participant's assessed needs and aim to improve their physical, social and emotional wellbeing.
Encourage active participation	Being an active participant, rather than a passive recipient of services, is an important part of being physically and emotionally healthy. Providers should focus on working with the participant to complete tasks where possible, and not taking over tasks the participant can do for themselves. This also means empowering older people and their supporters to actively participate in the assessment, planning and delivery of their services.
Focus on strengths	The focus should be on what a participant can do, rather than what they cannot. Wherever possible, services should aim to retain, regain or teach skills, and avoid creating dependencies.
Support participants to reach their potential	Providers should play an active role in working with participants to maintain and extend their activities in line with their capabilities.
Provide individualised support	Service delivery should be tailored according to the participant's goals, aspirations, capabilities and needs.
Regularly review	Participant reviews should occur at least annually and broader care management must be ongoing and delivered at least once per month. Reviews and care management should focus on progress towards participant goals and consider the support and duration of services required to meet these goals.

More information on wellness and reablement will be available on the department's website prior to 1 July 2025).

5.4 Support for diverse needs

Support at Home recognises that older people have different backgrounds and experiences and that funded aged care services should be appropriate, accessible and sensitive to the individual needs of all older people.

The department, Commonwealth agencies, providers and the aged care workforce must ensure that older people have access to person-centred aged care services. This includes valuing older people, their identities, cultures, abilities, diversity, beliefs and life experiences.

The Aged Care Diversity Framework provides guidance for an accessible aged care system for every older person.

Standard 1 of the strengthened Quality Standards requires providers to treat all older people with dignity and respect, and value their identity, culture, spirituality and diversity.

Where known and appropriate, there should be acknowledgement of the additional barriers, challenges and discrimination older people may experience, or have experienced. This may be as a result of ethnicity, culture, religion, gender, sexual orientation, disability and socioeconomic status.

Service delivery should be carried out in accordance with the Statement of Rights and the Statement of Principles, as well as considering the social, cultural, linguistic, religious, spiritual and psychological needs of older people. The department recognises this list is not exhaustive, and there are additional diverse groups such as people with disability, people with mental health challenges and people with cognitive impairment, including dementia.

Providers cannot discriminate against participants based on cultural, ethnic or spiritual backgrounds. All providers must deliver culturally safe services.

Providers who wish to claim specialised care offerings on My Aged Care must apply for Specialisation Verification. Specialisation Verification helps older people find verified providers on My Aged Care who offer specialised care for people with diverse backgrounds. This means they have met the criteria in the Specialisation Verification Framework and shown they have expertise in serving diverse needs groups.
More information on Specialisation Verification is on the department's website at Specialisation Verification for aged care services.

5.5 Dignity of risk

Providers should work with participants to balance their duty of care with a participant's right to make choices, even if their choices include some risk to themselves. This right is known as 'dignity of risk' and is an older person's right under the Statement of Rights.

Dignity of risk involves:

- Providers have a duty under the Act to ensure their actions in provision of care are consistent with the Statement of Rights

- Participants have the right to make informed decisions for themselves, including if those decisions involve risk (Section 23(1) of the Act)
- Supporters are enabled under the Act to support a participant with decision making regarding their care and preferences

A participant's choice related to taking personal risks should be documented in their care plan or goal plan and outline:

- the risk identified
- mitigation strategies that have been discussed and/or implemented
- the provider's recommendations
- the participant's choice
- confirmation the participant accepts the personal risks associated with their choices.

Standard 1 of the strengthened Quality Standards requires providers to support older people to exercise dignity of risk to achieve their goals and maintain independence and quality of life. Providers can demonstrate they meet this requirement by supporting older people to live the life they choose, including by understanding the older person's goals and preferences and enabling positive risk-taking that promotes the person's autonomy and quality of life.

More information on the strengthened Quality Standards is in section 3.2.

6.0 Assessment and access to Support at Home services

This chapter covers:

6.1 Overview
6.2 Registering a supporter
6.3 Accessing an aged care assessment
6.4 Aged care assessment
6.5 Support Plan
6.6 Notice of Decision
6.7 Classification
6.8 The Support at Home Priority System
6.9 Finding a Support at Home provider
6.10 Service agreements
6.11 Notifying Services Australia of a new participant
6.12 Developing a care plan and budget
6.13 Support Plan Review

Provider responsibilities

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and/or responsibilities.

The Aged Care Act 2024:

- Chapter 2, Part 3
- Chapter 4, Part 2

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

Providers of Support at Home services must comply with the strengthened Quality Standards based on the service type they offer and the category or categories under which they are registered.

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

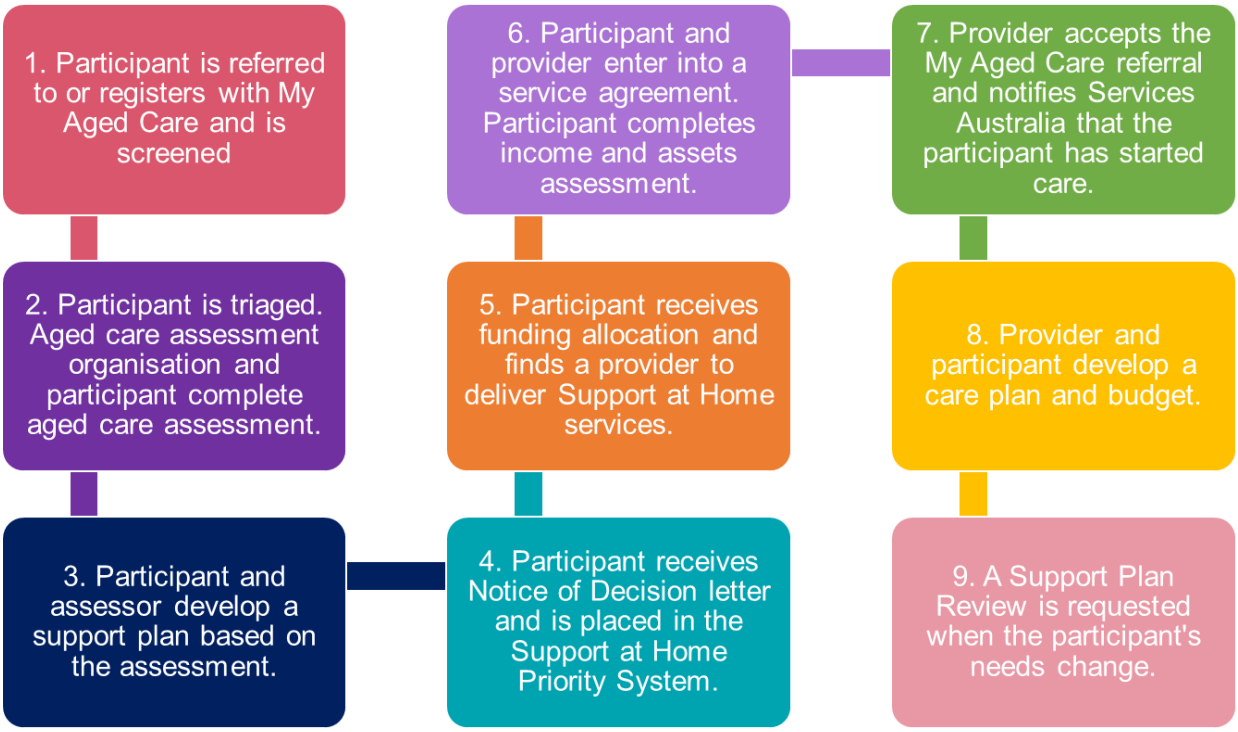
- Participants must register with My Aged Care to be referred for an aged care assessment.
- Eligible Support at Home participants will receive a Notice of Decision and support plan outlining their funding classification and approved services. This will include assistive technology and/or home modifications, if approved.
- To access services, participants will need to enter into a service agreement with their chosen provider.
- A Support Plan Review is completed when the participant's needs, goals or circumstances change, and can result in a change in the support plan or a new assessment.

6.1 Overview

This chapter outlines the steps that older people need to take to receive Support at Home services. It includes information about registering to receive Support at Home services, the aged care assessment process and how to access a provider. This section also sets outs the steps a provider needs to take after an individual has been assigned Support at Home funding, and before they can start providing in-home aged care services.

This information has been included to support providers in helping older people navigate this process, if needed.

The diagram below outlines the **step-by-step process for a participant to begin receiving Support at Home services.**



6.2 Registering a supporter

An older person may register a supporter to support the older person to make decisions.

An older person can register one or more supporters with My Aged Care, at any time.

With the consent of the older person, a supporter can help an older person to make and communicate their own decisions through their aged care journey, from engaging with My Aged Care to daily decisions about funded aged care services and

needs. Approved supporters can also request, access and receive information about the older person they support.

Participants who may require supported decision-making should be provided with equitable access and assistance to enable the person, as far as practicable in the circumstances, to:

- make and participate in decisions affecting them
- communicate their will and preferences.

More information on registering a support person will be available on the department's website prior to 1 July 2025.

6.3 Accessing an aged care assessment

Older people seeking access to funded aged care services need to register with My Aged Care and answer a series of questions about their situation and needs (screening) to determine their pathway to aged care services. They can do this by:

- calling My Aged Care on 1800 200 422
- using the Apply for an Assessment Online form on the My Aged Care website
- referral from their GP, health professional or hospital
- booking an appointment with an Aged Care Specialist Officer (ACSO).

Note: During the screening process, older Aboriginal and/or Torres Strait Islander people will be able to indicate a preference for their assessment to be conducted by an Aboriginal and Torres Strait Islander assessment organisation.

More information on Aboriginal and Torres Strait Islander assessment organisations is in section 6.3.1.1.

After completing screening, the My Aged Care Contact Centre or Aged Care Specialist Officer (ACSO) will refer the older person to an aged care assessment organisation. A Triage Delegate at the assessment organisation will review the referral and speak with the older person using the Integrated Assessment Tool (IAT) to determine:

- if they are eligible for an assessment
- the assessment pathway - for example, whether they require a home support or comprehensive assessment
- the assessment urgency and priority.

After triage is complete, referrals for an assessment are allocated to an aged care assessor to undertake the assessment.

More information for older people about accessing an aged care assessment is on the My Aged Care website at Apply for an Assessment.

6.3.1 Access supports

6.3.1.1 Aboriginal and Torres Strait Islander assessment organisations

Aboriginal and Torres Strait Islander assessment organisations will provide a choice for older Aboriginal and Torres Strait Islander people seeking access to a culturally safe aged care assessment. A small number of organisations commenced providing these services on 1 July 2025. Over time, these services will extend their reach and progressively cover more areas across Australia.

A culturally safe assessment process will help to improve the experience for older Aboriginal and Torres Strait Islander people and increase their uptake of aged care services. This will support them to maintain their independence at home for longer.

The organisations will help older Aboriginal and Torres Strait Islander people, their families, and carers, to access aged care services across urban, regional, and remote Australia.

More information on Aboriginal and Torres Strait Islander assessment organisations is on the department's website at First Nations Aged Care Assessments.

6.3.1.2 Care finder program

The care finder program can help vulnerable older people who require intensive support to interact with My Aged Care, and connect them to other relevant supports in the community. Vulnerable older people may be those who don't have family, friends, a carer or a supporter they are comfortable receiving assistance from.

Contact information for care finder services in each region is on the My Aged Care website at Help from a care finder.

More information about the care finder program is on the department's website at Care finder program.

6.3.1.3 Elder Care Support program

The Elder Care Support program can assist older Aboriginal and Torres Strait Islander people to access aged care services across urban, regional and remote parts of Australia. The Elder Care Support program provides assistance to:

- support older Aboriginal and Torres Strait Islander people to understand aged care services, navigate the assessment process and help with choosing a provider
- support families, friends and carers to understand how to access aged care services
- advocating for older Aboriginal and Torres Strait Islander people by working with assessors and providers to meet their needs

- supporting older Aboriginal and Torres Strait Islander people while they receive aged care services
- assisting with other types of health needs, such as disability supports.

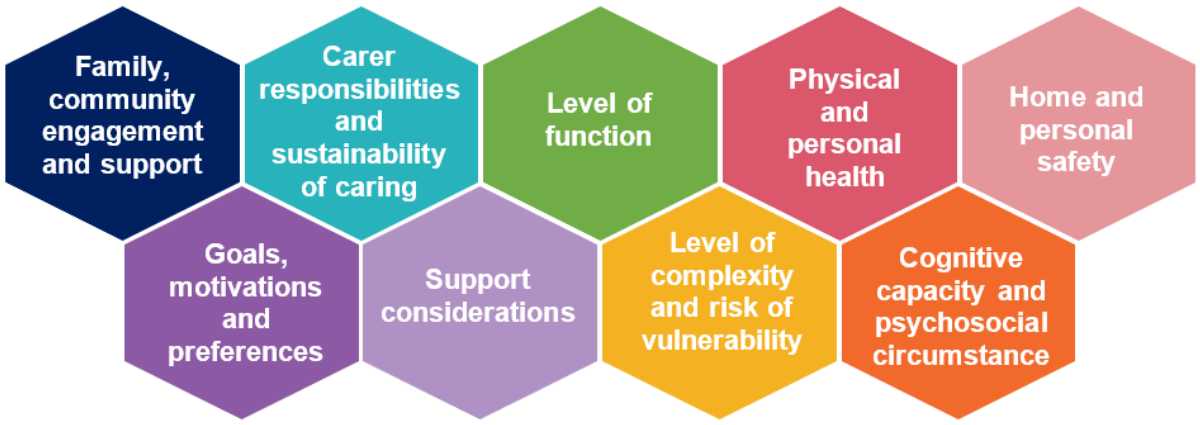
The department have partnered with the National Aboriginal Community Controlled Health Organisation (NACCHO) to establish the Elder Care Support program.

More information is on the department's website at Elder Care Support.

6.4 Aged care assessment

Eligibility for Support at Home is assessed by an aged care assessor using the Integrated Assessment Tool (IAT). The IAT is a needs-based assessment tool that determines the eligibility of older people for residential and in-home aged care services. It supports high quality assessments, due to the inclusion of several validated screening tools which are mandatory for completion.

The aged care assessment considers elements such as those contained in the image below (elements are not an exhaustive list).



The aged care assessment identifies an individual's strengths and areas of difficulty across each of the above elements, which will be considered as the aged care assessor works with them to develop a support plan. In developing the support plan, the older person will discuss the goals and the service types that best suit their needs with the assessor.

The aged care assessor will make culturally appropriate, person-centred, trauma informed care recommendations based on the person's identified care needs, at that time. After conducting the assessment, the aged care assessor will send their findings and recommendations (including the Support Plan) to the Assessment Delegate to determine eligibility for aged care services under the Act.

Everyone assessed will receive the outcome of their aged care assessment, including their eligibility to become a Support at Home participant and receive ongoing and/or short-term services. The outcome is called the Notice of Decision.

6.5 Support plan

Once an older person has been assessed as eligible for Support at Home, they are provided with a copy of their Support Plan (alongside the Notice of Decision). The support plan summarises the findings of the aged care assessment, including the older person's needs, goals and recommendations.

Information in the support plan includes:

- a summary of the older person's assessed needs and the reason for a referral for an aged care assessment
- a summary of the assessment findings
- the older person's goals (developed in partnership with the participant), supported by evidence-based strategies and solutions
- approved Support at Home funding classification and priority category
- the approved services the older person can access from the Support at Home service list
- approval funding for short-term supports (the AT-HM Scheme, the Restorative Care Pathway or the End-of-Life Pathway), if applicable

Other information in the support plan may include:

- information related to any previous assessments and services the older person has previously or is currently receiving
- links to any health and/or medically relevant documents
- information about an older person's Advance Care Plan (ACP), if applicable
- indication of the older person's consent to share the support plan via My Health Record (MHR)
- details of a nominated supporter, if applicable
- a date for a Support Plan Review (SPR).

6.6 Notice of Decision

In addition to the support plan, an older person will receive a Notice of Decision. Older people need delegate approval to access all Commonwealth funded aged care services. The assessor sends the draft support plan to an Assessment Delegate to approve an older person's access to services. Once the Assessment Delegate finalises their decision, the assessment organisation sends a Notice of Decision to

the older person. The Notice of Decision outlines the older person's eligibility for Support at Home.

The Notice of Decision includes:

- the approved service groups (service types, services, classification and priority where applicable)
- the reasons and evidence supporting the Assessment Delegate's decision
- the older person's rights of review, should they wish to query or dispute the decision
- the ongoing quarterly budget based on the assessed classification, and/or
- the approval for short-term supports (if required), including a budget for:
    - assistive technology and/ or home modifications
    - short term restorative support (for example, intensive allied health services)
    - end-of-life care.

Providers can view the Notice of Decision and support plan via the My Aged Care Service and Support Portal. Older people and/or their supporters can also view their Notice of Decision and support plan via their My Aged Care Online Account.

6.7 Classification

Older people approved to receive Support at Home will be assigned a **classification**.

Classifications cover:

- **Ongoing services** with 8 different funding classifications
- **Short-term services** with 3 short-term classifications:
    - the Assistive Technology and Home Modifications (AT-HM) Scheme
    - the Restorative Care Pathway
    - the End-of-Life Pathway.

6.7.1 Ongoing services

The table below outlines the **approximate funding amounts for each of the 8 ongoing service classifications**, and includes funding for care management.

Funding amounts for each classification are outlined in the Schedule of Subsidies and Supplements for Aged Care. Funding amounts are indicative and are subject to indexation revisions.

Classification	Quarterly Budget	Annual Amount
1	~$2,750	~$11,000
2	~$4,000	~$16,000
3	~$5,500	~$22,000
4	~$7,500	~$30,000
5	~$10,000	~$40,000
6	~$12,000	~$48,000
7	~$14,500	~$58,000
8	~$19,500	~$78,000

6.7.2 Transitioned HCP recipient and classifications

Transitioned HCP recipients who have not been reassessed under Support at Home continue to receive an equivalent level of funding as their previous Home Care Package. The previous annual package amount is divided into four to create the recipient's equivalent Support at Home quarterly budget.

Funding amounts for transitioned HCP recipients are outlined in the Schedule of Subsidies and Supplements for Aged Care. Funding amounts are indicative and are subject to indexation revisions.

Older people who, on 30 June 2025, were on the National Priority System or assessed as eligible for a Home Care Package will transition to Support at Home when funding becomes available. These participants will receive an equivalent level of funding to their approved HCP.

6.7.3 Short-term pathways

Short-term service classifications include three care pathways: the Restorative Care Pathway, the End-of-Life Pathway, and the Assistive Technology and Home Modifications (AT-HM) Scheme.

6.7.3.1 The Restorative Care Pathway and the End-of-Life Pathway

The table below outlines the **approximate funding amounts for restorative care and end-of-life care**.

Funding amounts for each classification are outlined in the Schedule of Subsidies and Supplements for Aged Care. Funding amounts are indicative and are subject to indexation revisions.

Service	Budget amount
Restorative Care Pathway	$6,000 (12 weeks). Can be increased to $12,000, when eligible*
End-of-Life Pathway	$25,000 (12 weeks)

*More information on the Restorative Care Pathway is in Chapter 13.0.

More information on the End-of-Life Pathway is in Chapter 14.0.

6.7.3.2 The AT-HM Scheme

The table below outlines the **approximate funding amounts for the funding tiers for assistive technology and/or home modifications.**

Funding tier	Funding allocation cap	Time allocated to expend funding
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000*	12 months

** Higher amounts for AT may be approved with prescription.*

More information on the AT-HM Scheme is in Chapter 12.0.

6.8 The Support at Home Priority System

Information related to the allocation of places is subject to consultation in April 2025 and subsequent finalisation of the Rules.

The Support at Home Priority System is the system that allocates Support at Home funding. An older person assessed as eligible for services will enter the Support at Home Priority System in one of its four priority groups (urgent, high, medium, standard). The older person will not be able to access government-funded services under Support at Home until funding has been allocated. The amount of time they wait for services will depend on the priority group they are in.

The Support at Home Priority System ensures the equitable allocation of Support at Home funding based on standardised and objective criteria. The Support at Home Priority System factors in:

- priority for in-home care services (urgent, high, medium, standard) determined using information collected by the aged care assessor using the IAT
- the date of approval for home care.

Older people who were actively seeking care at the time of their approval will be automatically placed in the Support at Home Priority System and set as ‘seeking services’. They will receive funding as soon as it is available, based on the above 2 factors.

Those who are not actively seeking care at the time of their assessment should inform their aged care assessor. They will then be set as ‘not seeking services’ and will not be allocated funding until they have advised otherwise. If an older person who was ‘not seeking services’ wishes to be allocated Support at Home funding, they will need to indicate that they are actively seeking care. Following this, they will be allocated funding as soon as it is available.

An older person can request to be set as ‘seeking services’ or ‘not seeking services’ at any point. This can be done by contacting My Aged Care, or by using the My Aged Care Online Account.

Note: Participants assigned to the Restorative Care Pathway or the End-of-Life Pathway will be allocated funding immediately.

Access to the Commonwealth Home Support Programme (CHSP) will be available for participants in urgent need situations ahead of receiving their budget allocation, if required. More information, is in section 17.1.

6.8.1 Interim access to funding

Information related to interim access to funding is subject to consultation in April 2025 and subsequent finalisation of the Rules.

To ensure people are not waiting any longer than necessary without access to care, participants can be assigned interim funding. Interim funding is an allocation of 60% of the total funding for their classification. This will provide funding to allow the participant to commence receiving the most critical services to help them remain living at home. The remainder of their budget will be assigned as soon as funding is available. The decision to allocate full or interim funding will depend on the level of demand, compared to available funding.

When interim funding is allocated, and to receive Support at Home services, participants will need to find a provider and enter into a service agreement. The participant and provider will need to work together to determine what approved services should be delivered within the interim budget.

A participant who has already been allocated their interim funding at 60% will then be allocated the remaining 40% when funding becomes available. The remaining 40% is not backdated.

6.9 Finding a Support at Home provider

When funding (including interim funding) becomes available and is allocated, the eligible participant will receive a letter notifying them that they have been allocated Support at Home funding.

After funding has been allocated, participants have 56 calendar days from the date their funding was allocated to find a provider and accept their place by entering into a service agreement. If a participant wants more time to find a suitable provider, they can contact My Aged Care and request a 28 day extension, giving them a total of 84 calendar days to enter into a service agreement.

If a participant has not entered into a service agreement within 56 calendar days (or 84 calendars days with the extension), the funding is withdrawn. This means funding for their classification is no longer available and providers cannot provide government-funded services.

If a person is assigned funding at their classification and the funding is withdrawn, they will be removed from the Support at Home Priority System. If they later decide they want to receive Support at Home services they need to re-join the Support at Home Priority System by contacting My Aged Care. People who re-join the Support at Home Priority System will have their date of entry recorded as the date they were originally approved for Support at Home.

Note: Unless the participant's needs have changed, they will not need to undergo another aged care assessment to rejoin the Support at Home Priority System.

Once a participant has chosen their provider, the provider will receive a referral in the My Aged Care Service and Support Portal through:

1. A system-generated referral – created either by the My Aged Care Contact Centre, ACSO or by an aged care assessor.
2. A direct referral – directly receiving a person's referral code (for example, an eligible person has presented their Support at Home Funding Assignment Notice and requested that the provider deliver their services).

From the referral record, providers can view the referral summary and a person's record. This will help providers make an informed decision about whether they can deliver the services required by the person and when they need services to start.

Support at Home operates via a single provider model whereby all services are overseen and delivered by a single registered provider. Providers should check the My Aged Care client record carefully for any active services. The provider should not commit to services if a participant is currently receiving in-home aged care or residential aged care, until a cessation date with their current provider has been confirmed.

Committing to deliver Support at Home services while another Support at Home entry record is in place may result in a claiming dispute, so keep records of all conversations with My Aged Care, the participant and any current/previous provider. Not confirming the end date with the current provider could lead to overpayment and debt collection by Services Australia, if 2 service providers claim for the same participant during the same period.

Find out more about managing referral participants' records on My Aged Care.

6.9.1 Single provider model

A single provider will oversee and deliver all Support at Home services for a participant, including care management and AT-HM services.

It is a requirement that all participants receive care management services for the Support at Home program. Under the single provider model, this means that registered providers, claiming for Support at Home services, must be:

- registered into (at minimum) *Category 4 Personal care and care support in the home or community* (including respite), and
- meet Outcome 5.1 (Clinical Governance) of Standard 5: Clinical Care.

Note: In addition to being registered in Category 4, providers must be registered in *Category 5 Nursing and transition care* in order to deliver and claim for nursing services.

Under the single provider model, providers can engage a third-party to deliver services on their behalf however, the provider remains responsible for ensuring their third parties and subcontractors comply with relevant obligations.

More information on registration categories is on the department's website at the new aged care regulatory model.

6.10 Service agreements

Information related to service agreements is subject to consultation in April 2025 and subsequent finalisation of the Rules.

When a participant chooses an organisation as their provider, the provider and participant must enter into a service agreement before services can be delivered.

The service agreement outlines rights and responsibilities and what services will be provided to the participant under the classification.

Note: A provider is not eligible to claim for government-funded services on behalf of the participant if a service agreement is not in effect.

Where a service agreement is not in effect and a provider claims subsidy from Services Australia, the provider is liable for a debt owed to the Australian Government for the period in which a service agreement was not in effect.

For service agreement inclusions and to ensure compliance with the Rules, providers should refer to the department's guidance material on service agreements which will be available prior to 1 July 2025.

Providers must work collaboratively to communicate, consult and reach agreement with the participant on the service agreement. Providers should ensure their service agreements do not contain unfair contract terms. Although providers may use standard form contracts for efficiency, it is important that providers consider a participant's rights when preparing their contracts. The *Competition and Consumer Act 2010* protects participants from unfair terms in standard form consumer contracts. The law offers participants increased protection in circumstances where they have little or no opportunity to negotiate with the provider.

Providers **cannot** charge for entry or exit to the service.

The service agreement sets out the terms and conditions by which a provider will deliver care and services to a participant. It is the legal contract between a provider and a participant and captures each parties' responsibilities. It is critical that providers seek legal advice and assistance in drafting service agreements.

The Act and Rules set out strict conditions by which the service agreement must comply. It is essential that providers understand the requirements under the legislation.

A service agreement must be readily accessible and written in a way the participant can understand (uses inclusive and plain English that avoids legal jargon, unusual words, phrases or idioms). It must not include any terms that would cause the participant to be treated less favourably in relation to any matter than they would otherwise be treated under Australian law.

To meet requirements of strengthened Quality Standard 1 (Outcome 1.4), providers must give older people the opportunity to exercise autonomy, the time they need to consider the agreement and an opportunity to seek advice. The provider must support individuals to understand and make informed decisions about their agreements, fees and invoices.

Providers must do this before entering into any agreements with older people about the delivery of funded aged care services.

6.10.1 Authorisation to enter a service agreement

Providers should confirm who has authorisation to enter into the service agreement based on the legislation in its state or territory. In some circumstances, state or

territory arrangements may be in place for an individual to act on an older person's behalf (as a substitute decision-maker).

An individual may act as a substitute decision-maker if they:

- have guardianship of the older person under a law of the Commonwealth, a State or a Territory; or
- were appointed by a court, tribunal, board or panel (however described) under a law of the Commonwealth, a State or a Territory, and have power to make decisions for the older person; or
- hold an Enduring Power of Attorney or like power, granted by the older person.

These people are encouraged to be registered as a supporter. However, they are not required to be registered to exercise their state or territory decision-making authority under the Act. Registration will attract significant advantages including the ability for a supporter to receive and access information and be recognised as part of the older person's formal support network across the aged care system.

Regardless of their status as a registered supporter, these individuals must only act in accordance with the relevant state or territory arrangement and comply with any duties and obligations attached to that arrangement.

6.10.2 Further considerations for service agreements

In addition to obligations under the Act, providers have obligations under consumer and competition law. When negotiating with participants for the delivery of care and services and drafting the service agreement, providers should also have regard to all these obligations.

The Australian Competition & Consumer Commission (ACCC) has developed guidelines for consumers and providers that outline consumer and business rights and obligations under the *Competition and Consumer Act 2010* (as they relate to in-home aged care services).

More information is on the ACCC's website at Guidelines on home care services.

The department cannot provide individual advice on business practices, nor is the department able to offer legal advice. Providers may wish to seek independent legal advice about business arrangements and how they align with the legislation.

The Commission has developed guidance for providers delivering care and services through Support at Home and the CHSP. This guidance focuses on what is expected of providers in setting prices for home services and making changes to home service arrangements including service agreements.

More information on pricing and agreements is on the Commission's website at Provider Guidance - Home Services Pricing and Agreements.

6.10.3 The participant can’t or won’t sign a service agreement

This information is subject to consultation in April 2025 and subsequent finalisation of the Rules.

Both the participant and the provider should sign the service agreement and the participant should be given a copy of the signed service agreement, as soon as practical.

A participant, however, does not necessarily need to sign the service agreement for it to be in place. As long as there is mutual agreement between the older person (or their substitute decision-maker) and the provider regarding the care and services to be delivered under Support at Home, the service agreement is considered ‘in place’.

In the event that a participant does not sign the service agreement, providers should keep detailed records of reasons why the service agreement is not signed. This is because the provider must always be able to provide proof that a service agreement is in place. Proof may include:

- a copy of the service agreement document that the provider offered to the participant
- a file note of the discussion with the participant about the basis of the service agreement (including the date the discussion took place)
- proof that the provider is providing Support at Home services, as described in the service agreement.

6.10.4 The participant does not agree to changes to an existing service agreement

At times, service agreements may need to change for a variety of reasons including aged care reforms, provider-led operational changes or updates to unit prices for services.

If a participant does not agree to the proposed changes, the provider needs to:

- negotiate to reach agreement with the participant and provide a detailed rationale in a format that the participant can understand
- encourage the participant to seek independent advice from aged care advocates, supporters, family members, carers, or legal advisers

More information on provider actions will be available for 1 July 2025 and following finalisation of the Rules including Continuity of Care legislation.

6.10.5 Communication differences and assistance

6.10.5.1 Translating and interpreting services

For participants who speak a language other than English as their first language, the Department of Home Affairs provides free interpreting services through the Translating and Interpreting Service (TIS National).

TIS National can assist participants or supporters to understand Support at Home, including the service agreement, the quarterly budget and monthly statements. When TIS National is used for this purpose, including if required to discuss the quarterly budget, there is no cost to the provider and no charges can be made to the participant budget.

TIS National is available 24 hours a day, 7 days a week and provides both telephone and onsite services. Bookings can be made:

1. online via the TIS National
2. by calling 131 450 for immediate telephone interpreting
3. by calling 1300 655 082 for on-site bookings.

Providers must register online for a TIS National Code. When accessing TIS National, providers will need to quote their service's unique code. If a provider is unsure of their participant's client code, they can contact TIS National.

Note: If providers are unable to access interpreters from TIS National that can communicate in the required language, they may work with the participant to engage a different organisation.

6.10.5.2 Aboriginal and Torres Strait Islander languages translation services

Providers can call My Aged Care and request to use **Interpreter Connect** when they are assisting an Aboriginal and Torres Strait Islander person regarding My Aged Care related issues or matters.

6.10.5.3 National Sign Language Program

The National Sign Language Program (NSLP) provides assistance to older people who are deaf, deafblind, or hard of hearing. The NSLP can provide free sign language interpreting and captioning services to those who are seeking to access or receive government funded aged care services.

The NSLP supports older people to better engage and fully participate in their aged care journey. Sign language services can be provided face-to-face or by remote video, and live captioning services are available to support participants to engage with:

- daily living activities
- health and medical appointments
- My Aged Care
- aged care assessors
- in-home aged care providers
- residential aged care providers
- other organisations involved in the provision of Government-funded aged care services.

The following sign language services are available:

- Auslan
- American Sign Language
- International Sign Language
- signed English for Deaf or people who are hard of hearing
- tactile signing and hand-over-hand for Deafblind consumers.

More information is on the department's website at the National Sign Language Program (NSLP).

Providers can book a sign language interpreter:

- online via the Deaf Connect website
- by calling Deaf Connect on 1300 773 803
- by emailing interpreting@deafconnect.org.au.

6.11 Notifying Services Australia of a new participant

Providers need to declare participant entry information to Services Australia within 28 calendar days of the service agreement being signed.

Providers will first need to accept the referral in the My Aged Care Service and Support Portal, and then complete the documentation to notify Services Australia. This can be completed through the Aged Care Provider Portal or through the submission of an Aged Care Entry Record (ACER) form (AC021).

Entry information must be provided to Services Australia as early as possible and within the 56 calendar days from the date the participant was allocated funding. The

ACER must be submitted within this timeframe to ensure the participant's Support at Home funding is not withdrawn.

If a provider does not advise Services Australia of entry information, or if they do not have a service agreement in place, they will not be paid any applicable subsidy or supplements.

At the same time as notifying Services Australia, the provider should also contact the department if their participant also receives a compensation entitlement.

6.12 Developing a care plan and budget

Providers will need to undertake care planning and budget planning for services and supports, with the participant, within 28 calendar days of service commencing.

More information on care planning and developing a care plan is in section 7.6.

More information on the development of a budget is in section 8.7.

6.13 Support Plan Review

A participant or provider can ask for a Support Plan Review (SPR) when:

- the participant's needs, goals or circumstances change,
- the participant needs additional services, or
- a time limited service has ended.

A participant can request a SPR through My Aged Care or from a Services Australia Aged Care Specialist Officer. With a participant's consent, providers can request SPRs through the My Aged Care Service and Support Portal.

A SPR may lead to:

- no changes to the support plan
- updates to the support plan
- a new assessment.

When requesting SPRs, providers must attach supporting documentation about the participant's current care arrangements, such as their quarterly budget and/or care plan.

More information on requesting a SPR is on the department's website at:

- When to Request a Support Plan Review from an Assessor fact sheet
- Aged care Support Plan Reviews and reassessments

For participants with assistive technology repairs and maintenance needs, providers will be required to submit, along with the Support Plan Review request, information that details the following for the aged care assessor to review:

- specific item(s), their service types and service sub-categories
- condition details of each item
- repair/maintenance quote for each item
- include a declaration statement.

At times, a participant may require additional services or care even if they are already receiving the highest Support at Home classification. When this happens, the provider, participant and their supporter may need to consider:

- reviewing their care plan to identify alternatives and priorities (for example, reducing higher cost services, such as support on weekends, and replacing with informal supports)
- exploring the availability of informal supports such as assistance from family, friends, community members or volunteers
- consider options for more short-term supports and accessing any HCP unspent funds
- purchasing additional care and services from their own funds, if manageable
- exploring other care pathways, including CHSP respite care services and residential respite care, as a short-term option to complement their current services
- exploring a move to a different home such as a serviced apartment in a retirement community
- evaluate their ability to continue living independently. If they are unable to sustain living independently in their own home, they may need to consider residential aged care.

7.0 Care management

This chapter covers:

7.1 Overview of care management
7.2 Goals of care management
7.3 Included care management activities
7.4 Excluded care management activities
7.5 Care partners
7.6 Care plan
7.7 Care notes
7.8 Care management funding for ongoing services
7.9 Claiming for care management

Provider responsibilities

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

Care management services must comply with the strengthened Quality Standards, including:

- Standard 1: The Individual
- Standard 2: The Organisation
- Standard 3: Care and Services
- Standard 4: The Environment
- Standard 5: Clinical Care
    - Outcome 5.1: Clinical Governance

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

- Care management activities are delivered by a Support at Home provider through a staff member known as a care partner.
- Providers and participants will need to work together to develop a care plan within 28 calendar days of services commencing.

Key points to remember

- Care partners must deliver a care management activity at least monthly and should review the care plan at least once every 12 months, or when there is a change to the participant's needs, services or circumstances.
- When thinking about how to approach the care planning process, providers should review information in the participant's Notice of Decision and support plan and apply wellness and reablement approaches within the person-centred and rights-based framework.
- Participants receiving ongoing services will have 10% deducted from their quarterly budget for care management.
- The 10% deducted from each participant in a service delivery branch will be pooled together in a care management account held by Services Australia.
- The provider will be able to use the funding in the account flexibly for any of the participants in the service delivery branch.
- The care management account can only be used by providers to claim for care management activities for ongoing services.

7.1 Overview

This chapter outlines the purpose and goals of care management, the role of care partners and the activities that must be undertaken, as well as funding and claiming arrangements.

Care management is a set of activities that contribute to the overall safety, wellbeing, health and quality of life of an older person. Care management ensures that care reflects individual preferences and culturally appropriate practices, while assisting participants to understand and access the level of support they require.

Care management applies to all participants receiving services under all Support at Home classifications. This includes self-managed participants who require a base level of care management in order for the provider to meet their obligations.

Care management involves initial and ongoing:

- care planning
- service planning and coordination
- development, review and evaluation of a participant's care plan and quarterly budget
- monitoring of services provided
- provision of information and education about the participant's care and services
- support to connect to health and other services when needed
- support to undergo a Support Plan Review, if needed.

Support at Home participants, who receive ongoing services, will have 10% deducted from their quarterly budget for care management. The 10% deducted from each participant will be allocated to the provider's care management account and pooled, together with the care management funding from all other participants within a service delivery branch. A pooled funding model for care management provides a flexible and responsive approach for providers to meet the changing care needs of their participants.

More information on care management funding is in section 7.8.

More information on care management for the Restorative Care Pathway is in section 13.5.

More information on care management for the End-of-Life Pathway is in section 14.5.

7.2 Goals of care management

Care management is designed to optimise participant safety, health, wellbeing and quality of life across a range of domains. The table below outlines the **goals of care management**.

Goals for care management activities	
Improved aged care outcomes	• Better management of ageing related conditions • Enhanced preventive and rehabilitative care by embedding wellness and reablement approaches • Improved understanding of the goals for service delivery • Increased overall wellbeing and quality of life • Increased outcomes for people living with dementia • Improved outcomes for Aboriginal and Torres Strait Islander participants through culturally safe care that respects identities, traditions and values
Enhanced continuity of care	• Improved communication with and collaboration across care providers • Reduced duplication of services • Smoother transitions between providers and care settings
Increased participant satisfaction	Person-centred care providing: • better engagement with participants, carers, and supporters • timely response to participant needs • improved communication and support around in-home aged care
Optimised use of resources	• Consolidated service planning and information sharing, including with primary care services • Reduced use of services including reduced hospitalisations
Empowered self-management	Active involvement by participants through: • collaboration and wellness approaches • increased self-efficacy, self-care skills and empowerment to make informed decisions about in-home aged care services • support to develop self-management strategies and engage in behaviours that promote wellbeing
Engaged carers and supporters	• Provision of resources and education to better equip carers and supporters to assist participants • Better inclusion of carers and supporters as active partners in the participant's care

7.3 Included care management activities

Providers must undertake initial and ongoing care management activities to meet the requirements under the strengthened Quality Standards (refer to section 3.2).

Care management activities may be delivered directly (i.e., speaking or meeting with the participant or their supporter) or indirectly (i.e., completing a specific activity on behalf of the participant without their direct involvement).

The table below outlines a list of **care management activities that can be claimed by providers from their care management account**. If providers are unsure whether an activity can be claimed under care management, they should seek advice from the department.

Care management for ongoing services – included activities	
Services	**Description**
Care planning	• Identifying participant needs, goals, preferences and existing supports • Reviewing the participant's support plan and assisting the participant to understand their approved services • Developing and reviewing care plans and quarterly budgets • Establishing and reviewing service agreements • Conducting risk assessments in relation to the participant and their home • Supporting the participant to complete and review advance care planning documents, if appropriate or required
Service planning and management	• Communication with aged care workers (involved in the delivery of services) regarding the participant's needs and wellbeing • Incorporating cultural protocols including engaging with culturally specific organisations • Communication with the participant, their carers and supporters • Managing the quarterly budget to ensure no overspends • Ordering client consumables • Facilitating transitions in and out of different care settings and ensuring continuity of care

Care management for ongoing services – included activities	
Services	**Description**
Monitoring, review and evaluation	• Engaging in ongoing care discussions and/or case conferencing with relevant health professionals, where required • Regular review of the participant's care notes • Monitoring and responding to changing needs • Identification of risks to the participant's health, safety and wellbeing and ongoing management of those risks • Evaluating the participant's goals, service quality and outcomes
Support and education	• Supporting participants (and their carer or supporter) to make informed decisions, including respecting their right to take risks, as per the supported decision-making framework • Supporting delivery of services with wellness and reablement approaches • Providing independent advice, information and resources on aged-related health matters • Health promotion information and education • Supporting participants to navigate age-related systems and programs and linking them to additional supports • Ensuring participant views, rights and concerns are heard and escalated, including in relation to complaints • Supporting the participant with providing feedback and complaints

7.4 Excluded care management activities

The table below outlines the **excluded care management activities** that cannot be claimed by the provider.

This is not an exhaustive list. If providers are unsure whether an activity can be claimed under care management, they should seek advice via the Support at Home Community of Practice (to be available for 1 July 2025).

Care management – excluded activities	
Administration and other costs	The following activities cannot be claimed: • scheduling • rostering staff • submitting claims • staff travel • staff training and education • program governance and compliance activities • record keeping • human resources activities

7.5 Care partners

Care management activities are delivered by a Support at Home provider through staff members known as care partners. Participants will be allocated a care partner by their provider.

It is the role of the care partner to help participants decide what services they want to receive, consistent with their aged care assessment, and work with the participant to determine how those services will be delivered. With consent of the participant, supporters, informal carers and family members can also be involved in these discussions. Care partners and care planning are critical to the delivery of quality care and services that meet the participant's needs and are tailored to participant preferences.

Care partners must deliver a care management activity at least monthly to each participant.

The types of activities to be delivered by the care partner are outlined in section 7.3.

The provider must also ensure care management services are delivered in line with Standard 3 of the strengthened Quality Standards.

Providers will have different models for delivering care management, based on their workforce and the types of services they deliver. This model may involve care partners who are experienced and trained aged care workers or care partners who have a health-related qualification, or both. The model may also include care management that is delivered by one or more care partners.

Care partners are appropriately trained aged care workers with relevant experience. Although there are no mandatory qualifications or professional registrations required, the following qualifications may be of value to people undertaking the care partner role.

- Diploma of Nursing – preferred

- Certificate III in Individual Support (Ageing)
- Certificate III Health Services Assistance
- Certificate IV in Aged Care
- Certificate IV in Disability
- Certificate IV in Community Services
- Diploma of Community Services (Case Management)
- Diploma of Ageing Studies and Services.

Some care partners will have more experience and higher-level qualifications, which will enable them to take on more complex tasks at the direction of their provider. These care partners may be referred to as clinically qualified care partners. Where this is the case, the individual must hold a university-level qualification in a relevant health-related discipline, for example, Bachelor of Social Worker, Physiotherapy or Nursing. Providers can employ care partners with a range of qualifications to implement a team-based approach to care management. A team-based approach can help providers respond to participant needs.

For example:

A provider who has a high case mix of participants with dementia may recruit a mix of nursing and social work-qualified clinical staff, who have expert knowledge in dementia, to deliver care management activities. This approach enables providers to best support participants and their supporters with the complex challenges that accompany dementia.

Where a provider employs both care partners and clinically-qualified care partners, the care partner may undertake the majority of care management activities with the participant. However, some participants with more complex care needs may have their service coordination and care planning overseen by a clinically-qualified care partner. For example, a provider may choose to appoint a clinically-qualified care partner for all participants receiving services under the End-of-Life Pathway or for all participants with a classification of level 6 or higher.

The role of a care partner and/or a clinically-qualified care partner should be outlined in the provider's clinical governance framework and should include activities for effective implementation of Standard 1 (Outcomes 1.1-1.3) and Standard 5 (Outcome 5.1) of the strengthened Quality Standards. Information to support effective implementation for these outcomes is on the Commission's website at Draft Strengthened Quality Standards Guidance.

7.5.1 Case study

Sarah

Care management

Sarah is a new Support at Home participant with a Classification 6. She receives care management services to coordinate her care.

Sarah is a part pensioner and in July 2025, she is assessed and is eligible for Support at Home. She is allocated a Classification 6.

Sarah finds a provider and requests a meeting to discuss their service offer. An initial appointment is scheduled with Lucy, one of the care partners within the provider organisation.

Lucy explains all about Support at Home and links the discussion back to Sarah's Notice of Decision and support plan. Lucy advises that the services that can be delivered include those outlined in the support plan (nursing, participant social support, transport, house cleaning and gardening). Together, Sarah and Lucy discuss what services Sarah would like to receive, the frequency of those services and options regarding workers Sarah might like to receive services from.

Sarah decides to enter into a service agreement with the provider and Lucy explains the details of the agreement, including how to cancel or reschedule services, the provider's pricing schedule, the collection of participant contributions, how to make a complaint, as well as the Code of Conduct for Aged Care and the Statement of Rights.

Sarah would like to commence services as soon as possible so, during the initial appointment, Sarah and Lucy create a care plan and a quarterly budget. The care plan includes all the services Sarah has been approved to receive through Support at Home. Sarah and Lucy also discuss and agree on an initial nursing appointment (to assess Sarah's skin integrity issues following a recent pressure sore), ongoing nursing, as well as regular check-ins as part of ongoing care management. Lucy advises Sarah that she will send out a copy of the service agreement and care plan once she returns to the office.

Back at the office, Lucy sends the scheduling team a request with the agreed days and times for Sarah's services. Lucy discusses Sarah's skin integrity with her supervisor,

Care management

Greg. Greg agrees that an initial nursing appointment should be completed to assess Sarah's skin integrity and provide education and recommendations for monitoring.

After the first 2 weeks of service delivery, Lucy wants to check-in with Sarah to see how everything is going. Lucy reviews the care notes to understand what services have been delivered and confirms that the initial nursing appointment was completed. The nursing notes are comprehensive and detail the plan for managing Sarah's skin integrity and the recommended frequency of nursing services.

Lucy calls Sarah and they discuss what has gone well in the first two weeks and if any changes need to be made. Sarah states she is happy with how things are going. Lucy and Sarah agree to check-in again at the end of the month, in 3 weeks' time.

Longer term and with regular nursing care, Sarah's skin integrity improves. Lucy continues to partner with Sarah and coordinate the daily activities relating to Sarah's care including onboarding a subcontractor for Sarah's gardening and ensuring Sarah has taxi vouchers for her GP appointments.

7.6 Care plan

A care plan is a key resource that documents a participant's needs, goals, preferences and how funded aged care services will help the participant realise their goals. Unlike service agreements which focus on prices, terms and conditions of service, as well as the rights and responsibilities of both parties, care plans are a person-centred document used to formalise a participant's choice and control over their services.

Care plans should include:

- identified goals and strategies to achieve these goals
- the participant's preferences around service delivery, such as care worker gender or attributes, or preferred days and times to receive services, as well as cultural preferences
- a detailed outline of the types of services to be delivered including when services are delivered, who will deliver the services, and the frequency
- a summary of AT-HM items the participant will receive (or is already receiving) and their costs (if applicable)
- dates to review the participant's service agreement and care plan
- any additional information related to the delivery of culturally safe, trauma aware and/or healing informed care, as required.

The care plan is developed by a care partner in collaboration with the participant and their carers or supporters (where relevant) and is informed by the Notice of Decision and support plan generated during the aged care assessment. The care plan is a living document that will change in line with the participant's needs, goals, preferences and situation.

Providers must work with the participant to develop a care plan within 28 calendar days of services commencing. The participant must be provided with a copy of the care plan. Providers must also work with the participant to develop an individualised budget plan and this is outlined in section 8.7.

When collaborating with a participant to develop a care plan, providers need to be able to demonstrate that care planning meets the requirements of Standard 3 of the strengthened Quality Standards. Providers achieve this by taking actions such as:

- identifying and recording the participant's current assessed ageing related care needs, goals and preferences, including advance care planning, if the participant wishes
- providing funded aged care services in a way that is culturally appropriate for people with specific needs and diverse backgrounds
- considering risks to the participant's health and wellbeing to inform the delivery of safe and effective care and services
- involving the participant (and, if the participant wishes, involvement of supporters and carers) in the development and review of the care plan
- involving other relevant health professionals, organisations or providers of care (if relevant).

The care plan should identify wellness and reablement approaches to help the participant meet their goals. Wellness and reablement approaches support providers to ensure that service delivery aligns with the core principles of Support at Home.

If the participant consents, there may be merit in case conferencing with their GP and other health professionals to support the development of their care plan. GPs and other health professionals may be able to access MBS items to fund their involvement in any case conferencing if the participant has a Chronic Disease Management Plan in place.

Providers will also need to help participants understand what services and assistive technology and/or home modifications they have been approved to receive and what combination of services they can afford within their quarterly budget. This should build on discussions and planning from the participant's aged care assessment.

Note: Participants accessing the Restorative Care Pathway concurrently with ongoing Support at Home services will also have a goal plan. Refer to Chapter 13.0 for more details.

7.6.1 Care plan review

Once the care plan is completed, care partners have an ongoing responsibility under Standard 3 of the strengthened Quality Standards to monitor and review the care plan to ensure the services delivered continue to meet the participant's needs.

The participant and care partner should review the care plan:

- regularly and at least once every 12 months
- if the participant's needs, goals or preferences change
- if the participant's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes
- if a participant receives a higher Support at Home classification
- If a participant receives approval for AT-HM
- If a participant commences on the End-of-Life Pathway
- if the participant wants to change their services or frequency of services
- if risks emerge or an incident occurs that impacts the participant
- if care or support responsibility changes between family, carers, or supporters
- at any time when requested by the participant.

A care plan review should include:

- a wellness and reablement focus
- a review of current ageing related care needs, care goals and preferences
- an evaluation of the quality and success of the services and supports that have been provided
- a renegotiation and update of the care plan and individualised budget
- support for the participant to continue to make informed choices about their care and services, and the life they choose to live, including whether they wish to change their level of involvement and decision-making in relation to management of their services or quarterly budget.

Where there is a change to the participant's care plan, the individualised budget will also need to be updated and these activities can be claimed under care management.

Review of a participant's care needs may identify changes required in the assessed services and support which may potentially require a higher Support at Home classification, need for short-term services, or entry to residential aged care. In these circumstances, another aged care assessment may need to be completed. With the participant's prior consent, providers can assist in referring the participant for an aged care assessment.

Providers can do this by submitting a Support Plan Review (SPR) request via the My Aged Care Service and Support Portal.

More information is in section 6.13.

7.7 Care notes

Providers are required to maintain care notes for all Support at Home participants. Care notes should be completed by care partners and other staff throughout the organisation such as allied health professionals and direct care workers. The system for recording care notes will be dependent on the provider's processes, information management and system infrastructure.

Care notes should reflect:

- records of important communications, interactions and observations held with the participant about their needs, goals, care and/or services
- records of important discussions held with the participant's supporters or carers.
- records of meetings or case conferences held in relation to the participant
- documentation of emerging risks, outcomes of risk and/or clinical assessments undertaken and/or mitigation strategies
- information on reported incidents or near-misses, along with subsequent investigations (unless recorded in a specific incident management system)
- details of complaints raised and actions taken (unless recorded in a specific complaints management system)
- information on billing issues or changes to service delivery.

Care notes should be regularly reviewed by care partners to ensure a holistic understanding of a participant's situation and needs and to inform ongoing care planning.

7.8 Care management funding for ongoing services

Support at Home participants, who receive ongoing services (not applicable for the Restorative Care or the End-of-Life pathways), will have 10% deducted from their quarterly budget for care management. This funding will be allocated to the provider's care management account at the start of every quarter (July, October, January, April). Providers can claim against the funding available in the care management account.

The amount of care management funding each quarter is variable and is based on the number of participants and the classification of each participant.

More information on how care management funding is calculated and allocated is in section 15.6.

7.8.1 Care management supplement

A care management supplement will be available to providers delivering services to participants who have been identified as:

- older Aboriginal and Torres Strait Islander people
- homeless or at risk of homelessness
- care leavers (i.e., a person who has spent time in institutional or out of home care (including Forgotten Australians and former child migrants)
- veterans who are approved for the Veteran's Supplement for aged care
- referred to Support at Home from the care finder program.

The supplement provides an additional 12 hours per year (3 hours per quarter) of care management activities. The supplement will be credited to the provider's care management service account at the start of every quarter.

Participants eligible for the supplement will be identified by Services Australia based on their aged care assessment. Where a participant meets more than one criteria for the care management supplement, the supplement will only be applied once.

7.8.2 Pooled funding and the care management account

The 10% deducted for care management, from each participant, will be allocated to the provider's care management account. This funding will be pooled together with the care management funding from all other participants. A pooled funding model for care management provides a flexible and responsive approach for providers to meet the changing care needs of their participants.

Pooling of funds will take place at the service delivery branch level of a provider. A service delivery branch is (definition to be provided upon finalisation of the Rules). Providers will be able to set up service delivery branches through which services are provided to participants. All participants must be connected to a service delivery branch.

The total care management funding for each service delivery branch will be determined by the mix of participants and their classifications.

The funding in the care management account can be used for any participant connected to the service delivery branch. Providers will be responsible for managing the available care management funding across the participants in the branch.

For example:

Jan, Graham, and Wei are Support at Home participants who all receive services through the same service delivery branch of their provider. Each participant has been allocated a different classification:

- Jan was assessed and allocated a Classification 4.
- Graham was assessed and allocated a Classification 3.
- Wei was assessed and allocated a Classification 7.

Each participant has 10% deducted from their quarterly budget for care management. While Wei's care management amount is higher than both Jan and Graham (due to her higher classification), the funds are pooled together in a care management account along with all other care management funding from participants within the service delivery branch.

The pooled funding model enables the provider to determine the frequency of care management activities for each participant and allows a flexible approach so they can respond quickly to any changing needs.

At level 3 and 4, Graham and Jan receive care management activities on a monthly basis. Wei has more complex needs and so her care partner provides care management support at least once every fortnight.

Following a period of illness and hospitalisation for a chest infection, Graham's care needs change and he requires increased assistance from his care partner. His care partner liaises with hospital staff and attends a case conference regarding his transition back home. Once home, Graham meets with his care partner and they review his care plan and quarterly budget to ensure that services are still meeting his needs. They agree to temporarily cease social support activities until Graham is feeling well enough to socialise. Graham requests a call from his care partner in 1 week to review this decision.

As funding is pooled, the provider is able to flexibly support Graham's temporary increased care needs while he requires additional support. The provider will be able to reduce support back down as Graham recovers and his support needs decrease again.

Providers and care partners will need access to the care management account through the My Aged Care Service and Support Portal and/or the Services Australia Aged Care Provider Portal. Providers can use these portals to:

- view their care management funding, debits and remaining balance
- view any rollover of funding from one quarter to the next
- view the start and end dates of the quarter
- generate reports related to the abovementioned activities.

Any funding in the account that is not fully utilised in a single quarter will automatically rollover into the next quarter (of the financial year) and accrue in the care management account. There is no limit on the amount of care management funding that can be rolled over into the next quarter within a single financial year.

The amount of care management funding transferred from one financial year to the next is limited. The maximum amount each service delivery branch can rollover to the next financial year is equal to the value of their 4th quarter (April) allocation. The 4th quarter allocation is the funding assigned by Services Australia and does not include any rollover funding from the previous quarter.

More information on allocation and rollover of care management funding is in section 15.6.

7.9 Claiming for care management

Providers will need to claim for care management activities delivered during the quarter on a payment in arrears basis. Claims will need to be itemised in the same way as other services under Support at Home. Providers will need to identify the individual participant for whom the care management activity was delivered and the day on which the activity took place. If the claim submission is successful, the amount to be claimed will be drawn down from the provider's care management account and paid to the provider.

The care management account can only be used by providers to claim for care management activities for ongoing services. Providers must not claim against the care management account for care management activities provided under the Restorative Care Pathway or the End-of-Life Pathway.

More information on claiming for care management for ongoing services is in 15.4.1.

More information on claiming for care management for the Restorative Care Pathway is in section 15.4.3.

More information on claiming for the End-of-Life Pathway is in section 15.4.4.

8.0 Participant budget and contributions

This chapter covers:

8.1 Overview
8.2 Budgets
8.3 Government funding
8.4 Participant contributions
8.5 Assessment of income and assets for participant contributions
8.6 Collection of participant contributions
8.7 Management of the budget

Provider responsibilities

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

The Aged Care Act 2024:

- Sections 273-274

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

Providers must comply with the strengthened Quality Standards based on the service type they offer and the category or categories under which they are registered.

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

- Each Support at Home participant receives a budget based on their approved classification category and level.
- Individual budgets include a combination of government funding and participant contributions.
- Participant contributions are determined by Services Australia and are based on an assessment of the participant's income and assets and the type of service being provided.
- Providers must work with participants to develop an individualised budget.

Key points to remember
• Quarterly budgets that are not fully utilised can accrue up to $1,000 or 10% (whichever is higher) and will carry over to the following quarter.

8.1 Overview

This chapter outlines the components of the Support at Home budget, including government funding and participant contributions. It also includes information on how providers should work with participants to develop and manage their budget and the key activities associated with budget management.

8.2 Budgets

Participants will be allocated a funding amount based on their Support at Home classification. For ongoing classifications, the funding amount will be divided into 4 approximately equal budgets that each cover 3 months of the year. This is known as a quarterly budget. For short-term classifications, the budget will cover the period specific to the pathway or scheme (i.e., 12 weeks for the Restorative Care and End-of-Life pathways or 12 months for the AT-HM Scheme).

Support at Home budgets are made up of government funding (what the Australian Government pays) and where applicable, contributions from the participant. Participant contributions will differ based on the service being delivered and the person's means to pay. Participant contributions are determined via an assessment of the participant's income and assets by Services Australia.

More information on participant contributions is in section 8.4.

Support at Home budgets for ongoing classifications are released by Services Australia at the beginning of each quarter (July, October, January, April) and are held on behalf of the participant in an account managed by Services Australia. Providers claim against this funding once services are delivered.

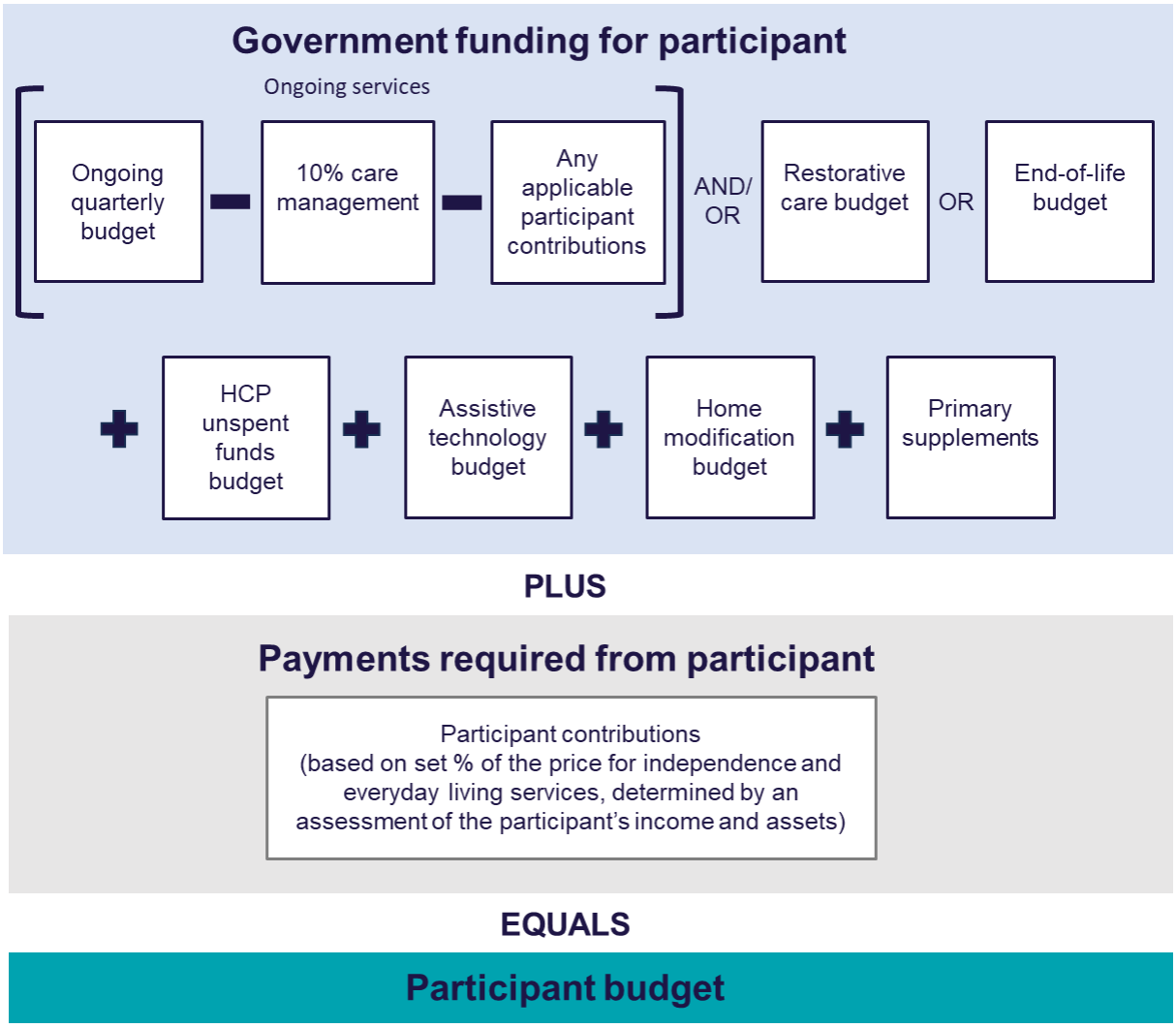
A participant's budget will be calculated from the entry date on the Aged Care Entry Record. For ongoing classifications with quarterly budgets, a participant may either enter Support at Home, or move to a higher classification, part way through the quarter. In this scenario, their budget will be calculated on a pro-rata basis from the date of entry to the last day of the quarter.

Each Support at Home participant will receive a budget made up of:

- funding from the Australian Government
- participant contributions, where applicable.

When the provider's claim for services is finalised, the total amount of the service price (consisting of a government funded amount and the participant contribution) will be debited from the participant's budget.

The diagram below outlines the **different funding components that make up the participant's budget**.



8.3 Government funding

Government funding for each participant is calculated as follows:

- funding for ongoing services
    - with 10% deducted and pooled for care management activities
    - less participant contributions, if applicable
- and/or funding for the Restorative Care Pathway or End-of-Life Pathway
- plus assistive technology (AT) and/ or home modification (HM) funding, if approved

- plus primary supplements, if applicable
- plus any HCP unspent funds, if applicable.

The table below provides a breakdown of the **different types of government funding available** under the Support at Home program.

Funding type	Description	Additional notes
Ongoing services or the Restorative Care Pathway or the End-of-Life Pathway	Funding provided for ongoing services or the Restorative Care Pathway or End-of-Life Pathway. Funding amounts are based on the ongoing or short-term classification the participant has been assigned (less any participant contributions).	Classifications are outlined in the Schedule of Subsidies and Supplements for Aged Care. For ongoing services, the quarterly budget will also include any unspent budget that has been carried over from the previous quarter.
Assistive technology and/or Home modifications	Participants approved for assistive technology and/or home modifications can access AT-HM funding to cover the cost of these specific supports.	Funding is based on the AT-HM funding tiers. Assistive technology and home modifications will have separate budgets and accounts so providers can easily manage funding across both service types.
Care management	10% of the participant's ongoing budget is allocated to the provider's care management account and can only be used for care management services.	The 10% deducted for care management, for each participant, will be pooled together and used by the provider to deliver care management services to all participants within a service delivery branch.
Primary supplements	Supplements available are: • oxygen • enteral feeding • Veterans. The dementia and cognition supplement will continue to	More information on primary supplements is in section 8.3.2.

Funding type	Description	Additional notes
	be available for grandfathered HCP care recipients who were receiving the supplement on 30 June 2025.	
Unspent Home Care Package (HCP) funds	Participants who were receiving a Home Care Package and had unspent funds as of 30 June 2025 will retain their unspent funds for use in their Support at Home quarterly budget.	Participants can use unspent funds to: • Pay for approved services once their quarterly budget has been fully exhausted • purchase approved AT-HM to meet assessed need. More information is in section 8.3.1.

8.3.1 Transitioned HCP recipients and HCP unspent funds

Transitioned HCP recipients who had unspent funds as of 30 June 2025 retained these funds for use under Support at Home.

HCP unspent funds may be divided into:

- provider-held participant portion HCP unspent funds
- Commonwealth portion HCP unspent funds (which may be held by the Commonwealth, the provider or both).

Providers can choose how to manage provider-held participant portion HCP unspent funds, including returning the unspent funds to the participant.

Participants can use Commonwealth portion unspent HCP funds to:

- pay for approved services once their quarterly budget has been fully exhausted
- purchase AT and/or HM to meet assessed need.

Where a transitioned HCP recipient has been re-assessed under Support at Home and receives approved AT-HM funding, unspent HCP funds must be used on assistive technology and home modifications before the provider can claim against their AT and/or HM funding account.

Where a transitioned HCP recipient has not undergone a re-assessment and does not have an approved AT and / or HM funding tier, HCP unspent funds can still be used to purchase equipment, products and home modifications from the AT-HM list. However, providers must document and justify the need and reasoning for the purchase and retain all evidence to support the claim.

More information on AT-HM is in chapter 12.0.

8.3.2 Primary supplements

For eligible participants, providers can also claim for supplements that will be included in the participant's budget. These are called primary supplements. Supplements are designed to help cover the costs associated with specialised care.

Providers can claim supplements for eligible participants on any Support at Home classification. Once an application form is completed, the form and supporting evidence should be uploaded to Services Australia's Aged Care Provider Portal. Providers should keep copies of all supplement forms and supporting evidence in the participant's records. If providers require assistance with this process, please contact Services Australia directly on 1800 195 206.

Once approved, primary supplements are added to the participant's budget. Although the participant will be eligible to receive oxygen and enteral feeding supports through primary supplement funding, this funding does not have to be used to provide that specific support. If funding is used to access different services or supports, it must be used in accordance with the Support at Home service list and the participant's assessed need.

The funding associated with primary supplements for Support at Home is outlined in the Schedule of Subsidies and Supplements for Aged Care.

The table below outlines the **primary supplements available** and any administration requirements. More information about each primary supplement is available at each link.

Supplement	Description	Process	Additional notes
Oxygen supplement for Aged Care	The oxygen supplement is for participants with a specified medical need for the continual administration of oxygen.	The provider is responsible for completing and lodging the application form with Services Australia. Once approved, the supplement is paid	Should the participant change providers, the supplement will automatically continue to be paid into the participant's budget.

Supplement	Description	Process	Additional notes
		into the participant's budget.	
Enteral feeding supplement for aged care	The enteral feeding supplement is for participants with a specified medical need for enteral feeding.	The provider is responsible for completing and lodging the application form with Services Australia. Once approved, the supplement is paid into the participant's budget.	Should the participant change providers, the supplement will automatically continue to be paid into the participant's budget.
Veterans' supplement for aged care	The veterans' supplement provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service.	DVA determines eligibility and advises Services Australia. No action is required by the provider.	Should the participant change providers, the supplement will automatically continue to be paid into the participant's budget.
Rural and remote supplement	The rural and remote supplement is available to participants who: • receive funding for AT-HM; **and** • reside in a locality with a Modified Monash Model (MMM) of 6 or 7.	Services Australia determines eligibility based on the MMM. This will be paid into the participant's budget. No action is required by the provider.	The amount of the rural and remote supplement is 50% of the assigned assistive technology and/or home modifications funding tier.
Dementia and Cognition Supplement	The Dementia and Cognition Supplement only applies to grandfathered HCP recipients who were	If the grandfathered participant was receiving the Dementia and Cognition Supplement on 30	Should the participant change providers, the supplement will continue to be automatically

Supplement	Description	Process	Additional notes
	receiving the supplement on 30 June 2025.	June 2025, the subsidy will be managed by Services Australia and allocated to the participant's budget.	allocated to the participant's budget.

8.3.3 Care management supplement

The care management supplement is available to providers delivering services to participants who are:

- older Aboriginal and Torres Strait Islander people
- homeless or at risk of homelessness
- care leavers
- veterans who are approved for the Veteran's Supplement for aged care
- referred from the care finder program for an aged care assessment.

Participants eligible for the supplement will be identified by Services Australia based on their aged care assessment. The care management supplement is allocated to the provider's care management account.

Should the participant change providers, the supplement will automatically be paid into the commencing provider's care management account from the month following commencement.

More information on the care management supplement is in section 7.8.1.

8.3.4 Fee reduction supplement

The fee reduction supplement offers financial assistance to participants experiencing financial hardship who cannot pay their Support at Home contributions due to their financial circumstances. Service providers will not be required to collect fees while a participant's hardship application is being assessed. If approved, the government will pay for some or all of their aged care fees.

To apply, a participant (or their nominee) must submit the Aged Care Claim for financial hardship assistance form (SA462) to Services Australia. They will assess against eligibility requirements, including the participant's realisable assets, whether they have had a means assessment for their aged care costs, and if the participant has less than 15% of the single basic age pension amount remaining after paying all essential expenses, including home care fees. If approved, the fee reduction

supplement is paid to the provider. This may waive all or some of the participant contribution.

Providers should check what assistance a financially disadvantaged participant may require in completing the SA462 form and supplying all required documentation to Services Australia. If the provider is unable to assist the participant, they should refer them on to a financial counsellor or the Aged Care Advocacy Line on 1800 700 600.

As this supplement is time limited, if the participant is transferring providers, the new provider should confirm the validity period of the fee reduction supplement.

Note: This supplement was previously known as the hardship supplement for aged care.

8.4 Participant contributions

Participant contributions are paid by participants and based on an assessment by Services Australia of their income and assets.

Contributions will be different for each participant and will be based on:

1. The type of service the participant received:
   - **clinical supports -** no contribution for services. Clinical care is fully funded by the government for all participants.
   - **independence -** moderate contributions for services. This recognises that many of these supports play an important role in keeping participants out of hospital and residential aged care.
   - **everyday living -** highest contributions for services. This recognises that the government does not typically fund these services for any individual at other stages of life.

2. The outcome of a participant's income and assets assessment, as well as their pension status:
   - full pensioner
   - part-pensioner
   - self-funded retiree and Commonwealth Seniors Health Card (CSHC) holder
   - self-funded retiree and non-CSHC holder

Note: The pension includes the Age Pension and any other income support payment.

If a person does not provide their income and assets information to Services Australia, they are a 'means not disclosed' participant, and their contributions are set are the maximum level.

Providers must support participants to understand their participant contributions.

The table below outlines the **indicative participant contribution rates**.

Actual contribution rates are determined by Services Australia through an assessment of the participant's income and assets. For full and part pensioners this will be based on information already provided for their pension assessment.

Income and assets assessment outcome	Service category – clinical supports	Service category – independence	Service category – everyday living
Full pensioner	0%	5%	17.5%
Part pensioner and self-funded CHSC holder	0%	Between 5% and 50%*	Between 17.5% and 80%*
Self-funded non-CSHC holder and means not disclosed^	0%	50%	80%

* Contributions will be applied on a tapered rate based on the participant's income and assets assessment.

^ A self-funded non-CSHC holder is an individual who is ineligible for the pension and the CSHC. A means not disclosed status refers to an individual who has not disclosed their assets and income.

Note:

1. Care management will have a clinical supports contribution rate of 0%.
2. Contributions for AT-HM items will be treated as equivalent to the independence category. However, AT-HM prescription and wrap around services (where required) will have a clinical supports contribution rate of 0%.

   More information is in section 12.7.

8.4.1 Grandfathering arrangements and participant contributions

For participant contributions, a no worse off principle applies for grandfathered HCP recipients who, on 12 September 2024, were either receiving a Home Care Package, on the National Priority System, or assessed as eligible for a package.

These participants will make the same contributions, or lower, than they would have had under HCP program arrangements, even if they are re-assessed into a higher Support at Home classification at a later date.

Grandfathered participant contribution arrangements include:

- previous HCP recipients who were not required by Services Australia to pay an income-tested care fee will continue to make no contributions for the remainder of their time in Support at Home. This group includes all grandfathered full rate pensioners.
- previous HCP recipients who, based on the outcome of their income test were required to pay an income-tested care fee, will transition to Support at Home with discounted contribution arrangements.

Services Australia will notify these participants and their provider of the grandfathered contribution amount payable. Grandfathered participant contribution arrangements also include maintaining the current lifetime cap.

8.4.2 Case study

John

Grandfathered, full pensioner

John is a grandfathered HCP recipient and full pensioner. He will <u>not pay</u> participant contributions under Support at Home.

John is a full pensioner and was previously receiving a HCP Level 3 package. This meant he paid **no income tested care fees** for his care under the HCP Program.

Since transitioning to Support at Home on 1 July 2025, he has continued to pay **no participant contributions** (or income tested care fees) and receives the **same level of funding** and this is managed through his care plan and quarterly budget allocation.

John **will never pay participant contributions** under Support at Home, even if he is reassessed to a higher Support at Home classification.

8.4.3 Lifetime participant contribution limits

There are lifetime caps that apply to participant contributions. The current caps are outlined in the Schedule of Fees and Charges for Residential and Home Care.

Participants who have reached a lifetime cap of $130,000 in individual contributions across Support at Home and the non-clinical care component of their contribution to

residential care, will not pay further individual contributions under Support at Home once this lifetime cap is reached.

Services Australia will notify the provider and the participant once the lifetime cap has been reached. The Government will pay the remaining participant contributions to the provider by way of increased government funding for the Support at Home classification.

8.5 Assessment of income and assets for participant contributions

To determine participant contributions for the Support at Home program, participants must have their income and assets assessed by Services Australia.

For full and part pensioners, Services Australia will use the information on a person's income and assets that has been provided for their pension assessment to determine their Support at Home contributions.

Non-pensioners, once approved for Support at Home, will need to complete an income and assets assessment if Services Australia does not already have their current financial details.

Participants must notify Services Australia within 14 days of any changes in their financial status that may impact their contribution.

Completing an income and assets assessment is not mandatory, however participants who choose not to complete one can be asked to pay the maximum participant contribution rate.

Providers must support participants to understand fees and their income and assets assessment. This may include providing information about the consequences of not disclosing their income and/or assets, how to request a review of the assessment decision by Services Australia, or how to apply for a fee reduction supplement through Services Australia.

If required, a participant can authorise a person or organisation to be a nominee and act on their behalf with Services Australia.

More information is on Services Australia's website at Authorising a person or organisation to enquire or act on your behalf form (SS313).

8.5.1 Notification of participant contributions

Services Australia will notify Support at Home participants of their contribution rate. This will occur regardless of whether the participant completed an income and assets assessment or if their pension information was used.

A participant can begin to receive services prior to their income and assets assessment being finalised. Services Australia assumes no participant contributions are payable and will pay the full monthly claim entitlement until the participant's assessment has been finalised or the participant is assigned a 'means not disclosed' status.

Once the income and assets assessment is finalised, Services Australia will apply the correct participant contribution rate and backdate this to the date the participant entered Support at Home (the date on the Aged Care Entry Record form).

To manage financial risk for new participants, participants can complete an income and assets assessment prior to signing a service agreement with a provider. In this case, the participant will receive a letter from Services Australia outlining their participant contribution rates. This letter is valid for 120 days. Unless there are significant changes in the person's income and/or assets that mean a reassessment is required, providers can use this letter as notification of the contribution rate.

Participants and providers can agree to make payments where the participant has not yet received their initial advice on their contribution rate. If a participant and provider agree that the participant will make payments before determination of their contribution rate, then:

- if a participant paid contributions fees less than what they were required to pay, this will result in a government overpayment to the provider. Services Australia will deduct the overpayment from the next payment to the provider. The provider should then recover the additional required contributions from the participant.
- if a participant paid contribution fees in excess of what they were required to pay, the provider must repay these to the participant.

Pensioners should not be impacted while awaiting an income and assets assessment, as their financial information reported for the age pension is automatically matched by Services Australia for their Support at Home assessment.

Note: If a participant is unable to pay their contributions due to financial hardship, they can apply for fee reduction supplement with Services Australia.

If a participant is assigned a 'means not disclosed' status, Services Australia assumes the highest participant contribution rates are payable. If a participant has not completed an income and assets assessment, this may result in the participant needing to pay more than required.

8.5.2 Adjustments to participant contributions

The table below outlines the **potential reasons for an adjustment** and the action required.

Reason for adjustment	Action required
Delayed income and assets assessment for new participants	If a commencing participant is paying a contribution and receives a delayed income and assets assessment which determines they should have been paying a different rate, the new rate will be backdated to the date the participant started receiving Support at Home services. This information is subject to finalisation of the Rules.
Change to pension thresholds	Changes in contributions due to changes in pension thresholds will flow through automatically. If the change means that the participant is re-assessed as needing to make a higher contribution, this will be applied at the beginning of the following quarter. If the change means that the participant is re-assessed as needing to make a lower contribution, this will be backdated, the provider paid the difference, and the provider must then refund the difference to the participant, once the participant contributions are finalised.

Change in financial status	Participants must notify Services Australia within 14 days of any changes in their financial status that may impact their contribution. It is the responsibility of the participant to update Services Australia of any changes. If the change means that the participant is re-assessed as needing to make a higher contribution, this will be applied at the beginning of the following quarter. If the change means that the participant is re-assessed as needing to make a lower contribution, this will be backdated, the provider paid the difference, and the provider must then refund the difference to the participant, once the participant contributions are finalised

At times, Services Australia will review participant contributions and may determine that a refund is required. If the participant has already left Support at Home and their exit balances have been finalised, the following applies:

- if the participant has changed to another provider, the previous provider will need to transfer the refunded contributions to the new provider
- if the participant has entered residential aged care or passed away, then the contribution will need to be refunded to the participant or their estate.

8.6 Collection of participant contributions

The collection and payment of participant contributions must be outlined in the participant's service agreement. Providers are responsible for establishing and managing processes for collecting contributions. The collection of contributions can be flexible and these may occur weekly, fortnightly or monthly, or at any other time as agreed with the participant.

Unless a full fee reduction supplement is in place, providers must collect participant contributions. Providers are encouraged to offer flexible options for the collection of contributions.

Note: The fee reduction supplement can only be approved through submission of the Aged Care Claim for financial hardship assistance form (SA462) to Services Australia.

There are lifetime caps that apply to participant contributions. Once the lifetime cap is reached, the participant will make no further contributions to their Support at Home services and the government will fund 100% of the person's Support at Home costs.

Services Australia will notify the provider and the participant once the lifetime cap has been reached.

More information is in section 8.4.3.

8.6.1 Case study

Annette

New participant, part pensioner

Annette is a new Support at Home participant. As a part pensioner, she makes contributions to her independence and everyday living services. Her provider collects her contributions.

Annette needs some help to keep living at home safely and independently. She was assessed and allocated a Classification 3 under Support at Home.

As a **part pensioner**, she contributes to the cost of her independence and everyday living Support at Home services.

Annette does **no**t pay for any clinical services that she accesses. However, based on her individual circumstances, including her pension status as a member of a couple and non-homeowner with a higher value of income than assets, her individually assessed contribution rate is **22%** for independence services and **41%** for everyday living services.

At the end of each month, Annette receives a monthly statement and a separate invoice from her provider. The invoice outlines the contributions she needs to pay for the services she has received. Annette calls her provider and makes the required payment over the phone.

8.6.2 Non-payment of participant contributions

Providers have a responsibility to communicate and consult with participants in relation to their participant contributions. Where a participant refuses to pay their contributions and does not have financial hardship provisions in place, providers must set up a discussion with the participant and/or their supporter to clearly inform participants of:

- their responsibilities
- the reasons for the collection of the participant contribution
- the possible outcomes if contributions are not paid.

Providers must comply with requirements related to the continuity of care for participants under section 149 of the Act.

Providers must make every effort to resolve payment issues with the participant (or their supporter). Providers must document all conversations with the participant and/or their supporter regarding non-payment of participant contributions.

More information on continuity of care requirements is in section 3.6.

8.7 Development and management of the budget

Providers must work in partnership with the participant and/or their supporter to develop an individualised budget. This needs to be completed alongside the development of the care plan. The budget must outline how the funding for the participant's ongoing and/or short-term services will be spent in relation to the types and frequency of services outlined in their care plan.

It is essential that participant's and/or supporters be assisted to understand the individualised budget.

The table below outlines the **requirements to be included in each budget** for Support at Home.

Source	Description
Funding	• The amount of funding from the Australian Government, including supplements, for ongoing classifications, the Restorative Care Pathway or the End-of-Life Pathway. • The amount of funding for the relevant AT-HM funding tier.
Cost	• The cost of each service. • The cost of any assistive technology product, repairs or maintenance service, and/or home modification. • The cost of any AT-HM prescription service or wrap-around service. • The cost of any administrative activities for assistive technology. • The cost of any coordination activities for home modifications.

Source	Description
Description	• A description of any assistive technology products, equipment repairs or maintenance services, and/or home modification supplies or services. • A description of any wrap around services for assistive technology and/or home modifications.

Contribution	• The contributions expected to be paid by the participant, for the period, including:
	  ○ the contribution rate for each service
	  ○ the contribution rate for each assistive technology product and/or home modification

Budget planning is an important process to ensure that the government funded aged care services the participant receives can be delivered within their funding allocation.

As previously outlined in section 8.2, if a participant requires services over and above the budget allocation, the provider and participant can enter into a private agreement for the purchase of additional services. Additional services are not funded by the government. Any private agreement for the participant to purchase additional services must be outlined in their service agreement and should also be documented in the care plan and budget.

In consultation with the participant, the budget should be regularly reviewed at the same time as any care plan review, to ensure that services and supports are being delivered within the funding allocation and that the budgeted services continue to meet the participant's evolving needs. In addition, the budget must be reviewed if the costs of providing services change or the participant requests a review.

8.7.1 Carryover of unspent quarterly budget

Providers should work in collaboration with participants to ensure they can benefit from the full use of their quarterly budget. However, in some cases and for varying reasons, a participant may not fully utilise their quarterly budget.

Unspent budget occurs when a participant has not fully utilised the government funding available to them within the quarterly period. Carryover of budget helps to address unplanned or emerging needs so providers can respond promptly to a participant's change in circumstances.

The carryover of unspent budget only applies for ongoing services. Funding for AT-HM is valid for 12 months (extensions may apply) and funding for the Restorative Care Pathway and the End-of-Life Pathway are valid for the duration of the episode.

When a participant has unspent budget at the end of a quarter, the funds will automatically carryover (in their home support account) to the next quarterly budget period. The rollover amount is the higher of:

- a capped amount of $1,000, or
- 10% of their quarterly budget (inclusive of supplements).

This means that the maximum amount available for a participant per quarter is their quarterly budget plus $1,000 or 10% from their previous quarterly budget.

Services Australia will calculate the balance of unspent budget to be carried over. This calculation occurs either 61 days after the last day of the previous quarter or the day after the provider submits their final claim for that quarter, whichever is sooner.

Once the carryover amount is confirmed, it is added to the participant's quarterly budget in their home support account and can be used to access services in accordance with the participant's assessed needs.

8.7.2 Case study

Larry

Carryover of unspent budget

As a Support at Home participant with a Classification 2, Larry will carryover his unused budget for use in the next quarter.

Larry was allocated a Support at Home Classification 2 with a quarterly budget of $4,170. After 10% ($417) is set aside for care management, Larry has $3,753 to spend on services for the quarter. In **Quarter 1**, he spent $2,000, leaving $1,753 in his budget. The amount he can carryover is $1,000 as this is higher than 10% of his quarterly budget.

In **Quarter 2**, Larry carried over $1,000 (from Quarter 1), which increases his nominal budget to $4,753 ($3,753 + $1,000). At the end of this quarter, Larry has $753 left in his budget which he is able to fully carryover as it is greater than the 10% of his base budget ($417), but lower than $1000.

In **Quarter 3**, Larry has a nominal budget of $4506 ($3753 + $753).

8.7.3 Overspend of quarterly funds

An overspend of quarterly funds occurs when a provider delivers services that exceed the participant's quarterly budget allocation. This should not occur and the care partner, in partnership with the participant, should manage the budget closely, ensuring sufficient funding is available to cover all scheduled services.

Note: While the care partner and participant should work collaboratively to manage the budget, it is the responsibility of the provider to ensure overspends do not occur.

A participant's home support account cannot go into a negative balance and Services Australia cannot reimburse providers for claims if the participant's budget has insufficient funds.

When funding is insufficient to meet all services being claimed, the excess services should either be:

- paid for directly by the participant, only if this arrangement has previously been agreed in the participant's service agreement, or
- written off by the provider.

Providers must ensure accuracy in claims and include all costs associated with services delivered within the relevant period. This includes not holding over claims for services delivered even if the budget has been exceeded.

For example:

Larry's quarterly budget for January to March is $4,170. The provider claims each month for services delivered in the previous month.

The provider claimed $1450 for services delivered in January and $1,420 for services delivered in February.

In March, services delivered totalled $1,410. The provider realises that there are insufficient funds in Larry's budget to cover this claim as his remaining quarterly budget is only $1,300.

Despite exceeding the budget, the provider submits the full claim for March of $1,410 and absorbs the shortfall of $110.

The provider and Larry review his care plan and quarterly budget to determine why the budget was exceeded. Together, they decide to adjust Larry's services by moving his Saturday nursing service to Friday. Because the weekend nursing rate is greater than the weekday nursing rate, this change results in Larry's quarterly budget coming back into surplus.

Note:

- Despite insufficient funds, the provider must submit the full claim for all services delivered in March.
- The provider cannot hold over $110 worth of services and claim this in April when Larry's new quarterly budget is allocated.

8.7.4 Budget for interim funding

To ensure people are not waiting any longer than necessary without access to care, participants can be assigned interim funding. Interim funding is an allocation of 60% of the total funding for their classification.

Providers will need to discuss the interim funding allocation with the participant and develop a quarterly budget that aligns with the interim funding and the participant's approved services.

When funding becomes available, the participant will be allocated the remaining 40% of their funding for the approved classification. The remaining 40% of the budget is not backdated to the assigned interim funding date.

When the full funding has been allocated, providers should review the participant's quarterly budget and care plan to include additional services.

Note: For all claims, including for interim funding, providers must ensure accuracy and include all costs associated with services delivered within the relevant period. This includes not holding over claims.

More information on interim funding is in section 6.8.1.

8.7.5 Management of HCP unspent funds

Services Australia will continue to manage HCP Commonwealth unspent funds for transitioned HCP recipients.

Where a participant has HCP Commonwealth unspent funds, these funds can be used to top up the quarterly or short-term budget and pay for assistive technology and/or home modifications.

Claiming rules apply and these are detailed in section 15.4.5 however:

- when the funds in the quarterly budget, restorative care budget or end-of-life budget are exhausted, providers can claim from a participant's HCP Commonwealth unspent funds, if available
- For assistive technology and/or home modifications, HCP Commonwealth unspent funds must be used, if available, **before** AT-HM funding tiers are accessed.

8.7.6 Case study

Hiroshi

HCP unspent funds and AT-HM

Hiroshi is a transitioned HCP recipient with HCP unspent funds. Following a re-assessment, Hiroshi has been assessed as needing assistive technology supports.

Hiroshi transitioned from the Home Care Packages (HCP) Program to Support at Home on 1 July 2025. He is a full pensioner and received an equivalent level of funding as per his previous HCP package and also retained his HCP unspent funds of $303.

Hiroshi has recently experienced a progressive worsening of his osteoarthritis and now requires greater assistance at home. Due to a change in circumstances, his care partner recommends he undergoes a Support Plan Review (SPR) to determine his eligibility for a higher classification. With Hiroshi's consent, a SPR is submitted, and it's determined that he would benefit from a re-assessment.

Hiroshi's aged care assessment is completed, he receives a Notice of Decision outlining that he is eligible to receive a Classification 5 with approved services for physiotherapy, occupational therapy and assistive technology funding of $500 (low tier). This provides Hiroshi with a higher level of care and supports to maximise his independence at home.

Once funding is allocated, Hiroshi meets with an occupational therapist to discuss his joint pain and how this causes difficulties with daily activities such as dressing. The occupational therapist recommends that Hiroshi start using assistive products for putting on and removing shoes, socks and clothing. Hiroshi agrees and talks to his care partner about ordering the products.

The products are ordered and delivered to Hiroshi and the occupational therapist ensures that Hiroshi can use the products correctly.

A summary of Hiroshi's services and supports for the period are:

- 1.5 hours of occupational therapy at $180 per hour
    - 1 hour for the initial consultation with Hiroshi
    - 0.5 hour follow up to ensure Hiroshi can use the products correctly

HCP unspent funds and AT-HM

- assistive products at a total of $201
- 0.75 hours of care management for the care partner to chat with Hiroshi.

At the end of the month, the provider claims for all services and consumables delivered to Hiroshi for the period. This includes occupational therapy services, the assistive technology products and care management (for his ongoing services). In submitting the claim, the provider:

- claims 0.75 hours of care management (ongoing services) from the provider's **Care Management Account**
- claims the assistive technology products ($201) from Hiroshi's **HCP Commonwealth unspent funds** account
- claims 0.5 hours of AT-HM related occupational therapy services ($90) from Hiroshi's **HCP Commonwealth unspent funds** account
- as only $12 remain in Hiroshi's HCP unspent funds, the remaining 1.0 hours of AT-HM related occupational therapy services ($180) is claimed from Hiroshi's **Assistive Technology budget** account.

As Hiroshi has $303 in HCP unspent funds, the provider must claim from this funding before claiming from Hiroshi's newly assigned AT funding.

After claiming, Hiroshi's:

- **HCP Commonwealth unspent funds** account has a balance of $12.
- **Assistive Technology budget** has a balance of $320. These amounts are displayed on Hiroshi's monthly statement.

For participant contributions, assistive technology products have a contribution rate equivalent to the independence category, or 5% for a full pensioner. However, Hiroshi is a grandfathered HCP recipient and, even though he has been re-assessed into a higher Support at Home classification, he does not need to make a participant contribution. Under the no worse off principle, Hiroshi will never be required to make a contribution for the services he receives.

More information on claiming is in chapter 15.0.

More information on participant contribution rates is in section 8.4.

9.0 Service list and delivering services

This chapter covers:

9.1 Overview
9.2 Support at Home service list
9.3 Provider set prices and prices charged
9.4 Capped prices
9.5 Confirmation of service delivery
9.6 Third-party service delivery
9.7 Managing complaints
9.8 Elder abuse

Provider responsibilities

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

The Aged Care Act 2024:

- Section 8

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

When **delivering services**, providers must comply with the strengthened Quality Standards, including:

- Standard 1: The Individual
- Standard 2: The Organisation
- Standard 3: The Care and services
- Standard 4: The Environment
- Standard 5: Clinical care (if the provider is registered to deliver nursing).

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

- The service list applies to all ongoing and short-term classifications.
- The service list has 3 categories (clinical supports, independence and everyday living), each with their own service types, services and participant contribution arrangements.
- The services a participant is eligible to receive are based on their assessed needs and outlined in their Notice of Decision and support plan. Providers must deliver services in accordance with the participant's assessed needs.
- Providers must not charge more for any services or supports other than an amount agreed with the participant.
- If providers are engaging third-parties to deliver services, the provider remains responsible for ensuring services are delivered in a way that meets the requirements of the Act and the strengthened Quality Standards.

9.1 Overview

This chapter outlines the Support at Home service list and provides key information and guidance relating to service delivery including pricing, confirmation of service delivery and delivery of services by third-parties.

For ongoing classifications, the Restorative Care Pathway and the End-of-Life Pathway, funded aged care services are grouped into three categories:

- **clinical supports** – such as nursing care, occupational therapy and physiotherapy
- **independence** – such as personal care, social support, respite care and community engagement and transport
- **everyday living** – such as domestic assistance, home maintenance and repairs and meals.

For services, equipment and supports related to assistive technology and home modifications, refer to chapter 12.0.

9.2 Support at Home service list

The Support at Home program has a defined service list which outlines what services are available to participants and what services are out of scope of the program. The service list is to be used for ongoing Support at Home services, the Restorative Care Pathway and the End-of-Life Pathway. Participants can only access government funded services from the Support at Home service list.

Note: Some services (e.g., hoarding and squalor) can only be accessed through the Commonwealth Home Support Programme (CHSP). For additional services and supports, separate to the Support at Home service list, refer to Part F: Program linkages.

Participants will not be automatically eligible for all services on the list. The services a participant is eligible for will be based on their assessed needs and outlined in their Notice of Decision and support plan. A provider can support the participant to choose the mix of services they need based on what has been approved however, a provider must only deliver services in accordance with the participant's assessed needs.

Support at Home services must be delivered in a home or community setting and providers can only deliver service types that are in the provider's registration category.

The table below is an extract of the Support at Home service list and outlines **the government-funded services available to participants**.

For the full service list with participant contribution arrangements and guidance on in-scope and out-of-scope activities, refer to Appendix 2.

Service type	Services
Clinical supports *Specialised services to maintain or regain functional and/or cognitive capabilities. Services must be delivered directly[1], or be supervised, by university qualified or accredited health professionals trained in the use of evidence-based prevention, diagnosis, treatment and management practices to deliver safe and quality care to older people.*	
Nursing care	Registered nurse[2]
	Enrolled nurse[2]
	Nursing assistant[2]
	Nursing care consumables[3]
Allied health and other therapeutic services	Aboriginal and Torres Strait Islander health practitioner
	Aboriginal and Torres Strait Islander health worker
	Allied health assistance
	Counselling or psychotherapy
	Diet or nutrition
	Exercise physiology
	Music therapy
	Occupational therapy
	Physiotherapy
	Podiatry
	Psychology
	Social work
	Speech pathology
Nutrition	Prescribed oral or enteral nutrition[4]
Care management	Home support care management

Service type	Services
Restorative care management	Home support restorative care management
Independence *Support delivered to older people to help them manage activities of daily living and the loss of skills required to live independently.*	
Personal care	Assistance with self-care and activities of daily living
	Assistance with the self-administration of medication
	Continence management (non-clinical)
Social support and community engagement	Group social support
	Individual social support
	Accompanied activities
	Cultural support
	Digital education and support
	Assistance to maintain personal affairs[5]
	Expenses to maintain personal affairs[6]
Therapeutic services for independent living	Acupuncture
	Chiropractic
	Diversional therapy
	Remedial massage
	Art therapy
	Osteopathy
Respite	Flexible respite
	Community and centre-based respite
Transport	Direct transport (driver and car provided)
	Indirect transport (taxi or rideshare service vouchers)
	Assistive technology[7]

Service type	Services
Assistive technology and home modifications	Home modifications[7]
Everyday living *Support to assist older people to keep their home in a liveable state in order to enable them to stay independent in their homes.*	
Domestic assistance	General house cleaning
	Laundry services
	Shopping assistance
Home maintenance and repairs	Gardening
	Assistance with home maintenance and repairs
	Expenses for home maintenance and repairs[8]
Meals	Meal preparation
	Meal delivery
Note: [1] 'Delivered directly' refers to a university qualified health professional delivering the services themselves. This is distinct from 'supervised' where they may be supervising another person. Clinical supports may be delivered via telehealth. [2] The hourly price of registered nurse, enrolled nurse and/or nursing assistant includes the cost of everyday nursing consumables that nurses are expected to carry (for example bandages, antiseptics). [3] The nursing consumables service enables reimbursement for specialised nursing products (e.g., prescribed skin emollients for management of skin integrity, oxygen consumables) that are specific to an individual participant and that a nurse would not be expected to carry as an everyday consumable. Everyday nursing consumables that are expected to be carried (e.g., bandages, antiseptics) must be included in the price for nursing. [4] The prescribed nutrition service provides reimbursement for prescribed supplementary dietary products (enteral and oral) and aids required to treat impairments or functional decline. This can include prescribed nutritional supplements purchased from a pharmacy.	

Service type	Services
[5] Assistance to maintain personal affairs refers to the hourly rate for a person to support a participant with managing their personal affairs. [6] Expenses to maintain personal affairs covers payment of internet and/or phone bills where the participant is at risk of, or is homeless, and support is needed to maintain connection to services. [7] Information for assistive technology and home modifications for the AT-HM Scheme is in chapter 12.0. [8] Expenses for home maintenance and repairs covers products that may need to be purchased while receiving services under the 'home maintenance and repairs' service type. For example, the expense of a new door handle or tap.	

9.2.1 Transitioned HCP recipient and the service list

Providers must complete a new service agreement with transitioned HCP recipients that aligns to the Support at Home program including the service list.

Transitioned HCP recipients, who have not been reassessed under Support at Home, are eligible to access any service on the Support at Home service list provided it meets the participant's needs. This is subject to the department's ability to ascertain what services the participant needs in line with the requirements of the new Act.

If a reassessment occurs, participants will receive a Notice of Decision and support plan outlining the approved Support at Home services they are eligible to receive.

9.3 Provider set prices and prices charged

The government is staging the introduction of price caps on services for the Support at Home program. From 1 July 2026, government set price caps will apply.

From 1 July 2025, for the first year of the program, Support at Home providers will set their own prices for Support at Home services. Prices must be reasonable.

The price for each service represents the entirety of the revenue that Support at Home providers will receive for delivering that service. Providers will not be able to charge participants separate administration fees, travel fees, or claim for these expenses under care management activities. All costs to deliver the service must be included in the unit price.

Providers will need to publish their prices, for all the services they deliver, on the My Aged Care Service and Support Portal.

The department will provide pricing guidance to assist Providers and will monitor prices charged in the first year of the Support at Home program to ensure prices are reasonable and are value for money.

To ensure transparency, accountability and participant satisfaction under Support at Home, providers must document the price of services (including the agreed price) in the participant's service agreement.

9.3.1 Agreed price

An important responsibility of a provider is to charge prices that are value for money and to charge no more for any care or service other than the amount agreed with the participant. This should be documented with the participant in their service agreement before the commencement of care and services.

A service agreement must contain prices for all services to be delivered to the participant (these prices can be listed in the pricing schedule or otherwise specified). It must also outline the process for obtaining agreement from the participant when a price variation is required and/or when a service price cannot be established before signing the service agreement.

Information about service agreements and what must be included is in section 6.10.

Providers must publish their service prices on the My Aged Care Service and Support Portal. Prices must include a maximum rate per hour/unit for common services and must specify the scope and duration of services. Providers can also attach their pricing schedule. This pricing information is available to older people on the My Aged Care website through the Find a provider tool.

In most cases, the provider should charge the participant the published price. In some cases, a provider may need to negotiate a different price. This could be because the participant has a particular request or need. In these instances, the provider must:

- negotiate and agree on the price with the participant
- outline the difference in price and why it is different in the service agreement and individualised budget
- include the pricing schedule as published in the service agreement.

Where there are changes to the price for regular services, this must also be agreed and documented between the provider and participant. This may be recorded or acknowledged:

- in a new, signed and dated service agreement, or
- in an updated pricing schedule and/or budget, signed and dated by the participant or supporter (note these form part of the service agreement), or
- by electronic signature or a file note record or email of a participant's (or participant's supporter) agreement to the change(s) where the participant is

unable to physically sign the updated service agreement, pricing schedule and/or budget.

Note: A supporter can only sign or agree to changes if they are communicating the decision of the participant (i.e., signing at the direction of the participant if the participant cannot sign) or if the supporter is exercising substitute decision-making powers.

If a participant has agreed to a price for a service that is different to the provider's pricing schedule recorded in a participant's service agreement, this agreement, and the reasons for the different agreed price, must be documented.

Agreement to prices of ad-hoc services that are not listed in the service agreement (but the participant has been approved to receive) must be documented or acknowledged:

- by digital signature, or
- by email correspondence, or
- in a file note record of verbal agreement.

Where it is not feasible to obtain prices before delivery of a service (i.e. for transport services such as taxis or rideshare), a provider must discuss this with the participant and ensure there is appropriate management of the participant's budget so an overspend does not occur.

More information on agreed price and setting prices will be available on the department's website prior to 1 July 2025.

Information on the process for agreement of prices for AT-HM services is in section 12.6.1.

9.4 Capped prices

From 1 July 2026, services and activities in the service list will have a capped price. Price caps will be set by government under advice from the Independent Health and Aged Care Pricing Authority (IHACPA).

A capped price means a provider can charge up to or equal to the nominated amount for that service but cannot charge a price that exceeds the capped price. Providers cannot charge additional fees on top of this capped price.

The price for each service represents the entirety of the revenue that Support at Home providers will receive for delivering that service. Providers will not be able to charge participants separate administration fees, travel fees, or charge these expenses to the care management account.

9.5 Confirmation of service delivery

To ensure transparency, accountability and participant satisfaction under Support at Home, providers are required to maintain documentation that demonstrates confirmation of delivery of care and services for all participants. This includes care and services that are delivered by third-party workers and delivered to self-managed participants.

The types of acceptable evidence in respect to confirmation of delivery of care and services to the participant can include:

- Care notes or reports detailing episodes of service. This may include photos for the delivery of equipment and/or completion of services such as gardening or home maintenance, where there are no privacy concerns.
- Record of worker sign in and out (electronic or hand-written). This may include documentation such as attendance records or clock in/out data. Geolocation data that registers care worker location and service times may be featured.
- Sign in book or QR code accessed at the participant's home.

For allied health services only, an invoice may be accepted. However, even for these services, providers are encouraged to seek file notes and/or reports of individual episodes of care or at the end of the treatment period.

Information on the confirmation of delivery for AT-HM services is in section 12.6.2.

9.6 Third-party service delivery

Providers can deliver Support at Home services directly or can engage a third-party worker or organisation (associated provider) to deliver services on their behalf. This includes where a provider:

- sources and coordinates services and supports through a third-party (including subcontractors, labour hire or brokered services)
- purchases goods, equipment, and assistive technology from a third-party.

Providers may engage third-parties on an ad-hoc or ongoing basis to meet the needs of participants or their requests for specific workers. However, services delivered must be drawn from the service list. Even when an associated provider is delivering services, providers remain responsible for ensuring services are delivered in a way that meets the requirements of the Act and the strengthened Quality Standards.

Third-party arrangements should be clearly documented in the participant's care plan. The care plan should be reviewed regularly to ensure that services delivered by third parties continue to meet the assessed needs of the participant.

The provider will also need to update the provider register with information relating to the associated provider. More information on registering associated providers will be on the department's website prior to 1 July 2025.

9.7 Managing complaints and feedback

Providers must have a complaints and feedback system in place for participants, their supporters or family members, aged care workers and others to provide feedback and make complaints.

Outcome 2.6a and 2.6b of the strengthened Quality Standards requires providers to encourage and support aged care workers, older people and others to make complaints and give feedback about the providers delivery of funded aged care services. The purpose of this function should be:

- For the older person and aged care workers to feel:
    - safe, encouraged and supported to give feedback and make complaints, without reprisal.
    - engaged in processes to address feedback and complaints
    - assured that appropriate action has been taken.

- For the provider to:
    - acknowledge feedback and complaints and manage them transparently and respond in a timely manner
    - regularly seek input and feedback from older people, supporters, carers, the workforce and others
    - use the input and feedback to inform continuous improvements for participants and the whole organisation.

The complaints function must be outlined in every service agreement.

If a complaint arises, the provider must:

- use their complaints resolution mechanism to address the complaint
- use an open disclosure process
- advise the complainant of any other mechanisms that are available to address complaints, such as referring them to the Commission.

It is important that providers view complaints as an opportunity to improve and refine the service they provide by gaining insights into the needs and wants of participants. If staff are open to complaints and educated on how to manage them, complaints can be an opportunity to address minor issues before they become significant, and to build positive relationships with participants, their families, and supporters.

Information on how to design a complaints function is on the Commission's website at Better Practice Guide to Complaint Handling in Aged Care Services.

The Commission also has case studies that outline strategies providers might use to resolve complaints. More information is on the Commission's website at Make a complaint | Aged Care Quality and Safety Commission

9.8 Elder abuse

Providers have a responsibility to remain observant of any risks and report or seek advice if there are risks to the participant's health, safety and wellbeing. This includes identifying and reporting elder abuse.

Providers have a responsibility under section 16(1) of the Act to notify the Aged Care Quality and Safety Commission when a reportable incident occurs.

Providers must ensure care and services are delivered in a way that:

- is free from all forms of abuse
- ensures the participants are treated with dignity and respect.

Providers must demonstrate that they understand the rights of individuals under the Statement of Rights. The provider must have practices in place to ensure that they comply with the Statement of Rights, with subsection 24(2) of the Act and with the Serious Incident Response Scheme (see 3.4). Provider failure to demonstrate they meet these requirements may result in the Commission taking enforcement action.

The World Health Organization defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person". It can take various forms, such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect.

If providers would like to talk to someone about potential or actual elder abuse they can call the National **1800 ELDERHelp (1800 353 374)** line. This service provides information on how to get help, support and referrals to assist with potential or actual elder abuse.

Providers may have obligations in relation to elder abuse under state or territory laws in the jurisdictions in which they operate. Each state and territory provides information about abuse and abuse prevention, as well as useful contacts and options for getting help. This information is available in the table below.

More information on elder abuse is available on the Commission's website at case studies.

State or territory	Organisation or resource	Contact
Australian Capital Territory	Older Persons ACT Legal Service (OPALS)	**1800 353 374**

State or territory	Organisation or resource	Contact
New South Wales	NSW Ageing and Disability Abuse Helpline	**1800 628 221**
Northern Territory	Older Person Abuse Prevention	**1800 037 072**
Queensland	Elder Abuse Prevention Unit	**1300 651 192**
South Australia	Adult Safeguarding Unit	**1800 372 310**
Tasmania	Elder Abuse Tasmania	**1800 441 169**
Victoria	Seniors Rights Victoria	**1300 368 821**
Western Australia	Advocare Elder Abuse Helpline	**1300 724 679**

10.0 Self-management

This chapter covers:

10.1 Overview of self-management
10.2 Scope of self-management
10.3 Care management activities for self-management
10.4 Using third-party workers
10.5 Obligations when using third parties

Provider responsibilities

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

The Aged Care Act 2024:

- Sections 20, 23 and 25

For **self-management**, providers must comply with the strengthened Quality Standards, including:

- Standard 1: The Individual
- Standard 2: The Organisation
- Standard 3: The Care and Services
- Standard 4: The Environment
- Standard 5: Clinical Care

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

- Self-management involves the participant leading and making key arrangements about their Support at Home services. This can involve different activities depending on the participant's needs, preferences and abilities.
- Care management activities are required to be delivered under a self-management approach to enable the provider to have oversight of quality, safety, governance and compliance requirements.
- Participants receiving ongoing services will have 10% of their quarterly budget deducted for their provider to undertake care management activities.
- Participants who self-manage are required to have a care plan developed in collaboration with the care partner.

Key points to remember

- Care partners must provide transparent information about the budget and spending parameters so participants can exercise flexibility and choice in making decisions.
- Under a self-management approach, participants may have the option to select their own aged care workers to meet their care needs and goals (including third-party workers).
- Providers who can support using third-parties as part of self-management should have a model in place outlining organisational requirements and arrangements.
- Third-party arrangements need to be agreed between the participant and the provider.

10.1 Overview

This chapter outlines self-management and how providers and participants can work together to maximise a participant's choice and independence.

Self-management is an important aspect of service delivery for all participants. Self-management is an approach that is underpinned by the understanding that older people best understand their own lives, and together with their supporters and carers, their own care and support needs. The objective of self-management is to maximise the choice and control a participant has over their Support at Home services and how those services are delivered.

Self-management involves the participant leading and making key decisions about the mix of services they need (in accordance with the services they are approved to receive), management of their budget and, in some instances, which organisations and/or workers will provide the services required.

Participants who opt to choose their own workers will do so with agreement, oversight and support from their provider to ensure quality and safety of service delivery and compliance with legislation and program guidance. Oversight and support will be provided through a participant's care partner and the provision of ongoing care management. Ongoing care management, with a self-management approach, is required in order for the provider to meet their obligations. Care management includes developing a care plan for all participants and the requirement to review the care plan annually or when the participant's care needs change.

10.2 Scope of self-management

Self-management will be different for each participant. The spectrum of activities a participant undertakes will vary depending on the participant's needs, preferences and abilities. Some participants, with involvement from their supporters and/or carers, may have greater involvement in self-managing than others. Some participants may choose to organise some of their services while the provider organises others.

Self-management activities may include:

- choosing and coordinating services in line with their assessed need and budget
- choosing their own suppliers and/or workers
- scheduling when services will be delivered and rostering workers
- managing their budget
- communicating with their workers
- communicating effectively with their provider
- paying invoices for services delivered and seeking reimbursement from their provider

- navigating the aged care system.

Self-management arrangements must be agreed between a participant and their Support at Home provider.

10.3 Care management activities for self-management

Care partners must support participants to evaluate, prioritise and review their care needs and goals. Care partners must provide transparent information about the budget and spending parameters so participants can exercise flexibility and choice in making decisions.

Providers must provide care management to all participants, regardless of the activities a participant is undertaking themselves. Care partners are expected to deliver one or more care management activities, at least once per month, to every Support at Home participant. Care management activities enable the provider to provide oversight of quality, safety, governance and compliance requirements.

Regardless of self-management arrangements, participants receiving ongoing services will have 10% deducted from their quarterly budget for care management. This funding is allocated to the provider's care management account and is pooled together with the care management funding from all other participants. This funding will be retained by the government and allocated to the provider's care management account at the start of every quarter.

Note: Unlike ongoing classifications, for short-term classifications there is no set percentage deduction from the budget for care management.

10.3.1 Care plan

All participants are required to have a care plan developed in collaboration between the care partner and participant. The self-management arrangement must be documented in the care plan. Providers and participants must work together to develop a care plan within 28 calendar days of services commencing. A copy of the care plan should be provided to the participant for their records.

More information about care management is in section 7.6.

10.4 Using third-party workers

For some participants, an important aspect of self-management is being able to select their own providers and workers, including workers from different organisations. This approach can be an option under self-management, if the

provider is able to support these arrangements, however, providers are not required to use third-party workers.

A third-party worker is an aged care worker who is not an employee of the provider but is engaged by the provider to deliver a service to a participant. The worker may be engaged on an ongoing or ad-hoc basis.

Under the new Aged Care Act, the provider remains responsible for meeting all regulatory requirements and provider obligations for all services delivered to a participant, including those delivered by third parties. This means that there may be circumstances where the provider cannot agree to particular workers or third parties being engaged where regulatory requirements and/or provider obligations cannot be met. For more information on third-party service delivery, refer to section 9.6.

Third-party worker arrangements should be clearly documented in the participant's care plan.

If a third-party worker is engaged at the participant's request, the provider can charge an overhead to cover their costs of supporting the third-party engagement. More info is available at section 10.5.1.

10.5 Obligations when using third parties

Providers, care partners and participants must have a sound understanding of the tasks and obligations involved when using third parties as part of self-management. If a provider can support these arrangements, they should have a self-management model that outlines organisational requirements and arrangements that can be supported.

To finalise an arrangement for third parties, providers and participants must mutually agree on the responsibilities and obligations of each party. The arrangement must be documented in the care plan. If mutual agreement cannot be reached or a participant fails to fulfil their obligations, the provider must assume full responsibility for all obligations and activities.

The table below outlines the minimum **obligations for providers and participants when using third parties**.

Provider Obligations	Shared Obligations	Participant Obligations
Delivery of care management activities, at least monthly.	Development and review of the Support at Home service agreement including third-party arrangements and agreed pricing for services.	Only accessing services aligned with assessed and approved needs, care plan and budget, as well as the Support at Home service list.

Provider Obligations	Shared Obligations	Participant Obligations
Provision of support and education regarding third-party use including legislative and regulatory requirements.	Regular review of the care plan, ensuring services are aligned with assessed needs and are meeting goals and preferences.	Ensuring that changes to services are pre-approved by the care partner before services are received.
Provision of information about Support at Home program guidelines including service lists.	Regular review of the budget ensuring services are value for money and are delivered within the budget parameters.	Knowing that unapproved changes to services may not be reimbursed.
Support knowledge building and oversight of budget.	Pro-active communication from both the provider and participant, supporters and carers (where relevant) to address changing needs, concerns, risks and/or issues requiring action.	Compliance with agreed provider requirements and processes.
Where third-party workers are used, ensuring these workers meet all worker obligations under the new Aged Care Act.		
Provision of assistance for subsidy claiming including ensuring invoices are submitted on time and are accurate.		
Oversight to ensure quality and safety of service delivery and compliance with legislation and program guidance.		

10.5.1 Self-management overhead cap

Where the participant is using third parties as part of self-management, there will be a cap on the overhead that the provider may apply on the third-party service price.

Providers will be able to charge an overhead to cover their costs of supporting the third-party use for activities such as:

- oversight to ensure a third-party worker meets worker obligations under the Act (e.g. carrying out worker screening, training the worker in the provider's complaints and incident management procedures)
- participant claiming and reimbursements.

The overhead that can be charged is capped at 10% of the actual cost of the third-party service. The overhead is not claimed separately by the provider and therefore, must be included in the final service price for the third-party worker.

Note: Providers should ensure that the overhead charged is proportionate to the activities the participant is undertaking to support the arrangement. The overhead cap does not apply if the provider has elected to engage a third-party to deliver services outside of self-management, and the participant is not contributing to coordinating the third party.

10.5.2 Final service price and payment for third-party workers

The provider and participant will need to agree on the service price for third-party workers that will be charged to the participant's budget. Consideration of the final service price should include whether GST is applicable. Generally, services delivered to a participant via a third-party worker are inclusive of GST.

More information is on the ATO website at GST and home care | Australian Taxation Office.

The provider and participant should also agree on who will receive the invoice and who will pay for the invoice. This discussion and the outcome should be documented.

Participants will still be required to pay contributions towards the cost (final service price) of non-clinical services delivered by a third party. Contribution rates will be determined based on the type of service delivered and the participant's pension status.

More information on contribution rates is in section 8.4.

10.5.3 Case study

Margaret

Self-management

Margaret would like to self-manage her care and engage a third-party worker to provide services.

Margaret has been assessed and is eligible for ongoing Support at Home services. She is allocated a Support at Home Classification 5. She expresses preference to receive physiotherapy from a physiotherapist she knows and trusts from her local private clinic. Margaret would also like to undertake some of the activities to organise and schedule the physiotherapist.

Margaret discusses this with her care partner, who explains the responsibilities and requirements of using third parties. They agree to proceed, and a joint meeting is held to document the obligations of Margaret and the provider. From this discussion:

- Margaret opts to select her own physiotherapist. The care partner agrees, provided that the physiotherapist can meet all third-party worker obligations under the new Aged Care Act before services commence. Margaret understands.
- Margaret provides a quote of services to the care partner.
- Margaret and the care partner develop the budget and support plan to include the physiotherapy service, checking that there is sufficient funds available to fund this service.
- Margaret and the care partner agree that the provider will pay the invoices.
- Margaret and the care partner agree to regularly review the care plan and quarterly budget and to communicate (at minimum) every 2 weeks to ensure changing needs, issues and concerns are promptly actioned.
- Margaret acknowledges that she understands she can only receive services in accordance with her Notice of Decision and support plan.

The care partner documents the above discussion in the care notes. A care plan is then developed, detailing the services, frequency of visits, and expected outcomes.

The care partner and Margaret agree on the final price for the service, including the overhead cap for third-party workers. This agreement is documented in her care notes.

Self-management

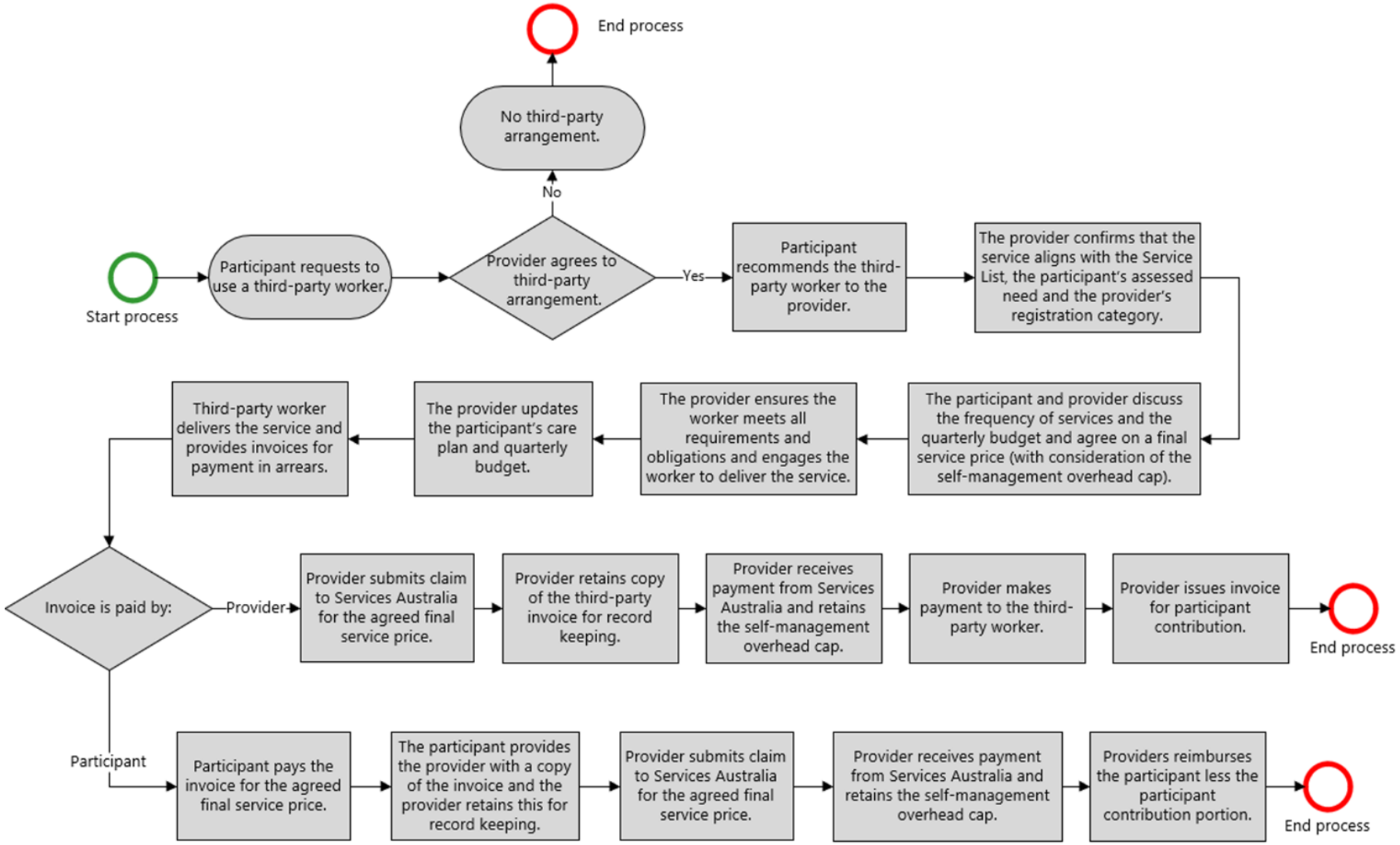
The provider conducts a thorough screening of the physiotherapist to ensure they meet all worker obligations under the new Act, including worker screening and registration requirements. Once all screening is completed, the provider decides to formally sub-contract the physiotherapist.

With all documentation and agreements in place, services commence, and Margaret begins receiving physiotherapy from her preferred physiotherapist at the local clinic. As part of the provider's ongoing care management responsibilities, the care partner conducts regular check-ins, as agreed with Margaret, to monitor the quality of care and ensure it aligns with Margaret's assessed needs.

After physiotherapy services are delivered, the physiotherapist sends the provider an invoice. The provider claims for this service in the Services Australia Aged Care Provider Portal and receives payment. The provider retains the overhead and pays the invoice from the physiotherapist. The provider retains the invoice as evidence of delivery.

Margaret does not need to pay a participant contribution for this service because physiotherapy falls under the clinical support category and is fully funded by the government for all participants.

10.5.4 Process for engaging a third-party worker as part of self-management



11.0 Exits, changing providers and temporarily stopping services

This chapter covers:

11.1 Overview
11.2 Temporarily stopping services
11.3 Changing provider
11.4 Exiting the Support at Home program
11.5 Provider initiated cessation of services

Provider obligations

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

The Aged Care Act 2024:

- Sections 149 and 226A-E

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

For **exits, changing providers and temporarily stopping services**, providers must comply with the strengthened Quality Standards, including:

- Standard 1: The Individual
- Standard 2: The Organisation
- Standard 3: The Care and Services

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

- There are no leave arrangements under Support at Home.
- A participant's funding will be reduced to zero and reallocated when a total of four consecutive quarters (one year) and 60 days have passed since the end of the quarter from when the last service was delivered.
- A participant can change Support at Home providers at any time.

Key points to remember

- If changing providers, the participant should agree to the exit date with the ceasing provider.
- Providers have 60 days to finalise their claims from the date the participant exits their service.
- The existing provider must transfer the participant's portion of unspent HCP funds (if applicable) to the new provider as soon as possible, but within 70 calendar days of the exit date.
- The Commonwealth portion of HCP unspent funds must be returned to Services Australia.
- For AT-HM, the ceasing provider should, as soon as reasonably practicable, contact the new provider to ensure continuity of prescription, purchase or loan of assistive technology and/or continuation of home modifications and management of claims for these items.

11.1 Overview

This chapter outlines temporarily stopping services, changing providers and exit arrangements under Support at Home. It also includes information for providers on provider initiated cessation of services.

There are no leave arrangements under Support at Home, a participant should notify their provider if they plan to temporarily stop their services for a period of time. Maximum periods for stopping services apply before it effects a participant's eligibility for ongoing funding.

A participant may change providers or permanently exit from Support at Home for various reasons and at any time. In doing so, the participant should notify the provider as soon as possible.

Exit dates should be confirmed to ensure there are no overlapping delivery of services by another provider or by a residential aged care provider. The only exception to this is if the participant is temporarily stopping services to access residential respite care or is permanently leaving Support at Home for residential care. In these cases, Support at Home services can only be delivered on the participant's entry and/or exit day to ensure the participant is supported to transition from home or back to their home.

11.2 Temporarily stopping services

Participants have the flexibility to temporarily stop receiving their Support at Home services for various reasons. While services are stopped, a participant will continue to receive their quarterly budget. However, carryover unspent budget limits will apply.

A participant should inform their provider when they intend to temporarily stop receiving services or if they need to access another aged care program.

Reasons a participant may temporarily stop receiving some or all services include, but are not limited to, the following circumstances:

- **hospital stay**: a participant needs to be admitted to the hospital for treatment or surgery.
- **transition care:** following a hospital stay, a participant may require services through the Transition Care Programme to aid their recovery.
- **residential respite care:** a participant may require planned or unplanned residential respite due to personal circumstances
- **other reasons:** this can include social leave, holidays or other personal circumstances.

Note: In certain circumstances, Support at Home services may be delivered concurrently with other aged care programs. Certain rules apply.

More information on program interactions is in chapter 17.0.

Care management should continue to be carried out on a monthly basis, even if services are temporarily stopped. This should be agreed with the participant. If the participant declines monthly care management, this should be documented in the participant's care notes.

There is a maximum period services can be stopped before a participant is no longer eligible for funding. A participant's funding will be reduced to zero and reallocated when a total of four consecutive quarters (one year) and 60 days have passed since the end of the quarter from when the last service was delivered. Providers should notify a participant when they have not delivered a service for an extended period of time. In doing so, providers should outline that funding may be discontinued if services have been stopped for the maximum period.

The provider is not required to report any temporary stoppages of services to the department or Services Australia. However, if no claims are made against the participant for an extended period, the department will send the participant reminders to resume services in order to avoid reallocation of funding. To reactivate funding when it has been reallocated, a participant will need to complete a Support Plan Review.

11.3 Changing provider

A participant can change providers for various reasons including needing different services than what the existing provider can offer or if they change locations (for example, following an interstate move). If a participant decides to make a change, their approval for services and budget will move with them to their new provider.

When a participant changes to a new provider, they should notify their ceasing provider (as early as possible) that they no longer wish to receive services and agree on an exit date. They should also advise their ceasing provider of who the new provider will be as this will enable information sharing to ensure continuation of appropriate care.

Note: For AT-HM, the ceasing provider should, as soon as reasonably practicable, contact the new provider to ensure continuity of prescription, purchase or loan of assistive technology and/or continuation of home modifications.

When determining the exit date, the provider and participant should consider the participant's situation, the terms of the service agreement and the legislative requirements of Support at Home. The agreed exit date should not unnecessarily disadvantage the participant and should be documented in the participant's care notes.

Providers should inform participants that they have four consecutive quarters (one year) and 60 days from the last quarter of when they last received a service to enter

into a new service agreement with another Support at Home provider. The commencing provider will need to complete and submit the Aged Care Entry Record within 28 days of the participant signing a service agreement.

Note: If a new Aged Care Entry Record is not received by Services Australia within the period, the participant's funding will be discontinued and the funding will be reallocated to another person on the Support at Home Priority System.

11.3.1 Ceasing provider obligations

The table below outlines the **obligations of the ceasing provider**.

Step	Action	Details
1	Agree on exit date	The participant and the ceasing provider should agree on the date that services will cease.
2	Notify Services Australia	Within 28 calendar days of the exit date the ceasing provider must notify Services Australia that the participant has ceased services.
3	Share information with the commencing provider	The ceasing provider must share information about services delivered with the commencing provider to assist the commencing provider with care planning and care management. This should include any in-train AT-HM processes, if applicable. This is a requirement under Standard 3 of the strengthened Quality Standards.
4	Complete delivery of services and supports	The ceasing provider must continue to provide care and services (as per the service agreement and care plan) to the participant up until the day before the agreed exit date.
5	Finalise claims	The ceasing provider must finalise all claims for services delivered to the participant up to the exit date. Claims must be finalised within 60 days as per the claiming rules in section 15.3. **Note:** This should include any AT-HM claims where possible. If there are outstanding claims for AT and/or HM, these

Step	Action	Details
		will need to be transferred to the commencing provider with the agreement of the participant.
6	Calculate HCP unspent funds, if applicable	If the participant is a transitioned HCP care recipient, the provider will need to determine if there are unspent HCP funds that need to be transferred to the new provider. More information is in section 11.3.3.
7	Issue final participant invoices and monthly statement	The ceasing provider must issue a final invoice for participant contributions (if applicable), as well as a final monthly statement to the participant.
8	Notify commencing provider of participant's financial balances and transfer of participant portion of HCP unspent funds.	Within 28 days of a participant's exit date the ceasing provider must share with the commencing provider the participant's remaining AT-HM budget and/or quarterly budget amount, inclusive of the total costs of services that have been delivered prior to the exit date. This should include services that have been delivered to the participant (prior to the exit date) but not claimed for. The participant portion of HCP unspent funds (if applicable) must be transferred to the new provider within 70 days of the exit date.
9	Transfer Commonwealth portion of HCP unspent funds to Services Australia	The Commonwealth portion of HCP unspent funds (if applicable) must be returned to Services Australia where they will be credited to the participant's home care account. Once credited, they will be available for the participant's continued use under Support at Home.

11.3.2 Commencing provider obligations

The table below outlines the **obligations of the commencing or new provider**.

Step	Action	Details
1	Accept the participant referral in the My Aged Care portal	The commencing provider must accept the participant's referral in the My Aged Care Service and Support Portal before submitting the Aged Care Entry Record to Services Australia.
2	Enter into a service agreement and agree on a commencement date	The commencing provider will need to discuss and sign a service agreement with the participant. The start date for the commencing provider must be on or after the exit date.
3	Receive final budget information from ceasing provider	The commencing provider will receive the participant's remaining quarterly budget amount. This will be inclusive of the total costs of services that were delivered by the ceasing provider, prior to the exit date. The commencing provider will receive the participants AT and/or HM budget and any transferred commitments as needed.
4	Confirm exit date with ceasing provider	The commencing provider should confirm the exit date with the ceasing provider to ensure there are no overlapping claims for services.
5	Create a care plan and quarterly budget	The commencing provider will need to work in partnership with the participant to develop a care plan and quarterly budget within 28 calendar days of services commencing.
6	Notify Services Australia of participant entry	The commencing provider must submit an Aged Care Entry Record to Services Australia within 28 calendar days of the participant signing a service agreement.
7	Receipt of participant portion of HCP unspent funds (if applicable)	The commencing provider will only receive the participant portion of HCP unspent funds. The Commonwealth portion will be held by Services Australia and can be used

Step	Action	Details
		for AT-HM purchases or to top-up the quarterly budget, if this has been exhausted.

11.3.3 Transitioned HCP recipients and transfer of HCP unspent funds

When a transitioned HCP recipient has HCP unspent funds and is changing to a new provider, the existing provider will need to:

- calculate the Commonwealth and participant portions of HCP unspent funds
- notify the new provider of the Commonwealth and participant portions of HCP unspent funds
- transfer the participant portion of HCP unspent funds to the new provider within 70 days
- return the Commonwealth portion of HCP unspent funds to Services Australia.

Note: Transitioned HCP recipients who joined the HCP Program after 1 September 2021 will never have any Commonwealth portion of unspent funds held by the provider. Any unspent funds held by the provider will be entirely made up of the care recipient portion.

More information is on the department's website at Improved Payment Arrangements for home care resources.

11.4 Exiting the Support at Home program

A participant may permanently exit from Support at Home for various reasons including moving into residential care or due to death.

Where possible, the participant (or their supporter) should notify the provider, in writing and as soon as possible, they will no longer be receiving in-home services and provide notification of the exit date.

If a participant moves into permanent residential aged care, their entry date to residential care will be the exit date from Support at Home.

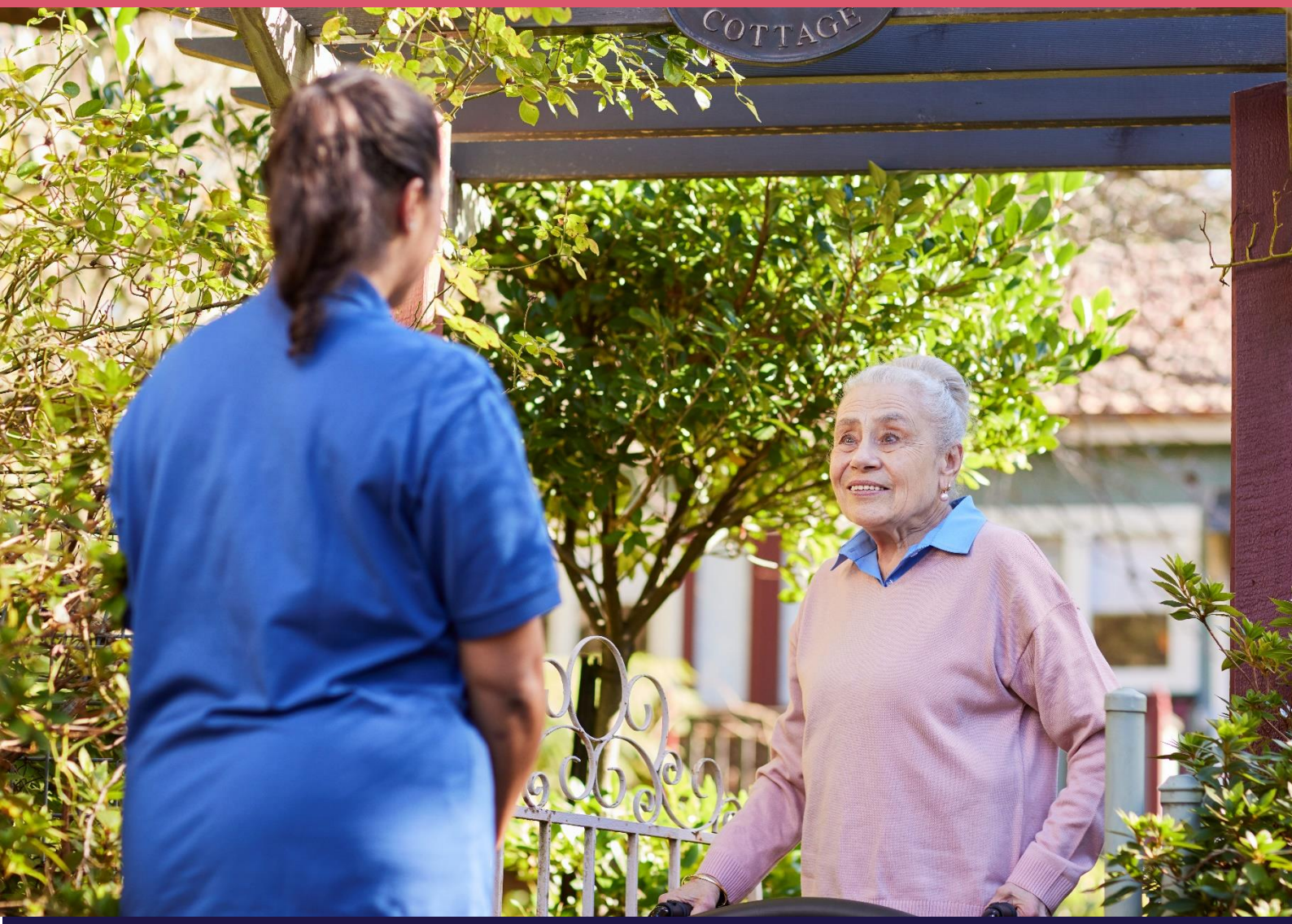
If a participant dies the exit date will be the date of death. The provider must update the My Aged Care Service and Support Portal and call My Aged Care to update the participant record. A provider has 60 days from the date after the participant dies to finalise all claims.

The table below outlines the actions **providers need to take when a participant exits**.

Step	Action	Details
1	If the participant is moving into permanent residential care, agree on exit date	Most commonly, the exit date will be the same as the entry date to residential care. The participant will be exited automatically from Support at Home.
2	In the participant has died, update My Aged Care	Providers will need to: a. update the My Aged Care Service and Support Portal with the departure code b. call My Aged Care to update the participant record so there are no future communications issued to the participant, their supporters, or their family.
3	Notify Services Australia	Within 28 calendar days of the exit date, the ceasing provider must notify Services Australia that the participant has ceased services.
4	Finalise claims	The provider must finalise all claims for services delivered to the participant up to the exit date or date of death. Claims must be finalised within 60 days after the date of death as per the claiming rules in section 15.3.
5	Calculate and transfer participant portion HCP unspent funds, if applicable	If the participant is a transitioned HCP recipient, the provider will need to determine if there is participant portion HCP unspent funds and if so, transfer these to the participant or their estate. More information is in section 11.3.3.
6	Issue final participant invoices and monthly statement	The ceasing provider must issue a final invoice for participant contributions (if applicable), as well as a final monthly statement to the participant.

11.5 Provider initiated cessation of services

Information on provider initiated cessation of services is subject to consultation on the Rules and parliamentary processes. More information will be provided prior to 1 July 2025.



PART D: Short-Term pathways

This section covers:

- the Assistive Technology and Home Modifications (AT-HM) Scheme
- the Restorative Care Pathway
- the End-of-Life Pathway

12.0 Assistive Technology and Home Modifications (AT-HM) Scheme

This chapter covers:

12.1 Overview
12.2 Accessing the AT-HM Scheme
12.3 AT-HM funding
12.4 AT-HM List
12.5 Sourcing AT-HM including the National Assistive Technology Loans Scheme
12.6 Evidence to verify AT-HM
12.7 Participant contributions

Provider obligations

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

The Aged Care Act 2024:

- Chapter 4, Part 2, Divisions 2 and 3

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

For **AT-HM**, providers must comply with Provider obligations and the Code of Conduct.

Refer to Appendix 1 for further detail on provider responsibilities.

Refer to Appendix 3 for the AT-HM Scheme guidelines

Key points to remember

- The Assistive Technology and Home Modification (AT-HM) Scheme supports older people to live at home and within their community with increased independence, safety, accessibility and wellbeing.
- An aged care assessment will determine whether participants are eligible and approved to access the AT-HM Scheme.

Key points to remember

- Eligible participants will have upfront funding to access products, equipment and home modifications through allocated funding tiers.
- Eligible participants must access services and supports from the AT-HM list and in line with their assessed needs from their Notice of Decision and support plan.
- More information, including on additional processes, is in the AT-HM Scheme guidelines (refer to Appendix 3).

12.1 Overview

This chapter provides an overview of the Assistive Technology and Home Modifications (AT-HM) Scheme under Support at Home.

The AT-HM Scheme supports older people to live at home and within their community with increased independence, safety, accessibility and wellbeing. The AT-HM Scheme provides separate supports under Support at Home, with separate funding tiers and program settings.

An aged care assessment will determine whether participants are eligible for assistive technology and/or home modifications funding. If eligible, a participant will be allocated an assistive technology and/or a home modifications funding tier. Participants can access both assistive technology and home modifications funding tiers at the same time if needed. This will provide access to upfront funding to access products, equipment and home modifications.

Participants will be allocated a funding tier for 12 months (in most instances) to spend their assistive technology and/or home modification funding. Participants may be required to make a contribution towards their assistive technology or home modifications.

More information on the operational requirements of the AT-HM Scheme is in the AT-HM Scheme guidelines in Appendix 3 (to be available for 1 July 2025).

12.1.1 What is assistive technology?

Assistive technology (AT) is any item, piece of equipment or product that is used to help a participant to do things more easily or complete activities they can no longer do independently. Examples of assistive technology include:

- mobility equipment such as walking sticks, walking frames and wheelchairs
- toileting supports including bedpans and commodes
- bathing devices including shower chairs and bath boards
- alternative and augmentative communication (AAC) products
- products for food preparation and eating including adaptive cutting boards and knives, as well as modified cutlery.

AT services refers to services delivered by a suitably qualified professional such as prescription, advice and wrap-arounds which help to match a person, their goals and their particular environments with specific products.

The AT-HM List sets out the assistive technology and home modifications that can be accessed and funded through the AT-HM Scheme. The AT-HM Scheme does not include items such as:

- everyday household appliances e.g., a dishwasher
- assessment or therapy tools used by a therapist
- products or technologies funded through an alternative national or state-based program (e.g., the Medical Aids Subsidy Scheme).

12.1.2 What are home modifications?

Home modifications (HM) provide changes to a participant's home, consistent with their aged care assessment, to create a home environment that is safer and more accessible, so the participant can remain living safely at home.

Examples of home modifications include:

- appropriate lever tap sets or lever door handles
- grab rails in the shower or bathroom
- internal and external handrails
- modified door locks
- non-slip materials and mats for floors and stairs.

In some circumstances, participants may be approved for more significant home modifications including:

- bathroom modification (e.g., level access shower and modifications to improve accessibility)
- ramps and stairlifts.

Included and excluded home modifications are outlined in the AT-HM List. The AT-HM Scheme does not include:

- general renovations to a home or dwelling
- restorations or repairs which are considered normal maintenance of home or dwelling
- changes to a home layout that do not relate to a participant's support needs.

12.2 Accessing the AT-HM Scheme

Older people will be assessed for the AT-HM Scheme as part of their aged care assessment or Support Plan Review. If eligible, a funding tier and approval for assistive technology and/or home modifications will be outlined in their Notice of Decision and support plan.

Funding for AT-HM will be separate from a participant's budget for ongoing or other short-term services. A participant can be assessed as needing both AT and HM and get access to separate funding tiers for these items. AT-HM funding will be available upfront for 12 months (in most instances).

12.2.1 Transitioned HCP recipients and access to AT-HM

Where a transitioned HCP recipient has not undergone a re-assessment and does not have an approved AT and/or HM funding tier, HCP unspent funds can be used to purchase equipment, products and home modifications from the AT-HM List. Providers must document and justify the need and reasoning for the purchase and retain all evidence to support the claim.

More information on verifying AT-HM purchases is in section 12.6.

If a transitioned HCP recipient has no HCP unspent funds and requires AT-HM, the provider can, with consent from the participant, refer them for a Support Plan Review by an aged care needs assessor.

These options should be discussed with the participant and documented in their care notes.

Where a transitioned HCP recipient has been re-assessed under Support at Home and receives approved AT-HM funding, the purchase of AT-HM must be first drawn from HCP unspent funds before the provider can claim from the AT-HM funding account.

Note: All purchases of AT-HM must align with the participant's needs, be agreed with the participant, be documented in their care plan and meet any prescription requirements, where applicable.

12.3 AT-HM funding

The table below outlines the **3 funding tiers for assistive technology and home modifications**.

More information on AT-HM funding tiers is in the AT-HM guidelines in Appendix 3.

Funding tier	Funding allocation cap	Funding period
Low#	$500	12 months
Medium#	$2,000	12 months
High^#	$15,000*	12 months (exceptions apply)

Funding tier	Funding allocation cap	Funding period
The following conditions apply to funding tiers: * Complex assistive technology may be accessed above the $15,000 cap, with a prescription from a qualified health/allied health professional and evidence of cost of the item/s. ^ Participants receiving services under the Restorative Care Pathway are not eligible to receive high-tier funding for home modifications. #		

12.3.1 AT-HM funding periods and caps

AT-HM funding is time limited and must be spent, not just committed, within a 12 month period (in most cases). The period of funding availability commences from the date the participant signs a service agreement with their provider. Following the 12-month period, AT-HM funding will no longer be accessible for use. Providers will need to claim for AT-HM within 60 calendar days of the 12-month period ending.

At times, there may be delays to home modifications which prevent the funding being spent within the 12-month period. Funding may be extended for an additional 12 months to complete complex home modifications (24 months in total) if evidence of progress is provided to Services Australia within the first 12 months.

Funding for high-tier home modifications will be capped at $15,000 per lifetime (this does not include any additional supplement a participant may be eligible for). Lifetime caps will be monitored by Services Australia.

Older people with specific complex and rapidly progressing conditions may have approval to access a range of assistive technology over a 24 month period to ensure they can remain living at home. Funding may be extended for an additional 24 months (48 months in total).

12.3.2 Prescription of AT-HM

Prescription of more complex assistive technology and all home modifications is required to be completed by a suitably qualified health/allied health professional. The AT-HM List outlines the types of equipment, products and home modification that requires prescription.

Depending on the equipment, products or home modification required, qualified professionals may include (but are not limited to):

- allied health professionals such as, occupational therapists, speech pathologists, physiotherapists and podiatrists
- health professionals including registered nurses and General Practitioners
- Aboriginal and community health workers

- rehabilitation specialists.

Proposed prescribers of AT-HM will operate within their professional scope to:

- identify any issues or problems that restrict an older person's physical, functional or cognitive ability
- assess the level of assistive technology needed to regain or maintain physical, functional or cognitive abilities
- identify an assistive technology product that will assist an older person to regain or maintain physical, functional or cognitive ability
- identify home modifications to support an older person to access and move around their home safely.

More information on the prescription of assistive technology and home modifications is in the AT-HM Scheme guidelines in Appendix 3.

12.3.3 Wrap around services and coordination activities

For assistive technology and home modifications, the participant may require additional services and/or training to ensure the equipment can be used safely. This is referred to as 'wrap around services' and must be paid for out of the AT-HM funding allocation.

Wrap around services include:

- delivery
- set up of assistive technology equipment
- training and education on the safe use of assistive technology equipment and/or home modifications
- follow-up on assistive technology and/or home modifications effectiveness in meeting needs.

Providers co-ordination costs associated with home modifications are funded through the AT-HM Scheme and must not exceed 15% of the quoted costs or up to $1,500 (whichever is lower). These costs should be included in the claim against the participants AT-HM budget.

Provider's administration costs associated with the provision of assistive technology are funded through the AT-HM Scheme and must not exceed 10% of the quoted costs or up to $500 (whichever is lower). These costs should be included in the claim against the participants AT-HM budget.

If the AT-HM funding is insufficient to cover wrap around services, the provider can:

- claim against the participant's HCP unspent funds, if available
- with consent from the participant, refer them for a Support Plan Review by an aged care needs assessor to increase the funding tier.

These options should be discussed with the participant and documented in their care notes.

More information on wraparound services and coordination is in the AT-HM Scheme guidelines in Appendix 3.

12.3.4 Repairs and maintenance

Assistive technology, repairs and maintenance, purchased through Support at Home, are funded through a participant's AT-HM funding allocation.

If the AT-HM funding is insufficient, the 12-month period has passed and/or the participant has no HCP unspent funds, the provider can, for repairs and maintenance only and with consent from the participant, refer them for a Support Plan Review by an aged care needs assessor to access an AT-HM funding tier.

These options should be discussed with the participant and documented in their care notes.

12.3.5 Supplements for AT-HM

The following supplements apply to participants with approved AT-HM funding:

- the rural and remote supplement for participants living in an area in the Modified Monash Model (MMM) 6 or 7
- the fee reduction supplement for participants experiencing genuine financial hardship.

More information on AT-HM supplements is in section 8.3.2.

12.4 AT-HM List

The AT-HM List sets out the defined equipment, products and home modifications that are available for Support at Home participants under the AT-HM Scheme.

The AT-HM List is sorted into the following categories:

- **managing body functions** – including pressure cushions, anti-oedema stockings and memory support products
- **self-care products** – including adaptive clothing or shoes and assistive products for toileting, bathing and showering
- **mobility products** – including walking frames, wheelchairs and lifting devices
- **domestic life products** – including assistive products for food preparation, eating, drinking and house cleaning
- **communication and information management** products – aids that assist with reading and writing, as well as alternative and augmentative communication (AAC) devices

- **home modifications** - including accessible showers, grabrails, fixed ramps and safety barriers.

The AT-HM List also outlines the prescription category for each item. The prescription category is the suggested level of skill or qualification required to effectively provide recommendations for the safe and effective use of assistive products or installation of home modifications.

More information on the AT-HM List and the prescription category is in the AT-HM Scheme guidelines in Appendix 3.

12.4.1 Assistance dogs

If a participant is not eligible for the government-funded Physical Assistance Dogs Program, costs associated with assistance dog maintenance may be included under the AT-HM Scheme where the services directly relate to the upkeep of the dog.

A dog must meet the definition of an assistance dog used by Health Direct and be required to enable participation in activities of domestic life.

Participants requiring assistance dogs will be identified and approved for funding through the aged care assessment. Funding for assistance dogs is a specific need and participants will receive separate funding for this purpose. Funding for assistance dogs is capped at $2,000 per annum for ongoing maintenance of the assistance dogs e.g., paying veterinary bills, animal vaccinations, deworming and flea treatments, essential grooming and dog food.

Funding for assistance dogs can be approved in isolation or in addition to an AT-HM funding tier.

Funding will be automatically allocated every 12 months however; funding cannot accrue or rollover.

If the participant no longer requires this specific funding, the provider must notify Services Australia through the Services Australia Aged Care Provider Portal.

12.5 Sourcing assistive technology and home modifications

Providers are responsible for arranging and sourcing any required AT-HM, including prescription, and wrap around services, in accordance with the participants assessed needs.

Providers can source assistive technology products and equipment through the:

- purchase or loan of assistive technology:
    - equipment and products can be sourced and purchased from a registered provider or supplier

- rental arrangements from a registered provider, supplier, peak body / organisation or other service provider.
- AT-HM Loans Scheme (when and where available) for a loan arrangement through state and territory government programs.

Providers can provide coordination services for home modifications or subcontract this service to a third-party.

More information on the AT-HM Loans Scheme and purchasing of equipment is in the AT-HM Scheme guidelines in Appendix 3.

12.6 Evidence to verify AT-HM

To ensure transparency, accountability and participant satisfaction under Support at Home, providers must document the price charged and confirmation of delivery for AT-HM items. The price charged will be the final agreed price. Documentation of the price charged and confirmation of delivery will enable providers' claims to be properly verified. These requirements apply for items across all inclusion and risk categories.

Evidence requirements for the purchase of AT-HM items are tiered, based on the risk level associated with the purchase. There are three tiers:

- low risk
- under advice
- prescribed

The tiered evidence requirements provide a structured approach to balancing participant autonomy with accountability and safety. More information is available in the AT-HM List.

The table below outlines the **evidence providers must obtain before claiming for AT-HM items**.

Evidence tier	Evidence requirements
Low risk	An invoice is sufficient to demonstrate the agreed price. **Note:** The price paid must fall within the agreed and documented budget allocation for this item.
Under advice	An invoice plus at least one additional piece of documentation, including: • A quote for an assistive technology item (if more than one item then these should be itemised) that is signed or agreed by the participant. • A prescription from a health/allied health professional showing an assessed need for the assistive technology. **Note:** Under advice items do not require a prescription but may benefit from professional advice to ensure that they are selected, installed or used effectively. If a prescription is not obtained, the quote is sufficient evidence.
Prescribed	A prescription from a health/allied health professional showing an assessed need for the assistive technology and/or home modifications. AND Written agreement (e.g. invoice) on the price of assistive technology and/or home modification between the provider and supplier.

12.6.1 Final agreed price of AT-HM

The price charged to a participant's fund for assistive technology and/or home modifications can be no more than the invoiced cost of the AT-HM plus any costs for prescription, wrap around services and administration/coordination services. All AT-HM costs must be agreed and documented between the provider and the participant prior to purchase.

When finalising claims and payment for AT-HM, providers must obtain:

- a final invoice for the AT-HM item
- the final invoice must be itemised if there is more than one item purchased
- Progress payments for home modifications can be claimed over time as needed.

More information on wrap around services is in section 12.3.3 and the AT-HM Scheme guidelines in Appendix 3.

12.6.2 Confirmation of delivery

Providers must be able to provide confirmation of delivery for AT-HM items to enable the AT-HM claim to be properly verified.

For all AT-HM items, providers must obtain an **invoice plus at least one additional piece of documentation** to demonstrate confirmation of delivery. This includes:

- care notes confirming delivery of AT-HM items to the participant
- clinician records after the delivery of AT-HM items that confirm the item has been received
- signature of the participant on a delivery slip, receipt or invoice (or in an electronic application) confirming delivery of AT-HM items
- photos or videos of installed assistive technology or completed home modifications
- records created by an electronic system that demonstrate delivery and show:
  - details of items
  - participant's name and address
  - details of delivery (including date and time)
  - photos of the AT-HM item at participant's address.

12.7 AT-HM participant contributions

Participant contribution categories apply for AT-HM services and funding tiers. The majority of AT-HM will attract a contribution rate equivalent to the independence category. Prescription and wrap-around services (where required) fall under the clinical supports category with no participant contributions required as this category is fully funded by the government for all participants.

More information on participant contributions for AT-HM is in section 8.4.

13.0 Restorative Care Pathway

This chapter covers:

13.1 Overview
13.2 Goals of restorative care
13.3 Eligibility
13.4 Episodes and funding
13.5 Care management for restorative care
13.6 Goal planning
13.7 Service list
13.8 Temporarily stopping restorative care services
13.9 Support Plan Review
13.10 Participant contributions
13.11 Exiting from restorative care

Provider obligations

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

Service delivery under the **Restorative Care Pathway** must comply with the strengthened Quality Standards, including:

- Standard 1: The Individual
- Standard 2: The Organisation
- Standard 3: The Care and Services
- Standard 4: The Environment

And if the provider is delivering nursing services, they must also comply with:

- Standard 5: Clinical Care
    - Outcome 5.1: Clinical Governance

Refer to Appendix 1 for further detail on provider responsibilities.

Refer to Appendix 4 for the Restorative Care Pathway clinical guidelines.

Key points to remember

- An episode of restorative care provides up to 12 weeks of intensive allied health and/or nursing services aligned to a participant's assessed needs.
- Each restorative care episode provides a unit of funding of up to $6,000.
- An episode will include the delivery of restorative care management activities. Funding for restorative care management is taken from the individual restorative care budget and not care management pooled funds.
- A goal plan must be established for each participant (this is in lieu of the service agreement and care plan required for ongoing Support at Home services).
- An exit plan must be completed by the restorative care partner to consider next steps upon conclusion of the episode.
- A Support Plan Review can be completed to request additional funding or an extension if required. It can also be used to request a reassessment for other aged care services as the episode concludes.

13.1 Overview

This chapter outlines the Restorative Care Pathway and its key elements including eligibility, episodes and care management.

The Restorative Care Pathway is an approach to care that focuses on early intervention through intensive clinical and care support and monitoring. The aim of this is to maintain or regain function and to reduce or prevent functional decline.

Clinical services (allied health and nursing) are central to restorative care outcomes and play a key role in maintaining and improving health and wellbeing.

Restorative care provides a short-term period of care of up to 12 weeks. Restorative care management activities may be intensive and involve assessing the progress of a client on a weekly or more regular basis. Participants will receive coordinated allied health and nursing services to help them achieve their goals, stay at home for longer and delay entry into higher levels of care.

The goal planning and service delivery of restorative care must be multidisciplinary in nature and drawn from the Support at Home service list. Services delivered under restorative care will be funded through a participant's restorative care budget and participant contributions apply to services not in the clinical service category.

More information is in the Restorative Care Pathway clinical guidelines in Appendix 4 (to be available for 1 July 2025).

13.2 Goals of restorative care

The Restorative Care Pathway provides an intensive short-term period of care designed to:

- support participants to regain their ability to carry out daily activities
- help participants to manage new or changing age-related conditions
- prevent or delay the need for ongoing in-home care services or the need to access higher levels of ongoing care
- provide reablement education and skills to participants on how they can retain better function as they age for longer independent living.

This is achieved through a reablement approach which utilises a multidisciplinary care team of allied health and/or nursing professionals. Strengthened Quality Standard 3 (Outcome 3.2) requires providers to deliver quality funded aged care services ensuring the services optimises their quality of life, reablement and maintenance of function.

More information on reablement is in section 5.3.2.

13.2.1 Multidisciplinary care

Multidisciplinary care is defined as a practice of care in which several clinicians from different disciplines collaborate to form a multidisciplinary team (MDT). For example, three different allied health professionals such as physiotherapist, occupational therapist and dietician. The MDT provides a participant with a comprehensive, outcome-focused treatment plan and clinical supports.

The type and number of clinicians within the MDT should be selected based on the individual needs of the participant and in accordance with the participant's assessed needs (as outlined in their Notice of Decision and support plan). A Support Plan Review may be required if specific allied health or nursing services are required but were not approved at assessment.

More information on Support Plan Reviews is in section 13.9.

The inclusion of a medical professional as part of the MDT is considered good practice and should be undertaken where possible. However, this is not a mandatory element of the pathway. While a medical professional may be engaged for the planning or delivery of the Restorative Care Pathway, funding must not be used to pay for services that can be claimed through the Medicare Benefits Schedule (MBS). These aspects of care must be paid for by the participant or claimed through the MBS, if applicable.

Providers delivering restorative care services must have documented procedures and protocols available to support the MDT in the care and review of participants, including ensuring a suitable restorative care partner is available to lead the MDT.

This includes:

- the processes for communicating participant information to relevant health professionals
- the processes for goal planning and case conferencing with members of the MDT
- the pre-determined intervals for goal planning, reviews and case conferencing, as well as guidelines for determining when additional reviews or case conferencing may be required
- the process for ensuring the MDT creates, reviews and integrates care notes and participant records
- protocols to ensure the MDT is comprised of an appropriate mix and experience of qualified health professionals to enable the provision of effective participant services
- ensuring a suitable care partner is appointed to oversee and promote effective MDT and inter-agency working

- having suitable processes in place for exit plans to be considered and developed as early as possible to ensure post-restorative care support is discussed with the older person as an ongoing priority.

More information on the MDT is in the Restorative Care Pathway clinical guidelines at Appendix 4.

13.3 Eligibility

Eligibility to access the Restorative Care Pathway is determined through an aged care assessment, which will indicate if a restorative care episode is appropriate.

For existing Support at Home participants, a restorative care episode can be accessed at the same time as ongoing Support at Home services. This means that the participant can continue to use their ongoing quarterly budget to access ongoing services at the same time as their restorative care funding to access additional services. Services through the Restorative Care Pathway should be clinically focused and different to the ongoing services being delivered.

New participants to the Support at Home program being assessed to access the Restorative Care Pathway will be reviewed at the end of the episode to determine if ongoing services are required.

The tables below outline the **suitability and eligibility criteria to receive services under the Restorative Care Pathway**.

Suitability requirements for restorative care	
Need	There is a demonstrated **need** for short-term, targeted support that is likely to help a participant to: • remain living at home without the need for ongoing Support at Home services, OR • remain at the same Support at Home classification without the need for higher level ongoing services, OR • remain accessing low level CHSP without the need for additional services.
Intensive clinical and/or allied health	**Intensive allied health and/or nursing services** will likely address an issue that will benefit from several clinical interventions over a short-term period.
Participant motivation	The **participant demonstrates motivation** through willingness and capacity to engage in goal-setting and actively participate in short-term interventions to increase independence.

Eligibility requirements for restorative care
A person is **ineligible** to receive restorative care if they are: • receiving, or eligible to receive the End-of-Life Pathway • have accessed two separate episodes or two units of funding for Support at Home restorative care in the past 12-month period • receiving, or eligible to receive services through the Transition Care Programme (TCP) • receiving permanent residential aged care or residential respite.

13.4 Episodes and funding

An episode of restorative care provides up to 12 consecutive weeks of allied health and/or nursing services aligned to a participant's assessed needs. Each restorative care episode provides a unit of funding of up to $6,000.

Participants can access a maximum of 2 units of funding over a 12-month period. This can be made of up to:

- 2 separate episodes, at different periods within the year (non-consecutive), or
- 2 units of funding, within a single 12-week period (subject to approval by an aged care assessor).

If requiring 2 separate episodes across as 12-month period, these episodes cannot be consecutive. A participant will need to wait at least 3 months from completion of the original episode before being eligible to receive a second episode within the 12-month period.

Participants with higher needs may be eligible to receive a second allocation of funding, concurrently with their first episode, if it becomes clear that $6,000 will not be sufficient to meet the participant's goals.

More information is in section 13.4.3.

13.4.1 Commencement of an episode

An episode of restorative care commences from the start date outlined in the participant's Aged Care Enty Record. The provider will first need to accept the referral in the My Aged Care Service and Support Portal, and notify Services Australia of the participant's entry to the program via the Aged Care Entry Record (ACER) form (AC021).

Note: The start date on the goal plan should be the same as the commencement date on the ACER.

More information on notifying Services Australia of entry to care is in section 6.11.

13.4.2 Extensions to episodes

In some circumstances, a participant may not be able to reach their goals within the 12-week episode. An extension of 4 weeks is available to participants, extending a single episode to a total of 16 weeks, if approved by an aged care assessor via a Support Plan Review.

An extension to an episode should be identified early to allow sufficient time for a Support Plan Review to be completed before the end of the episode.

An extension to an episode does not attract an increase in funding unless additional funding has been approved by the aged care assessor, as part of the Support Plan Review.

13.4.3 Additional funding for an episode

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode.

If the participant requires additional funding within a single 12-week episode, the provider can submit a request for a Support Plan Review. The request for review should be submitted as soon as possible following commencement of the restorative care episode.

If approved, a participant can access an additional unit of funding (up to $6,000), to provide a combined total of up to $12,000, for a single episode of restorative care.

If additional funding is approved, a participant will not be eligible for a further episode of restorative care within a 12-month period as they have accessed the maximum 2 units of funding within the first episode.

13.5 Care management for restorative care

Like ongoing Support at Home services, participants receiving restorative care services must also receive care management. Care management for the Restorative Care Pathway is delivered through a Support at Home provider, by a staff member known as a restorative care partner. A restorative care partner is a mandatory element of delivering the Restorative Care Pathway.

While care management for ongoing Support at Home has 10% of the budget set aside for care management activities, there is no specific limit or amount deducted from the budget for restorative care management activities. The budget used for restorative care management will be determined between the provider and participant however, it should be proportionate and in the best interests of the participant.

13.5.1 Restorative care management activities

Restorative care management activities should be appropriately delivered to reflect the intensive nature of the episode.

The table below outlines the **activities that can be delivered under the Restorative Care Pathway**. Activities in bold text highlight the difference between restorative care management activities versus care management for ongoing services.

Activity	Description
Goal planning	• Identification of the participant's needs, goals, preferences and existing supports aligned to the support plan developed during their aged care assessment • Conducting risk assessments in relation to the participant and their home • **Goal plan development and reviews** • Identification and selection of services within the participant's budget (**with a focus on applying a multi-disciplinary approach utilising allied health and nursing services**).
Service planning and management	• Budget management • Communication and coordination with range of relevant stakeholders including providers and associated providers, assistive technology suppliers, carers and supporters • Facilitating transfers to other providers for care, if required • **Where assistive technology has been approved, coordinating assistive technology and home modifications with relevant qualified professionals (e.g., clinicians or builders).**
Monitoring, review and evaluation	• Care discussions with relevant stakeholders, the participant and their carers, and/or supporters • Case conferencing, where applicable • Monitoring and responding to changing needs and emerging risks • Evaluation of goals, service quality and outcomes • **Reviewing multi-disciplinary outcomes, as well as coordinating and/or completing relevant assessment tools (within scope of practice)** • **Completion and submission of exit plans.**

Activity	Description
Support and education	• Supporting the process of informed decision making • Problem solving issues and risks, as they arise • Ensuring the participant's views, rights and concerns are heard and escalated • Identification of risk and responding to abuse and neglect • Management of complaints and concerns • Provision of independent advice, information and resources • Delivering reablement advice and strategies • Health promotion and education • System navigation and linkage support.

13.5.2 Restorative care partner

Restorative care management activities are delivered by a Support at Home provider through a staff member known as a restorative care partner.

Given the clinical requirements of the Restorative Care Pathway, a restorative care partner must be a nursing or allied health professional. This is to support the required clinical coordination and oversight of all clinical services outlined in the participant's support plan.

A restorative care partner should hold a relevant university health qualification (for example, allied health or nursing) which allows them to work autonomously. The clinical scope of a restorative care partner supports:

- complex goal planning activities
- conducting clinical assessments and evaluations (within their professional scope)
- contributing to the multidisciplinary team (within their professional scope)
- referral for, and prescription of, AT-HM, if the participant has been approved for AT-HM services or supports (within their professional scope)
- all other activities as outlined in the restorative care management activities.

To deliver care management under the Restorative Care Pathway, the restorative care partner must have appropriate skills and knowledge for clinical coordination and oversight for short intensive periods of care. A restorative care partner may also be employed as a care partner for ongoing Support at Home services.

If the participant is receiving an episode of restorative care concurrently with ongoing Support at Home services, the restorative care partner and care partner for ongoing services must work together to plan and deliver services that are not duplicative and comprehensively address all needs of the participant. This includes ensuring the

budget is applied to the relevant approved services only and no cross subsidising of services or activities occurs between ongoing and restorative care.

13.6 Goal planning

Goal planning is a critical element of the Restorative Care Pathway. Restorative care partners will need to work closely with participants to identify achievable goals for the restorative care episode that align with their aged care assessment.

Goals should be specific, measurable and achievable within the 12-week episode. Each goal should be documented in the goal plan and be accompanied by the relevant clinical service to be delivered.

Goal planning should also include frequent progress reviews to determine how the participant is tracking towards reaching their goals and what supports (if any) may be required following the end of the episode to inform the exit plan.

More information on goal planning is in the restorative care clinical guidelines in Appendix 4 (available for 1 July 2025).

13.6.1 Goal plan

All participants accessing restorative care must have an individualised goal plan. The goal plan replaces the service agreement and care plan which are required for ongoing Support at Home services. As the goal plan acts as the service agreement, the goal plan must be finalised before the start of the episode.

The restorative care partner, together with the participant, their supporter if they wish, and other members from the MDT need to develop a goal plan for each episode of restorative care.

To assist in informing the goal plan, a restorative care partner should review the participant's support plan and any other existing care plans (for ongoing Support at Home services) or previous goal plans (from previous restorative care episodes), if available. The participant and restorative care partner must work together to develop the goal plan.

A goal plan must include:

- the start date and estimated completion date of the episode
- identification of the participant's needs, specific goals, preferences and existing supports which have all been drawn from the support plan developed during the aged care assessment
- identification of any other services or supports the participant is receiving to help support meeting the goal
- any risks identified through assessments of the participant or their home

- the specified services to be delivered including the frequency and expected dates of delivery
- the budget for the episode which must include the delivery of restorative care management services
- the process for monitoring and evaluating the episode including any assessment tools and measures to be used by the MDT and the dates of evaluation.

Note: The goal plan is a requirement for the Restorative Care Pathway only.

More information on inclusions for the goal plan, as well as a template for a goal plan, is in the Restorative Care Pathway clinical guidelines in Appendix 4.

Once the goal plan is completed, an Aged Care Entry Record (ACER) form should be submitted for claiming purposes.

13.6.2 Case study

Georgios

Restorative Care Pathway

Georgios is an active person within his Greek community. He has had a recent fall and wants to return to his normal activities as soon as possible.

Georgios is a keen swimmer who loves to spend time at his local pool where he has established a rich support network of friends within his Greek community. Recently, Georgios had a fall which has limited his ability to complete his usual daily activities. Georgios contacted My Aged Care for assistance and they referred him for an aged care assessment.

Georgios was assessed and, as he is seeking to regain function and would benefit from intensive allied health intervention, he was approved to access services under the Restorative Care pathway.

During the assessment, the assessor discussed that the Restorative Care pathway would be an intensive short-term (12-week) period of care aimed at getting Georgios back to doing daily tasks independently. During the assessment, the assessor recommended that Georgios could benefit from accessing cultural support so he can continue to engage with his Greek community whilst he was unable to return to the pool. Georgios agreed that this would be beneficial.

Once approved, Georgios approached his local Greek-based Support at Home provider. Before Georgios can start accessing the care, the provider's restorative care partner Nikolas, met with him to discuss goal planning and establish a goal plan. During goal planning, Nikolas and Georgios discussed and agreed on:

- the start date and estimated completion date of the episode
- identification of Georgios' needs, specific goals, preferences, and approved services outlined in the Notice of Decision and support plan
- the services that Georgios wants to receive including the frequency of services and the dates these are to be delivered

Restorative Care Pathway

- the budget for the episode, including weekly restorative care management activities
- the process for monitoring and evaluating the episode including the assessments and measures to be used and the dates of evaluation.

Georgios commenced the episode and regularly spoke with Nikolas regarding his progress. 8 weeks into the 12-week episode, Georgios and Nikolas identified that two of the recorded goals were unlikely to be achieved within the episode timeframe. With Georgios' consent, Nikolas requested a 4-week extension. The assessor who originally assessed Georgios agreed and approved the extension.

Prior to the completion of the restorative care episode (12 weeks + 4 week extension), Georgios and Nikolas met to discuss and complete the exit plan. They agreed that the goals set at the start of the program had been achieved.

Georgios explained that he had lost some confidence following his fall and would like to continue to build his strength and balance on an ongoing basis. With Georgios' consent, Nikolas submitted a Support Plan Review (SPR). The SPR will be reviewed by an aged care assessor and will determine if Georgios is eligible to receive ongoing in-home aged care services.

13.7 Service list

Participants receiving restorative care must access services from the Support at Home service list that align with their assessed need in their Notice of Decision and support plan. Assistive technology and/or home modifications may also be delivered during an episode of restorative care, if the aged care assessor determines this is required.

It is expected that a majority of a participant's budget is spent on clinical supports (for example, allied health and/or nursing) designed to restore function and improve independence.

Where participants are concurrently accessing a restorative care episode and receiving ongoing Support at Home services, duplication of services should be avoided. Non-allied health and nursing services through the Restorative Care Pathway should only be used to achieve goal outcomes.

13.7.1 Assistive technology and home modifications

Participants accessing a restorative care episode can also access supports through the AT-HM Scheme, where these supports will contribute to the overall outcomes of the restorative care episode.

Approval for AT-HM supports will be granted through an aged care assessment.

AT-HM supports during a restorative care episode may provide:

- low, medium or high tier assistive technology supports
- low or medium tier home modifications supports.

A participant is not eligible to receive the highest tier for home modifications whilst accessing restorative care. Upon exiting restorative care, the participant may undergo a Support Plan Review to determine eligibility for other Support at Home services and supports, including high tier home modifications.

13.8 Temporarily stopping restorative care services

There are no leave provisions for participants accessing a restorative care episode. Regardless of personal circumstances, an episode is limited to 12 consecutive weeks. However, an extension to an episode may be granted for a further four weeks in certain circumstances through a Support Plan Review.

13.9 Support Plan Review

A restorative care partner will need to refer a restorative care participant for a Support Plan Review:

1. to request an extension to the participant's restorative care episode
2. to request an additional unit of funding for the restorative care episode
3. for a reassessment of the participant before the completion of a restorative care episode.

Requests for a Support Plan Review should be completed as soon as it is identified that an extension to the episode is required. If additional funding is required, the request for a Support Plan Review should be submitted as soon as possible from the commencement of the episode

A request for a Support Plan Review must only be done with consent from the participant.

More information on Support Plan Reviews is in section 6.13.

13.9.1 Reassessment at completion of an episode

Upon exiting the restorative care pathway, participants may undergo a Support Plan Review and reassessment to determine their need for ongoing services.

For participants who have not previously accessed Support at Home, reassessment will determine if a participant's function has been restored sufficiently or if there is a need for ongoing Support at Home services.

For participants who were accessing ongoing Support at Home services prior to completing the restorative care episode, a reassessment will determine if they remain at the same classification or if a higher classification is required.

Note: Even if a participant's function has improved following a restorative care episode, a participant cannot be reassessed to a lower classification.

13.10 Participant contributions

For all Support at Home services, including the Restorative Care Pathway, participant contribution arrangements apply for services delivered in the independence and everyday living service categories. For services in the clinical supports category (for example, nursing), no participant contribution is required as these services are fully funded by government.

More information on participant contributions for restorative care services is in section 8.4.

13.11 Exiting from the Restorative Care Pathway

The restorative care partner must work with participants to plan and coordinate their care, including exiting from a restorative care episode and obtaining access to ongoing care, if required.

Exit plans should be based on the goal plan which has been completed and reviewed throughout the episode. Due to the short-term nature of the pathway, exit planning should ideally begin at the start of the restorative care episode.

To do this, the provider must, in collaboration with the participant, prepare an exit plan that:

- outlines the start and end dates of the episode
- details the goals and services received to achieve the goals and whether the goals were met or not met
- describes any AT-HM prescribed and/or received during the episode

- provides recommendations from the MDT on the participant's functional requirements (for example, completely independent and no further support required OR participant requires some ongoing assistance and a reassessment is recommended)
- Outlines whether the participant is already receiving adequate ongoing Support at Home services or whether ongoing or higher level services may be needed (requiring reassessment).

Note: An exit plan is a requirement for the Restorative Care Pathway only.

More information on exit plans is in the Restorative Care Pathway clinical guidelines in Appendix 4.

Once the exit plan is completed, a copy must be provided to the participant. A copy may be attached to a Support Plan Review request as supporting evidence for discussion with an aged care assessor.

14.0 End-of-Life Pathway

This chapter covers:

14.1 Overview
14.2 Eligibility
14.3 Funding
14.4 Access to the End-of-Life Pathway
14.5 Care management for the End-of-Life Pathway
14.6 Services
14.7 Participant contributions
14.8 Exiting from the End-of-Life Pathway

Provider obligations

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

The Aged Care Act 2024:

- Sections 23(2)(b) and 25(3)(d) of the Act

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

Providers of Support at Home services must comply with the strengthened Quality Standards based on the service type they offer and the category or categories under which they are registered.

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

- The End-of-Life Pathway will support participants who have been diagnosed with 3 months or less to live and wish to remain at home, by providing an increase in the level of services available.
- A total of $25,000 is available per eligible participant over a 12-week period.
- An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:
  - A doctor or nurse practitioner advising estimated life expectancy of 3 months or less to live, and

Key points to remember
○ Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator) of 40 or less.

14.1 Overview

This chapter outlines the End-of-Life Pathway and its key elements including eligibility, funding, access and care management.

Older people who have been diagnosed with 3 months or less to live who wish to stay at home, may be eligible to access the End-of-Life Pathway under Support at Home.

The End-of-Life Pathway provides the highest funding classification (per day) for in-home aged care services. A total of $25,000 is available per eligible participant over a 12-week period.

The End-of-Life Pathway is intended to provide additional in-home aged care services (such as personal care, domestic assistance and general nursing care) to complement services available under state and territory-based palliative care schemes.

The strengthened Quality Standards require aged care providers and workers to recognise the older person's needs, goals and preferences for palliative and end-of-life care. Their dignity must be preserved and they must have access to palliative and end-of-life care when required. Participants and their families and carers must be informed and supported during their last days of life (Outcome 5.7).

14.2 Eligibility

A participant can access one episode of the End-of-Life Pathway through the Support at Home program. An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:

- a medical practitioner or nurse practitioner provides an estimated life expectancy of 3 months or less to live, and
- a score of 40 or less on the Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator).

Note: The AKPS is a measure of an individual's overall performance status or ability to perform their daily activities. It is a single score assigned by a clinician based on observations of a patient's ability to perform common tasks relating to activity, work and self-care. An AKPS score of 100 signifies normal physical abilities with no

evidence of disease. Decreasing numbers indicate a reduced ability to perform activities of daily living. These requirements are consistent with the current palliative care entry pathway for residential aged care.

14.3 Funding

A one-off budget of $25,000 is available for participants through the End-of-Life Pathway. This is the highest funding classification category (per day) available in the Support at Home program. Funding can be used to access the participant's approved services from the Support at Home service list, including care management.

If approved for assistive technology, dedicated AT-HM funding can also be used to access equipment from the AT-HM list. If eligible, primary supplements will also apply to participants.

Funding for the End-of-Life Pathway is discrete from other Support at Home classifications. If an existing Support at Home participant moves to the End-of-Life Pathway, this will replace their ongoing classification. Unlike an ongoing classification, participants cannot accrue funds under the End-of-Life Pathway. This means that any unspent budget from an End-of-Life Pathway classification will not follow a participant if they live beyond 12 weeks and move to an ongoing classification.

14.3.1 Funding period

The End-of-Life Pathway provides services over a 12-week period to support the increased need for services in the last 3 months of life. The pathway will commence from the start date outlined on the Aged Care Entry Record.

Older people who require services beyond 12 weeks may:

- continue to draw down from the $25,000 budget up until the 16 week mark, if funding is still available
- access HCP unspent funds, if available
- work with their provider to request an urgent Support Plan Review to move to an ongoing Support at Home classification.

14.4 Access to the End-of-Life Pathway

The End-of-Life Pathway is available to participants already accessing Support at Home as well as older people who are not currently accessing services through the Support at Home program. Information for existing participants is in section 14.4.2 and information for new participants is in section 14.4.3.

14.4.1 The End-of-Life Pathway Form

The End-of-Life Pathway Form is required to be completed and submitted before a participant can be assessed as eligible for the End-of-Life Pathway. The form captures specific medical information related to the participant's medical condition and evidence of end-of-life.

The participant, their supporter or substitute decision maker, or the provider must download the form and provide this to the appropriate medical practitioner (their GP, non-GP specialist or nurse practitioner) for completion. Upon completion, the form will need to be submitted for consideration by the aged care assessor.

More information on the End-of-Life Pathway Form, including where to access and submit the form, will be available for 1 July 2025.

14.4.2 Existing Support at Home participants

If eligible, existing Support at Home participants can transition from an ongoing classification to the End-of-Life Pathway via a high-priority Support Plan Review. The End-of-Life classification replaces the previous ongoing classification and a budget of $25,000 is allocated to the participant under the End-of-Life Pathway.

Where possible, participants are encouraged to retain their existing provider, if their provider can meet their needs under the End-of-Life Pathway. While it is possible to change providers to access the End-of-Life Pathway, it is generally not recommended given the risk of delays in receiving services.

The table below outlines how **existing Support at Home participants can access the End-of-Life Pathway**.

Existing participants: Access to the End-of-Life Pathway	

1.	Existing Support at Home participants should ideally work with their current aged care provider to access the End-of-Life Pathway.
	Assistance from the provider may include:
	• downloading and discussing the End-of-Life Pathway Form and medical eligibility for the Pathway, noting that eligibility includes 3 months or less to live AND a Karnofsky score of 40 or less
	• assistance to access their GP, non-GP specialist or nurse practitioner who can provide the necessary medical evidence and sign the End-of-Life Pathway Form. Once completed and signed, the form can be:
	  ○ uploaded through the 'Make a Referral' or 'GP e-referral' channels (this triggers a request for a high-priority aged care assessment) OR
	  ○ returned to the participant to be submitted to My Aged Care.

Existing participants: Access to the End-of-Life Pathway	
	• requesting a high priority Support Plan Review though the My Aged Care Service and Support Portal, which can include suggested services the participant may need, for consideration by the aged care assessor. At this time, the completed End-of-Life Pathway Form should be uploaded. • As an alternative to the provider requesting a high priority Support Plan Review, an existing participant may contact My Aged Care who can also request a high-priority Support Plan Review.
2.	An aged care assessor undertakes an high-priority Support Plan Review using information in the system obtained from the End-of-Life Pathway Form and any additional information provided by the participant's care partner.
3.	The participant is approved for the End-of-Life Pathway and receives a Notice of Decision and new support plan.
4.	The provider must accept the referral in the My Aged Care Service and Support Portal, and notify Services Australia of the participant's entry to the program via the Aged Care Entry Record (ACER) form (AC021). The provider must continue to work with the participant to plan and coordinate the required services. Care coordination should include the participant's doctor, medical team and/or any state or territory palliative care services. Information relating to the services being delivered and information from treating professionals and palliative services should be documented by the provider.

14.4.3 New participants

Older people who are not currently accessing Support at Home, who would like to access the End-of-Life Pathway, can be referred for a high-priority aged care assessment. An aged care assessor will confirm their eligibility for the End-of-Life Pathway and approve a list of services they may access.

The table below outlines how **new participants, not currently accessing Support at Home, can access the End-of-Life Pathway**.

New participants: Access to the End-of-Life Pathway	
1.	The older person, their supporter or substitute decision maker, acting with their consent or on behalf of them in accordance with a state or territory arrangement, may take any of the following steps to initiate access to the End-of-Life Pathway:

New participants: Access to the End-of-Life Pathway	
	Option 1: Access their GP, non-GP specialist or nurse practitioner to discuss their eligibility for the End-of-Life Pathway. The medical practitioner can then either: • complete and sign a copy of the End-of-Life Pathway Form and upload through the 'Make a Referral' or 'GP e-referral' channels (this triggers a request for a high-priority aged care assessment) OR • complete and sign a hardcopy of the End-of-Life Pathway Form and give to the older person to submit. The older person or their supporter will then need to contact My Aged Care to request an assessment. **Option 2:** Apply online for an aged care assessment via the My Aged Care website. If an End-of-Life Pathway Form has already been signed by a medical practitioner, it can be uploaded at this time. Otherwise, completion of the End-of-Life Pathway Form can be arranged prior to assessment by accessing a General Practitioner, non-GP specialist or nurse practitioner. **Note:** A high-priority aged care assessment will be requested regardless of whether an End-of-Life Pathway Form has been uploaded through the 'apply online' service. **Option 3:** Contact My Aged Care on 1800 200 422 or visit an Aged Care Specialist Officer (ACSO) at a Services Australia service centre to request access to the End-of-Life Pathway. My Aged Care will register, screen and refer the older person for a high-priority aged care assessment. The older person will need to access their GP, non-GP specialist or nurse practitioner to complete the End-of-Life Pathway Form (if they haven't already done so) and provide the form to their assessor at their aged care assessment.
2.	An aged care assessor undertakes an assessment with the older person using the Integrated Assessment Tool (IAT) to determine eligibility for the End-of-Life Pathway and the services they require.
3.	The participant is approved for the End-of-Life Pathway and receives a Notice of Decision and support plan. As part of the Notice of Decision, an aged care assessor will provide an inactive ongoing Support at Home classification. The inactive classification can be used at the conclusion of the End-of-Life Pathway, in the event that the older person requires services beyond the funding period.

New participants: Access to the End-of-Life Pathway	
4.	The participant engages a Support at Home provider that can deliver the recommended services. The provider will first need to accept the referral in the My Aged Care Service and Support Portal, and notify Services Australia of the participant's entry to the program via the Aged Care Entry Record (ACER) form (AC021).
5.	The provider assigns the participant a care partner and works with the participant to plan and coordinate the required services. Care coordination should include the participant's doctor, medical team and/or any state or territory palliative care services. Information relating to the services being delivered and information from treating professionals and palliative services should be documented by the provider.

14.5 Care management for the End-of-Life Pathway

Like ongoing Support at Home services, participants receiving services under the End-of-Life Pathway must also receive care management through a Support at Home provider, by a staff member known as a care partner.

Care management activities for the End-of-Life Pathway are outlined in section 7.3. In addition to these activities, care partners must ensure there is robust liaison and care coordination with the participant's doctor, medical team and/or any state or territory palliative care services. This is essential to ensure the participant is receiving holistic and sufficient care.

Care management for the End-of-Life Pathway needs to be claimed directly from the participant's End-of-Life Pathway budget. There is no cap on the amount of care management that can be claimed under the End-of-Life Pathway. This recognises there may be significant planning and coordination required with medical teams and state and territory support services. However, it is expected that care management claims are proportionate and in the best interests of the participant.

14.5.1 Care plan

A care plan should be developed for participants receiving services under the End-of-Life Pathway, in the same way as for ongoing classifications as described in section 7.6.

More information on the care plan for the End-of-Life Pathway will be available for 1 July 2025.

14.6 Services

End-of-Life Pathway participants can access services from the Support at Home service list, determined on a needs-basis in accordance with their high-priority aged care assessment or high-priority Support Plan Review.

Participants under the End-of-Life Pathway may be approved to receive funding for assistive technology however, they are not eligible to receive any funding for home modifications. The only exception to this is if home modifications were already underway for an existing participant prior to entering the End-of-Life Pathway. In these cases, the home modification may be completed.

14.6.1 Palliative care services

Participants accessing the End-of-Life Pathway will likely need palliative care to support them to stay at home.

The Australian Government provides funding to state and territory governments for the delivery of generalist and specialist palliative care services in their jurisdictions. This arrangement enables each state and territory government to make decisions about the provision and delivery of palliative care services in their health systems, to meet the needs of their community. This forms part of their responsibilities through hospital and community service provision.

The End-of-Life Pathway is designed to complement these services. For example, an older person may access palliative nursing services and medication management through state and territory services, while utilising Support at Home funding to access additional meals and personal care. Care partners will be required to work as part of a multi-disciplinary team to ensure the mix of services under Support at Home is complementary, coordinated and in the best interests of the older person.

14.6.2 Aboriginal and Torres Strait Islander end of life care

Palliative care services for Aboriginal and Torres Strait Islander participants include:

- Aboriginal and Torres Strait Islander Peoples Palliative Care Resources - Palliative Care Australia
- Gwandalan National Palliative Care Project
- Indigenous Program of Experience in the Palliative Approach (IPEPA)

Aboriginal and Torres Strait Islander participants are also able to access Aboriginal or Torres Strait Islander Health Practitioner and Health Workers under the service list, in addition to cultural support.

More information on the Support at Home service list is in section 9.2.

14.6.3 Case study

Sanjeeta

End-of-Life Pathway

Sanjeeta would like to remain living at home following a diagnosis of terminal cancer.

Sanjeeta is a Support at Home participant accessing services through a Classification 5. Last week, Sanjeeta received a diagnosis of late-stage pancreatic cancer and was given a prognosis of 2-3 months to live.

Sanjeeta communicates her strong wishes to receive palliative care services at home. Sangeeta's medical practitioner liaises with a specialist community palliative care service and arranges a joint meeting with the treating team, palliative care service, and Sanjeeta's family to discuss options for care.

While the medical team support Sanjeeta and her family to arrange in-home palliative care services, her daughter Ava (who is her appointed supporter and helps communicate on her behalf) contacts the existing Support at Home care partner to discuss Sanjeeta's diagnosis.

Sanjeeta's care partner suggests the End-of-Life Pathway and explains that the Pathway will allow Sanjeeta to receive increased support over a 12-week period. The care partner advises that, if Sanjeeta would like to proceed, the End-of-Life Pathway Form will need to be completed and the eligibility requirements (3 months or less to live and a Karnofsky score of 40 or less) would need to be met.

Following the advice from the care partner, Ava discusses the options with Sanjeeta who agrees to proceed. Sanjeeta and Ava access their GP who provides Sanjeeta with a score of 40 on the Australia-modified Karnofsky Performance Scale (AKPS) reflecting that she is in bed more than 50% of the time. The medical practitioner completes and signs the End-of-Life Pathway Form. Ava provides the care partner with the signed form and the care partner requests a high-priority Support Plan Review (SPR) via the My Aged Care Service and Support Portal. The care partner uploads the form when applying for the SPR.

An aged care assessor completes the Support Plan Review and Sanjeeta is approved for the End-of-Life Pathway. She receives a Notice of Decision and is advised that her ongoing Classification 5 will become inactive while she accesses services under the End-of-Life Pathway.

Sanjeeta's care partner continues to provide care management activities including liaising with palliative care nursing services which are provided and funded through the state government in Victoria (where Sanjeeta resides). The care partner provides Ava with Hindi resources from Palliative Care Australia which she can share with Sanjeeta and the extended family.

To keep Sanjeeta comfortable and reduce the risk of pressure areas, the care partner organises a pressure care mattress for Sanjeeta as she has approval for AT.

Working closely together, Ava, the care partner and the state-based palliative care service continue to liaise, coordinate and provide the required services to keep Sanjeeta safe, secure and comfortable.

Nine weeks after commencing the End-of-Life Pathway, Sanjeeta passes away. Ava notifies Sanjeeta's provider that her mother has passed away and the provider then notifies Services Australia.

14.6.4 Palliative care resources for providers

The Australian Government provides funding for education, experiential learning and resources in the Palliative Approach to Care. The Program of Experience in the Palliative Approach – PEPA is available to all aged care workers.

Aged care workers are expected to utilise a palliative approach to care when caring for older people across the three tiers of support for aged care. In 2020, PEPA released Learning Guides for Care Workers as a learning resource on adopting a palliative approach to care. An aged care worker who has a working knowledge of the palliative approach to care will be able to assess and plan for the palliative care and end-of-life needs of participants.

The End of Life Directions for Aged Care (ELDAC) Project, aims to improve the palliative care skills and advance care planning expertise of aged care providers and GPs providing health care for recipients of aged care services. ELDAC provides a range of resources to support aged care workers to deliver quality palliative care including toolkits, services to improve connections between aged, primary and palliative care services and palliative care navigation services.

Also available to the aged care sector is palliAGED, a resource that provides palliative care evidence and practice information for those providing care and for older people in Australia, their families and friends. palliAGED is managed through the Flinders University CareSearch project.

Additional palliative care resources include:

- National Palliative Care Standards - Palliative Care Australia
- Palliative care initiatives and programs | Australian Government Department of Health and Aged Care
- National guidelines for spiritual care in aged care

14.7 Participant contributions

Consistent with ongoing Support at Home, participant contribution arrangements apply for independence and everyday living services accessed under the End-of-Life Pathway. For services in the clinical supports category (for example, nursing), no participant contribution is required as these services are fully funded by government.

More information on participant contributions under Support at Home is in section 8.4.

14.8 Exiting from the End-of-Life Pathway

Exit from the End-of-Life Pathway may take place for one of the following reasons:

- the participant has passed away
- the participant no longer wishes to, or is no longer able to, remain at home
- the participant has a change in medical circumstances and services under the End-of-Life Pathway are no longer required
- the period of funding for the End-of-Life Pathway has finished (maximum 16 weeks).

In the event that the participant requires ongoing Support at Home services following the completion of the End-of-Life Pathway, the following will apply:

- participants who were accessing ongoing Support at Home services prior to accessing the End-of-Life Pathway can be transferred to their previous Support at Home classification via a high-priority Support Plan Review.
- participants who were new to Support at Home when they commenced the End-of-Life Pathway can be transferred to the inactive classification that was assigned at their aged care assessment, via a high-priority Support Plan Review.

In the event of death or if Support at Home services are no longer required, providers will be required to advise Services Australia.

More information on permanently exiting Support at Home is in section 11.4.

Part E: Provider payment arrangements

This section covers:

- Provider claiming
- Payments to providers
- Monthly statements for participants

15.0 Provider claiming and payment arrangements

This chapter covers
15.1 Overview 15.2 Claiming process 15.3 Submitting a claim 15.4 Claiming rules 15.5 Validation and payment of a claim 15.6 Allocation and payment of care management funding

Provider responsibilities
Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities. The Aged Care Act 2024: • Chapter 4, Part 2, Divisions 1, 2, 3 and 6 of the Act   Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025. The strengthened Quality Standards are relevant throughout this program manual as a whole and providers should familiarise themselves with them. Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember
• Providers must be registered for the specific registration category that the service is being claimed from. • Services delivered under Support at Home will be paid on a payment in arrears basis. • Providers must only claim for services that have been approved in the participant's Notice of Decision. • Providers should be accurate in their claiming and claim the prices associated with the services delivered, even if they have exceeded the funding available.

Key points to remember
• Providers must keep evidence of all services and purchases to support their claims.

15.1 Overview

This chapter outlines the provider claiming and payments arrangements for Support at Home, including rules for claiming. Services delivered under Support at Home will be paid on a payment in arrears basis. Services Australia manages and processes payment claims, including calculating participant contributions.

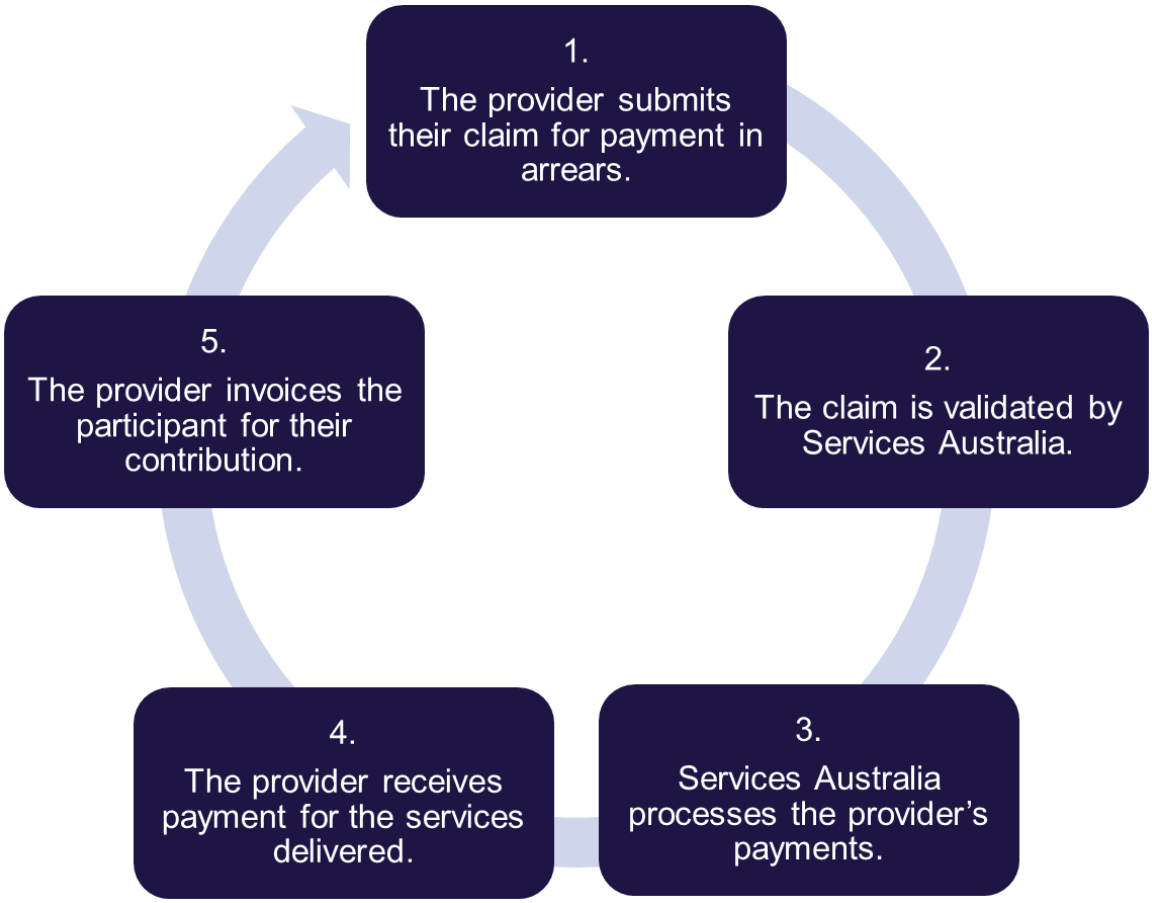
Providers must only claim for services that have been approved in the participant's Notice of Decision and support plan and must only claim for the agreed price.

To support claims, providers should keep evidence of all services and purchases.

Participant contributions will be collected by and paid directly to the provider.

15.2 Claiming process

The diagram below outlines the **process for provider claiming**.



15.3 Submitting a claim

Providers claim for services delivered through the Services Australia Aged Care Provider Portal or business-to-government (B2G) software.

Claims must include an itemised list of all services and supports, including care management and AT-HM, delivered for the period.

For ongoing services, a provider has 60 days after the last day of the quarter to submit their claim for each participant. The last day of the quarter will be the last day in September, December, March or June. The start and end date of each quarter can also be viewed through the providers claiming portal.

For short-term services, a provider has 60 days after the completion of the episode to submit their claim for each participant. For participants receiving both short-term and ongoing services, providers should ensure services are claimed against the correct budget. For example, if a participant is receiving both restorative care and ongoing services, claims for restorative care services must only be submitted against that funding source.

Providers can determine the frequency of their claiming and can submit claims daily, weekly, fortnightly, monthly or quarterly.

Providers should be accurate in their claiming and claim the prices associated with the services delivered, even if they have exceeded the funding available for the period.

Claims must be itemised against the correct funding source (i.e., ongoing quarterly budget, care management account, restorative care budget, HCP unspent funds etc).

The table below outlines what **information a provider must submit for a successful claim**.

No.	Claim details
1.	Be registered for the specific registration category that the service is being claimed from.
2.	Ensure the participant has been allocated funding for Support at Home services.
3.	Claim only for services delivered: • that the participant has been approved to receive through their aged care assessment, and • for the period when the participant is in the care of the provider (i.e., the provider cannot claim for a service delivered before the entry date on the Aged Care Entry Record or after the participant's exit date).

No.	Claim details

4.	Include the following mandatory information:
	• an identifier of the participant who received the service (for example, participant name, participant MAC ID, Services Australia participant identifier)
	• an identifier of the provider
	• a service identifier of the service type provided to the participant:
	  ○ service type
	  ○ service
	  ○ service delivered by a third-party organisation indicator, if applicable
	  ○ service unit type
	  ○ service unit price
	• The funding details of the service delivered:
	  ○ the number of units of the service
	  Note: if the unit type is in hours, then part hours claims (for example, 15, 30, 45 minutes) can be submitted.
	Note: For AT-HM Scheme claims, additional mandatory information will be required to identify the item, prescription (if needed) and wrap around services provided.

5.	Completed provider declaration.

15.4 Claiming rules

The table below outlines the **claiming rules for all provider claims**.

Specific rules for care management, AT-HM, the Restorative Care Pathway and the End-of-Life Pathway are outlined in subsequent sections.

More information on claiming through the Aged Care Provider Portal is available from Service's Australia claiming guidance (available for 1 July 2025).

Rule	Details
Timeframe for submission	Claims for the previous quarter must be finalised within 60 days of the start of the new quarter (or 60 days after short term care concludes).
Service date	The service delivery date being claimed for cannot be in the future.

Rule	Details
Frequency	Claims can be submitted up to daily. Once a claim is finalised and submitted for a day, no further claims for this day can be submitted.
Claim amount	Providers must claim the full cost of services delivered within the quarter. If the participant's budget is insufficient, the provider will only be paid up to the level of the budget remaining. The provider will need to absorb the outstanding cost or, with prior agreement, invoice the participant (refer to section 8.7.3). Outstanding amounts cannot be added to future claims unless a system error occurred.
Evidence	Providers must be able to provide evidence for all claims including confirmation of delivery for services delivered by the provider and services delivered through third-party arrangements.
Exits	For exiting participants, claims must be finalised within 60 days from the participant's exit date, unless an exception is approved.
Exceptions process	Exceptions to claiming rules may apply under specific circumstances, such as (but not limited to): • technical difficulties • staff shortages • Commonwealth administrative error • participant death. In such cases: • request for an exception should be submitted within 60 days with evidence provided. • The Service Australia delegate may approve variations, but once the participant's account is closed (for example, following the death of a participant or entry into permanent residential aged care), no further exceptions are allowed. More information is in Service's Australia claiming guidance.
Audit or review	Claims with unusual patterns, such as sudden price increases or excessive budget utilisation, may be flagged for review. For example, claiming more than

Rule	Details
	50% of a participant's quarterly budget in a single invoice could trigger a review for program assurance purposes. For short term service claiming, high percentages of non-allied health or nursing service claims (in restorative care) or high levels of care management (for the Restorative Care or End-of-Life pathways) may be flagged for review.
Cancellations and no shows	Information about cancellation of services and no show policy is subject to consultation on the Rules and will be available for 1 July 2025.

15.4.1 Claiming for care management

The table below outlines **additional claiming rules specific to claiming for care management services**.

Care management rule	Details
Funding source	Funding for care management services for ongoing classifications will be drawn from the **Care Management Account**.
Care management for short-term pathways	Providers must not use the care management account to claim for care management services delivered under the Restorative Care Pathway or the End-of-Life Pathway. These claims should be made against the respective **Restorative Care Pathway Payments** account or the **End-of-Life Budget account**.
Submission and rules	The care management account can only be used by providers for care management services. Claims against the care management account are subject to all other submission and claiming rules outlined in sections 15.3 and 15.4.

15.4.2 Claiming for AT-HM

The table below outlines **additional claiming rules specific to claiming for AT-HM services and supports**.

AT-HM rule	Details
Funding source	Funding for assistive technology will be drawn from the **Assistive Technology fund** account. Funding for home modifications will be drawn from the **Home Modification fund** account. Claims for AT-HM should also include prescription, wrap-around services, AT administration and home modification coordination costs. **Note:** In the first instance, a claim for AT-HM must draw down on HCP Commonwealth unspent funds from the funding source **HCP Commonwealth unspent funds** where these are available.
Timeframe	Providers can issue a claim for payment at any time and up to 60 days post the 12-month allocation period ending.
Prescription	For AT-HM services requiring prescription, providers cannot submit a claim until the prescription is available. The prescription can be claimed separately to the AT-HM item and can be claimed prior to the claim for the AT HM item.
Price for assistive technology	The price claimed for the AT items should match the invoice or other evidence provided. If a provider submits a claim for assistive technology that is above the allocated high tier nominal cap of $15,000, the provider must seek approval of the required additional amount, prior to submission of any claims. In seeking approval, the provider must provide supporting evidence of need such as a prescription and quote, as well as: • service type and service • item description, justification for purchase and any conditions • whether the item is purchased or loaned • declaration that the provider has followed the AT-HM Scheme guidelines.

AT-HM rule	Details
Price for home modifications	Providers can submit one or more quotes for home modifications at the time of claiming. Claims for progress payments can be made over time as needed.
Repairs and maintenance	Repairs and maintenance should be claimed from the relevant AT-HM funding source. If there are insufficient funds for AT-HM, or the allocation period has passed, providers must claim from the **HCP Commonwealth unspent funds** account, if available. If no HCP Commonwealth unspent funds are available, the provider can submit a request for a Support Plan Review.
Provider declaration	On submission of the claim, providers must make the following declaration: • *I hereby confirm that I am registered for the service/s that I am providing, and all claims submitted are accurate and complete. All supporting documentation related to these claims is readily available and can be provided upon request.*
Submission and rules	Claims against the AT-HM accounts are subject to all other submission and claiming rules outlined in sections 15.3 and 15.4.
Evidence	Providers must retain all invoices for services claimed under AT-HM. For prescribed AT-HM, additional evidence is required and this is outlined in section 12.6. Where quotes have been provided these should also be retained.

15.4.3 Claiming for the Restorative Care Pathway

Restorative care rule	Details
Funding source	Funding for restorative care services will be drawn from the **Restorative Care Pathway Payments** account. **Note:** When a participant is receiving services through an ongoing classification and the Restorative Care classification at the same time, the provider will need to:

Restorative care rule	Details
	• manually select the funding source **client quarterly budget** for claiming services as part of the ongoing classification. • Manually select the funding source **Restorative Care Pathway Payment** for claiming services as part of the restorative care classification. A provider does not need to specify the funding source if the participant is only accessing the restorative care classification.
Timeframe	An episode of restorative care commences from the start date outlined in the participant's goal plan. All claims must be finalised within 60 days of completion of the episode.
Care management services	No separate care management account is available for the Restorative Care Pathway. Providers will claim for restorative care management services from the **Restorative Care Pathway Payments** account. There is no cap on claims for care management services for the Restorative Care Pathway. Providers must not use the **Care Management Account** (used for care management services for ongoing Support at Home classifications) to claim for restorative care management services.
Insufficient funds	If there are insufficient funds within the restorative care funding source, providers can claim from the **HCP Commonwealth unspent funds account**, if funding is available.
Submission and rules	Claims for the Restorative Care Pathway are subject to all other relevant submission and claiming rules outlined in sections 15.3 and 15.4.

15.4.4 Claiming for the End-of-Life Pathway

End-of-life rule	Details
Funding source	Funding for end-of-life services will be drawn from the **End-of-Life budget** account.

End-of-life rule	Details
Timeframe	All claims must be finalised within 60 days of the completion of the episode.
Care management	No separate care management account is available for the End-of-Life Pathway. Providers will claim for end-of-life care management services from the **End-of-Life budget** account. There is no cap on claims for care management services for the End-of-Life Pathway. Providers must not use the **Care Management Account** (used for care management services for ongoing Support at Home classifications) to claim for end-of-life care management services.
Ongoing Support at Home services	If a participant is receiving ongoing Support at Home services and enters the End-of-Life Pathway, claiming for ongoing services will be disallowed for the period of the end-of-life episode. However, the participant's ongoing quarterly budget will continue to be credited.
Insufficient funds	If there are insufficient funds within the end-of-life funding source, providers can claim from the **HCP Commonwealth unspent funds account**, if funding is available.
Submission and rules	Claims for the End-of-Life Pathway are subject to all other submission and claiming rules outlined in sections 15.3 and 15.4.

15.4.5 Transitioned HCP recipients and claiming from the HCP Commonwealth unspent funds account

Transitioned HCP recipients who had unspent funds as at 30 June 2025 retained these funds for use under Support at Home.

When funds in the quarterly budget, restorative care budget or end-of-life budget are exhausted, providers can claim from a participant's HCP Commonwealth unspent funds, if available. The prioritisation of claiming is:

1. participant quarterly budget or restorative care budget or end-of-life budget
2. HCP Commonwealth unspent funds.

For AT-HM, HCP Commonwealth unspent funds must be used, if available, before AT- HM funding tiers are accessed. For AT-HM, the prioritisation of claiming is:

1. HCP Commonwealth unspent funds
2. AT and/or HM budget.

15.5 Validation and payment of a claim

Services Australia will validate the provider's claim to process the payment.

When the provider's claim for services is finalised, Services Australia will:

- deduct the government funded amount and the participant contribution rate from the participant's budget
- pay the provider the government funded amount.

Claims submitted online to Services Australia are expected to be approved and payments made within a 7 day processing timeframe.

The table below outlines the information that Services Australia must validate before finalising a claim.

Note: If a claim fails validation, the Services Australia Aged Care Provider Portal will generate an error message. This error message will detail the specific issue that the provider must address to successfully resubmit a claim.

No	Description
1.	A participant must be a valid My Aged Care client and have a current Support at Home classification allocation.
2.	The participant must be approved for the service(s) the claim is being made for.
3.	The participant must have sufficient quarterly budget and/or other relevant funding sources.
4.	Where a participant has simultaneous program entries e.g., Support at Home and residential respite at the same time, different services can be claimed for on the same date, however the same service can only be claimed from both programs on the entry and exit dates (e.g., the service of nursing cannot be claimed by the Support at Home provider or residential respite provider for the same day except on entry or exit for the respective programs).
5.	Where a client exits Support at Home and enters residential care on the **same day,** services from both programs can be claimed on the residential care entry date, regardless of whether they are the same services or not.

No	Description
	Services delivered through Support at Home can only be claimed for up to the residential care entry date. **Note:** A client may be approved to access both Support at Home and residential care, however a client cannot be entered into Support at Home and residential care at the same time.
7.	Any extra validation rules for services or service types must also be met.

15.5.1 Adjustments

Information on adjustments to claiming or payments is in Service's Australia claiming guidance (available for 1 July 2025).

15.6 Allocation and payment of care management funding

Support at Home participants, who receive ongoing services, have 10% deducted from their quarterly budget for care management. This funding will be pooled together with the care management funding from all other participants. Pooling of funds will take place at the service delivery branch level of a provider. Care management funding is credited to the provider's care management account/s on the first day of each quarter (July, October, January and April).

Services Australia will calculate the amount of care management funding to be allocated to each provider and will hold this in the care management account for provider's to claim against. The amount of care management funding for the next quarter will be calculated on the last day of each quarter (that is, the last day of September, December, March and June).

Calculation of care management funding will be based on:

- **Care management funding =** care management quarterly base rate + care management quarterly supplement.
- **Care management quarterly base rate =** 10% from each participant's ongoing quarterly budget.
- **Care management quarterly supplement =** 12 hours of care management divided by 4 quarters.

Providers must use this funding to claim for care management services delivered to their participant cohort during the quarterly period.

Providers will not receive care management funding for new (or transferring) participants as soon as the participant commences. Rather, a provider must submit the entry details of the new (or transferring) participant to Services Australia before

the last day of the quarter. Services Australia will then calculate the pro-rata care management funding for the participant for the next quarter and allocate this to the provider at the start of the following quarter.

Note: While providers will not immediately receive care management funding for new or transferring participants, the funding available to the participant (i.e. 90% of the Support at Home classification) will remain the same.

If there is a change to a participant's budget during the quarter (e.g. they are re-assessed or there is a change in indexation), care management funding will be adjusted on a pro-rata basis from the date of the change and allocated to the provider.

When a new provider is established, care management funding for participants will be calculated on a pro-rata basis for the first and second quarters of operation. The first quarter of operation for the provider is determined from the date of the earliest participant entry notification. During the first and second quarters of operation, the provider will receive a pro-rata amount of care management funding for any new participant. From the third quarter onwards, new providers will receive care management funding on the first day of the following quarter for their participant cohort.

15.6.1 Carryover of care management funding

A provider's unspent care management funding will carryover to the following quarter, with no limit, in a single financial year. However, there is a limit to how much care management funding can be carried over from Quarter 4 of a financial year to Quarter 1 of the next financial year. The carryover amount is limited to the value of the provider's Quarter 4 care management funding.

For example:

A provider was allocated $2,500 of care management funding on 1 April (at the start of Quarter 4) in financial year 2025-26. This was added to $1,000 of carryover funding from Quarter 3 to make a total of $3,500 of care management funding available for Quarter 4.

On 30 June (the last day of Quarter 4 and last day of the 2025-26 financial year) the provider had $2,750 of care management funding remaining.

In Quarter 1 of the 2026-27 financial year, the provider will carryover $2,500 in care management funding. The remaining $250 will be returned to the Government, as this amount exceeds the value of the provider's Quarter 4 care management funding.

New providers who started operation in Quarter 3 or Quarter 4 of the financial year will not have a limit on their carryover amount. These providers will carryover all unspent care management funding to Quarter 1 of the new financial year.

For example:

A new provider commenced operations in Quarter 3 of the 2025-26 financial year (their first participant had a start date in Quarter 3). The provider was allocated a total of $1,000 of care management funding for the remainder of Quarter 3 and $3,500 of care management funding for Quarter 4 (under a pro-rata basis).

On 30 June (the last day of Quarter 4 and last day of the 2025-26 financial year) the provider has $3,000 remaining in their care management account. This consists of:

- Quarter 4 care management funding
- carryover from Quarter 3.

In Quarter 1 for the 2026-27 financial year, the provider will carryover the entire leftover care management funding of $3,000.

16.0 Participant statements

This chapter covers:

16.1 Overview
16.2 Inclusions for monthly statements

Provider obligations

Providers will need to review legislation to ensure compliance with the requirements for registered providers. In addition to the obligations outlined in Part B, the summary below provides a high-level reference for providers. This is not an exhaustive list of all provider obligations and responsibilities.

Information relating to Rules and provider responsibilities is subject to consultation and parliamentary processes. References will be updated prior to 1 July 2025.

The strengthened Quality Standards are relevant throughout this program manual as a whole and providers should familiarise themselves with them.

Refer to Appendix 1 for further detail on provider responsibilities.

Key points to remember

- Monthly statements outline the funding available, services delivered, contributions made by the participant and remaining funding available for a calendar month period.
- Providers must issue monthly statements to participants no later than the last day of the following month.
- Providers must issue a final statement to participants upon cessation of ongoing services, the Restorative Care Pathway and/or the End-of-Life Pathway.

16.1 Overview

Providers are required to issue monthly statements to participants to show what has been spent on Support at Home services and the remaining budget available.

Under the strengthened Quality Standards, providers are required to communicate critical information relevant to the participant's care and services. Providers can demonstrate they meet this requirement by implementing systems for communicating structured information and providing statements to participants.

A statement should clearly show services delivered so that the participant and/or their supporter can easily understand how and what the provider is charging.

For ongoing and short-term classifications, providers must issue participants with a statement each month and a final statement upon exiting Support at Home.

The statement must be issued no later than the last day of the following month. For example, if services are delivered in August, the provider must provide the August statement no later than 30 September.

For restorative care and end-of-life classifications, providers must issue a final statement at the conclusion of the episode.

16.2 Inclusions for the monthly statement

Information related to inclusions for monthly statements is subject to consultation in April 2025 and subsequent finalisation of the Rules.

The table below outlines what information must be **itemised in the monthly statement**.

To support providers, further guidance on monthly statements will be available via the department's website prior to 1 July 2025.

Inclusions	Details
Funding for ongoing services, the Restorative Care Pathway or the End-of-Life Pathway	• The amount of funding available to the participant for the quarter or for their episode of restorative care or end-of-life services. • The amount of funding available in the participant's ongoing home support account at the start of the calendar month. • The amount of funding for the participant remaining at the end of the calendar month.

Inclusions	Details

	• The name and amount of any primary supplements allocated to the participants home support account for the quarter.
	• The carryover funding from the previous quarter, if any.
	• For ongoing classifications, the amount of money from the budget that has been allocated to the Care Management Account for the quarter.
	• The total of HCP unspent funds (for transitioned HCP recipients) including:
	  ○ The provider held Commonwealth portion
	  ○ the participant's portion.
	Note: If the participant is receiving ongoing Support at Home services at the same time as the Restorative Care Pathway, the statement should clearly outline what funding amount applies to each classification.

Funding for AT-HM	• The amount of assistive technology and/or home modification funding available to the participant for the allocation (12-month) period. • The amount of assistive technology and/or home modification funding available in the participant's assistive technology account and/or home modifications account at the start of the calendar month. • Any forward commitments for AT-HM that have been made during that month to ensure sufficient funding is available to meet these commitments when they require payment. For example, if an AT item has been ordered, it should show as a commitment for that month. • The amount of assistive technology and/or home modification funding for the participant remaining at the end of the calendar month. **Note:** Funding for assistive technology and home modifications are in separate accounts and must be displayed separately.

Services delivered	• Itemised list of each service or item (including AT-HM) delivered during the calendar month, including:
	  ○ the name of the service or item as per the service list
	  ○ the price charged by the provider
	  ○ the date the service was delivered

Inclusions	Details
	• the number of hours or units of each service delivered. The name of the supplier for any third-party services or items delivered. • Any AT-HM services or items purchased or delivered or committed.
Participant contributions	• The contribution rate paid or will be paid by the participant for each service or item (including AT-HM) delivered in the calendar month. • The total amount of contribution paid by the participant for the calendar month • The total amount of contribution owing from the participant for the calendar month.
Adjustments or refunds	• Any adjustments or refunds from previous months, including the service name and delivery date if relating to a service.
Expiry of funding	• Expiry dates of funding AT-HM, restorative care or end-of-life services, if applicable. • Any funding that expired during the calendar month for AT-HM, restorative care or end-of-life services.

Part F: Program linkages

This section covers:

- Interactions with other programs and schemes
- Grants
- Business and Workforce Advisory Service
- Service Development Assistance Panel

17.0 Interactions with other programs and schemes

17.1 Overview

While a participant receives services under Support at Home, it may be possible for them to also receive services and supports through a range of other programs and schemes to access specialised services or access additional short-term services.

The Act and its Rules governs how the Support at Home program interacts with other programs. As providers of services under the program, providers must comply with these laws.

More information on participant programs are on the My Aged Care website. Participants can also call the My Aged Care Contact Centre on **1800 200 422**.

17.2 CHSP and Support at Home

Information is subject to consultation on the Rules and parliamentary processes. This section will be updated prior to 1 July 2025.

17.3 Transition Care Program (TCP) and Support at Home

Information is subject to consultation on the Rules and parliamentary processes. This section will be updated prior to 1 July 2025.

17.4 Residential aged care and Support at Home

Information is subject to consultation on the Rules and parliamentary processes. This section will be updated prior to 1 July 2025.

17.5 Multi-Purpose Services (MPS) Program and Support at Home

Information is subject to consultation on the Rules and parliamentary processes. This section will be updated prior to 1 July 2025.

17.6 Aboriginal and Torres Strait Islander aged care services

Information is subject to consultation on the Rules and parliamentary processes. This section will be updated prior to 1 July 2025.

17.7 National Disability Insurance Scheme and Support at Home

Information will be available for 1 July 2025.

17.8 Disability Support for Older Australians (DSOA) program and Support at Home

Information is subject to consultation on the Rules and parliamentary processes. This section will be updated prior to 1 July 2025.

17.9 Other

17.9.1 Aged Care Volunteer Visitors Scheme

The Aged Care Volunteer Visitors Scheme (ACVVS), formerly known as the Community Visitors Scheme, supports volunteers to make regular visits to older people who are socially isolated or are at risk of social isolation or loneliness.

The ACVVS provides friendship and companionship by matching individuals with volunteer visitors. Providers should refer participants to ACVVS whose quality of life could be improved by the companionship of a regular volunteer visitor.

As part of the Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, the ACVVS has been expanded to include services that specifically cater for the needs of LGBTI older people.

Support at Home participants can access ACVVS without any impact on their service provision.

More information is on the department's website at Aged Care Volunteer Visitors Scheme (ACVVS).

17.9.2 Continence Aids Payment Scheme

The Continence Aids Payment Scheme (CAPS) is an Australian Government scheme that provides a payment to eligible people with moderate to severe incontinence to assist with some of the costs of their continence products.

Under a Support at Home classification, the amount of care will vary from person to person, depending on factors such as the type of care and services being offered to the person, how and when those services are delivered, and whether some of the available budget is being used for specific items such as aids and equipment.

The care and services provided must be identified in the care plan and must fit within the available budget for the classification. Continence management (non-clinical) is listed under the service type of personal care.

A Support at Home participant can receive assistance under the CAPS as long as they are not already receiving funding for continence aids through Support at Home and as outlined in their notice of decision and support plan.

More information is on the department's website at Continence Aids Payment Scheme (CAPS).

17.9.2.1 National Continence Helpline

A major resource of help for carers is the National Continence Helpline, run by the Continence Foundation of Australia.

The National Continence Helpline is staffed by professional continence nurse advisors who provide prompt and confidential advice and referral for people with incontinence, their families and carers, as well as health professionals and organisations with an interest in continence management.

The National Continence Helpline can arrange for resources and publications and provide advice regarding continence products and suppliers. The National Continence Helpline operates from 8am to 8pm, Monday to Friday on 1800 33 00 66.

18.0 Additional services

18.1 Business and Workforce Advisory Service

The Business and Workforce Advisory Service (BWAS) allows eligible aged care providers – including those in regional, rural and remote areas – to apply for free, independent, and confidential advice to improve their operations.

The service assists providers to review their operations and offers advice on:

- business management
- financial strategies
- workforce challenges.

The Aged Care Business and Workforce Advisory Service provides practical advice to eligible providers. The advice provided is confidential.

More information is on the department's website at Business and Workforce Advisory Service.

18.2 Service Development Assistance Panel

The Service Development Assistance Panel (SDAP) provides free professional support to aged care providers who:

- are in rural or remote areas (MM4 to MM7), or
- provide care to Aboriginal and Torres Strait Islander people.

Panel members help providers in three main areas:

- capability and support
- sector development
- infrastructure project management.

Panel members are qualified and experienced professionals who work with services to improve the way they deliver and administer aged care to address challenges like:

- clinical care
- financial and workforce planning
- governance and regulation

- policies and procedures
- training.

SDAP provides culturally appropriate support to all Aboriginal and Torres Strait Islander aged care services.

More information is on the department's website at Rural, Remote and First Nations Aged Care Service Development Assistance Panel (SDAP)

Part G: Glossary

This section covers:

- Terms and meanings

Term	Meaning
The Act	Aged Care Act 2024.
Aged Care Quality and Safety Commission (the Commission)	The Commission is a statutory body, responsible for overseeing provider compliance with the strengthened Aged Care Quality Standards across the aged care sector.
Aged Care Entry Record (ACER) form	Aged Care Entry Record form (AC021) is used to notify Services Australia of new participants entering care, or changes to existing participants' circumstances.
Assistive Technology and Home Modifications (AT-HM) List	A list that sets out the defined equipment, products, and home modifications that can be purchased for eligible participants under the AT-HM Scheme.
Assistive Technology and Home Modifications (AT-HM) Scheme	The Scheme providing assistive technology and/or home modifications for eligible participants.
Associated provider	An entity that delivers services on behalf of a registered provider.
AT-HM Scheme guidelines	The AT-HM Scheme guidelines provide additional information and processes in relation to the AT-HM Scheme. The guidelines are available in Appendix 3.
Care management	A service involving a suite of activities that contribute to the overall safety, wellbeing, health and quality of life of an older person.
Care management account	An account held by Services Australia where 10% of an ongoing participant's quarterly budget is set aside and pooled together with all other participants within a service delivery branch.
Care partner	A person who provides care management for participants in an ongoing class or accessing the End-of-Life Pathway.
Care plan	The plan a Support at Home participant will develop with their care partner, which outlines what services will be delivered and how.

Term	Meaning
Carryover of unspent quarterly budget	A participant's unspent quarterly budget amount which will carry over to the following quarter.
Claiming	Claiming is the process by which providers submit payment claims to Services Australia for subsidy against services delivered to a participant under Support at Home.
Classification	Refers to the classification of a Support at Home participant, including: • Ongoing classification (Classifications 1-8) • Short-term classifications (AT-HM Scheme, Restorative Care Classification and End-of-Life Classification).
Commonwealth Home Support Programme (CHSP)	The Commonwealth Home Support Programme provides entry level home and community care services for frail older people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over. CHSP will transition to the Support at Home program no earlier than 1 July 2027.
Continuity of Care	A definition for Continuity of Care will be available for 1 July 2025 and following finalisation of the Rules.
Contribution framework	Where a person receives an income support payment such as Age Pension, their income and assets assessment from that will be used to determine their percentage contribution.
The department	The Australian Government Department of Health and Aged Care.
Dignity of risk	The concept that all adults have the right to make decisions that affect their lives and to have those decisions respected, even if there is some risk to themselves.
End-of-Life Pathway	A short-term pathway providing in-home services and supports for participants with a prognosis of three months or less to live who meet eligibility criteria.

Term	Meaning
End-of-Life Pathway Form	A form completed by a medical practitioner or nurse practitioner to determine a participant's eligibility for the End-of-Life Pathway.
Exit plan	Completed upon conclusion of a restorative care episode to ensure next steps are considered. It is formed from the goal plan to determine how a participant has met their goals, and to determine what support may still be required.
Fee Reduction Supplement	The program offers time-limited financial assistance for participants in genuine hardship, processed through Services Australia, with new providers confirming validity if participants change providers.
Goal plan	A document for those accessing the Restorative Care Pathway, outlining specific short-term goals including, services to be delivered and who is responsible for meeting each goal to help the individual regain function. It replaces the service agreement and care plan for people accessing the Restorative Care Pathway.
Government	Unless otherwise noted, the government refers to the Federal Government of Australia.
GPMS	Government Provider Management System
Grandfathered home care package recipient	Refers to home care package recipients who, on 12 September 2024, were receiving a Home Care Package, on the National Priority System, or assessed as eligible for a package. Grandfathered HCP recipients will be no worse off under the contribution arrangements for Support at Home. Also refer to the definition for *transitioned HCP recipient.*
HCP unspent funds	Unspent funds from the participant's Home Care Package budget that are available to use under Support at Home. This includes: • the balance of the provider-held care recipient contributed unspent funds • the provider-held Commonwealth portion of unspent funds

Term	Meaning
	the Services Australia home care account balance (Government held unspent funds).
Home Care Packages (HCP) Program	An Australian Government program that previously provided funding for packages aimed at supporting people to remain living at home. The Home Care Packages Program ceases on 30 June 2025.
Income and assets assessment	An assessment of a participant's income and assets to determine the participant contribution rate. The assessment is completed by Services Australia.
Integrated Assessment Tool (IAT)	A tool used by aged care needs assessors to assess eligibility for older people to access government subsided aged care services. The IAT replaced the National Screening and Assessment Form (NSAF) on 1 July 2024.
Key personnel	Key personnel are: • people responsible for the executive decisions of the applicant (this includes directors and board members), whether or not the person is employed by the applicant. • people having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant, whether or not the person is employed by the applicant. • any person responsible for nursing services provided, or to be provided, by the applicant, whether or not the person is employed by the applicant. • any person who is, or is likely to be, responsible for the day-to-day operation of an aged care service conducted, or proposed to be conducted, by the applicant, whether or not the person is employed by the applicant.
Lifetime contribution limit	The maximum amount a participant will contribute to their care over their lifetime for both in-home and residential aged care services. Once this limit is reached, the participant is no longer required to make further contributions towards their care.

Term	Meaning
Monthly statement	A document provided to participants every month that shows the quarterly budget funds available to that participant, and what has been spent from the budget and contributions paid.
My Aged Care	My Aged Care is the starting point to access Australian Government-funded aged care services. The phone line and website can help older people, their families and carers to get the help and support they need.
My Aged Care Service and Support Portal	My Aged Care Service and Support Portal is the portal that registered Support at Home service providers must use to manage information about their services, their participants and service referrals.
National Assistive Technology Loans Scheme	A rental arrangement through state and territory governments for the provision of high-quality new and refurbished assistive technology goods and equipment.
Notice of Decision	Refers to the letter that details the outcome of an older person's aged care assessment.
No worse off principle	A previous HCP recipient will be no-worse off under Support Home and will not make higher participant contributions than they did under the Home Care Packages program. This applies to grandfathered HCP recipients who, on 12 September 2024, were receiving a Home Care Package, on the National Priority System (NPS) or assessed as eligible to receive an HCP.
Participant	An individual who is receiving services under Support at Home.
Participant contributions	Refers to a participant's contributions on the services they have received under the Support at Home program.
Participant Contributions Framework	A framework outlining the contribution rates participants need to pay based on their income and assets assessment and the services they receive.
Prescribed assistive technology	Assistive technology that requires a prescription from a qualified professional.

Term	Meaning
Primary supplements	Supplements available to eligible participants to help cover the costs associated with specialised care. This includes the oxygen, enteral feeding and veterans' supplement.
Price	The amount a provider will charge for delivering a service in Support at Home, inclusive of both Government subsidy and any participant contributions.
Quarterly budget	A Support at Home participant's annual classification funding amount divided into 4 quarters, with added supplements if applicable.
Registered provider (provider)	A registered provider of aged care is an organisation that has been assessed and approved to provide high-quality, safe and consistent care to older people under the *Aged Care Act 2024*.
Residential aged care	This program provides high levels of care to people in a residential aged care home.
Responsible person	Refer to Section 12 of the *Aged Care Act 2024* for a definition of a responsible person.
Restorative Care Pathway	A short-term pathway providing up to 12 weeks of intensive allied health and/or nursing services and supports aimed to help the participant regain function and/or manage new or changing age related conditions.
Restorative Care Pathway Clinical Guidelines	The Guideline providing information about the characteristics of restorative care, functional decline, and clinical practice points to help support delivery.
Restorative care partner	A person with relevant university health-related qualifications who provides care management services for participants accessing the Restorative Care Pathway. They are responsible for supporting the episode, including coordinating a multidisciplinary team of allied health and/nursing professionals based on the person' individual needs, managing the budget and providing support with reablement.
Rules	The Rules refer to the subordinate legislation of the *Aged Care Act 2024*.

Term	Meaning
Rural and Remote Supplement	Available to participants in areas classified as Modified Monash Model (MMM) 6 or 7 who receive AT-HM funding.
Self-management	A participant-led approach where the participant leads and makes key decisions about when services will be delivered, and in some instances which organisations will provide the services.
Service Agreement	An agreement entered into by a participant and a provider outlining rights and responsibilities and what services will be provided to the participant under the classification. This definition is subject to change based on finalisation of the Rules.
Service Development Assistance Panel (SDAP)	A panel providing free professional support to aged care providers in rural or remote areas or those providing care to Aboriginal and Torres Strait Islander people.
Service list	A defined list of services outlining included and excluded services available to participants under the Support at Home program.
Specified needs	Refers to specified needs that require ongoing and uncapped funding for assistive technology such as assistance dogs.
Strengthened Aged Care Quality Standards (Strengthened Quality Standards)	The strengthened Aged Care Quality Standards came into effect in line with the Aged Care Act 2024. Based on the services being delivered, all providers registered in categories 4, 5 and 6 are expected to be compliant with the relevant standards.
Subsidy	An Australian Government payment made on behalf of a participant for services delivered and claimed for by a provider. This subsidy is paid from a participant's quarterly budget.

Term	Meaning
Support at Home Priority System	Refers to the Support at Home queue and replaces the National Priority System under the Home Care Packages Program. The amount of time an eligible older person will need to wait to access government-funded services will depend on their priority group: urgent, high, medium, standard.
Support plan	A plan developed by an aged care assessor that: • summarises the findings of the participant's aged care assessment • makes recommendations for services and supports • provides guidance on how recommended services may be delivered.
Transitioned home care package recipient	Refers to all existing home care package recipients who transitioned to the Support at Home program on 1 July 2025.