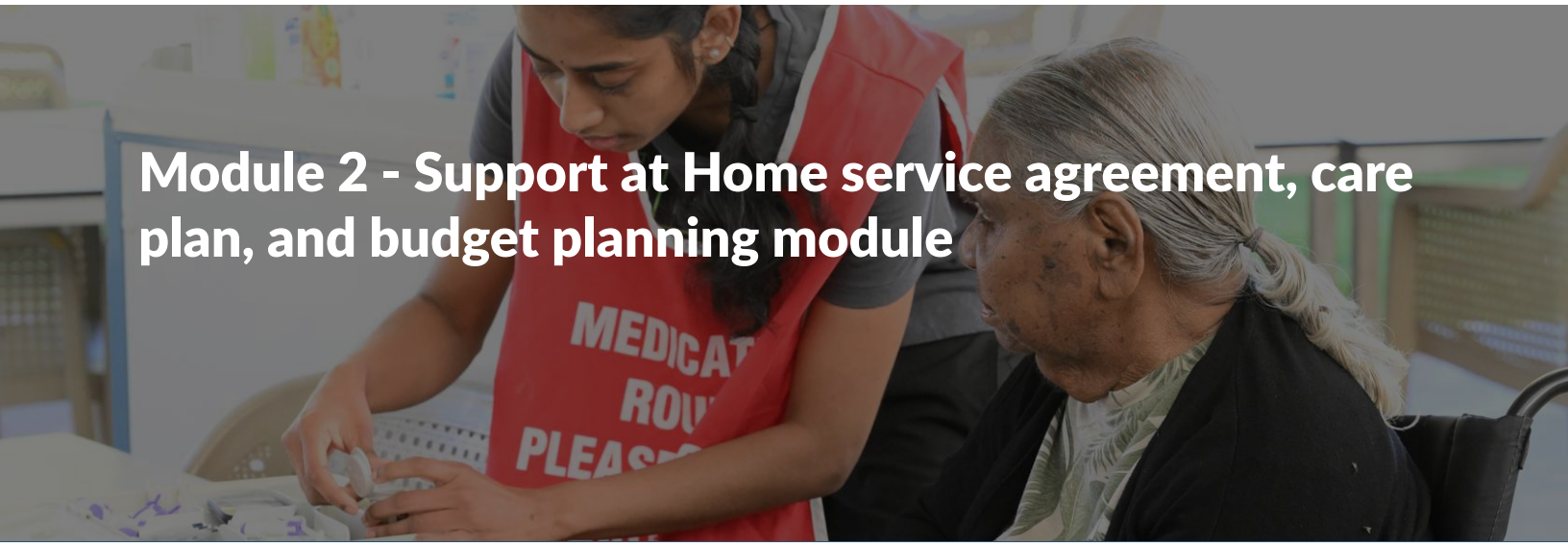


Module 2 - Support at Home service agreement, care plan, and budget planning module

About

This Support at Home module gives providers a comprehensive view of the service agreement, care plan and budget planning for the Support at Home program. This module also covers delivering care management and self-management under Support at Home.

The department reserves the right to change or add supplementary information to this training.

Duration

This course will take approximately **30 minutes** to complete. You can access the learning resources at any time.

Start

Select **Start course** above or **select a specific lesson below** to begin.

Welcome

OVERVIEW OF SERVICE AGREEMENTS, CARE PLANS AND PARTICIPANT BUDGETS

 Overview

SERVICE AGREEMENTS AND CARE PLANS

 Service agreements

 Care plans

PARTICIPANT BUDGETS

 Participant budget and contributions

CARE AND SELF-MANAGEMENT

 Care management

 Self-management

COURSE WRAP-UP

 Knowledge check

 Helpful resources

 Course wrap-up

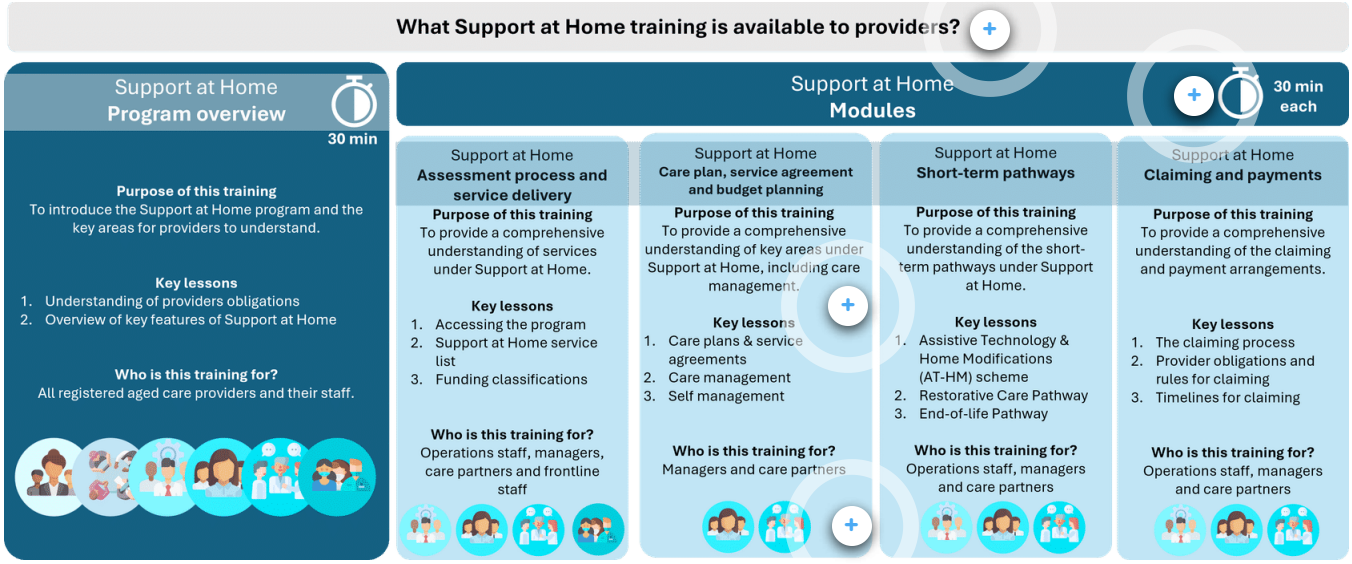
Lesson 1 of 10

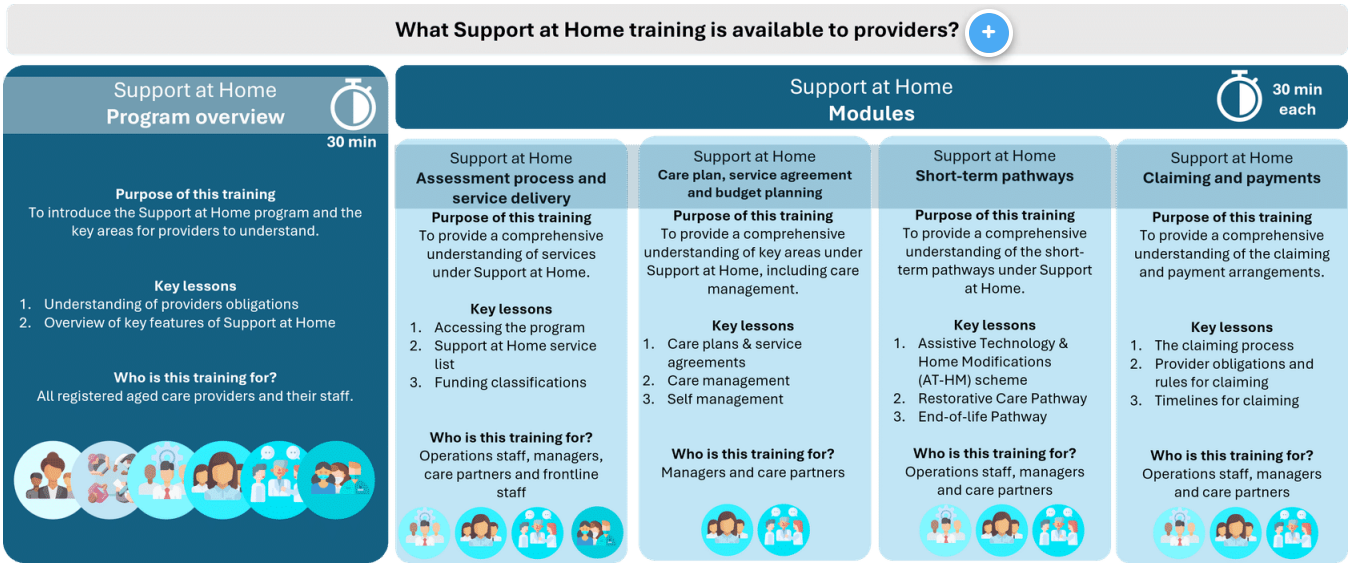
Welcome

The Department of Health and Aged Care acknowledges and pays respect to the Traditional Owners and Custodians of the lands throughout Australia. We recognise the strength and resilience of Aboriginal and Torres Strait Islander people, and their continuing connections to land, sea and community. We pay our respects to Elders past, present and emerging. We also extend our respect to any Aboriginal and Torres Strait Islander people participating in this learning.

Aboriginal and Torres Strait Islander people should be aware that this training may contain images of deceased persons in photographs.

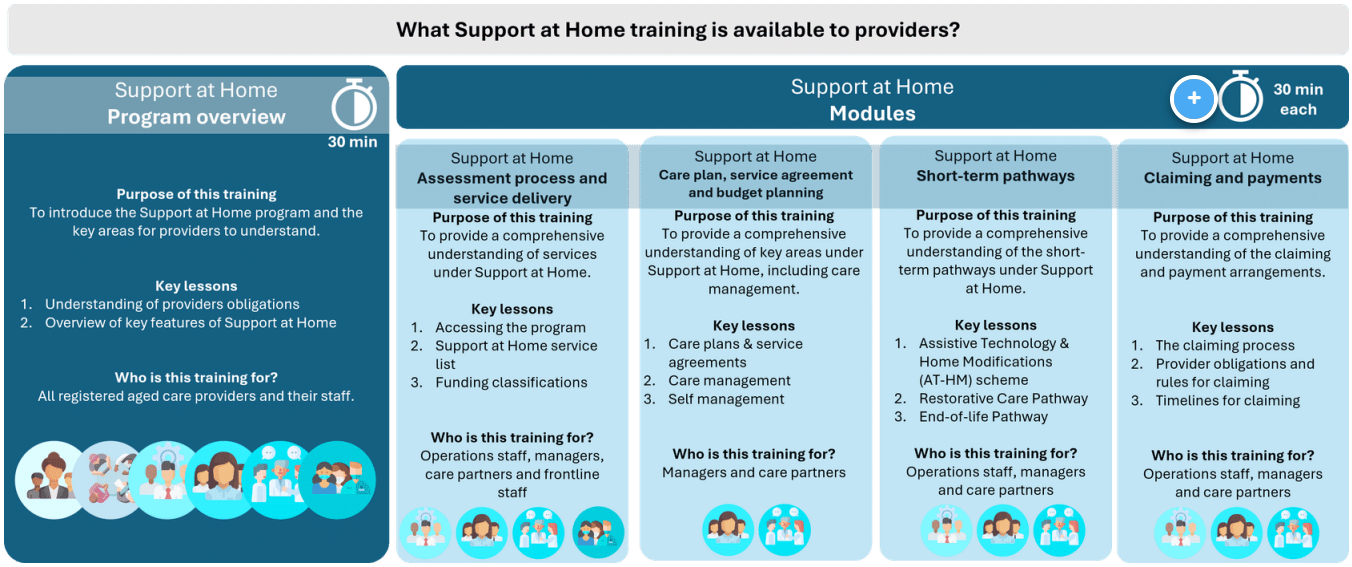
The diagram below provides an overview of the Support at Home training modules available.





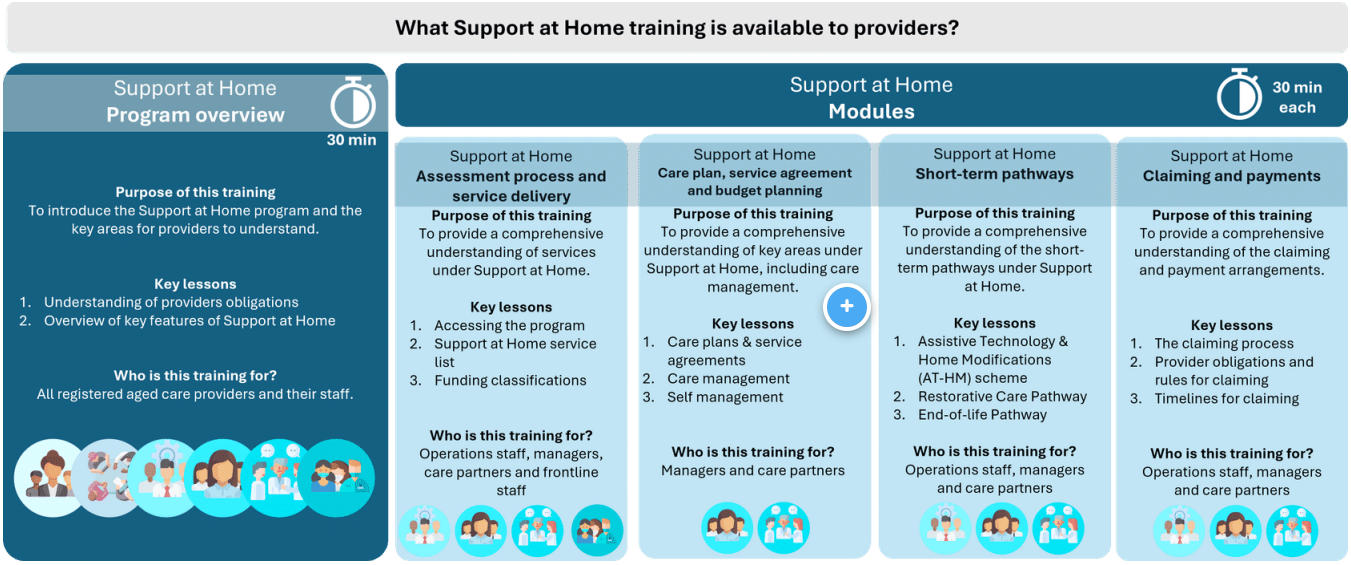
Is this training mandatory?

No, but this training is strongly recommended. This training will help providers understand the Support at Home program prior to the changes taking effect from 1 July 2025.



How long will it take to complete this training?

About 30 minutes.

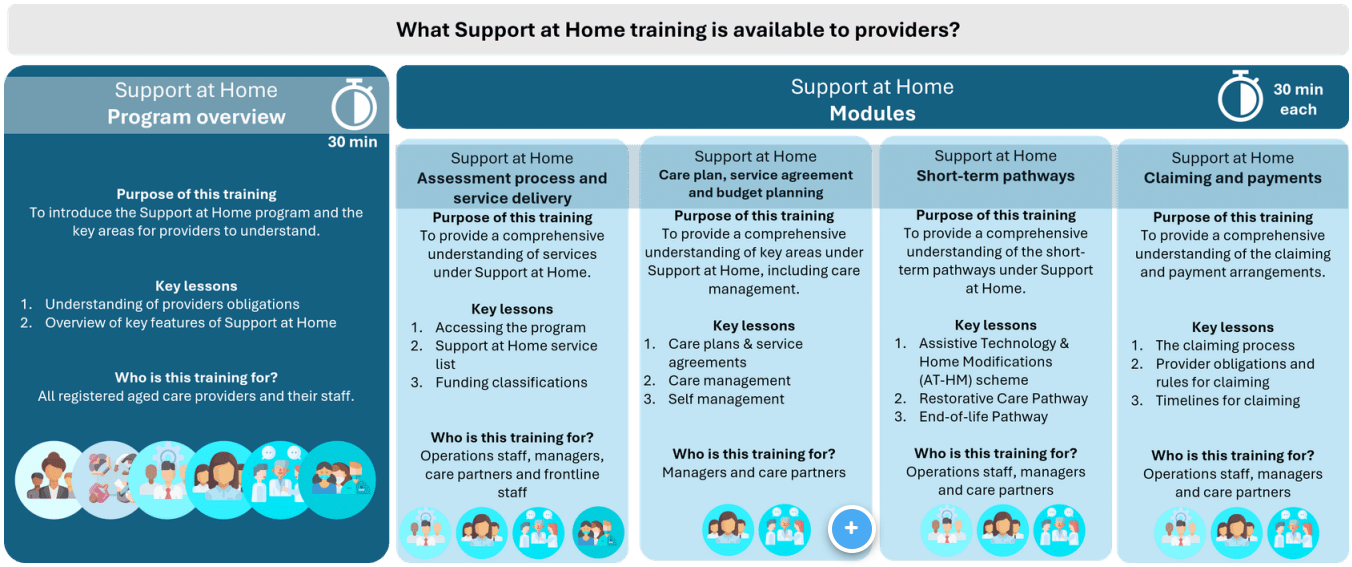


Purpose of this training

This training supports providers to deliver government-funded aged care services.

This training will cover the following:

- Service agreements
- Care plans
- Participant budgets
- Care management
- Self-management



Who is this training for?

This training has been developed for all registered aged care providers and their staff.

This module may be more relevant to managers and care partners within provider organisations.

This includes staff members who need a comprehensive understanding of delivering care management services under Support at Home.

This training may also be relevant to other groups such as independent aged care advocates and third-party providers.

Accessibility

This training has been developed to meet accessibility standards. Learners who are using assistive technologies (such as Job Access with Speech) will also be able to complete the training.

The department is committed to inclusion, and we are aware that each of us experience inclusion differently. Please let us know what we can do to make this course accessible and inclusive for you. If you would like to request a different

reasonable adjustment or to provide accessibility feedback please email learning.and.capability@health.gov.au.

NEXT LESSON: OVERVIEW

Overview

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.

For new participants, a provider needs to:

1. Create a service agreement with the participant.
2. Submit a **start notification** to Services Australia for the purposes of claiming.
3. Develop a **care plan** and **individualised quarterly budget**.

Once the care plan is completed, providers are required to deliver care management activities to help participants understand:

- what services they want to receive consistent with their aged care assessment,
- the contribution they may need to pay for those services, 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.

NEXT LESSON: SERVICE AGREEMENTS

Service agreements

Service agreements are a written agreement between a participant and a provider. The service agreement outlines rights and responsibilities and what services will be provided to the participant.

Service agreements need to include:

1. What services will be provided.
2. Who will provide the services.
3. The responsibilities of the participant and the provider.

4 How much the services will cost.

Providers are required to work with participants to create clear and fair service agreements before any services begin.

Image outlining the obligations of providers when creating a Support at Home Service Plan

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Once a service agreement is entered into, providers need to ensure:

- Services Australia is notified of the participant entry details.
- Care planning and budget planning for services and supports must be completed with the participant.

A service agreement must be in place before the provider commences providing services.

Further considerations for service agreements

The participant can't or won't enter into a service agreement

- A service agreement is considered entered into if the older person and provider have a mutual understanding.
- Providers will need to document to show that a valid service agreement exists. 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

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. These reasons may include 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 will need 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

Communication differences and assistance

Providers and participants can access several free services to help with communication:

- **Translating and Interpreting Service (TIS National):**
  For participants who speak a language other than English. Free interpreting is available 24/7 through the Department of Home Affairs.
- **Aboriginal and Torres Strait Islander Language Services:**
  Providers can call **My Aged Care** and request **Interpreter Connect** when supporting participants with My Aged Care matters.
- **National Sign Language Program (NSLP):**
  For older people who are deaf, deafblind, or hard of hearing. Offers free sign language interpreting and captioning services.

For additional information, refer to the Support at Home program manual.

Learn more about service agreements

Image of a magnifying glass

- View Chapter 6 of the Support at Home Program Manual.

NEXT LESSON: CARE PLANS

Care plans

Providers and participants must work together to develop a care plan and budget.

Providers need to create care plans with participants

A care plan is a formal document that outlines the participant's needs, goals, preferences and how funded aged care services will help the participant realise their goals.

- It is a personalised document used to formalise a participant's choice and control over their services. The care plan should be closely aligned to deliver those services and supports outlined in the Support Plan.
- Care plans are developed in collaboration with the older person by the care partner within the provider.

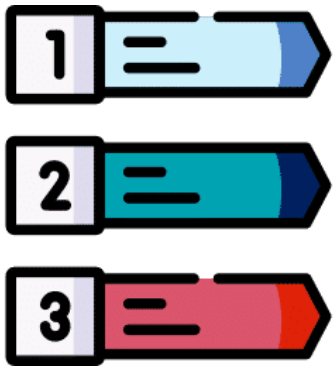
- A care plan must be completed for each participant, before or on the day services commence.
- Once a care plan is completed, the care partner is required to formally update and review this care plan as often as needed. Care plans must be reviewed at least annually.
- Changes to care plans may have impacts on the participant's budget. The participant needs to approve changes to their care plans and budget impact.

Care plans need to include:

Flip the cards below to reveal the key items care plans should include:

Identified **goals** and **strategies** to achieve these goals

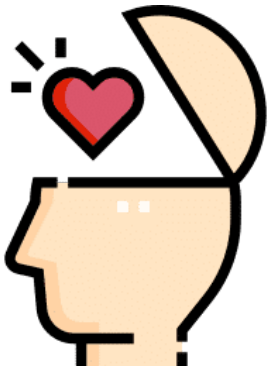
The **participant's preferences** for service delivery



A detailed outline of the **types of services** to be delivered

A summary of **AT-HM items** the participant will receive (or is already receiving) or the need for further assessment for AT-HM, and **the costs** (when known)

Dates to review the participant's **service agreement** and **care plan**



Additional information related to the delivery of **culturally safe, trauma aware and/or healing informed care**, as required

The care plan should be reviewed:

- Regularly, and at least once every 12 months
- When the participant enters the End-of-Life Pathway
- When the participant's needs, goals, or preferences change
- If participants want to change their services or service frequency
- If there is a decline in physical, cognitive, or mental health
- When new risks emerge or an incident occurs
- When a higher Support at Home classification is allocated
- If care responsibilities among family, carers, or supporters shift
- If the participant receives AT-HM scheme funding
- At any time, upon the participant's request

Learn more about care plans

Image of a magnifying glass

- View Chapter 7 of the Support at Home Program Manual.

NEXT LESSON: PARTICIPANT BUDGET AND CONTRIBUTIONS

Participant budget and contributions

Providers will need to work with the participant to develop their individualised budget.

Individualised budgets are developed alongside the care plan

Individualised budgets will outline how funds will be spent in relation to the types and frequency of services outline in the participants care plan

Individualised budgets will be reviewed regularly to ensure that services and supports fit the budget and meets the needs of the participant

The table below outlines the **requirements to be included in each individualised 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 funding tiers for assistive technology and home modification.
Cost	• The cost of each service. • The cost of assistive technology products, equipment and home modification. • The cost of AT-HM prescription service or wrap-around service (including repairs or maintenance). • The cost of administrative activities for assistive technology. • The cost of coordination activities for home modifications.
Description	• A description of assistive technology products, equipment repairs or maintenance services, and home modification supplies or services. • A description of wrap around services for assistive technology and home modifications.

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

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Participants will now have the flexibility to manage their ongoing funding on quarterly basis.

Funding allocation

Participants are allocated ongoing Support at Home funding in line with their approved services. The participant will receive 1 of 8 tiered classifications based on their assessed needs.

For short-term classifications, the budget will cover the period specific to the pathway or scheme (i.e., 16 weeks for the Restorative Care, 12 weeks for the End-of-Life pathways or in most cases 12 months for the AT-HM scheme).

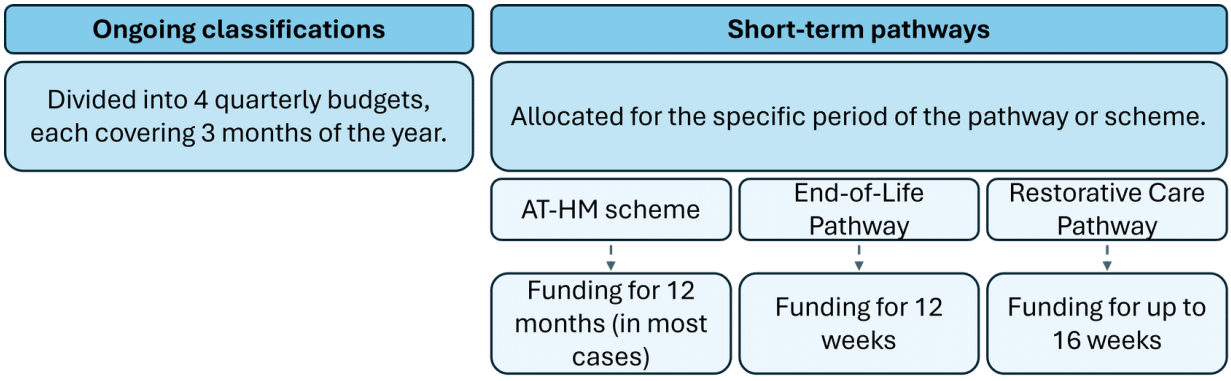

Image outlining the budget allocations for ongoing classifications and short-term pathways

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Transitioned HCP care 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.

Participant budget

The diagram below illustrates the government funding components that make up a participant's budget.

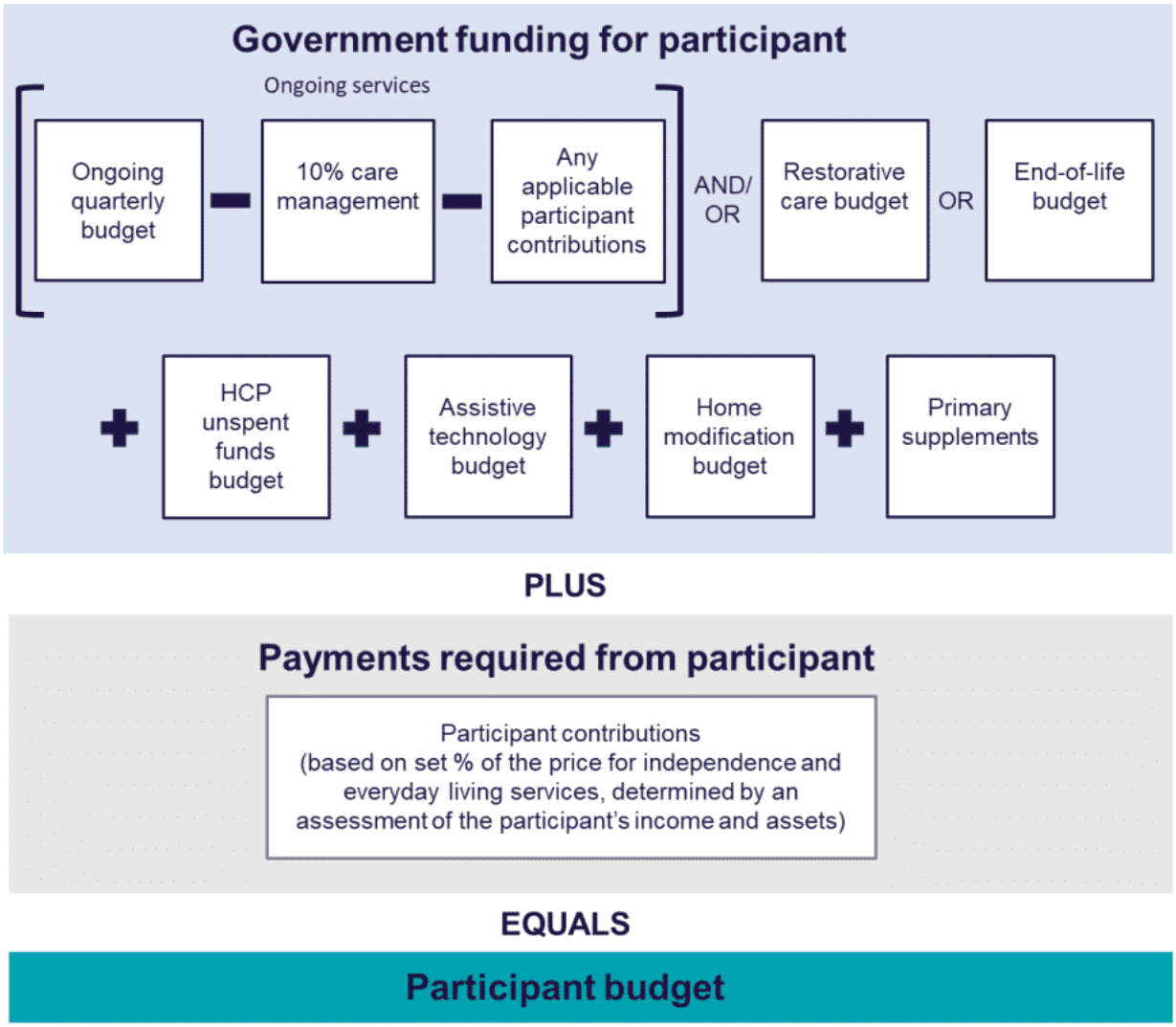

Image outlining the components that make up the participant budget

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Providers will need to work closely with the participant and/or their supporter to develop a budget. This budget should outline how the participant's funding will be used, **detailing the types and frequency of services**.

The budget will need to be **completed alongside the care plan** to ensure services align with the participant's needs.

For detailed information, view Chapter 8.3: Government Funding in the

Support at Home Program Manual.

Participant supplements

To help cover the costs of specialised care, eligible participants can access additional financial support through various supplements that are available under the Support at Home program.

Primary supplements

Eligible participants can receive additional payments called primary supplements, which are added to their budget. These supplements help cover the costs of specialised care.

Providers can claim supplements for eligible participants, regardless of their Support at Home classification.

To claim, providers complete an application form and upload it along with supporting evidence to Services Australia's Aged Care Provider Portal.

Once approved, the primary supplements are added to the participant's budget.

The primary supplements available are:

- Oxygen supplement: Provides participants with a specified medical need for the continual administration of oxygen.
- Veteran's supplement: Provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service.
- Remote supplement: The 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.

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 veterans' 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.

Fee reduction (hardship) supplement

The fee reduction supplement helps participants who are struggling financially and can't pay their Support at Home contributions.

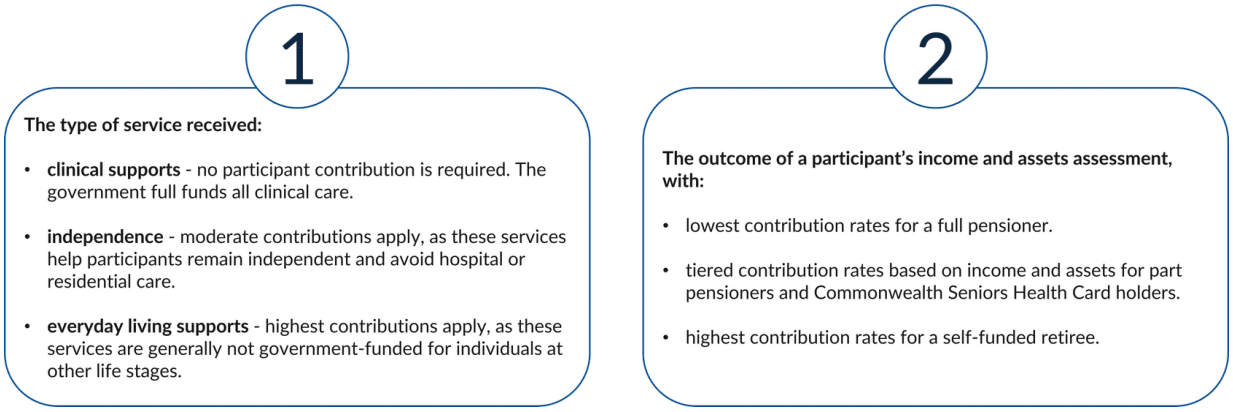
Service providers cannot invoice a participant or collect fees while their hardship application is being assessed. If approved, the government will cover some or all of the participant's aged care fees.

To apply, a participant (or their nominee) must submit the Aged Care Claim for financial hardship assistance form (SA462) to Services Australia.

Participant contributions

Participant contributions are payments made by the participant. The amount of the contribution is based on an **income and assets assessment** completed by Services Australia. Once the assessment is complete, Services Australia informs the participant and the provider of the required contribution rate.

The amount each participant contributes depends on:



Participant contributions depend on the type of service received and the outcome of the participant's income and asset assessment, and their pension status.

- If a participant does not choose to disclose their income and assets to Services Australia, they are classified as **'means not disclosed'**. The participant's contribution rate will be set at the maximum level.

- Participants will be able to use the Support at Home Fee Estimator to get an estimate of their potential contribution under the Support at Home program.

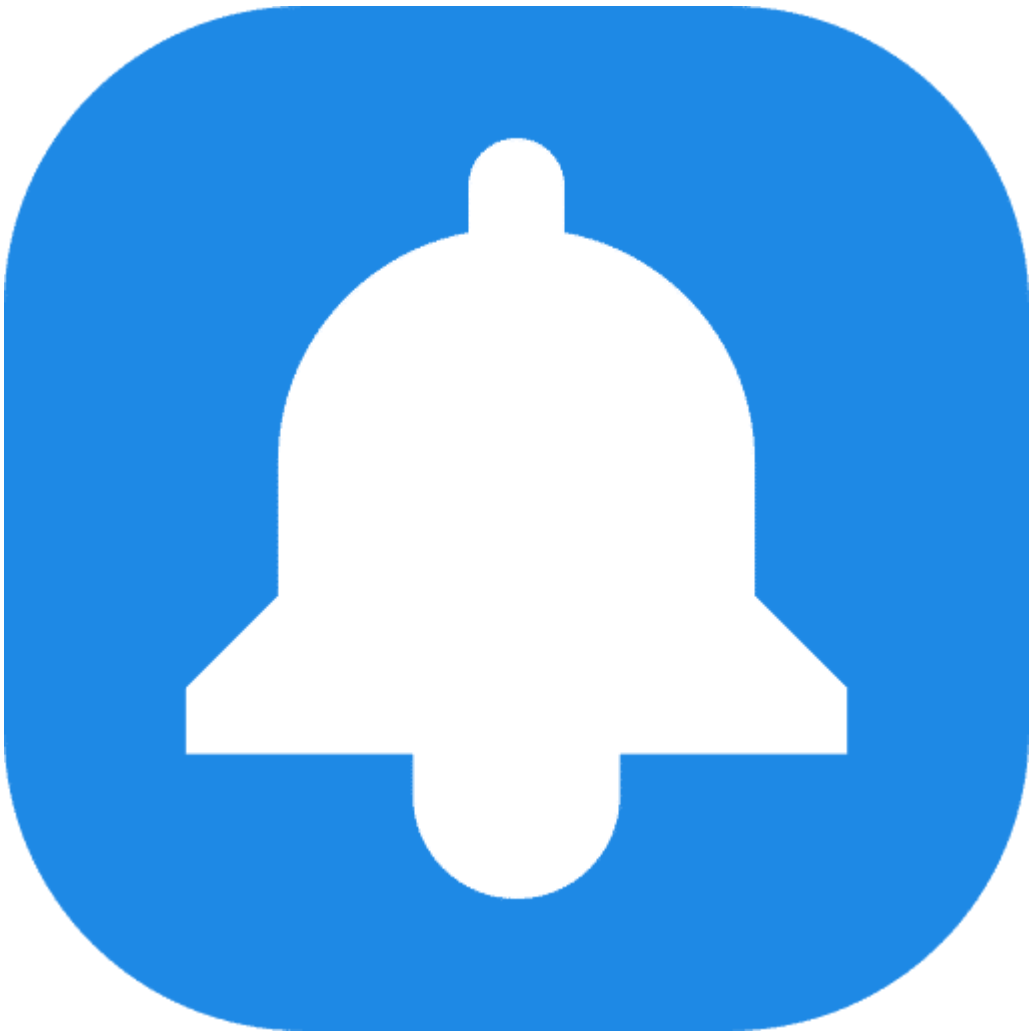
Services Australia will determine the participant contribution rate based on an income and assets assessment.

Full and part pensioners

Services Australia will use the information on an older 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, the older person 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 of financial status changes

- For any changes to a participant's financial status, the participant must notify Services Australia within 28 days of the changes.
- Services Australia will notify Support at Home participants of their contribution rate.

Collecting participant contributions

The **requirement to pay participant contributions** will need to be addressed in the participant **service agreement**. Providers should also consider detailing the process for collection and management of participant contributions in the service agreement.

- Providers are responsible for establishing and managing the processes for collecting contributions.
- Contributions can be collected weekly, fortnightly, monthly or as agreed with the participant.

If a participant refuses to pay their contributions and does not have financial hardship provisions in place, providers will need to talk with the participant and explain:

Their responsibilities

The reasons for the collection
of the participant contribution

The possible outcomes if contributions are not paid

Adjustments to participant contributions

Potential reasons for an adjustment and the action required by the provider is outlined below.

DELAYED INCOME AND ASSETS ASSESSMENT FOR NEW PARTICIPANTS | CHANGE TO PENSION THRESHOLDS | CHANGE IN FINANCIAL STATUS | HARDSHIP

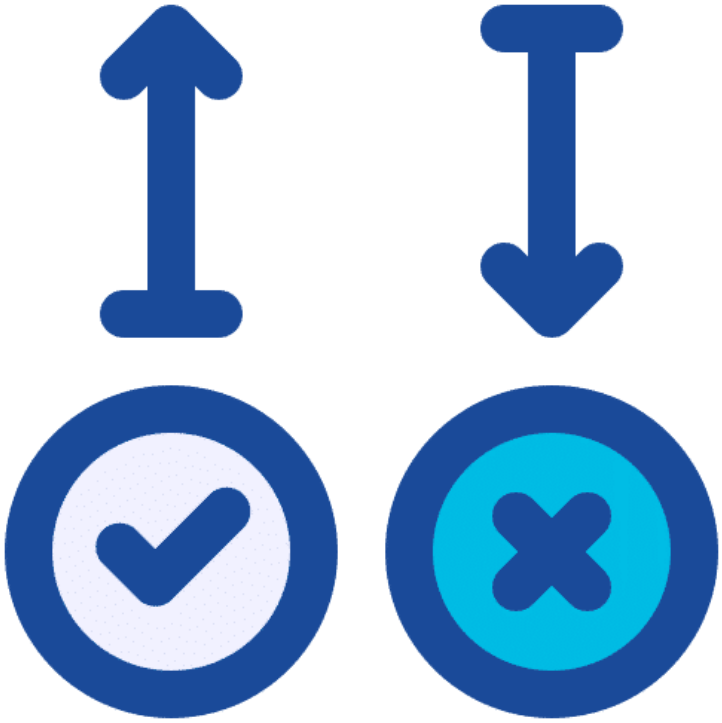
While a participant is waiting for an income and asset assessment, they may be paying a different contribution rate. Once the assessment is completed, the new rate will be backdated to the date they started receiving Support at Home services.

DELAYED INCOME AND ASSETS ASSESSMENT FOR NEW PARTICIPANTS	CHANGE TO PENSION THRESHOLDS	CHANGE IN FINANCIAL STATUS	HARDSHIP

Changes in contributions due to changes in pension thresholds will occur automatically.

If the change means the participant needs to pay a higher contribution, it will be applied at the start of the next quarter.

If the change means the participant needs to pay a lower contribution, the difference will be backdated. The provider will need to then refund it to the participant once the contributions are finalised.

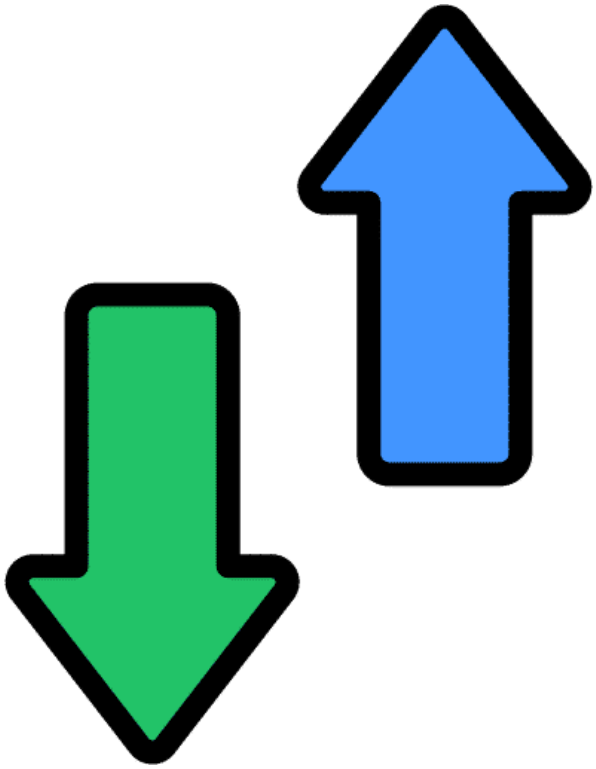


DELAYED INCOME AND ASSETS ASSESSMENT FOR NEW PARTICIPANTS	CHANGE TO PENSION THRESHOLDS	CHANGE IN FINANCIAL STATUS	HARDSHIP

Participants must inform Services Australia within 28 days if there's any change in their financial status that could affect their contribution.

It is the participant's responsibility to notify Services Australia of any changes.

If the change means the participant has to pay a higher contribution, it will be applied at the start of the next quarter.
If the change means the participant has to pay a lower contribution, the difference will be backdated. The provider will need to refund the difference to the participant once the contributions are finalised.

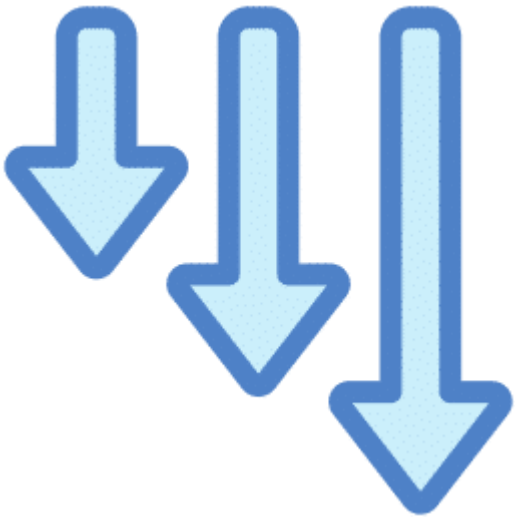


DELAYED INCOME AND ASSETS ASSESSMENT FOR NEW PARTICIPANTS | CHANGE TO PENSION THRESHOLDS | CHANGE IN FINANCIAL STATUS | HARDSHIP

If a hardship application has been successful, a participant may have reduced or waived contributions.

Providers and participants will be informed by Services Australia if a participant's hardship application is successful.

If successful, Services Australia will pay the provider the difference through a fee reduction supplement.



Providers will need processes to manage non-payment of participant contributions.

Providers have a responsibility to communicate and consult with participants regarding their contributions.

It is also the responsibility of providers to take all reasonable steps to ensure that they collect these contributions. The government will not cover the shortfall if a participant does not pay.

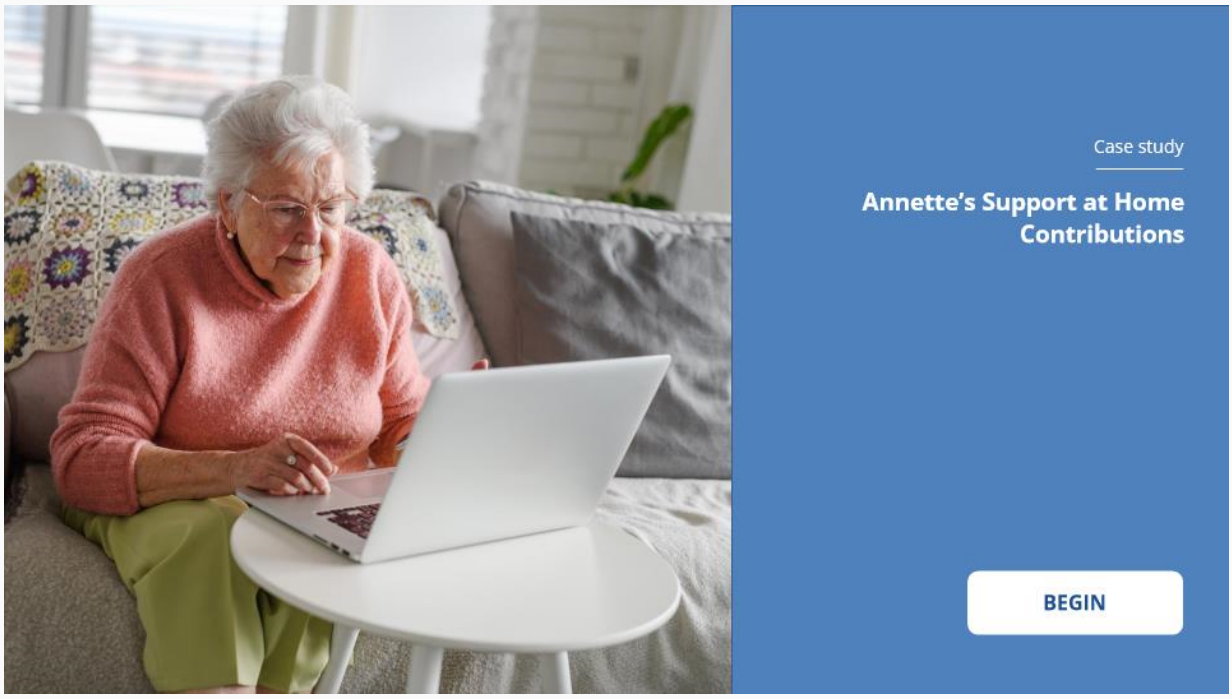
If a participant refuses to pay and does not have financial hardship in place, providers will need to:

Initiate a discussion with the participant and/or their support to explain:

- Their payment responsibilities
- The reasons for collecting contributions
- Possible outcomes if contributions are not paid

Seek resolution and make every effort to resolve payment issues with the participant or their supporter.

Keep records of all discussions regarding non-payment.



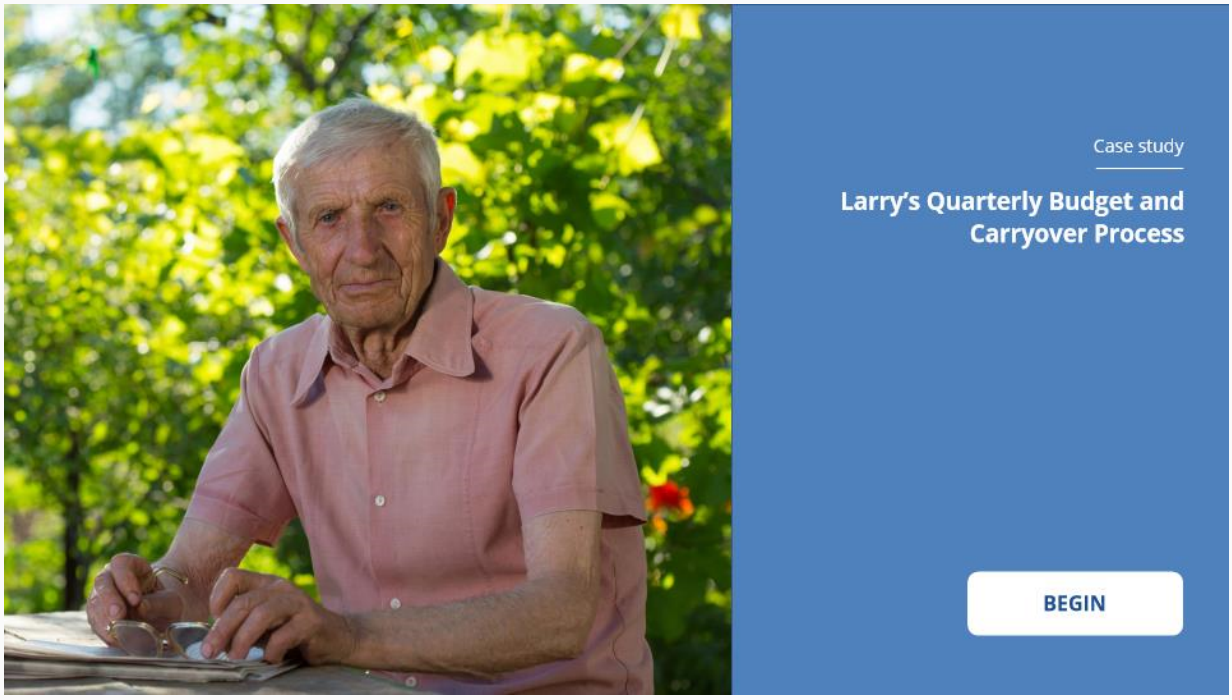
Carryover of unspent budget

If a participant does not use their full quarterly budget for ongoing services, they can carry over the unspent amount to the next quarter. This allows flexibility to cover **unplanned or emerging needs**.

The amount of budget that can be carried over is capped and will be up to the higher value of:

- $1,000; or
- 10% of their quarterly budget (including supplements).

This means a participant's maximum available budget in a quarter will include their regular quarterly budget plus either $1,000 or 10% of the previous quarter's budget.



Learn more about participant budget and contributions

Image of a magnifying glass

- View Chapter 8 of the Support at Home Program Manual.

NEXT LESSON: CARE MANAGEMENT

Care management

Care management is a set of activities delivered by providers, designed to support the safety, wellbeing, and quality of life of older people.

Care management is the term used to describe the suite of activities delivered by the provider to plan, organise, schedule, review and monitor care and service delivery for the participant.

Providers are required to **deliver care management services to all older people in Support at Home**. This includes older people who self-manage their services.

The staff members who complete these activities are known as **care partners.**

Care partners deliver care management services

- Care partners help participants decide which services they want to receive, complete the care plan and ensure that services align with participants aged care assessment.
- Care partners are appropriately trained aged care workers with relevant experience. Mandatory qualifications are not required but the following qualifications may be of value to people undertaking the care partner role:
    - Diploma of Nursing
    - Cert 3 in Individual Support (Ageing)
    - Cert 4 in Aged Care
- 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.
- A team-based approach to care management can help providers respond to participant needs.

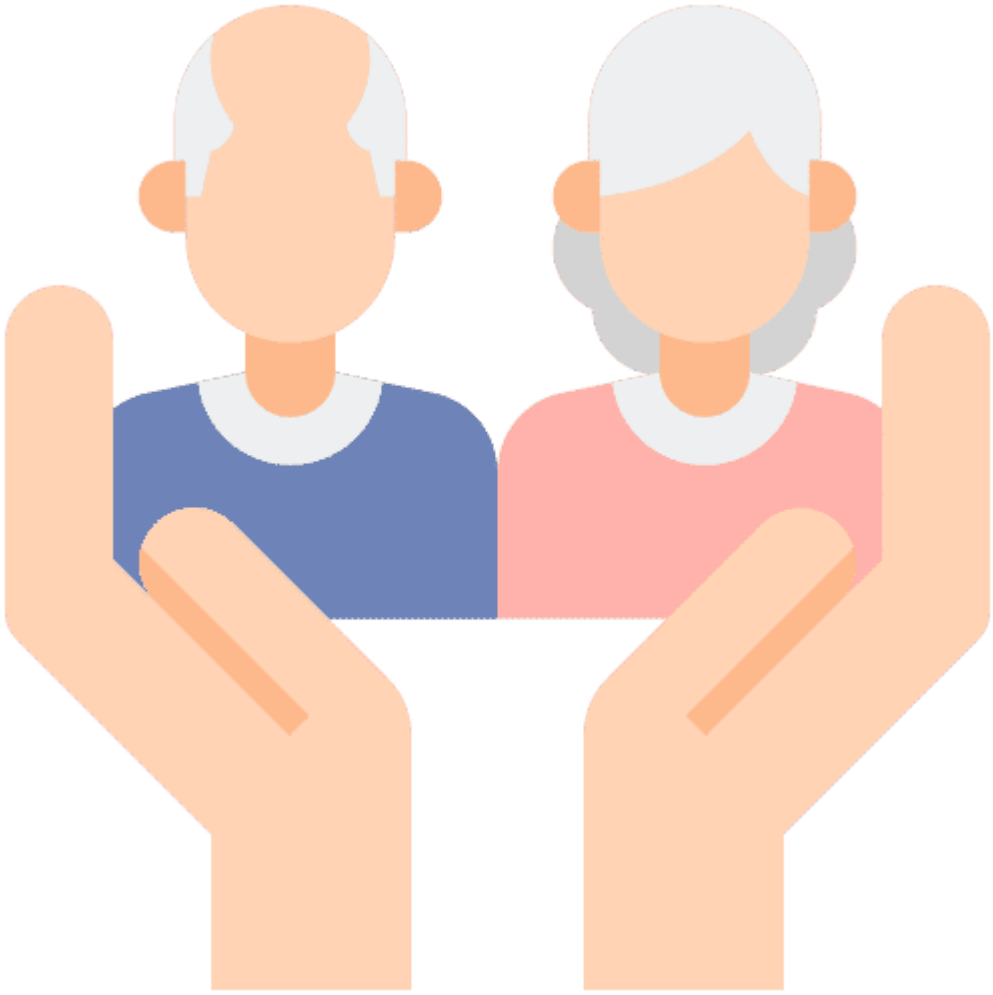


Image of two people being supported by a pair of hands

Care management activities are expected to be delivered monthly at a minimum and this should be delivered directly. A full care plan review will need to be undertaken at least once every 12 months.

Providers will need to carry out both initial and ongoing care management to meet the Aged Care Quality and Safety Commission's Strengthened Quality Standards.

This can be done directly, by speaking or meeting with the older person or their registered supporter, or indirectly, by completing tasks on the participant's behalf

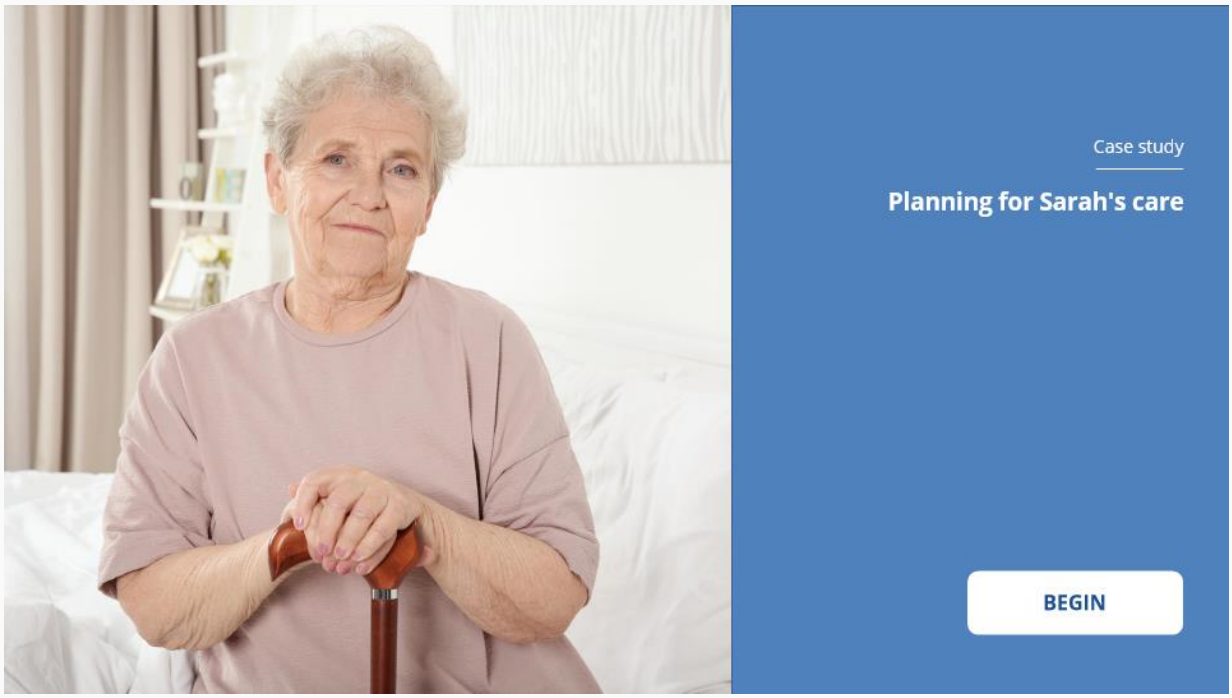
without their direct involvement.

These activities ensure participants receive the appropriate support while maintaining high-quality care.

The following are examples of care management activities that providers can and cannot claim from their care management fund.

Click the services below to expand the activities that can or cannot be claimed:

Refer to the Guidance for setting Support at Home prices – fact sheet for providers when considering pricing excluded activities.



Care Management Funding

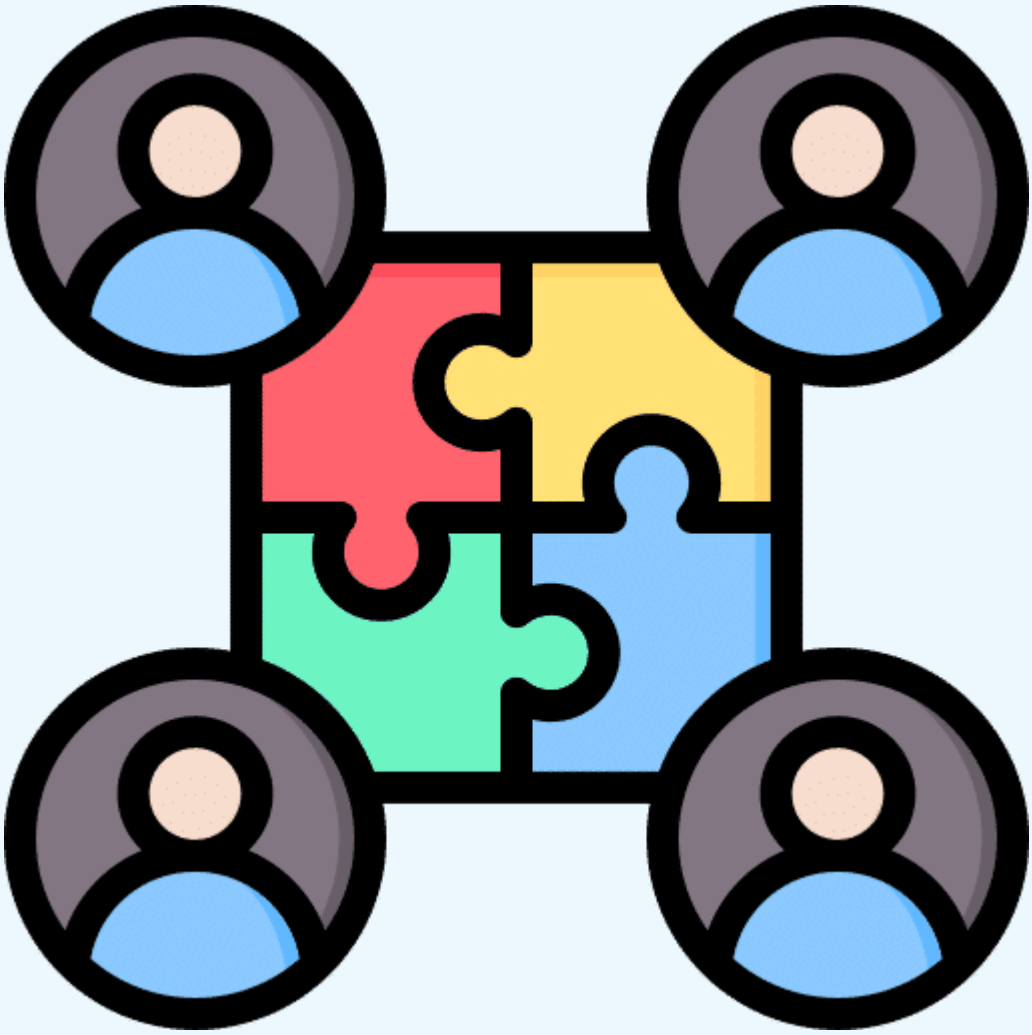


Image of multiple people contributing to the same pooled fund

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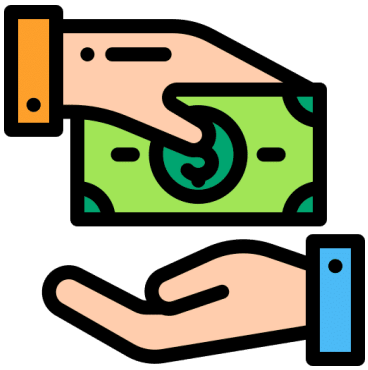
Providers will claim care management services from a dedicated fund.

- Participants receiving ongoing services will have 10% of their quarterly budget automatically allocated to care management. Providers can use the care management fund to claim for care management activities.
- The **care management fund** combines funds from all participants that are eligible to receive services into a **pooled fund** at the service

delivery branch level for the provider. This fund is held by Services Australia.

Explore how care management funding is allocated, paid and carried over:



Allocation and payment of care management

- Services Australia calculates care management funding for each provider.
- Funding for the next quarter is calculated on

Carryover of care management funding

- Providers can use care management funding flexibly for any participants receiving services.
- Unused funding rolls over to the next quarter and

Learn more about care management

Image of a magnifying glass

- View Chapter 7 of the Support at Home Program Manual.

NEXT LESSON: SELF-MANAGEMENT

Self-management

Self-management allows participants to have greater choice and control over their services and how they are delivered.

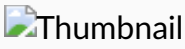
Image of an older person (F)

- Self-management is where an older person or their support person chooses to manage their own care services. They can make decisions about their services, budget and workers, based on their approved support plan.
- Self-managed clients will need to partner with a provider to obtain support and oversight. This provides assurance to self-managed participants that services selected are safe and

compliant with legislation and program guidance.

- Self-management gives older people more choice and control over how their care is delivered. It will look different for each person depending on their needs, preferences, and abilities.

Some of the self-management activities an older person can undertake include:



Care management activities need to be delivered for self-managed participants. This is so that the provider has oversight of quality, safety, governance and compliance.

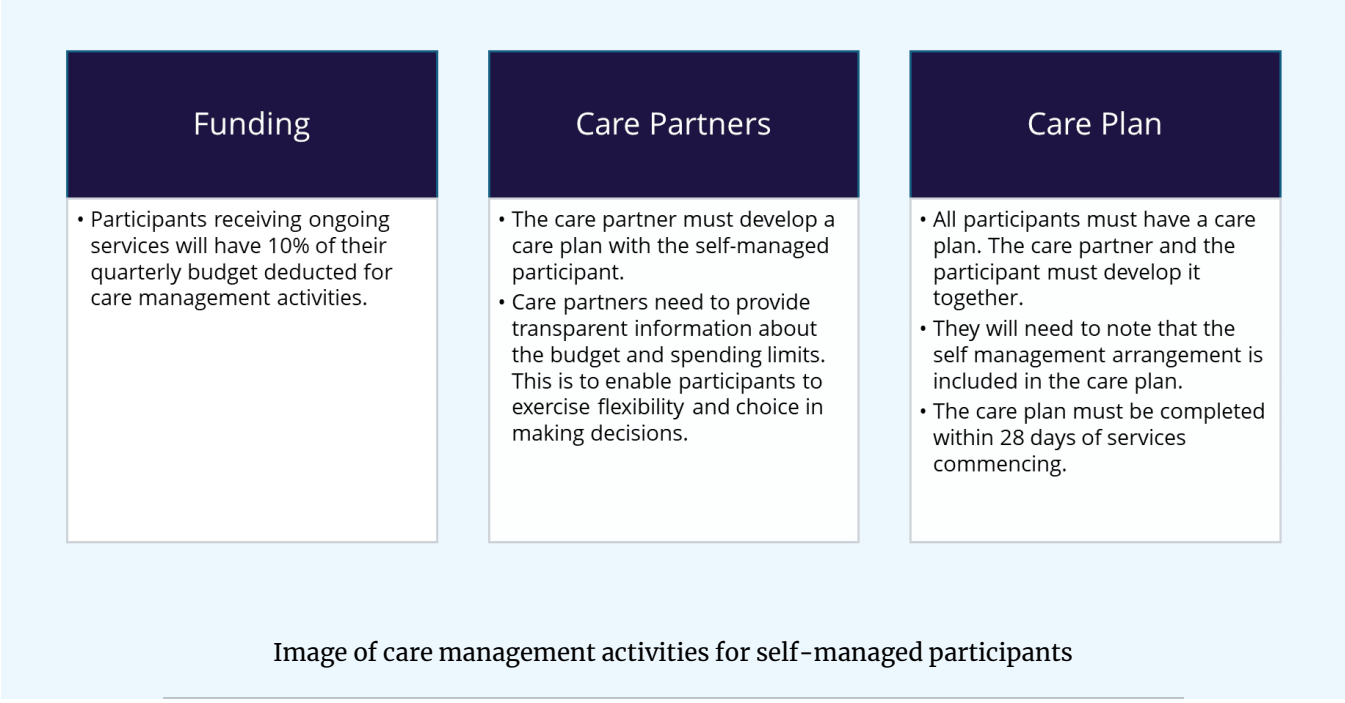


Image of care management activities for self-managed participants

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For some older people, an important aspect of self-management is being able to select their own third-party workers.

Image of a carer looking after an older person

- Providers can use third-party workers directly or through an associated provider. However, providers are still responsible for making sure services meet the Act and Quality Standards.
- Providers and participants will need to agree on each party's roles and responsibilities before finalising any third-party agreement. This includes the price charged to the participant's budget.
- Any use of third-party workers should be clearly documented, for example, in the participant's care plan.

Providers can charge an overhead to cover costs of supporting a third-party provider. This is capped at 10% of the actual cost of the third-party service.

Providers, care partners and participants will need to have a sound understanding of the tasks and obligations involved when using third parties as part of self-management.

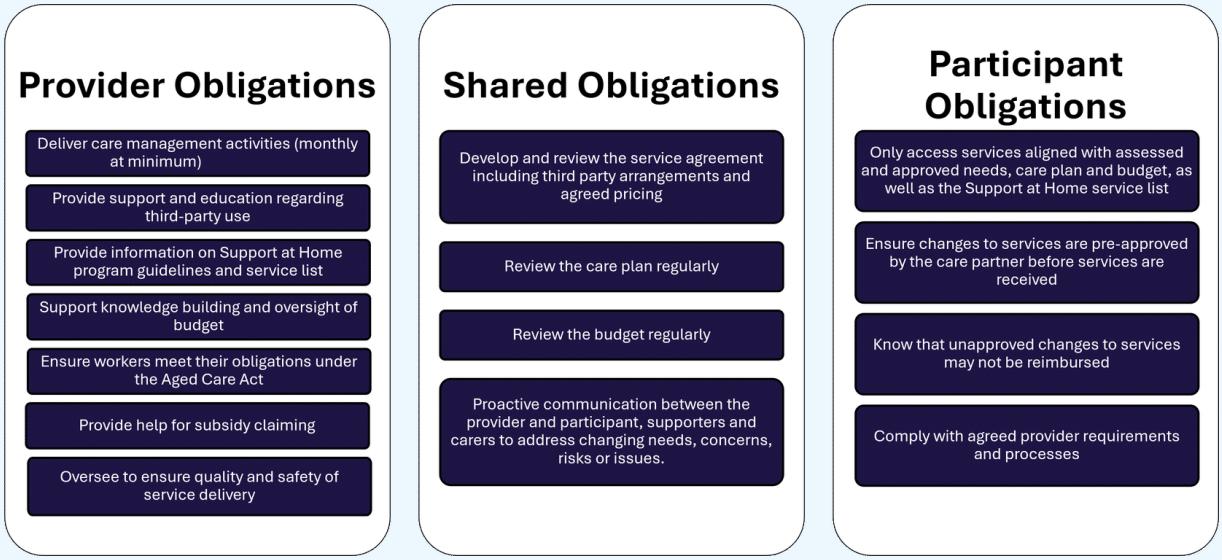
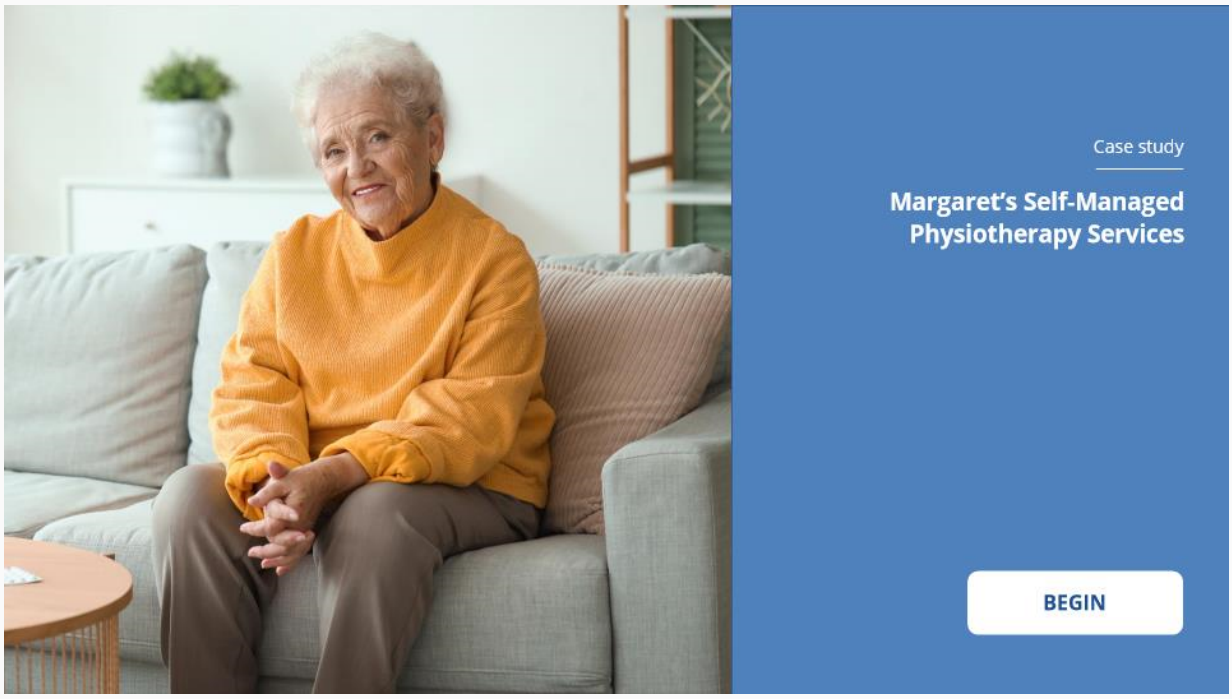


Image outlining the obligations of a provider and participant when using third parties



Learn more about self-management

Image of a magnifying glass

- View Chapter 10 of the Support at Home Program Manual.

NEXT LESSON: KNOWLEDGE CHECK

Knowledge check

Test your knowledge by answering the questions below.

Question

01/06

Which organisation do providers need to notify of services commencing when they accept a Support at Home participant?

- ○ Department of Health, Disability and Ageing
- ○ Department of Veterans' Affairs
- ○ Services Australia
- ○ Australian Taxation Office

Question

02/06

What must a service agreement include?

(Select all correct options)

- [ ] What services will be provided
- [ ] Who will provide the services
- [ ] The responsibilities of the participant and the provider
- [ ] Service price

Question

03/06

What are participants individual budgets a combination of?

(Select 1 option)

- ◯ Participant contributions only
- ◯ Government funding only
- ◯ Government funding and participants contributions

Question

04/06

How much of a participant's unused quarterly budget can accrue and will carry over to the following quarter?
(Select 1 option)

- ○ $100 or 10% (whichever is higher)
- ○ $1000 or 10% (whichever is higher)
- ○ $1000 or 5% (whichever is higher)

Question

05/06

What is the name of the staff member who delivers care management activities? (Select 1 option)

- ◯ Manager
- ◯ Care partner
- ◯ Support worker
- ◯ Registered nurse

Question

06/06

What percentage of self-managed participants' ongoing quarterly budget will be deducted for their provider to undertake care management activities?
(Select 1 option)

- ○ 3%
- ○ 5%
- ○ 8%
- ○ 10%

Helpful resources

The links below will open in a new window. Links are regularly reviewed, however if a link is not working, please search for the information directly within the department's website.

Webpages

1. Support at Home program webpage
2. Support at Home provider training webpage
3. My Aged Care webpage
4. New Aged Care Act webpage

Guidelines and procedures

1. Support at Home program manual – A guide for registered providers
2. Support at Home Program Provider Transition Guide
3. Support at Home: Claims and Payments Business Rules Guidance
4. Support at Home service list
5. Assistive Technology and Home Modifications List (AT-HM List)

Fact Sheets

1. Support at Home program – Frequently asked questions – February 2025
2. Guidance for setting Support at Home prices – fact sheet for providers
3. Summary of indicative Support at Home prices

Existing Home Care Package care recipients

Existing Home Care Package (HCP) and Short-Term Restorative Care (STRC) care recipients will transition to the Support at Home program.

Providers will continue to support and deliver services to these transitioned care recipients.

Refer to the Support at Home provider transition guide for detailed information on supporting transitioning existing HCP and STRC care recipients.

NEXT LESSON: COURSE WRAP-UP

Lesson 10 of 10

Course wrap-up

Thank you for completing the Support at Home service agreement, care plan and budget planning module.

We appreciate the time and effort you dedicated to completing this training, engaging with the information, and applying your knowledge.

You should now understand your responsibilities and obligations as a Support at Home provider.

We'd love your feedback!

To help us continue improving this training, please take a moment to complete a short survey about your experience in completing the Support at Home service agreement, care plan and budget planning module. This survey will take no more than 1-2 minutes to complete.