Australian Government
Department of Health, Disability and Ageing

Support at Home

Guidance for General Practitioners

October 2025

This resource contains information that will enable General Practitioners (GPs) to prepare for upcoming changes to in-home aged care. It provides practical steps to enable GPs to continue to play a critical role in supporting older people to live at home for longer.

Support at Home program

Support at Home is a new in-home aged care program that will commence from 1 November 2025. It will replace the Home Care Packages (HCP) Program and Short-Term Restorative Care (STRC) Programme. Support at Home will ensure improved access to services, equipment and home modifications to help older people remain healthy, active and socially connected to their community.

GPs play a key role in supporting older people across the aged care system. This role will continue under the Support at Home program, helping ensure older Australians receive care that meets their needs and goals.

GPs support older people by:

- often being the first point of contact when health or care needs arise
- referring patients for aged care assessments
- helping to develop personalised care plans
- working with other health professionals to coordinate care
- making clinical decisions with older people, including prescribing medicines and recommending other supports.

What is changing?

From 1 November 2025, the Support at Home program will replace the Home Care Packages Program and the Short-Term Restorative Care (STRC) Programme. It will provide:

- upfront supports to maintain independence, including assistive technology and home modifications
- new classification and budget levels to better meet a person's aged care needs
- participant contributions based on an assessment of income and assets.

Home Care Package care recipients and those already waiting for a package will be transitioned to Support at Home and do not need to be reassessed to enter the program.

The Commonwealth Home Support Program will transition to Support at Home no earlier than 1 July 2027. Until that time, CHSP will continue to operate as a separate program for existing clients and new clients with low-level needs.

What is not changing?

Under Support at Home GPs will continue to:

- refer patients for aged care assessments through My Aged Care
- make clinical decisions with older people, including prescribing medications and recommending other supports
- guide patients through care options and pathways
- support access to services that match each person's health and care needs
- work with care teams to coordinate support and improve health outcomes for patients.

Support that can be accessed through Support at Home

Support at Home offers older people a wide range of support. Based on their aged care assessment and eligibility, they will have access to an approved list of services and be provided support to make sure the services they receive meet their needs.

GPs play an important role in helping patients access support through the Support at Home Program. They are often the first point of contact for identifying care needs, initiating referrals, and supporting patients navigate care pathways.

For GPs, understanding how older people move through referral, assessment, and access services, enables them to play an informed and active role in coordinating care and guiding patients based on their individual needs and circumstances.

GPs role in enabling access to the Support at Home program

Understanding eligibility for an aged care assessment

From 1 November 2025, eligibility for subsidised aged care will change with the introduction of the Aged Care Act 2024. GPs are encouraged to review the updated guidance to ensure referral are made correctly, especially for younger patients.

To access aged care services, including the Support at Home program, older people must undergo an aged care needs assessment conducted by an aged care assessor. Under the new Act, the following groups will be eligible for an aged care assessment:

- people aged 65 years and over the age of 65, or
- Aboriginal and Torres Strait Islander people aged 50 years and over
- People aged 50 years and over who are homeless or at risk of homelessness.

Eligibility also depends on having care needs, such as:

- physical, cognitive or social difficulties with activities of daily living, quality of life, and/or
- requiring assistive technology, equipment or support, such as help to use equipment or products to stay physically, mentally or socially able to function independently.

Making a referral for an aged care assessment

To support timely and accurate referrals for aged care assessments, GPs have access to several streamlined referral options through My Aged Care.

GPs can refer patients for their first aged care assessment using the following methods:

- **Make a Referral** online tool available via the My Aged Care website, to determine eligibility for government funded aged care services
- **e-Referrals** directly from GPs practice management systems
- **Phone referral** by calling the My Aged Care Contact Centre on **1800 200 422.**

Support at Home classification levels

For GPs, understanding how services are structured under Support at Home can help inform care planning and referrals.

The Support at Home has 8 classifications for ongoing services, and these are linked to different levels of care. The more care an older person needs, the higher the classification will be. Each classification has a quarterly budget.

Along with the 8 ongoing classifications, there are 3 short-term classifications:

- the **Restorative Care Pathway** helping older people maintain and improve their independence through primarily allied health services
- the **End-of-Life Pathway** providing dedicated funding to access services to support older people to remain at home in their last 3 months of life.
- the **Assistive Technology and Home Modifications (AT-HM)** scheme for separate funding for products, equipment and home modifications.

The Support at Home program has a defined service list which outlines the funded services available to eligible participants and the services that are excluded.

The Assistive Technology and Home Modification (AT-HM) list defines the products, equipment and home modifications that are available for Support at Home participants under the AT-HM scheme.

The services an older person is eligible to receive are based on their assessed needs. Participants can only access government funded services from the Support at Home service list.

Care plans

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. The care plan is a living document that will change and evolve over time, in line with the participant's needs, goals, preferences and situation.

Once an older person is approved for the Support at Home program, an aged care provider will allocate a care partner (a care coordinator) to develop the care plan. If a participant consents, the care partner may invite a GP to participate in a case conference to support the development of the care plan. This promotes continuity and coordination of care for patients. GPs may work with a care partner to ensure the participant's clinical needs are addressed.

GPs may be able to claim Medicare Benefit Schedule (MBS) items 735, 739, 743, 747, 750 or 758 for participating in case conferencing, if the participant has a Chronic Condition GP Management Plan (CCGPMP) in place, or if GPs organise and coordinate a multidisciplinary case conference. These items support collaborative care planning for patients, especially for patients with long-term health needs.

Short-term Pathways

GPs play an important role in identifying when short-term support may help an older person maintain independence to avoid unnecessary escalation of care.

Under Support at Home, three short-term pathways are available to help older people remain independent and living at home for longer. These pathways provide targeted, time-limited support based on assessed needs.

Assistive Technology and Home Modifications (AT-HM) scheme

The 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 approval to access the AT-HM scheme. If approved, participants will have separate funding to access products, equipment and home modifications through allocated funding tiers.

GPs may be involved in prescribing certain assistive technology, equipment, or home modifications. Some items require a prescription made by a suitably qualified health professional, and all home modifications require a prescription from an occupational therapist working within their scope of practice.

The AT-HM list which items require a prescription. Depending on the type of equipment, product or home modification, GPs may be well placed to provide these prescriptions. Below are examples of what GPs or other health professional may prescribe.

- **GPs** may prescribe dose administration aids for medication management or some mobility products as outlined in the AT-HM list, if there is an assessed need
- **occupational therapists** may prescribe self-care items such as an adjustable shower chair or home modifications including ramps and handrails.
- **physiotherapists** may prescribe walking aids such as crutches and walking frames with a seat or equipment for managing body functions, like a seat cushion
- **speech pathologists** may prescribe communication supports, including letter and symbol sets and boards, or face-to-face communication software
- **nurses** may prescribe fastening devices for urine collectors.

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.

GPs should refer to an occupational therapist if home modifications are required. Occupational therapists are responsible for conducting home assessments and working with builders and aged care providers to ensure home modifications are aligned to the older person's needs and support safe, independent living at home.

Restorative Care Pathway

The Restorative Care Pathway is an approach to care that focuses on early intervention through intensive clinical and care support, along with ongoing monitoring. It is particularly useful for older people who are at high risk of injury, illness, or hospitalisation, or who are recovering from these experiences.

The Restorative Care Pathway aims to:

- maximise ongoing independence for older people
- prevent, delay and/or reverse physical, functional and cognitive decline through targeted interventions
- enhance quality of life
- support older people to remain living at home.

GPs play an important role in supporting participant outcomes within a reablement approach that utilises a multidisciplinary health team. While GP involvement is considered best practice, it is not mandatory. When included, a GP can contribute to the development of the goal plan and oversee progress throughout the 16-week restorative care episode, helping to ensure coordinated and clinically informed care.

Under the Restorative Care Pathway, participants may:

- have access of up to 16 weeks of multidisciplinary restorative care including home based nursing and allied health
- access restorative care services alongside any Support at Home services they already receive
- receive an extra budget of $6,000 (or up to $12,000 if required with evidence) for multidisciplinary allied health services
- have access to assistive technology, equipment and home modifications through the Assistive Technology and Home Modifications (AT-HM) scheme if needed.

Referral to the Restorative Care Pathway

GPs may be involved in referring their patients to the Restorative Care Pathway after an illness or injury to help them maintain or regain their independence. To access the Restorative Care

Pathway, they will require an aged care assessment completed by an aged care assessor and meet the suitability and eligibility criteria.

At the conclusion of the restorative care episode (up to 16 weeks), an older person may request a Support Plan Review to assess whether their functional goals have been met or if further support is needed through ongoing services.

For existing Support at Home participants, a restorative care episode can be accessed alongside ongoing services. A Support Plan Review can be completed to request additional funding (evidence will be required). It can also be used to request a reassessment for other aged care services as the episode concludes, if required.

A Support Plan Review may be requested by:

- the older person or their registered supporter through My Aged Care or through a Services Australia Aged Care Specialist Officer (ACSO)
- a service provider through My Aged Care Service and Support Portal
- GPs, hospital, or community health professional through the My Aged Care contact centre or a My Aged Care web referral.

End-of-Life Pathway

The End-of-Life Pathway is a short-term pathway to support participants who have been diagnosed with 3 months or less to live and wish to remain at home, by providing more funding to access in-home aged care services.

The End-of-Life Pathway is designed to complement services received through states and territories, including palliative care services.

Under the End-of-Life Pathway, an older person will have access to a budget of $25,000 over 12 weeks. If the older person requires services beyond 12 weeks, an urgent Support Plan Review can be undertaken to transfer the participant to an ongoing Support at Home classification. The End-of-Life Pathway budget can be used up to the 16-week mark to support continuity of care

On the End-of-Life Pathway, older person will have access to:

- a budget of up to $25,000 over a 12-week period, with 16 weeks to use the funds on aged care services if needed, to provide more flexibility as their needs change over time.
- assistive technology and equipment through the Assistive Technology and Home Modifications (AT-HM) Scheme if needed (for example, a height adjustable bed).

Eligibility

An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:

- a doctor or nurse practitioner advises estimated life expectancy of 3 months or less to live
- Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator) of 40 or less.

Note that participants will also need to meet general entry criteria for accessing funded aged care services, including being aged 65 or over (or age 50 or over for an Aboriginal or Torres Strait Islander person or homeless or at risk of homelessness).

Supporting patients to access the End-of-Life Pathway

GPs can support a patient to access the End-of-Life Pathway by confirming eligibility and fill in and sign and End-of-Life Pathway form for the patient. Doing so may require you to retain the medical decision making for your patient whilst they are palliative and work closely with their aged care provider team to ensure continuity and coordination of care.

Submitting an End-of-Life Pathway form

The End-of-Life Pathway form captures the medical eligibility for accessing the pathway. This will include details of their prognosis and their Australian-modified Karnofsky Performance Status (AKPS) score. The End-of-Life Pathway form will be available on the department's website from the commencement of Support at Home on 1 November 2025.

The End-of-Life Pathway form will be processed as a priority and can be completed by a GP, non-GP medical specialist or a Nurse Practitioner.

Further Resources

Support at Home service list and program guide

- Support at Home service list
- Support at Home Program manual
  - 13.0 Assistive Technology and Home Modifications Scheme
  - 14.0 Restorative Care Pathway
  - 15.0 End-of-Life Pathway

Short term pathways

Assistive Technology and Home Modifications scheme

- Support at Home AT-HM Scheme
- Support at Home AT-HM list
- Support at Home – Assistive Technology and Home Modifications (AT-HM) scheme (fact sheet)

Restorative Care Pathway

- Support at Home – Restorative Care Pathway
- Restorative Care Pathway Clinical Guidelines

End-of-Life Pathway

- Support at Home – End-of-Life Pathway (fact sheet)
- End-of-Life Pathway – fact sheet for doctors and nurse practitioners

Support at Home training

- Learning package 1: The Program Overview training module introduces Support at Home and explains how it will operate. This includes fundamental concepts and processes that underpin Support at Home.
- Module 3: Short-term pathways provides detail around Assistive Technology and Home Modifications (AT-HM) scheme, Restorative Care Pathway and End-of-Life Pathway, and how they operate.