Australian Government
Department of Health, Disability and Ageing

Support at Home

Guidance for health professionals

October 2025

This resource contains information that will enable community health practitioners to prepare for upcoming changes to in-home aged care. It provides practical steps to enable community health practitioners 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.

Health professionals 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.

Health professionals support older people by:

- recommending home modifications or prescribing assistive technology
- referring patients for aged care assessments
- helping to develop personalised care plans
- working with other health professionals to coordinate care
- supporting the wellness and reablement approach to delivering care.

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 health professionals will continue to:

- refer patients for aged care assessments through My Aged Care
- 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.

Health care professionals deliver services that are a part of a wellness and reablement approach to service delivery. This approach aims to build on people's strengths, capacity and goals to promote greater independence and autonomy.

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

How health professionals may be involved

Health professionals have an important role to play in the Support at Home program. Their involvement can vary depending on their discipline and scope of practice, but all contribute to helping older people live safely and independently at home.

Examples include:

- **Occupational therapists** can recommend home modifications or prescribe assistive technology that will minimise hazards, reduce the risk of falls and slips and create a safe environment that allows older people to be as independent as possible.
- **Exercise physiologists and physiotherapists** may assist with musculoskeletal issues and provide fall prevention programs that assist with strength and balance.

- **Speech pathologists** can assist if a person requires assessment for assistance with speech, communication and swallowing.
- **Nurses** can provide wound care, continence management, assessment, treatment and monitoring of clinical conditions, administration of medications and specialist services linkage.

Health professional's role in enabling access to the Support at Home program

Understanding eligibility for an aged care assessment

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, health professionals have access to several streamlined referral options through My Aged Care.

- **Make a Referral** online tool available via the My Aged Care website, to determine eligibility for government funded aged care services. The Make a Referral form will take approximately 15-20 minutes to complete
- **Phone referral** by calling the My Aged Care Contact Centre on **1800 200 422.**

If the person you are referring has registered previously, you can help them call My Aged Care on **1800 200 422** to discuss any changes in circumstance/care needs. If the person you are referring has registered previously, you can help them call My Aged Care on **1800 200 422** to discuss any changes in circumstance/care needs.

Support at Home classification levels

For health professionals, 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 your 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. Health professionals may be involved in care planning if required. This could mean for example, that a physiotherapist and occupational therapist work with the provider and the participant to develop a plan that identifies the person's goals, the services they will receive such as weekly physiotherapy or installation of a handrail or shower chair, and their preferences for how services are delivered. These preferences may include the gender or attributes of the care worker, preferred days and times for receive services, and any cultural considerations.

Eligible health professionals can claim a Medicare Benefit Schedule (MBS) item for case conferencing if the participant has a current GP chronic condition management plan (GPCCMP) in place. Fee for service and private health insurance rebates may also be options to discuss with the person.

Short-term Pathways

Health professionals are directly involved in delivering short-term support that helps older people 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.

Some types of assistive technology, particularly complex items, may require a prescription from a suitably qualified health or allied health professional to ensure they are safe and appropriate for the participant's needs. All home modifications require a prescription from an occupational therapist working within their scope of practice.

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

- **occupational therapist** may prescribe self-care products such as an adjustable shower chair or home modifications including a ramp or handrail
- **physiotherapist** 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 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.

Health professionals may also provide wraparound services to ensure participants can use products safely. Wrap around services include, but are not limited to:

- set up of assistive technology equipment
- training and education on the safe use of assistive technology, equipment or home modifications
- follow-up on the effectiveness of assistive technology and/or home modifications in meeting the older person's needs.

Occupational therapists will conduct home assessments and work with builders and providers to ensure home modifications meet the participants needs and support them to live safely within their home environment.

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.

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.

Health professionals play an important role in supporting participant outcomes within a reablement approach that involves a multidisciplinary team. Community-based health professionals may be key members of this team, working in partnership with the aged care provider to help deliver care services and contribute to the goal plan.

All older people accessing the Restorative Care Pathway must have an individualised goal plan. A goal plan must be in place before or on the day services commence and should be reviewed and updated as the episode progresses. The restorative care partner, together with the older person, their registered supporter (if required), and other members from the multidisciplinary team need to develop a goal plan for each episode of restorative care.

Community health professionals may help develop the goal plan by mapping out a programs that support achievement of identified goals. For example, an older person who has had a fall may be unable to complete a regular activity such as swimming. In this case, the goal plan would outline how the person could receive intensive allied health intervention to regain function and return to their everyday activities.

Referral to the Restorative Care Pathway

To access the Restorative Care Pathway, the older person 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), older people 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).

Health professional's involvement in the End-of-Life pathway

Health professionals including nurses may be involved in the End-Of-Life Pathway by assisting with:

- mobility
- fatigue management
- nutritional needs
- working closely with the aged care provider's care team.

Their involvement ensures that the older person receives coordinated, compassionate, and responsive care that aligns with their preferences and supports their dignity and comfort during the final stages of life.

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

- 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)
- Support at Home – End-of-Life Pathway (fact sheet)
- Support at Home prices for allied health and nursing services – 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.