Australian Government
Department of Health, Disability and Ageing

Support at Home

Support at Home – Provider Application for Care Management Supplement Form

ABOUT THIS FORM

This form is for Support at Home providers to notify the Department of Health, Disability and Ageing (the department) of applicability of the care management supplement as per section 205-10 of the *Aged Care Rules 2025*.

The rate for the Care Management Supplement is available at: Schedule of Subsidies and Supplements for Aged Care.

STEPS

1. Providers attach this completed form with supporting evidence to the participant's record in the **My Aged Care Service and Support Portal** under Type of attachment '*SP Care Plan*'.
2. Provider contacts the **My Aged Care service provider and assessor helpline** on 1800 836 799 to have the submission validated for processing.
3. The department advises Services Australia to apply the care management supplement to your care management account (that is, your service delivery branch account) as per section 203 of the *Aged Care Act 2024* if the circumstances for applicability of the supplement are met.

For assistance with this form, please contact **SaHOperations@health.gov.au**.

PRIVACY

Information obtained in the course of performing functions or duties, or exercising powers, under the *Aged Care Act 2024* is protected under the *Aged Care Act 2024* and may only be used or disclosed in accordance with the *Aged Care Act 2024*.

The privacy and security of personal information is important to us and is protected by law. We collect this information so we can process and manage applications and payments, and provide services. We only share this information with other parties where you have agreed, or where the law allows or requires it.

For more information, please see our Privacy Notice.

PARTICIPANT CONSENT

Do you have the participant's consent to share this information with the Department of Health, Disability and Ageing for the purpose of identifying applicability of the care management supplement?

☐ Yes

☐ No

Note: Participant consent is recommended prior to submission of this form.

PARTICIPANT INFORMATION

Participant name

Participant ACID

APPLICABLE CIRCUMSTANCES

Please select any that apply to the participant:

- ☐ The individual is an Aboriginal person
- ☐ The individual is a Torres Strait Islander person
- ☐ The individual is homeless or at risk of homelessness
- ☐ The individual is a care leaver, that is, an individual who has spent time in institutional care or out of home care (such as orphanages and foster care) and includes an individual who is a Forgotten Australian, a former child migrant or an Aboriginal or Torres Strait Islander person from the stolen generations
- ☐ The individual is referred to the provider as an eligible client by the care finder program funded by the department

Note: The care management supplement applies where at least one criterion has been met. The Department of Veterans' Affairs and Services Australia will identify where the veterans' supplement for aged care applies to the individual, for the purposes of the care management supplement.

PROVIDER INFORMATION

Provider name

Registered Provider ID

NAPS Service ID

DECLARATIONS

- I declare that the information provided in this form is complete and correct.
- I understand that giving false or misleading information to the Commonwealth is a serious offence under section 137.1 of the schedule to the Criminal Code Act 1995.
- I declare that I am authorised on behalf of the registered provider to complete this form.

Authorised person's full name

Authorised person's phone number

Authorised person's email

Signature of authorised person

Date