Australian Government
Department of Health, Disability and Ageing

Support at Home program manual

A guide for registered providers

Version 4.2

December 2025

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 program 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 a provider's specific circumstances.

Providers are solely responsible for complying with all relevant legislation when delivering funded aged are services. Providers should obtain their own independent legal and professional advice relevant to their specific circumstances to fully understand how to comply with all legislation relevant to delivering care and services under the Support at Home program, 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.

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 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 of Health, Disability and Ageing (the department) will review and update the information in this program manual as needed. The most up-to-date version of this program 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 represent or guarantee the accuracy or completeness of information in this program manual. To the extent permitted by law, the department also does not accept any liability for any loss or damage caused to any person (including providers) resulting directly or indirectly from use or reliance on this program 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, Disability and Ageing: www.health.gov.au
- My Aged Care: www.myagedcare.gov.au
- Aged Care Quality and Safety Commission: www.agedcarequality.gov.au
- Services Australia: www.servicesaustralia.gov.au
- Australian Competition and Consumer Commission: www.accc.gov.au
- Australian Taxation Office: www.ato.gov.au

Version history

The table below outlines the revisions to the manual made by the department since the commencement of the new *Aged Care Act 2024* on November 1 2025.

Date	Summary of changes
March 2025	Version 1.0
May 2025	Version 2.0
June 2025	Version 3.0
September 2025	Version 4.0
October 2025	Version 4.1
December 2025	Version 4.2 • Chapter 4: Inclusion of link to the new Support at Home program assurance webpage. • Section 8.8.1: New information regarding manual application for the care management supplement. • Section 9.5.3: Update to specify that if a higher contribution is required, the adjustment will apply from the beginning of the following quarter for ongoing classifications or at the beginning of the next episode for short-term pathways. • Section 10.2: Update to specify that Aboriginal and Torres Strait Islander persons are eligible for all services. • Section 13.4: Update to clarify that the AT-HM cap on administration and/or coordination costs applies to the total cost of the item, item bundle or total quoted cost. • Section 14.3: Update regarding access to the restorative care episode and ongoing classification, at the same time. • Section 18.2: New information about accessing specialised support services (vision advisory services); additional information about accessing cottage respite; other CHSP services cannot be accessed by Support at Home participants, section removed.

Contents

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, Disability and Ageing (the department) has prepared the Support at Home program manual 2025-2027 (program manual) for registered providers (providers) delivering funded aged care services under the *Aged Care Act 2024* (the Act) through the Support at Home program. The program manual outlines how the Support at Home program should be delivered.

Providers delivering the Support at Home program must be registered under the Act. Registered providers must comply with the conditions on their registration. They must also meet a number of other duties and obligations under the Act. Civil penalties or offences may apply for breaching the duties, obligations or conditions of registration.

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

1.1 Audience

This program manual is intended for providers delivering services through the Support at Home program. This program manual serves as an operational guide to assist providers to understand and comply with provider obligations and legislation for delivering services through the Support at Home program. It is intended to provide guidance that will support providers to deliver high-quality care that meets the needs of individuals accessing Support at Home (participants).

1.2 Scope

This program manual explains government policy, legislative context, operational detail and guidelines for the delivery of services through the Support at Home program. It also outlines the responsibilities of providers under the legislation.

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

- an overview of the Support at Home program
- governance of the program including the person-centred legislative framework, aged care system governance, program assurance and the Supported Decision-Making framework
- 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
- changing providers, ceasing 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 (CHSP).

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

- legislation made by the Commonwealth, states or territories
- provider registration
- the strengthened Aged Care Quality Standards (strengthened Quality Standards)
- 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 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 access to Support at Home • Starting funded aged care services, including service agreements

Part	Description
	• Care management • Participant budgets and contributions • The Support at Home service list and key information for service delivery • Self-management • Ceasing 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 Program (CHSP), Transition Care Programme (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 care recipients, grandfathered HCP care recipients and transitioned STRC clients.

Note: All previous HCP care recipients are 'transitioned HCP care recipients', with a subset having grandfathered provisions applied.

- **Transitioned HCP care recipient:** A Home Care Package recipient who transitioned to Support at Home on 1 November 2025. This also includes older people who were on the National Priority System prior to 1 November 2025 but had not received a Home Care Package.
- **Grandfathered HCP care 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.

- **Transitioned STRC client:** A Short-Term Restorative Care client who transitioned to Support at Home on 1 November 2025. This includes older people who were part-way through a STRC episode or who had approval to access STRC but had not commenced receiving services.

More information on grandfathering arrangements is in section 9.4.1.

1.3.2 Related documents

Related documents outlined in this program manual are available via the department's website Support at Home program manual a guide for registered providers.

1.3.3 Future program elements

This icon is used throughout the program manual to highlight future program elements of Support at Home that are not part of the program commencement on 1 November 2025.

1.4 How the program manual is updated

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, Disability and Ageing

More information about Support at Home, including a copy of this program manual, is available on the department's website at Support at Home program.

Providers, peak bodies and advocacy agencies can access additional information and operational support through the Support at Home Community of Practice.

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 *Aged Care Rules 2025* can be found on the Federal Register of Legislation.

As the Register is updated from time to time, this program manual does not include links to the 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 (including volunteers) 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 Commission's website.

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	Engagement.WA@health.gov.au
New South Wales Australian Capital Territory	Engagement.NSWACT@health.gov.au
Victoria	vic.office@health.gov.au
Queensland	Engagement.QLD@health.gov.au
South Australia	Engagement.SA@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)	https://mac.org.au/picac/	(08) 8241 9900
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 has developed self-paced learning packages to help providers transition to the Support at Home program. These packages include detailed information on the Support at Home program and are available from the department's website Support at Home provider training.

The Support at Home training is designed to complement existing resources including this program manual and the Support at Home Program Provider Transition Guide.

1.7 Grants

Providers can register on Grant Connect to receive updates on current and future opportunities.

Part B: Governance for Support at Home

This section covers:

- legislative framework
- aged care system governance
- program assurance

2.0 Legislative framework

This section of the program manual outlines key themes in the Act. Operational information, as it relates to the Rules, is included throughout this program manual from Part C.

The following laws govern the Support at Home program:

- *The Aged Care Act 2024* (the Act) – This is the overarching principal legislation.
- *The Aged Care Rules 2025* (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 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.

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 objects of the Act set out the key concepts and considerations that must be considered when executing powers and functions under the Act.

In summary these objects 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 objects 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 Guide to Aged Care Law.

2.2 Registered providers under the Act

Under the Act, registered providers are entities that deliver Commonwealth-funded aged care 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 aged care home, through:

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

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.

2.2.1 Provider Requirements Search tool

The department has developed an interactive online tool to help providers understand and comply with the requirements under the new Act and associated Rules.

The search tool is designed to support both existing and prospective providers by:

- compiling all relevant requirements, including conditions of registration, obligations and statutory duties, into a single, accessible location

- providing direct links to the Federal Register of Legislative Instruments, allowing users to verify information against official legislative sources
- offering a resource page with educational materials, guidance documents and links to relevant web pages to further support understanding and compliance.

The search tool is especially useful for determining a provider's specific requirements based on the services they deliver, ensuring clarity and confidence as providers navigate the new regulatory framework. It also has information for aged care workers and responsible persons about their responsibilities.

Note: The search tool does not provide information on how to apply to be a registered provider, requirements from the System Governor and the Aged Care Quality and Safety Commission or penalty provisions. The information provided by the search tool is intended as a summary only and is not a substitute for the Aged Care Act or associated Rules.

The Provider Requirements Search tool is available on the department's website at Aged Care Provider Requirements Search.

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, aged care workers (including volunteers) and/or registered supporters perform functions or exercise powers under the Act.

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 registered providers and aged care 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 delivering funded aged care services must take all reasonable and proportionate steps to act compatibly with these rights.

A summary of the Statement of Rights is outlined in the Guide to Aged Care Law.

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 registered providers, aged care workers, registered 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 Guide to Aged Care Law.

2.4 Registered supporters

The Act establishes a legal framework for the registration of supporters. This framework helps to embed supported decision-making across the aged care system (Chapter 1, Part 4). The System Governor is responsible for registering supporters when an application is made through My Aged Care. More information on the System Governor is in section 3.0, and more information on how to register a supporter is available at 6.2.

Under the Act, every older person is presumed to have the ability to make decisions. Some older people may want or need support making decisions. Supported decision-making is the process of providing support to help older people make and communicate their own decisions, rather than having decisions made for them. This allows older people to remain in control of their lives.

Older people can seek to register people who can support them to make aged care decisions, if they want or need this support. These people are called ‘registered supporters’. An older person can have more than one registered supporter.

Registered supporters help older people to make and communicate their own decisions about their aged care services and needs, including speaking to My Aged Care, aged care assessors, aged care providers, and the Commission. Registered

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

As an older person is presumed to have the ability to make decisions, having a registered supporter does not prevent an older person from doing something they can otherwise do. Older people can keep receiving information, making decisions, and communicating directly with others including their aged care provider, My Aged Care and assessment organisations. To this end, becoming a registered supporter does not provide a person with decision-making authority for the older person. A registered supporter's role is to support the older person to make and communicate their own decisions.

Aged care providers must continue to go directly to the older person for decisions, even when there is a registered supporter. However, an older person can ask a registered supporter to help them make and communicate their decisions. An older person's ability to make decisions and communicate their will and preferences may change from day to day, or over time. An aged care provider's understanding of who the older person's registered supporters are, and the role they can perform, is essential in respecting the older person's rights.

Some registered supporters also have guardianship, enduring power of attorney or similar legal authority. These people are appointed decision makers for the older person and can make decisions on behalf of the older person under Commonwealth, state or territory arrangements. An appointed decision maker can only make decisions on the older person's behalf in line with their active, legal authority.

There is no requirement to register a supporter, including where that person is also an appointed decision-maker under a Commonwealth, state and territory arrangement. The absence of a registered supporter or an appointed decision-maker in an older person's life is no grounds for exclusion from access to, or receipt of, aged care services or the older person's involvement in their own decision-making for aged care matters.

Not every older person will want or need someone to support them and not every older person will want a registered supporter. Some older people might feel they are already supported by their carers and other significant people in their lives, without needing any of them to become a registered supporter.

Transition arrangements were in place up to 31 October 2025 for regular and authorised representative relationships in My Aged Care. This means if an older person had a regular or authorised representative active in My Aged Care on 31 October, their representative became a registered supporter under the Act. This ensured continuity of decision-making support for older people seeking or receiving aged care services.

More information on registered supporters is available on the department's website at Supported decision-making under the new Aged Care Act.

3.0 Aged care system governance

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

The aged care governance arrangements also include 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 the registration of aged care providers that 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 before they can commence delivering funded aged care services. The registration process will be overseen by the Commission. More information on provider registration is available on the Commission's website at Registration Model.

Providers must meet the conditions of their registration. 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.

A registered provider must also comply with their obligations and duties under the Act. The obligations and duties refer to the delivery of safe and quality services, and the rights of an individual to receive safe and quality services from their provider.

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

If a provider fails to meet the conditions of registration or their obligations, the Commissioner has the power to undertake regulatory action. This may include suspending or revoking a provider's registration or civil penalties.

More information on provider obligations is in the Commission's Provider Handbook and the department's Guide to Aged Care Law.

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 strengthened Quality Standards apply to registration categories 4, 5 and 6, based on the services being delivered. The standards only apply to services in those registration categories and not other services that the provider may deliver. The Aged Care Quality and Safety Commission (the Commission) will monitor and regulate providers by auditing their ability to comply with all provider obligations, including the requirements of the strengthened Quality Standards.

More information about strengthened Aged Care Quality Standards is on the department's website.

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, Section 14-1, Chapter 1, Part 5 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 about SIRS, including resources and guidelines on SIRS, is in Chapter 5, Part 2, Division 2, 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 is in Chapter 4, Part 6, Division 1, Subdivision B of the Rules and on the department's website at Screening requirements for the aged care workforce.

3.6 Starting and ceasing funded aged care services

It is a condition of registration that providers must comply with any requirements in the Rules relating to starting and ceasing funded aged care services. Providers must also ensure there are appropriate continuity of care arrangements in place for people receiving funded aged care services.

More information on starting funded aged care services is in chapter 7.0.

More information on ceasing funded aged care services and the continuity of those services is in section 12.4.

3.7 Financial reporting obligations

Registered providers delivering services under the Support at Home program have reporting obligations and must complete a Quarterly Financial Report (QFR) and an Aged Care Financial Report (ACFR).

3.7.1 Quarterly Financial Report

The QFR was introduced on 1 July 2022 as part of broader initiatives to improve financial reporting, transparency and strengthen prudential compliance for providers. The QFR is completed using the Government Provider Management System (GPMS).

More information on the QFR is available on the department's website at Quarterly Financial Report.

3.7.2 Aged Care Financial Report

The ACFR allows the Australian Government to collect financial information for providers and parent entities where applicable. The ACFR is completed using the Forms Administration Portal.

More information on the ACFR is available on the department's website at Aged Care Financial Report.

4.0 Program assurance

The System Governor's functions, include 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 related to that function.

Assurance activities could relate to 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 individuals to whom they deliver funded aged care services
- keep records and information
- apply and document procedures.

In undertaking assurance activities, the System Governor (or a person assisting the System Governor) can request that a provider or other person give information and documents that are relevant to the assurance activity. The System Governor may publish reports on program assurance activities which may include findings, conclusions or recommendations in relation to a registered provider.

A registered provider must cooperate with the review process including relevant findings. Failure to do so could result in consequences under the Act.

More information on program assurance is available on the department's website at Support at Home program assurance.

Part C: Service delivery for Support at Home

This section covers:

- program overview
- assessment and access to aged care services
- starting funded aged care services
- care management
- participant budgets and contributions
- service list and delivery of services
- self-management
- ceasing and temporarily stopping services.

5.0 Support at Home program overview

This chapter covers:

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

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 3, Parts 4 and 5, Chapter 3
- Sections 20 and 23.

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.

Key points to remember

- Support at Home replaced the Home Care Packages (HCP) Program and the Short-Term Restorative Care (STRC) Programme.
- Support at Home has 8 classifications for ongoing services and 3 short-term classifications: the Restorative Care Pathway, the End-of-Life Pathway and the Assistive Technology and Home Modifications (AT-HM) scheme.
- Providers must be guided by the Statement of Rights that underpin the Support at Home program and should 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.

Support at Home replaced the Home Care Packages (HCP) Program and the Short-Term Restorative Care (STRC) Programme.

Support at Home provides coordinated 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) care 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 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 10.0.

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) in an approved residential aged care home for older people who cannot live independently in their own home. More information about residential aged care is on the department's website.
- **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.
- **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.
- **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.
- **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.

More information on how the Support at Home program interacts with other programs and schemes is in Chapter 18.0.

5.3 Wellness and reablement

Wellness and reablement are person-centred, holistic approaches to service delivery that 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.

By focusing on capacity-building and restoring or maintaining function, wellness and reablement approaches directly contribute to the wellbeing outcomes described in the Act and the strengthened Quality Standards. These support older people to live safely, independently, and with a sustained sense of meaning and connection in their own homes and communities.

More information on wellness and reablement is on the department's website at wellness and reablement resources.

5.3.1 Wellness approach

Wellness is a philosophy that informs how providers should 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 should underpin 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

Support at Home providers are required to demonstrate the capability for and commitment to continuous improvement towards the delivery of high quality care. High quality care is defined in the Act and includes delivering services in a way that

puts the individual first, upholds their rights under the Statement of Rights and prioritises other important matters. This includes delivering funded aged care services in a way that prioritises mental health and wellbeing (section 20(c)(i) of the Act) and uses reablement approaches to support the improvement of wellbeing, independence, autonomy, physical and cognitive capacity (section 20(c)(v) of the Act).

To underpin the delivery of care in this way, providers should aim to adopt wellness and reablement approaches that aim to support the improvement of the individual's wellbeing. Wellness and reablement are closely related and often implemented together.

Under the strengthened Quality Standards, providers have a responsibility to deliver funded aged care services in a way that optimises the individual's quality of life, reablement and maintenance of function, where this is consistent with their preferences.

The strengthened Quality Standards also 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).

Wellness and reablement approaches support providers to ensure that service delivery aligns with these standards. 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.

In applying wellness and reablement approaches, Support at Home providers should 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.

5.3.4 Embedding wellness and reablement

The table below outlines the **key components and actions providers should 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.
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 those who support the older person, including their registered 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 capabilities, aspirations and goals	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.

5.4 Support for diverse needs

Support at Home is designed to be a person-centred system, which enables providers to deliver aged care services that treat older people as unique individuals. Under the Act, older people have a right to quality and safe aged care services, with their individual identity, culture, spirituality and diversity valued and supported.

The aged care system should offer accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed funded aged care services if required by an individual and based on the needs of the individual, regardless of their location, background and life experiences.

This may include individuals who are:

- Aboriginal or Torres Strait Islander persons, including those from stolen generations
- veterans or war widows
- from culturally, ethnically and linguistically diverse backgrounds
- financially or socially disadvantaged
- experiencing homelessness or at risk of experiencing homelessness
- parents and children who are separated by forced adoption
- adult survivors of institutional child sexual abuse
- care-leavers, including Forgotten Australians and former child migrants placed in out of home care
- lesbian, gay, bisexual, trans/transgender, intersex or other sexual orientations, gender diverse or bodily diverse
- living with disability or mental ill-health
- neurodivergent, deaf, deafblind, vision impaired or hard of hearing
- living in rural, remote or very remote areas.

The strengthened Quality Standards require providers to demonstrate that they understand and value individuals, including their identity, culture, ability, diversity, beliefs and life experiences. A person's diversity may not define who they are, but it is critical that providers recognise and embrace each person's diversity and who they are holistically as a person, and that this drives how providers and aged care workers (including volunteers) engage with older people and deliver their funded aged care services.

Providers must deliver funded aged care service with, and tailored to, individuals, taking into account their needs, goals and preferences. Providers must deliver funded aged care services to individuals in a way that is free from all forms of discrimination, abuse and neglect, treats individuals with dignity and respect, and respects the personal privacy of individuals.

Resources to support aged care providers to meet the needs of older people from diverse backgrounds and life experiences are available on the department's website at Working with diverse groups in aged care.

5.4.1 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 those who support the participant (including their registered 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.

5.4.2 Translation services

For participants requiring translation services, the Australian Government funds a free aged care translation service called Different languages, same aged care. This service is designed to help aged care providers communicate with older people from culturally and linguistically diverse backgrounds. This service can be used to translate written materials for the benefit of older people from culturally and linguistically diverse backgrounds who prefer to communicate in a language other than English.

Support at Home providers can use this free service to produce translated versions of print and digital materials in different languages, as well as 'Easy Read' or 'Easy English' translations. Translation specialists will work with you to understand your requirements. Your materials will be translated and returned to you in the desired formats.

For more information about this service or to request a translation, visit the department's website diversityagedcare.health.gov.au.

5.4.3 Aboriginal and Torres Strait Islander languages interpreter 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.

5.4.4 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
- Single Assessment System workforce
- 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.

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 is supported through the following provisions in the Act:

- providers have an obligation under the Act to ensure they act compatibly 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)
- registered supporters are enabled under the Act to support a participant to make and communicate their own decisions 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.

For detailed case studies on dignity of risk, visit the Commission's website.

6.0 Assessment and access to Support at Home services

This chapter covers:

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 1, Part 4 (Supporters)
- Chapter 2, Part 3 (Classification).

The *Aged Care Rules 2025*:

- Chapter 2, Part 3 (Classification).

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.

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 home modifications, if approved.
- To access services, a participant will need to find a provider and enter into a service agreement with their chosen provider.

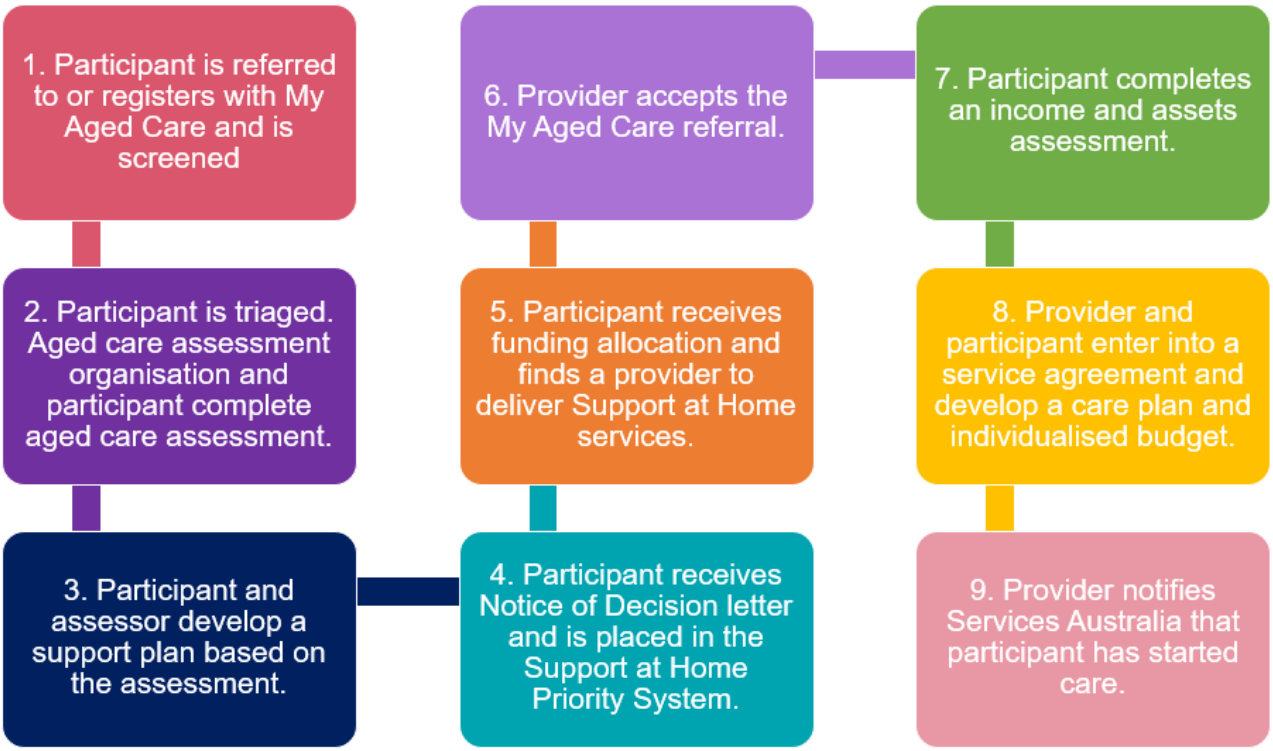
- A Support Plan Review is completed when the participant's needs, goals or circumstances change and can result in a change in the support plan or a new assessment.

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 out 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

For older people and the people who support them, the process to be or have a registered supporter in My Aged Care will mostly stay the same as previously creating a representative relationship in My Aged Care.

A person can request to register a supporter by contacting My Aged Care, an aged care assessor, an Aged Care Specialist Officer, or by completing the registration form online, via a printed copy, or via their My Aged Care Online Account.

In most cases, an older person will be asked to consent to registering a person as their registered supporter and to that person receiving information about them.

An older person does not need to consent to the registration of a supporter if that supporter is also an appointed decision maker for the older person under a Commonwealth, state or territory arrangement and their legal authority is active.

More information on registered supporters is in section 2.4.

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 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.

6.3.1 Access supports

6.3.1.1 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:

- 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
- advocate for older Aboriginal and Torres Strait Islander people by working with assessors and providers to meet their needs
- support older Aboriginal and Torres Strait Islander people while they receive aged care services
- assist 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 about Elder Care Support is on the department's website.

6.3.1.2 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 November 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 is on the department's website Aboriginal and Torres Strait Islander assessment organisations.

6.3.1.3 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 registered 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.

6.3.1.4 National Aged Care Advocacy Program

The Australian Government funds the Older Persons Advocacy Network (OPAN) to deliver the National Aged Care Advocacy Program (NACAP) across Australia. The program provides free, confidential and independent information and support.

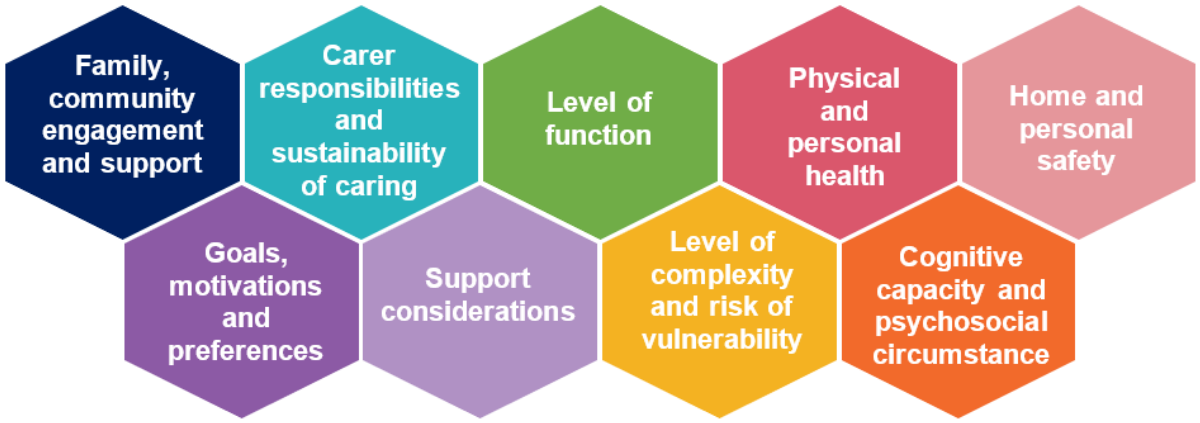
If a participant has questions or concerns regarding their Support at Home services, they can speak to an aged care advocate by calling the Aged Care Advocacy Line on 1800 700 600 and be connected with the aged care advocacy organisation in their state or territory.

More information on NACAP is on the department's website at National Aged Care Advocacy Program.

6.4 Aged care assessment

An aged care needs assessor will determine the older person's aged care needs using the Integrated Assessment Tool (IAT). The IAT supports high quality assessment, 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 person-centred, culturally appropriate, 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 to access 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
- details of any registered supporters or persons who have sought, or are seeking, to become registered supporters
- a date for a Support Plan Review.

6.6 Notice of Decision

In addition to the support plan, an older person will receive a Notice of Decision. This is called the **Outcome of your application for government-funded aged care services**. Older people need approval from an Assessment Delegate to access 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 to access Support at Home.

The Notice of Decision describes:

- the approved funded aged care services, including the:
    - classification level
    - assistive technology and home modifications funding tier, if approved
    - short-term pathways, if approved
- reasons and evidence supporting the Assessment Delegate's decision
- older person's rights of review, should they wish to query or dispute the decision.

Providers can view the Notice of Decision and support plan via the My Aged Care Service and Support Portal. Older people can also view their Notice of Decision and support plan via their My Aged Care Online Account. An older person's registered supporter/s (if any) may also be authorised to access to this information.

6.7 Classification

Older people approved to access 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 **funding amounts for each of the 8 ongoing service classifications**. These funding amounts include 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 the number of days in a quarter and indexation revisions.

Classification	Quarterly budget*	Annual amount*
1	$2,682.75	$10,731.00
2	$4,008.61	$16,034.45
3	$5,491.43	$21,965.70
4	$7,424.10	$29,696.40
5	$9,924.35	$39,697.40
6	$12,028.58	$48,114.30
7	$14,537.04	$58,148.15
8	$19,526.59	$78,106.35
*Quarterly budgets and annual amounts are effective from 1 November 2025 and are subject to change in July each year in line with indexation.		

6.7.2 Transitioned HCP care recipient and classifications

Transitioned HCP care recipients will continue to receive an equivalent level of funding (including supplements) as their previous Home Care Package. The previous annual package amount is divided into four to create a Support at Home quarterly budget.

HCP classification	Support at Home classification	Support at Home quarterly budget*	Support at Home annual amounts*
HCP Level 1	Transitioned HCP Level 1	$2,746.63	$10,986.50
HCP Level 2	Transitioned HCP Level 2	$4,829.86	$19,319.45
HCP Level 3	Transitioned HCP Level 3	$10,513.83	$42,055.30
HCP Level 4	Transitioned HCP Level 4	$15,939.55	$63,758.20
*Quarterly budgets and annual amounts are effective from 1 November 2025 and are subject to change in July each year in line with indexation.			

Funding amounts for transitioned HCP care 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 31 October 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. The funding available for these pathways is outlined in the sections below.

6.7.3.1 The Restorative Care Pathway

The table below outlines the **approximate funding amounts for restorative 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	$6,011.04 (up to 16 weeks).
*Budget amounts are effective from 1 November 2025 and are subject to change in July each year in line with indexation.	

6.7.3.2 Transitioned STRC clients

Transitioned STRC clients, who commenced their STRC episode prior to 1 November 2025, will continue to receive care from their provider under Support at Home transitional arrangements. Providers will need to ensure services delivered from 1 November 2025 align with the Support at Home service list and AT-HM list.

Older people who have an active STRC approval and have not commenced an STRC episode by 1 November 2025, have had their approval converted to a Restorative Care Pathway approval. This approval remains valid for 6 months from the date of the original STRC approval. After 6 months has lapsed, this approval is no longer valid and a re-assessment will be required to access restorative care.

More information on the Restorative Care Pathway is in Chapter 14.0.

6.7.3.3 The End-of-Life Pathway

The table below outlines the **approximate funding amounts for 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*
End-of-Life Pathway	$25,035.36 (12 week episode, may be extended up to 16 weeks).
*Budget amounts are effective from 1 November 2025 and are subject to change in July each year in line with indexation.	

More information on the End-of-Life Pathway is in Chapter 15.0.

6.7.3.4 The AT-HM scheme

The table below outlines the **funding amounts for the funding tiers for assistive technology 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[1]	12 months
[1] Participants who have assistive technology costs above $15,000 can access additional funding with evidence, such as a valid prescription. More information on the AT-HM scheme is in Chapter 13.0.		

6.8 The Support at Home Priority System

The Support at Home Priority System ensures the equitable allocation of Support at Home funding to participants. An older person will not be able to access government funded services under Support at Home until funding has been allocated.

Older people approved to access Support at Home services will enter the Support at Home Priority System in one of its four priority categories (urgent, high, medium, standard). An older person's priority category is determined based on standardised criteria using information collected by the assessor during their aged care needs assessment. The amount of time they wait for services will depend on the priority category they are in.

The Support at Home Priority System factors in:

- priority for in-home care services (urgent, high, medium, standard)

- 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 factors. When funding is assigned to a participant, they will be notified via letter from the Department of Health, Disability and Ageing.

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 CHSP will be available for participants in urgent need situations ahead of receiving their budget allocation, if required. More information is in section 18.1.

6.8.1 Interim funding

Participants who receive funding through Support at Home may receive interim funding for a period of time. Interim funding is an allocation of 60% of the total funding for a participant’s classification. Interim funding may also be referred to as the minimum service offer (MSO). The intent of interim funding is to ensure Support at Home participants are not waiting any longer than necessary without access to care. This will allow the participant to start 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.

Interim funding may be allocated to a participant if demand for Support at Home is higher than expected and would lead to wait times increasing. This includes an older person who is:

- on the National Priority System on 31 October 2025 and assessed as eligible for a Home Care Package
- assessed as eligible for Support at Home services from 1 November 2025.

It should be noted that full funding will always be allocated to older people who are:

- categorised as an urgent priority on the Support at Home Priority System
- approved for the Restorative Care Pathway or End-of-Life Pathway.

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, as well as develop a care plan and individualised budget. 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. When the remaining funding is allocated, the care plan and individualised budget should be reviewed and updated. In some cases, the service agreement may require updating, for example, if the services to be delivered to the participant will change.

More information on developing a care plan for interim funding is in section 8.6.1.

More information on developing an individualised budget for interim funding is in section 9.7.4.

6.8.1.1 Notification to participant of interim funding

A participant will receive a letter notifying them of their interim funding allocation. The letter will outline that the:

- minimum service offer (MSO) has been allocated and that this is 60% of their approved Support at Home classification
- funding available is lower than the approved classification funding
- participant can commence receiving services
- remaining funding will be released as soon as it is available.

When full funding is available, the participant will receive a second letter outlining that they have received their full funding allocation. This is referred to as the full service offer (FSO).

6.8.1.2 Notification to provider of interim funding

A provider will be alerted to the allocation of interim funding through the My Aged Care Service and Support Portal, via the:

- Referral page – the ‘place assigned’ field will display ‘MSO’ for minimum service offer.
- Approvals page – the ‘place assigned’ field will display ‘MSO’ for minimum service offer.

When full funding is allocated to the participant, the provider will receive a notification in the My Aged Care Service and Support Portal stating the ‘participant receiving MSO is assigned FSO’. This means that the minimum service offer (MSO or interim funding) has been replaced with the full service offer (FSO or full funding). Providers will also be able to view this change in the My Aged Care Service and Support Portal on the approvals page. The additional funding will be applied on a pro-rata basis from date the full funding was allocated.

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 calendar 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:

- a system-generated referral – created either by the My Aged Care Contact Centre, ACSO or by an aged care assessor
- a direct referral – directly receiving a person's referral code (e.g., 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 managed and delivered through a single service delivery branch of a 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 services delivered to 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. Under this model, each participant is linked to a single service delivery branch of a registered provider. The service delivery branch is responsible for coordinating, delivering, and claiming payments for all services including ongoing services and services provided under the End-of-Life Pathway, Restorative Care Pathway, and the Assistive Technology and Home Modifications (AT-HM) scheme.

It is a requirement that all participants receive care management services for Support at Home. This means that registered providers, claiming for delivery of 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 registered provider remains responsible for delivery of the services and compliance with relevant obligations.

More information is on the department's website at New aged care regulatory model.

6.9.2 Service delivery branch

Under the Act, a service delivery branch is the place of business of the registered provider through which funded aged care services are delivered to an individual.

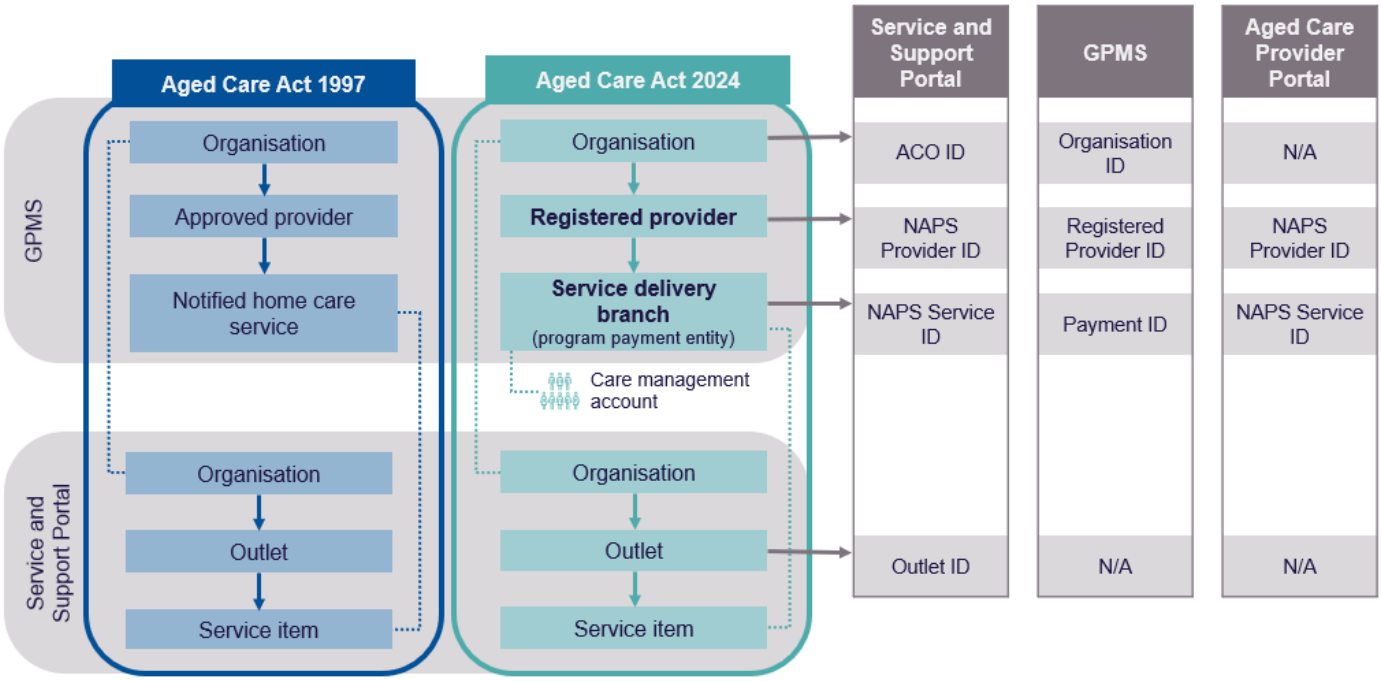
Pooling of care management funds will take place at the service delivery branch level of a provider. A provider must have a service delivery branch to claim for services delivered and receive subsidy from Services Australia. All participants under Support at Home must be connected to a service delivery branch.

A service delivery branch is a type of Program Payment Entity (PPE). It is equivalent to the NAPS Service ID in both the My Aged Care Service and Support Portal and the Aged Care Provider Portal.

More information on pooling of care management funding at the level of the service delivery branch is in section 8.9.2.

6.9.2.1 Structure of the service delivery branch

The diagram below outlines the **structure of the service delivery branch**.



7.0 Starting funded aged care services

This chapter covers:

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 2.
- Section 155.

The *Aged Care Rules 2025*:

- Chapter 4, Part 4, Division 4, Subdivisions A and B (Starting services)
- Sections 148-65 and 148-70 (Agreements)
- Section 155 (Provision of information).

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.

Key points to remember

- Before funded aged care services commence, the provider and participant must enter into a service agreement.
- A service agreement must be readily accessible and written in plain English.
- Providers have an obligation to provide and explain relevant information to the participant such as the Statement of Rights, Code of Conduct and participant contributions.
- Providers need to provide a start notification to Services Australia once a participant has entered into the service agreement.
- A provider or participant can request a Support Plan Review when the participant's needs, goals or circumstances change or the participants needs additional services.

7.1 Overview

This chapter outlines the steps providers need to take when a participant starts aged care services.

When a participant chooses an organisation as their provider, the provider and participant must enter into a service agreement before services can commence. The provider also has obligations to give and explain certain information related to funded aged care services.

Once a service agreement has been established, the provider must submit a start notification (also known as an entry notice or Aged Care Entry Record) to Services Australia. The service agreement and a valid start notification enable the provider to commence providing services under Support at Home and to make claims for payment.

Providers must also develop a care plan and individualised budget with participants.

7.2 Service agreements

It is a condition of registration that a provider has a service agreement in place for each individual accessing funded aged care services. The service agreement outlines rights and responsibilities, what services will be provided to the participant, and what prices will be charged. More information on what needs to be included in a service agreement is in section 7.2.1.

Providers must work collaboratively to communicate, consult and reach agreement with the participant (and, if requested, any other significant person e.g., registered supporter, family member, carer or advocate) 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.

7.2.1 Inclusions for service agreements

The following sections outline what must be included in a Support at Home service agreement.

Providers will need to establish new service agreements with all transitioned HCP care recipients. This must be completed prior to 1 November 2025. A new service agreement may be a whole new agreement or a variation to a current Home Care Agreement.

For transitioned HCP care recipients, providers will need to ensure that service agreements meet the requirements of the Act. Providers must assess the extent to which their existing home care agreements meet these requirements.

The Support at Home – Template for service agreements provides an example of the minimum requirements for service agreements under the Act. Providers can use this template to develop new service agreements or to identify where existing Home Care Agreements require variations.

More information on service agreements is in section 148-65 and 148-70 of the Rules and on the department's website at Support at Home service agreement resources.

7.2.1.1 Contents of a service agreement

The table below outlines the legislative requirements for contents of service agreements.

Requirement

• Details of the provider and participant entering the service agreement including:
  ○ Name of the registered provider, address and contact details.
  ○ Name of the participant, including address and contact details.
• A copy of the participant's Notice of Decision

• A copy of the participant's Support Plan. • Key dates including when the service agreement is entered into or will start, the participant start date (when services will commence), and service agreement review date. • For short-term pathways, the end date for services and where applicable, the date the service agreement ends. • How the participant will be involved in decisions relating to their care.

• Service agreements must include a list of the services the provider will deliver to the participant. For each service, this must include:
  ○ the name of the service as per the aged care service list
  ○ the service group and type that the service belongs to
  ○ if the service will be delivered by a third party.
• For each service, the provider must include the price the participant will be charged.
• The price does not need to be the same as the prices a provider has published on their website or provided to My Aged Care. However, if the price is higher, this must be noted along with the reason why the price is higher.
• If prices will regularly increase by a known amount, providers can include a clause that covers this. The clause must include the date of the increase, the amount and method by which the price will increase, and the reason for the increase.
• For other services, where the price is not known (for example, ad-hoc allied health, home maintenance or assistive technology) providers should include the process by which they will contact the participant to notify them of the price when it is known and obtain their agreement for the price. As a minimum, this must include providing the price in writing to the participant.

• How and when the service agreement may be terminated (see 12.4.2 for how a provider should notify a participant).
• A statement that the participant agrees to pay any applicable contributions following the delivery of a service.
• Information relating to the cooling-off period, outlining that a participant may withdraw from a service agreement after entering a service agreement. The participant must notify the provider (verbally or in writing) within 14 days of entering the service agreement and before services commence.

7.2.1.2 Variation of a service agreement

The table below outlines the legislative requirements for the variation of service agreements.

Requirement
With one exception, a service agreement must only be varied by mutual consent and following adequate consultation between the provider and the participant. The participant must provide consent to the variation. More information on variations of service agreements is in section 7.2.3.

7.2.1.3 Review of service agreements

The table below outlines the legislative requirements for the review of service agreements.

Requirement
The service agreement must be reviewed every 12 months and when requested by the participant.
Providers must give participants an opportunity to: • participate in reviews of their service agreement • consider whether any updates need to be made to the service agreement. • Where necessary, vary the service agreement in accordance with the requirements set out under 7.2.1.2.

7.2.2 Entering a service agreement

Both the participant and the provider must mutually enter into a service agreement and the participant should be given a copy of the signed service agreement, as soon as practical.

In the event that a participant cannot sign the service agreement, providers should keep detailed records of the participant's agreement to the service agreement. 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).

7.2.2.1 Authorisation to enter a service agreement

Providers should confirm who has authorisation to enter into the service agreement on behalf of an older person based on the law in their state or territory. In some circumstances, Commonwealth, state or territory arrangements may be in place for

an individual to enter into a service agreement on an older person's behalf (as an active, appointed decision-maker).

Under the Act, a person may serve as an active, appointed decision-maker for an older person 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, but are not required to be registered supporters to exercise their Commonwealth, state or territory decision-making authority. Registration has the advantage of being recognised as part of the older person's formal support network across the aged care system. Additionally, registered supporters who are also active, appointed decision makers automatically receive certain information about the older person they support.

Regardless of their status as a registered supporter, an active, appointed decision-maker must only act in accordance with the relevant Commonwealth, state or territory arrangement and comply with any duties and obligations attached to that arrangement.

7.2.3 Variations to service agreements

Service agreements will need to be updated when there is a change to the terms of the agreement detailed above. This may occur when:

- a participant has a change in classification
- a participant enters a short-term pathway
- a participant has a Support Plan Review and is approved to receive new services.

Where this occurs, providers and participants may vary the service agreement in accordance with the Rules. For more information see section 7.2.1.3.

Note: A service agreement may only be varied without mutual consent where a provider needs to implement the *A New Tax System (Goods and Services Tax) Act 1999* (GST Act). In these circumstances, the provider must give reasonable notice in writing about the variation to the participant. For more information, refer to 148-65(5) of the Rules.

7.2.3.1 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 or support from aged care advocates, registered supporters, family members, carers, or legal advisers.

7.2.4 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 Aged Care Quality and Safety 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 Aged Care Quality and Safety Commission.

7.3 Additional information for participants

Providers have an obligation to provide and explain information to participants who are seeking to access or accessing funded aged care services. This section provides a summary of the kinds of information to be provided and explained to the participant.

More information on the provision of information is in section 155 of the Rules and on the department's website at Support at Home service agreement resources.

7.3.1 Before or when commencing services

The table below outlines the information that providers must provide and explain to participants before or when they start to receive funded aged care services.

Requirement
Statement of Rights • Participant has been provided with information on their rights under the Statement of Rights and a copy of the Statement of Rights. • Participant has been assisted to understand all the above information provided and the Statement of Rights.

Complaints and Feedback
• Participant has been provided with a copy of the document outlined in section 165-20(1)(f) of the Rules that describes:
  ○ how to make a complaint or give feedback to the provider
  ○ what the person can expect in relation to how the feedback or complaint is managed
  ○ how feedback or a complaint can be made to the Complaints Commissioner
  ○ explanation that no-one will be victimised or discriminated for providing feedback or complaints to a provider or Complaints Commissioner.
• Participant has been assisted to understand the information given in the above document.

Code of Conduct • Participant has been provided with a copy of the Aged Care Code of Conduct. • Participant has been assisted to understand the Aged Care Code of Conduct.
Protection of personal information • Participant has been provided an explanation that their personal information will be protected and only used in the ways authorised under section 168 of the Act. • Participant has been assisted to understand the information provided.
Contributions • Participant has been provided information on means testing and contributions in a home and community setting, and their obligations to keep their income and asset details up to date. • Participant has been assisted to understand the process of applying for hardship assistance from Services Australia if they cannot afford their Support at Home contributions.

Requirement
• Participant has been assisted to understand the information provided.
Ceasing services • Participant has been given information about the circumstances in which the provider may cease services under section 149-35(2) of the Rules. • Participant has been given an explanation of the provider's requirement to provide notice when intending to cease delivery of funded aged care services (section 149-40 of the Rules). • Participant has been assisted to understand the information provided.
Care plans and monthly statements • Participant has been given an explanation of the requirement for the provider to develop a care plan with the participant before services commence (section 148-80(1) of the Rules). • Participant has been provided detail on what kind of information the care plan will include. • Participant has been given information that the provider will give them a monthly statement in accordance with sections 155-40 and 155-45 of the Rules (as outlined above). • Participant has been assisted to understand the information provided.
Financial position of the provider • Participant has been notified in writing that if they make a request, the provider must give them the following information and documents within 7 days: o a clear and simple presentation of the provider's financial position o a copy of the most recent statement of the audited accounts of the service delivery branch or the organisation that includes the service delivery branch.

7.3.2 While delivering services

The table below outlines the information that providers must provide and explain to participants while delivering funded aged care services.

Requirement
Assisting participants to choose the best services • Participant will be provided with information that assists them to choose the services that best meet their needs and preferences within their assessed needs and budget.
Invoices • Participant will be provided with invoices that are clear and understandable.

Requirement

Monthly and final monthly statements
• Participant will be given a statement each month.
• Statements will be provided by the last day of the following calendar month (e.g., 28th February for a January statement)
• Statements will include details of all services delivered in the month prior (e.g., services delivered in January).
• Statements will be provided for all months, including
  o partial periods
  o months when no services are delivered
  o the month after the final claim is made for services to the participant.
• Statements must contain all other information as required in the relevant rules made under section 155 of the Act.
• With the exception of the final monthly statement, participants will be helped to understand the information provided in the monthly statements.
Note: To support providers, a monthly statement template is available on the department's website at Support at Home monthly statement template.
More information on monthly statements is in chapter 17.0.

Individualised budgets • Providers will prepare an individualised budget in partnership with the participant in relation to the goals, assessed needs and preferences, available resources and selected services. • If the participant's means tested contribution rate changes, providers will need to discuss the change with the participant, and work with the participant to update their individualised budget. • Participants will receive a copy of the itemised budget when it is completed. • Individualised budgets must contain all other information as required in the relevant rules made under section 155 of the Act. • Participants will be assisted to understand the individualised budget.

Financial position of the provider.
• If requested, participants will be provided the following information and document within 7 days after receiving request:
  o a clear and simple presentation of the provider's financial position
  o a copy of the most recent statement of the audited accounts of the service delivery branch or the organisation that includes the service delivery branch.

7.4 Notifying Services Australia of a new participant

Providers need to provide a start notification to Services Australia once a participant has entered into a service agreement.

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 through the Aged Care Provider Portal.

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. Entry information 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 they will not be paid any applicable subsidy or supplements.

Where a start notification 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 start notification and service agreement was not in effect.

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

Note: All transitioning HCP care recipients and STRC clients will continue to have a valid Support at Home start notification from commencement of Support at Home. Providers will not need to submit a new start notification.

7.5 Developing a care plan and budget

Providers will need to develop a care plan with the participant before or on the day care starts. An individualised budget must also be prepared and provided to the participant as soon as practical.

More information on care planning and developing a care plan is in section 8.6.

More information on the development of a budget is in section 9.7.

7.6 Support Plan Review

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

- the participant's needs, goals or circumstances change
- the participant needs additional services (including access to the Restorative Care Pathway, End-of-Life Pathway or AT-HM scheme funding)

- a time limited service has ended.

A participant can request a Support Plan Review through My Aged Care or from a Services Australia ACSO. With a participant's consent, providers can request Support Plan Reviews through the My Aged Care Service and Support Portal.

A Support Plan Review may lead to:

- no changes to the support plan
- updates to the support plan
- a new assessment (note, access to the Restorative Care Pathway will require a new assessment).

When requesting Support Plan Reviews, 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 Support Plan Review 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 active, appointed decision maker (where relevant) 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 Commonwealth 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.

8.0 Care management

This chapter covers:

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 148(e).

The *Aged Care Rules 2025*

- Sections 148-80 and 148-85 (Requirements for care plans).

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

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 before or on the day care starts.

Key points to remember

- A direct care management activity must be delivered at least monthly.
- Care partners should update 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 trauma-informed, culturally safe, 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 will be pooled together in a care management account held by Services Australia. Pooling of funds will occur at the level of the service delivery branch.
- 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.

8.1 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.

8.2 Care management

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 the delivery of approved funded aged care services reflects individual needs, preferences and culturally appropriate practices, while assisting participants to understand and access the level of support they require.

Care management involves regular and ongoing communication with the participant and their family members or those who support the participant, including their registered supporters. At its core, care management involves the establishment of relationship-based support and planning between the care partner, the participant and those that support them.

Care management involves initial and ongoing:

- understanding of rights and obligations and the establishment and review of service agreements
- care planning
- service planning and management
- 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
- assistance to request a Support Plan Review, if needed.

Note: Care management will be different for each participant based on their individualised needs, goals, support network, communication preferences, level of involvement and cultural background.

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

Care management must be delivered to each participant at least monthly. This should be a direct care management activity of at least 15 minutes.

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 8.8.

Note: While care management activities are also mandatory for the Restorative Care Pathway and the End-of-Life Pathway, the 10% set aside for care management pool from a participants ongoing budget (if applicable), does not apply for these short-term classifications.

More information on care management for the Restorative Care Pathway is in section 14.5.

More information on care management for the End-of-Life Pathway is in section 15.5.

8.3 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. • Improved outcomes for people from culturally and linguistically diverse backgrounds through the use of interpreters, culturally appropriate communication, and care planning that respects family and cultural values.
Enhanced continuity of care	• Improved communication with and collaboration across care providers. • Reduced duplication of services.

Goals for care management activities	
	• Smoother transitions between providers and care settings.
Increased participant satisfaction	Person-centred care providing: • Relationship-based support and planning through establishing trust and understanding the participant's needs. • Regular and ongoing engagement with participants, carers and registered supporters. • Timely and flexible responses to participant needs • Improved communication and support around in-home aged care. • With the consent of the participant, inclusion of family members and carers, particularly in culturally and linguistically diverse communities where decision-making may be shared.
Optimised use of resources	• Consolidated service planning and information sharing, including with primary care services. • Reduced use of services including reduced hospitalisations.
Increased self-determination	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 independence and engage in behaviours that promote wellbeing.
Engaged carers and supporters	• Provision of resources and education to better equip carers and registered supporters to assist participants. • Better inclusion of carers and registered supporters as active partners in the participant's care, in line with the participant's wishes. • Support for carers to navigate aged care systems and access services in ways that are respectful of their cultural context, caregiving roles, and communication needs.

8.4 Care management activities

Providers must undertake initial and ongoing care management activities to meet the requirements under the strengthened Quality Standards.

Care management activities may be delivered directly (i.e., speaking, communicating or meeting with the participant and/or their registered supporter) or indirectly (i.e., completing a specific activity on behalf of the participant without their direct involvement). Care management should include a balance of direct and indirect activities and this will be dependent on the individual and changing needs of each participant.

Note: Providers must deliver at least one direct care management activity, to each participant, every month. The minimum duration of this care management activity is 15 minutes.

8.4.1 Included care management activities

The table below outlines a list of **care management activities that can be claimed by providers from their care management account**.

Care management for ongoing services – included activities	
Services	**Description**
Care planning	• Identifying participant needs, goals, preferences and existing supports through discussion with the participant, their registered support and/or their family members. • 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	• Planning and ongoing management to ensure comprehensive, coordinated and effective delivery of funded aged care services. • Communication with the participant, their carers and registered supporters. For example, speaking with the participant about their service options, changes to service prices or cultural preferences for workers.

	• Communication with aged care workers (involved in the delivery of services) regarding the participant's needs and wellbeing. • Incorporating cultural protocols and preferences for service delivery, including engaging with culturally specific organisations. • Communication with the participant, their carers and those who support the participant, including their registered supporters. • Managing the quarterly budget to ensure no overspend. • Ordering client consumables. • Facilitating transitions in and out of different care settings and ensuring continuity of care.
Monitoring, review and evaluation	• Engaging in ongoing care discussions and/or case conferencing with the participant, their registered supporter or family members and/or relevant health professionals, where required. • Internal case conferencing amongst care partners and/or the multidisciplinary team to respond to changing needs and optimise care. • 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 to make informed decisions, including respecting their right to take risks, and engaging with their registered supporters and carers (or other people who provide support to the participant), as appropriate. • Organising interpreter services or translated materials to support with care and service planning. • Supporting delivery of services with wellness and reablement approaches. • Providing independent advice, information and resources on age-related health matters. • Health promotion information and education.

	• Supporting participants, their registered supporter and family members to navigate age-related systems and programs and linking them to additional supports.* • Ensuring participant views, rights and concerns are heard and escalated.* • Supporting the participant to provide feedback and make complaints.* *These activities require *supporting* the participant to navigate, access and provide information but does not include completion of these activities (e.g., supporting the participant to make a complaint can be claimed under care management however, investigation and resolution of the complaint cannot be claimed as a care management activity).

8.4.2 Excluded care management activities

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

Note: Excluded items should be considered in setting service prices or accounted for in a provider's daily overhead expenses. Information on service prices is outlined in the New Support at Home pricing guidance.

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.

Care management – excluded activities	
Administration and other costs	The following activities cannot be claimed from Support at Home care management funding: • Scheduling services for a participant. • Creating staff rosters, assigning staff to participants for service delivery and making staff replacements. • Submitting claims for services delivered. • Staff travel to/from a scheduled service. • Staff training and education, including mandatory and on-the-job training. • Program governance and compliance activities, including SIRS reporting and complaint resolutions. • Completion of financial and operational reporting. • Record keeping, including care notes completed by aged care workers (who are not care partners) and auditing of records.

Care management – excluded activities	
	• Human resources activities, including recruitment and performance management. • AT-HM services and activities as outlined in section 13.5.

8.5 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.

Care partners are required to:

- deliver relationship-based, person-centred, coordinated care that supports each participant's goals and preferences
- monitor and responds to changes in health, circumstances and wellbeing
- promote independence through wellness and reablement approaches
- support the participant (and their carers and registered supporters) to navigate aged care systems and services
- ensure services are delivered in a culturally safe manner
- maintain clear and respectful communication that considers the participant's communication preferences
- document care accurately to ensure transparency and continuity of support.

Care partners are critical to the delivery of quality care and services. It is important the care partner establishes a trusting relationship with the participant, their registered supporter and their family members to gain a full understanding of the supports required.

8.5.1 Relationship-based support and planning

The relationship between the care partner and the participant is at the core of successful delivery of Support at Home. It involves the care partner building rapport, trust and empathy with the participant and understanding their age-related health issues and needs, in the context of the participant's life. This is known as relationship-based support and planning.

Building a trusting relationship leads to a better understanding of the participant's expectations for service delivery, as well as increased engagement by the participant to support them in their decision-making. It enables the care partner to undertake more effective service planning and respond more promptly to the participant's changing needs. This, in turn, can lead to improved aged care outcomes, enhanced continuity of care and increased participant satisfaction.

Relationship-based support and planning is not a discrete activity or task. Rather, it should be incorporated into the delivery of all care management activities.

8.5.2 Role of the care partner

In addition to the included care management activities outlined in section 8.4.1, the table below provides guidance on the role of the care partner and how they can support the participant during different stages.

This is not an exhaustive list and should be used as a guideline, noting that delivery of care management activities will depend on the individual needs and goals of each participant.

Note: Care management services must be delivered in line with Standard 3 of the strengthened Quality Standards.

Role of the care partner	
Stage	**Activity**

Starting funded aged care services	For new participants to Support at Home, the primary focus of the care partner will be to:
	• Build rapport with the participant and their family or registered supporter through active engagement.
	• Explain the Support at Home program, including the:
	  ○ Notice of Decision and support plan
	  ○ Support at Home service list and the services the participant is eligible to receive
	  ○ participant's classification level and budget they have been allocated
	  ○ 10% deduction from the participant's budget for care management activities
	  ○ role of the care partner.
	• Review the participant's support plan.
	• Understand the participant's needs and goals, as well as communication preferences and any cultural supports that are required.
	• Determine any existing supports that will be continued alongside the delivery of Support at Home.
	• Support the participant in deciding what services they want to receive, consistent with their aged care assessment.
	• Collaborate with the participant to determine how their services will be delivered, including preferences for workers and times/days for services.

	• Establish a service agreement with the participant (see section 7.2 for more information) and provide the participant with a copy. • Provide the participant with additional information, as required by the Rules (see section 7.3 for more information). • Develop a care plan and budget (see section 8.6 and 9.7 for more information) and provide the participant with a copy. • Identify any risks to the participant's health, safety and wellbeing and, with the participant, identify strategies for managing these risks.
Ongoing care and service planning	Ongoing care and service planning refers to the day-to-day management of a participant in relation to their individualised needs. All participants will have a basic ongoing requirement for their care partner to: • Support the participant to continue to understand elements of the Support at Home program. • Monitor and maintain the participant's budget, ensuring the services delivered are within the budget allocation. • Monitor any changing needs through direct communication with the participant, their registered supporter and aged care workers. • Review care plans regularly and, with the involvement of the participant and/or, at the request of the participant, their registered supporter, update the care plan at least every 12 months. • Support the participant to maintain or rebuild independence through wellness and reablement approaches. • Liaise regularly with family and informal carers to ensure the participant's wellbeing and capacity is supported. • In partnership with the participant, evaluate their goals and the effectiveness of service delivery. • Coordinate referrals to allied health, nursing or community services. • Engage with culturally specific organisations. • Monitor and address risks related to social isolation, mental health and elder abuse. • Arrange interpreter services.

	• Review the service agreement every 12 months, or upon the request of the participant. • Support the participant to complete or review advance care planning documents. • Submit requests for a Support Plan Review. • Support the participant to access the Restorative Care Pathway or End-of-Life Pathway, if required. • Liaise with professionals and other providers to facilitate transitions in and out of different care settings (e.g., hospital and residential respite). • Provide information and resources on age-related health matters • Support the participant to provide feedback and make complaints.
Ceasing funded aged care services	In addition to sections 12.3 and 12.4, when ceasing funded aged care services, the primary focus of the care partner will be to: • Communicate with the participant, their carers and registered supporters to confirm the cessation of services and the exit date. • Liaise with other professionals and providers to facilitate transitions in and out of different care settings, including transfer to residential care. • Communicate with third-party providers to cease the delivery of services. • Communicate with/to any new providers or professionals regarding care requirements for the participant. • Support the participant and their family or informal carers to prepare for the transition. • Ensure appropriate continuity of care arrangements are in place, up to and including the exit date, if required.

8.5.3 Qualifications for care partners

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
- 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 Work, 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 those who support the participating, including their registered 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 Strengthened Quality Standards Guidance.

8.5.4 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 December 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.

At the initial appointment, Lucy introduces herself and explains her role as a care partner. She asks about Sarah and her situation and learns that Sarah doesn't yet know much about in-home aged care services. 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 service types outlined in the support plan (nursing care, personal care, social support, transport, domestic assistance, home maintenance and repairs). 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. Lucy takes note of all of Sarah's preferences and requirements.

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 the services Sarah would like to receive which are nursing from a registered nurse, indirect transport through a taxi, general house cleaning and gardening. Sarah is approved to receive all of these services based on her support plan. The care plan also includes Sarah's family members who are involved in her care. Lucy asks Sarah if she has an appointed decision maker or registered supporter and Sarah says 'no'.

Care management

Sarah and Lucy also discuss and agree on an initial nursing appointment (to assess Sarah's skin integrity issues following a recent skin tear), 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 the initial care plan once she returns to the office. Lucy also tells Sarah that she will finalise the care plan and quarterly budget once the initial nursing appointment has been completed.

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, Greg. Greg is also a registered nurse and 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, especially the plan for her skin integrity. Now that the skin integrity plan is confirmed, Lucy and Sarah update the care plan and quarterly budget and Sarah confirms the arrangements. Lucy advises Sarah that she will send out a copy of the revised care plan. Lucy and Sarah agree to check-in again at the end of the month, in 3 weeks' time. Lucy documents the conversation in the care notes.

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. Lucy and Sarah continue to check-in and update the care plan and budget as Sarah's needs and services change.

8.6 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 (as outlined in section 148 of the Rules):

- the participant's care needs, 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 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
- strategies for the identification and management of risks
- 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 (or clinically qualified care partner) in collaboration with the participant and their carers or registered 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 and evolve over time, in line with the participant's needs, goals, preferences and situation. As changes are required, a care plan review should be completed.

Providers must work with the participant to **develop a care plan before or on the day care starts**. The participant must be provided with a copy of the care plan. Providers must also work with the participant to develop an individualised budget and this is outlined in section 9.7.

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
- documenting the participant's decision-making capacity and preferences for decision-making, including their wishes about the involvement of any registered supporters or other people supporting them, including when and how they wish to be supported
- documenting communication preferences
- detailing the participant's broader support network including informal carers, family members, friends and community engagement
- 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 registered 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 and be conducted in a manner that meets the communication preferences of the participant.

Note: Participants accessing the Restorative Care Pathway concurrently with ongoing Support at Home services will also have a goal plan. Refer to Chapter 14.0 for more details.

8.6.1 Care plan for interim funding

All participants, including those who receive interim funding, require a care plan. Interim funding is an allocation of 60% of the total funding for a participant's classification. Care partners should note that 10% of the participant's interim funding is deducted for care management.

In developing a care plan for interim funding, the care plan should focus on the delivery of priority services to address specific needs and to ensure the participant can remain living safely at home.

The care plan should be developed in the same manner as outlined in section 8.6.

When funding becomes available, the participant will be allocated the remaining 40% of their funding for their approved classification. When this happens, providers should review and update the care plan and individualised budget with the participant.

Note: Care management funding for the participant will be adjusted on a pro-rata basis from the date the full funding was allocated. The adjustment will be credited to the provider's care management account.

8.6.2 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 update the care pan 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 the AT-HM scheme
- 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 registered 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 request via the My Aged Care Service and Support Portal. More information is in section 7.6.

8.7 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 registered 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.

8.8 Care management funding for ongoing services

Support at Home participants, who receive ongoing services (not applicable for the Restorative Care Pathway or the End-of-Life Pathway), will have 10% deducted from their quarterly budget for care management. This funding will be allocated to the provider's care management account (referred to in the Act as a service delivery branch 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 8.8.2.

8.8.1 Care management supplement

A care management supplement will be available to providers delivering services to participants who are:

- 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 of care management activities. The supplement will be credited to the provider's care management account at an hourly rate of $120.00 (subject to indexation revisions).

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.

Providers will be credited the supplement for those transitioned HCP care recipients identified as eligible from 1 November 2025.

Note: If the care management supplement has not been applied for a participant who meets the abovementioned criteria, Providers can complete the Provider Application for Care Management Supplement Form.

More information on the calculation of the care management supplement is in section 8.8.2.

8.8.2 Calculation and allocation of care management funding

Support at Home participants, who receive ongoing services, have 10% from their quarterly budget allocated to 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 service delivery branch and will hold this in the care management account for providers 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 supplement base daily rate =** 12 hours of care management multiplied at the hourly rate of $120.00 (subject to indexation revisions) divided by 365 days.
- **Care management quarterly supplement =** Care management supplement base daily rate multiplied by the number of days in the quarter.

Providers must use this funding to claim for care management services delivered to their participant cohort during the quarterly period.

If a participant's quarterly budget increases during the quarter, care management funding will be adjusted on a pro-rata basis from the effective date of the new ongoing classification or consumer price index (CPI) change. The adjustment will be credited to the provider's care management account.

8.8.2.1 Existing accounts and calculation of care management funding

HCP providers who transition to Support at Home will receive upfront care management funding on commencement of the program. This funding will be available through their care management accounts and will be at a pro-rata rate for the period of 1 November 2025 to 31 December 2025. The pro-rata rate will be calculated based on the transitioned HCP care recipients connected to the notified home care service on 31 October 2025.

From commencement of Support at Home, new participants (including those transferring from another provider) who join part way through a quarter, will not have care management funding allocated to the existing care management account for the quarter in which their start notification is received. Rather, Services Australia will calculate the care management funding for the participant for the next quarter and allocate this to the provider at the start of the following quarter.

This means, care management activities for these participants must be funded through the provider's pooled care management funds allocated at the start of that quarter.

Note: A provider must submit a start notification for a participant to Services Australia by 10pm (legal time in the Australian Capital Territory) on the last day of the quarter in which care commenced so that their care management funding for the next quarter can be allocated. Providers will not receive back-dated care management funding if a participant's start notification is not received by the last day of the quarter.

8.8.2.2 New accounts and calculation of care management funding

When a new care management account is established (for a new service delivery branch), care management funding for participants will be calculated on a pro-rata basis from the start notification date, for the first and second quarters of operation. The first quarter of operation for the provider is based on the date of the earliest participant start notification (following the establishment of the care management account).

During the first and second quarters of operation, the provider will receive a pro-rata amount of care management funding for any new participant (including those transferring from another provider).

From the third quarter onwards, providers will receive care management funding on the first day of the following quarter for their participant cohort. The participant cohort is the number of participants connected to the service delivery branch on the last day of the previous quarter.

For example:

Sunnyside Home Care has recently been registered as an aged care provider and commenced operations on 7 November 2025. They have a care management account but do not yet have any funding as they do not have any participants.

On 21 November 2025, Sunnyside Home Care signs a service agreement for their first Support at Home participant. They submit a start notification to Services Australia with a start date of 21 November 2025. Services Australia receives the start notification and allocates the pro rata care management funding to the provider's care management account. The pro rata care management funding is for the period of 21 November to 30 December 2025. As the first start notification was submitted in November, the first quarter of operation is quarter 1, from November to December.

The second quarter of operation for Sunnyside Home Care is January to March. During this period, the provider submitted a start notification to Services Australia for five new Support at Home participants. During quarter 2 of operations, Services Australia allocates pro rata care management funding for each of the new participants for the period from which they commenced to the end of quarter (31 March).

At the end of their 2nd quarter of operation, Sunnyside Home Care has six Support at Home participants.

From the third quarter of operation (and onwards), care management funding is allocated to the provider's care management account on the first day of the quarter (1 April). Quarterly allocation of care management funding is based on the number of participants connected to the service delivery branch on the last day of the previous quarter. For Sunnyside Home Care, this means that they receive care management funding for six Support at Home participants.

8.8.3 Carryover of care management funding

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.

However, 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.

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.

8.9 Pooled funding and the care management account

For each participant with an ongoing classification, 10% of the quarterly budget 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. This is important as participants needs are variable and are subject to change over both the short and long term.

Rather than allocate a fixed number of hours of care management to each participant each month, the pooled funding approach enables providers to flex up and down with care management support depending on the classification, changing needs and psychosocial factors of each participant. This is especially important in enabling providers to react promptly to address emerging needs that require urgent and/or higher levels of care management support.

While providers may determine a basic split of care management hours based on a participant's Support at Home classification, they should be able to demonstrate how care partners can respond flexibly to address the changing needs of their participant cohort. This should be outlined in the provider's clinical governance framework.

8.9.1 Principles for the allocation of individual care management

When determining how many hours of care management should be provided to each participant, providers should be guided by the principles in the table below.

Principles for the allocation of individual care management	
Needs-based allocation	Care management resources are allocated to a participant based on their assessed needs, emerging risks, and the complexity of their individual circumstances and psychosocial factors. Allocation of care management hours should not be solely based on the participant's Support at Home classification.
Proactive engagement	Care partners must maintain regular contact with all participants, including scheduled check-ins and reviews, to ensure that needs are identified and addressed in a timely manner.

	This requires care partners to be proactive when engaging with the participant, even in the absence of participant-initiated contact.
Monitoring and identification	Care partners should use system alerts, care note reviews, and internal case conferencing to identify participants who may require more intensive care management support.
Management processes and flexible adjustment	Care partners should use provider-specific processes, system alerts and reporting to frequently review, manage and adjust care management resources based on the individual and changing needs of participants.

8.9.2 Pooled funding and the service delivery branch

Pooling of funds will take place at the service delivery branch level of a provider. Providers must notify the department when they open service delivery branches or make any changes to their service delivery branches (e.g. merge, close or update information). 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. Services Australia will calculate the amount of care management funding to be allocated to each service delivery branch and will hold this in the care management account for providers to claim against (for more information on allocation of care management funding, see section 8.8.2).

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 service delivery 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.

For more information and examples on care management see the case study Managing participants with pooled care management funding.

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 above mentioned activities.

8.10 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. Providers can make both whole-hour and part-hour claims. Part hour claims can be in 15 minute increments e.g., 15, 30, or 45 minutes. 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 16.4.1.

More information on claiming for care management for the Restorative Care Pathway is in section 16.4.3.

More information on claiming for care management for the End-of-Life Pathway is in section 16.4.4.

9.0 Participant budget and contributions

This chapter covers:

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
- Sections 273-274 (Participant contributions)
- Sections 314 – 318 (Means testing).

The *Aged Care Rules 2025:*

- Chapter 4, Part 5, Division 1
- Chapter 7, Part 2, Divisions 1 and 2 (Subsidies and supplements)
- Chapter 10, Part 2, Division 1 (Means testing).

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.

Key points to remember

- Each Support at Home participant receives a budget based on their approved classification category and level.
- Participant contributions are determined by Services Australia based on an assessment of the participant's income.
- The services a participant receives are paid for through a mix of government funding and participant contributions.

Key points to remember

- Providers must work with participants to develop an individualised budget that outlines how funding will be spent in relation to the types and frequency of services in their care plan. A copy of the individualised budget must be given to the participant.
- 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.

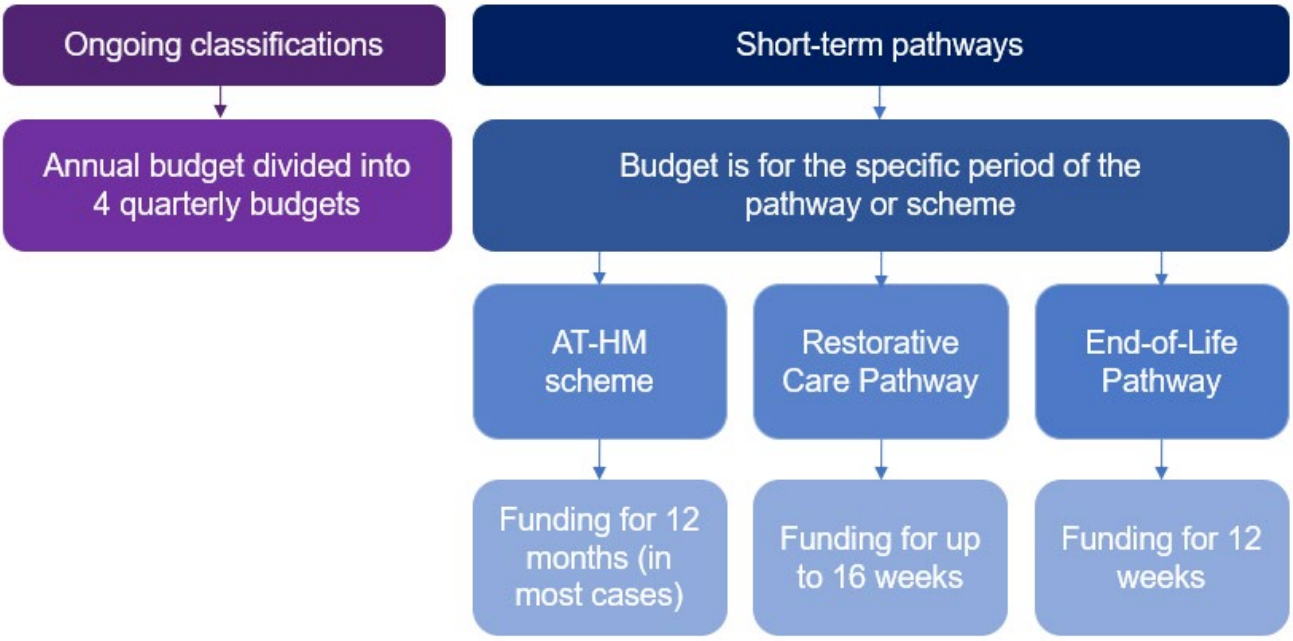
9.1 Overview

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.

9.2 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 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., up to 16 weeks for the Restorative Care Pathway, up to 12 weeks for the End-of-Life Pathway or 12 months for the AT-HM scheme, in most cases).

The diagram below provides an **overview of budgets for ongoing classifications and the short-term pathways.**



Services received under Support at Home are funded through a mix 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 assessed financial capacity to pay. Participant contributions are determined via an assessment of the participant's income and assets by Services Australia.

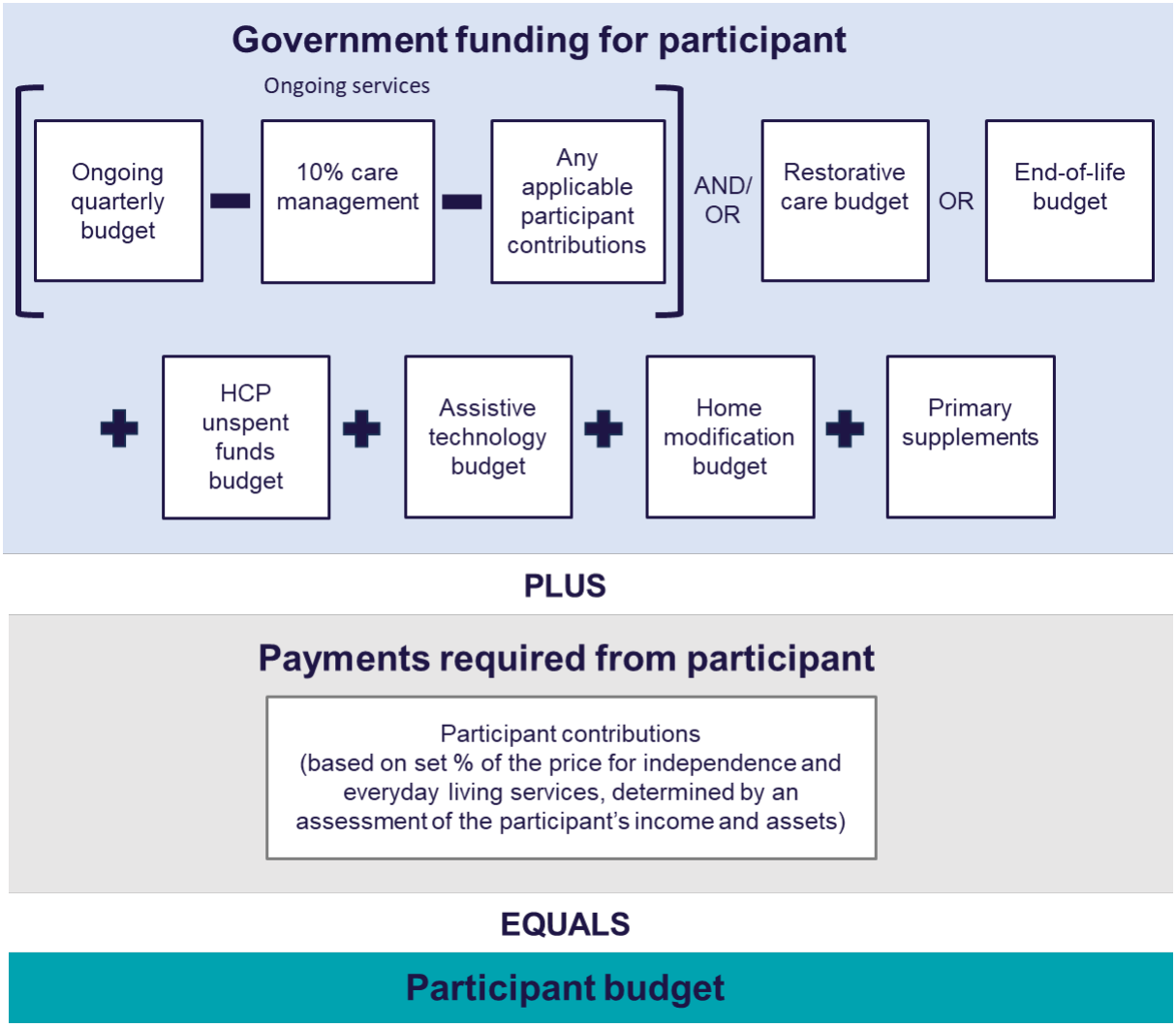
More information on participant contributions is in section 9.4.

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, a participant may enter Support at Home part way through the quarter and their budget will be calculated on a pro-rata basis from the date of entry to the last day of the quarter. If a participant moves to a higher classification part way through the quarter (or they receive a full funding allocation), their quarterly budget will be adjusted from the date of effect of their higher classification.

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**.



9.3 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 and/or home modifications funding, if approved
- plus primary supplements, if applicable
- plus any Commonwealth portion 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 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.

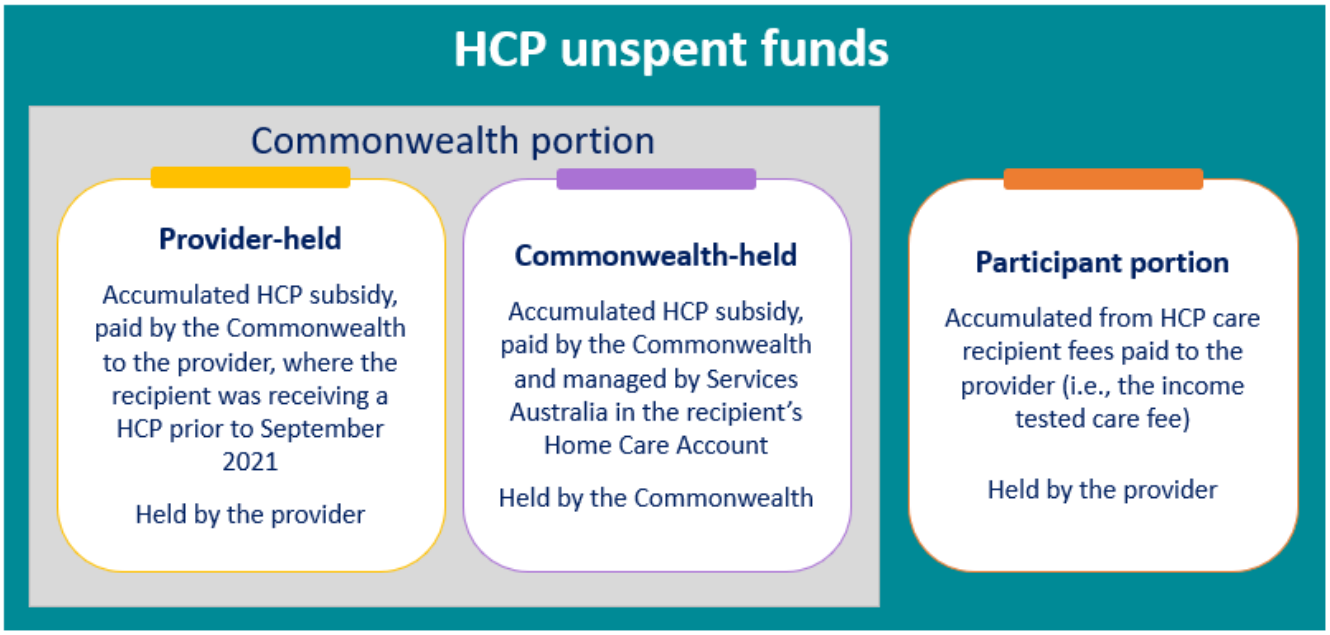
Funding type	Description	Additional notes
Primary supplements	Supplements available are: • oxygen • enteral feeding • Veterans. The dementia and cognition supplement will continue to be available for transitioned HCP care recipients who were receiving the supplement on 31 October 2025.	More information on primary supplements is in section 9.3.2.
Unspent Home Care Package (HCP) funds	Participants who were receiving a Home Care Package and had unspent funds as of 31 October 2025 will retain their unspent funds for use in their Support at Home quarterly budget.	Participants can use Commonwealth portion HCP unspent funds to: • pay for approved services once their quarterly budget has been fully exhausted • access assistive technology or home modifications to meet assessed needs. More information is in section 9.3.1.

9.3.1 Transitioned HCP care recipients and HCP unspent funds

Transitioned HCP care recipients who had unspent funds as of 31 October 2025 retained these funds for use under Support at Home.

Participants will retain HCP unspent funds when they are reassessed and assigned a Support at Home classification.

The diagram below outlines how **HCP unspent funds may be divided**.



9.3.1.1 Participant portion HCP unspent funds

Participant portion HCP unspent funds are held by the provider. Within 70 days of 1 November 2025, a provider and participant must agree (in writing) that the balance of the participant portion HCP unspent funds will be

- refunded to the participant
- retained by the provider and used to pay for the participant's contributions to the services they receive.

If the HCP unspent funds are to be refunded to the participant, this must occur within 14 days after the agreement is made. If the HCP unspent funds are retained by the provider, the provider must refund any unused amounts to the participant when the provider ceases service delivery.

More information on cessation of services and return of HCP unspent funds is in Chapter 12.0.

9.3.1.2 Commonwealth-held HCP Commonwealth unspent funds

Commonwealth portion HCP unspent funds held by the Commonwealth in home care accounts will be transferred to Support at Home home care accounts from 1 November 2025. Participants can continue to use HCP Commonwealth unspent funds for Support at Home services. Section 9.3.1.4 outlines how these funds can be used.

9.3.1.3 Provider-held HCP Commonwealth unspent funds

Under Support at Home, provider-held HCP Commonwealth unspent funds will continue to be held by providers. Providers can elect to return HCP Commonwealth unspent funds for a participant. Providers must obtain the participant's written agreement to return these funds.

There are circumstances whereby the provider must return provider held HCP Commonwealth unspent funds to the Commonwealth. These are:

- the participant changes providers
- the participant dies/is deceased
- the provider ceases to deliver funded aged care services to the participant.

Participants can continue to use HCP Commonwealth unspent funds for Support at Home services. Section 9.3.1.4 outlines how these funds can be used.

Note: The provider-held HCP Commonwealth unspent funds available are as per the documented amounts in the October 2025 Home Care Package claims.

Note: Transitioned HCP care 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.

9.3.1.4 How to use Commonwealth portion HCP unspent funds

Participants can use Commonwealth portion HCP unspent funds to:

- pay for approved services once their quarterly budget has been fully exhausted
- access assistive technology and/or home modifications to meet assessed need.

The priority order of claiming when using Commonwealth portion HCP unspent funds is outlined in section 16.4.5.

For purchases of assistive technology or home modifications, Commonwealth portion HCP unspent funds must be used before the provider can claim against the participant's assistive technology or home modification funding accounts.

All transitioned HCP care recipients will have a transitional approval for assistive technology and home modifications with no separate funding allocation. This enables transitioned HCP care recipients to readily access AT-HM items and use Commonwealth portion HCP unspent funds to access equipment, products and home modifications from the AT-HM list. More information on AT-HM is in Chapter 13.0.

Note: There are no contributions payable for services, products or equipment paid entirely from Commonwealth portion HCP unspent funds. However, if the service, product or equipment is partially funded through HCP Commonwealth unspent funds and partially funded through a Support at Home budget (including short-term pathways and AT-HM) then a participant contribution will apply. The participant contribution is calculated based only on the portion of the claim from the Support at Home budget (not the HCP unspent funds) and will be determined using the participant's contribution rate for the service type.

9.3.2 Primary supplements

For eligible participants, providers can also apply 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	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 into the participant's budget.	Should the participant change providers, the supplement will automatically continue to be paid into the participant's budget.
Enteral feeding supplement	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.	Should the participant change providers, the supplement will automatically continue to be paid into the participant's budget.

Supplement	Description	Process	Additional notes
		Once approved, the supplement is paid into the participant's budget.	
Veterans' supplement	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.
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.	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 remote supplement is 50% of the assigned assistive technology and/or home modifications funding tier.
Dementia and cognition supplement **and** the EACH-D supplement	The dementia and cognition supplement and the EACH-D supplement only apply to transitioned HCP care recipients who were receiving the supplement on 31 October 2025.	If the transitioned participant was receiving the dementia and cognition supplement or the EACH-D supplement on 31 October 2025, the subsidy will be managed by Services Australia and allocated to the participant's budget.	If the participant changes providers, the supplement will continue to be automatically allocated to the participant's funding. If the participant is reassessed into an ongoing Support at Home classification, this supplement will be discontinued (as it is considered as an inclusion in the classification).

9.3.3 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
- 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 credited to the provider's care management account.

Should the participant change providers, the supplement will be credited to the incoming provider's care management account.

More information on the care management supplement and the calculation and allocation of care management funding is in sections 8.8.1 and 8.8.2.

9.3.4 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 cannot invoice participants for their contributions while their hardship application is being assessed. If approved, the government will pay for some or all of their aged care fees, backdated to the date of application. If the application is not approved, it is the responsibility of the provider to recover the participant contributions from the participant.

To apply, a participant 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 whether they meet gifting rules. If the eligibility requirements are met then the participant's income and essential expenses are assessed. The participant is eligible for the fee reduction supplement if they have less than 15% of the single basic age pension amount remaining after paying all essential expenses (including their Support at Home contributions).

If approved, the fee reduction supplement is paid to the provider and the participant's contributions are reduced by that amount. 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.

Providers should request that participants notify them when they submit an application independently, to ensure that contributions are not collected while the application is under assessment.

As this supplement may be 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.

9.4 Participant contributions

Participant contributions are paid by participants and based on an assessment by Services Australia of their income and assets. For veteran's, the income and asset assessment is completed by the Department of Veterans' Affairs however, a participant will still apply through and be notified of their outcome by Services Australia.

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 –** services such as personal care will attract moderate contributions.
   - **Everyday living –** services such as cleaning and gardening will attract the highest contributions.

2. The outcome of a participant's income and assets assessment, which is based on 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 at the maximum level.

Providers must support participants to understand their participant contributions. To estimate contributions, providers can help participants use the Support at Home fee estimator available on My Aged Care.

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

Contributions are charged based on services delivered. Actual contribution rates for a participant are determined by Services Australia through an assessment of the participant's income and assets (more information is in section 9.5). 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 13.5.

9.4.1 Participant contributions for transitioned and grandfathered HCP care recipients

Participant contribution rates will also depend on whether an older person was a transitioned HCP care recipient or a grandfathered HCP recipient.

Section 1.3.1 of this manual provides the following definitions:

- **Transitioned HCP care recipient:** A Home Care Package recipient who transitioned to Support at Home on 1 November 2025. This also includes older people who were on the National Priority System prior to 1 November 2025 but had not received a Home Care Package.

- **Grandfathered HCP care recipient:** A Home Care Package recipient who, on or before 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.

Note: Transitioned and grandfathered HCP care recipients will pay a contribution rate (if required). They will not pay an income-tested care fee as this was abolished under Support at Home.

9.4.1.1 Grandfathered HCP care recipient and contributions

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

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 care 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 care recipients who, based on the outcome of their income test were required to pay an income-tested care fee, will pay contribution rates that are the same or less under Support at Home.

The table below outlines the **contribution rates for grandfathered HCP care recipients approved on or before 12 September 2024**.

Income and assets assessment outcome	Service category – clinical supports	Service category – independence	Service category – everyday living
Full pensioner	0%	0%	0%
Part pensioner and self-funded CHSC holder	0%	Between 0% and 25%	Between 0% and 25%
Self-funded non-CSHC holder and means not disclosed	0%	25%	25%

To ensure grandfathered HCP care recipients pay the same or less under Support at Home, their contribution rate will be determined solely based on income, with a

fortnightly cap applied to limit the total amount payable to provide an additional protection.

Grandfathered HCP care recipients will continue to pay these transitional rates, even if they are reassessed to a higher Support at Home classification. Services Australia will notify participants and their provider of the grandfathered contribution amount payable. Grandfathered participant contribution arrangements also include maintaining the HCP lifetime cap, including if they subsequently enter residential aged care.

Services Australia will already hold income information about most grandfathered HCP participants, unless they are 'means not disclosed' or have yet to receive an HCP. In these cases, Services Australia will contact the participant from 1 November or when they begin receiving services for income information.

Note: The My Aged Care Service and Support Portal includes the participant's approved date(s) under the 'Client summary' tab. For most participants, a first approval date on or before 12 September 2024 indicates that they are eligible for the grandfathered participant contribution arrangements.

9.4.1.2 Transitioned HCP care recipient and contributions

Transitioned HCP care recipients who are not eligible for grandfathering arrangements, are required to pay Support at Home contributions at the ongoing contribution rates for the services they receive in the independence and everyday living categories.

If a transitioned HCP care recipient receives a pension, Services Australia will calculate their contributions based on the income and assets information from their Age Pension record. For non-pensioners, Services Australia will request assets and, if required, income information from the care recipient from 1 November 2025.

If a transitioned HCP care recipient is a Commonwealth Seniors Health Card (CSHC) holder, Services Australia will use their income information they have on record and will request information on a care recipient's assets to finalise the income and asset assessment.

Services Australia will request income and asset information if a transitioned HCP care recipient is a fully self-funded retiree. Completing an income and assets assessment is not mandatory, however participants who choose not to complete one will be asked to pay the maximum participant contribution rate.

More information on the contribution rates payable by transitioned HCP care recipients are outlined in the table in section 9.4.

9.4.2 Case study

John

Grandfathered, full pensioner

John is a grandfathered HCP care recipient and full pensioner. He will not pay 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, he has continued to pay **no participant contributions** and receives the **same level of funding.**

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

9.4.3 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 in individual contributions across Support at Home and the non-clinical care component of their contribution to residential aged care, will not pay further individual contributions under Support at Home once this lifetime cap is reached.

Note: If the participant enters residential care in the future, they will not have to pay any contribution towards their non-clinical care however may still pay a hotelling contribution.

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.

9.5 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 28 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 will be asked to pay the maximum participant contribution rate, applicable to their circumstances.

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.

Providers and participants can also use the Support at Home fee estimator to estimate a participant's contribution rates.

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).

9.5.1 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.

To manage financial risk for new participants, participants can complete an income and assets assessment prior to entering into 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.

To avoid a provider needing to recover backdated contributions, participants and providers can agree that the participant makes payments at an interim rate, where the participant has not yet received initial advice on their contribution rate.

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).

If a participant was making payments before determination of their final contribution rate, then the provider will need to assess whether they need to partially refund or recover payments from the participants.

The table below outlines when a **provider may need to refund or recover participant contributions**.

<table>
<tr><th>Services Australia paid:</th><th>The participant paid:</th><th>The provider must:</th></tr>
<tr><td rowspan="2">Services Australia will always pay 100% of the government subsidy while the income and assets assessment is being undertaken.
Once the participant's contribution rate is finalised, Services Australia will deduct any overpayment from the next payment to the provider. This is because the provider may have received too much government subsidy.</td><td>Contributions that were less than what they were assessed as needing to pay.</td><td>Calculate the difference between what the participant paid and what they were assessed as needing to pay and recover the difference from the participant.</td></tr>
<tr><td>Contributions that were more than what they were assessed as needing to pay.</td><td>Calculate the difference between what the participant paid and what they were assessed as needing to pay and refund the difference to the participant.</td></tr>
</table>

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.

9.5.2 Case study

Michael

New participant and contributions

Michael is new to the Support at Home program having been assessed as eligible in December 2025. He wants to make contributions towards his services before his income and assets assessment is finalised.

Michael is new to Support at Home having been assessed and allocated a Classification 4 in December 2025.

Michael knows he will need to make contributions towards his services and he discusses this with his provider before signing a service agreement. The provider gives him a copy of the service price list and the Support at Home contributions framework. As a **part-pensioner**, Michael will contribute to the cost of his independence and every living services. He does not pay for any clinical services that he receives.

The provider tells Michael that Services Australia will use his income and assets to determine his contribution rate. As he is a part-pensioner, the provider tells Michael that Services Australia will use the information they already hold about his income and assets and he does not need to do anything.

The provider explains to Michael that he does not need to make contributions while Services Australia undertake the income and assets assessment. However, the provider explains that once the income and assets assessment is finalised, Michael will need to make back-dated payments for any contributions he was required to pay. Michael does not want to receive an invoice for back-dated payments so he agrees to make payments until his income and assets assessment is finalised.

The provider and Michael use the Support at Home fee estimator to calculate what Michael might need to pay. Michael is **single**, **retired**, on a **part-pension** and **owns his house**. Based on the Support at Home fee estimator, Michael may need to pay approximately 28% for services in the independence category and approximately 50% for services in the everyday living category.

Michael and the provider agree that he will make these contributions until his final contribution rate is finalised. Michael signs the service agreement and the provider starts delivering services.

Shortly after commencing Support at Home, Michael receives a letter from Services Australia detailing his final contribution rate. Michael is assessed as needing to pay 26% for services in the independence category and 47% for services in the everyday living category.

Michael tells his provider about the letter. The provider explains to Michael that the estimated contribution rate he had agreed to pay was actually slightly **more** than what he was **assessed as needing to pay**. The provider tells Michael that they will calculate the difference between what he has paid and what he was meant to have paid and will **refund Michael the difference**.

9.5.3 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.
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 for ongoing classifications or at the beginning of the next episode for short-term pathways. If the change means that the participant is re-assessed as needing to make a lower contribution, this will be backdated to the date of the change, 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 circumstances	Participants must notify Services Australia within 28 days of any changes in their financial circumstances. 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 for ongoing classifications or at the beginning of the next episode for short-term pathways. If the change means that the participant is re-assessed as needing to make a lower contribution, this will be backdated to the date of the change, 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.

9.6 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, or a fee reduction application is being assessed, 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 on lifetime caps is in section 9.4.3.

9.6.1 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 **not** 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.

9.6.2 Contributions while awaiting outcome of income and assets assessment

Service providers and participants can agree a temporary contribution rate while a new participants income and assets are being assessed by Services Australia.

If this is agreed, a participant's pension status should be taken into consideration. For example, a full pensioner's ongoing contribution rate is most likely going to be 5% for independence service and 17.5% for everyday-living services (unless a hardship application has been made) whereas non-pensioners who do not hold a Commonwealth Seniors Health card will most likely have 50% for independence service and 80% for everyday-living services. For part-pensioner and Commonwealth Seniors Health Card holders, providers and participants could use the Support at Home fee estimator to estimate a participant's contribution rates. The Support at Home fee estimator is available on My Aged Care.

Participants may wish to make regular payments or pay once services have been delivered.

Service providers and participants will be notified of the new contribution rate by Services Australia once their assessment has been finalised. The new rate will be backdated to the first service delivery date and providers will need to refund any overpayment of contributions or collect any underpayment.

9.6.3 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 active, appointed decision maker 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 and Division 4, Part 4, Chapter 4 of the Rules.

Providers must make every effort to resolve payment issues with the participant. Providers must document these conversations.

9.7 Development and management of the individualised budget

Providers must work in partnership with the participant, those who support the participant including their registered supporter, and/or the participant's appointed decision maker to develop an individualised budget. This should be completed alongside the development of the care or goal plan, or as soon as practical. 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 registered 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 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.
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 9.2, 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.

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.

9.7.1 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 carryover amount is capped and will be up to the higher value 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.

9.7.2 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 $3,995.42. After 10% ($399.54) is set aside for care management, Larry has $3,595.88 to spend on services for the quarter. In **Quarter 1**, he spent $2,000, leaving $1,595.88 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 $4,595.88 ($3,595.88 + $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 ($399.54), but lower than $1,000.

In **Quarter 3**, Larry has a nominal budget of $4,348.88 ($3,595.88 + $753).

9.7.3 Overspend of quarterly funds

An overspend of quarterly funds occurs when a provider delivers services that exceed the participant's quarterly budget allocation. 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.

Overspends 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.

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 $1,450 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.

9.7.4 Individualised budget for interim funding

Participants who receive funding through Support at Home may receive interim funding for a period of time. This applies to older people who were:

- on the National Priority System on 31 October 2025 and assessed as eligible for a Home Care Package
- assessed as eligible for Support at Home services from 1 November 2025.

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 priority services to be delivered in accordance with the participant's approved services. The

individualised budget should consider that 10% of the participant's 60% interim funding is deducted for care management.

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. Rather, the additional funding will be applied on a pro-rata basis from the date the full funding was allocated.

When the full funding has been allocated, providers should review and update the participant's quarterly budget and care plan to reflect the change in funding and services to be delivered.

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.

9.7.5 Management of HCP unspent funds

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 home modifications.

Claiming rules apply and these are detailed in section 16.4.5 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 home modifications, Commonwealth portion HCP unspent funds must be used, if available, **before** AT-HM funding tiers are accessed.

9.7.6 Case study

Hiroshi

HCP unspent funds and AT-HM

Hiroshi is a transitioned HCP care recipient with HCP Commonwealth 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 the Support at Home program. He is a full pensioner and received an equivalent level of funding as per his previous HCP package and also retained his Commonwealth portion HCP unspent funds of $303 (these funds are held by Services Australia).

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 to determine his eligibility for a higher classification. With Hiroshi's consent, a Support Plan Review is submitted, and it's determined that he would benefit from a re-assessment.

Hiroshi's aged care assessment is completed and 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 AT-HM related occupational therapy at $180 per hour
    - 1 hour for the initial consultation with Hiroshi

HCP unspent funds and AT-HM

    - 0.5 hour follow up to ensure Hiroshi can use the products correctly
- assistive products at a total of $201
- 0.75 hours of care management for the care partner to engage with Hiroshi to identify his changing needs and ongoing supports, as well as submit the request for a Support Plan Review.

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)
- claims 1.5 hours of AT-HM related occupational therapy services ($270)
- claims the assistive technology products ($201).

As Hiroshi has $303 in Commonwealth portion HCP unspent funds, Services Australia will draw down from this account before processing claims from Hiroshi's newly assigned AT funding. Services Australia will:

- deduct the 0.75 hours of care management from the provider's **Care Management Account**
- deduct $270 for AT-HM related occupational therapy services from Hiroshi's **HCP Commonwealth unspent funds account**
- deduct $33 for assistive technology products from Hiroshi's **HCP Commonwealth unspent funds account**
- deduct the remaining $168 for assistive technology products from Hiroshi's **Assistive Technology Budget Account**.

After claiming, Hiroshi's:

- **HCP Commonwealth unspent funds** account has a balance of $0
- **Assistive Technology Budget Account** has a balance of $332. 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 care 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. As Hiroshi did not make any contributions under HCP, he will never be required to make a contribution for the services he receives for Support at Home.

More information on claiming is in Chapter 16.0.

More information on participant contribution rates is in section 9.4.

10.0 Service list and delivery of services

This chapter covers:

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 (Service list)
- Section 165 (Complaints, feedback and whistleblowers).

The *Aged Care Rules 2025*

- Chapter 1, Part 3, Division 2 (Support at Home service types)
- Chapter 4, Part 10, Division 2 (Complaints feedback and whistleblowers).

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).

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 have an arrangement with a third-party 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.

10.1 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 and short-term pathways, 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.

10.2 Support at Home service list

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 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.

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 (see sections 6.5 and 6.6). A provider can support the participant to choose the mix of services they access based on what has been approved however, a provider must only deliver services in accordance with the participant's assessed needs and approvals.

Note: Under section 66 of the *Aged Care Act 2024*, Aboriginal and Torres Strait Islander persons are eligible to receive **all** services and service types on the Support at Home service list.

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 the Support at Home service list.

Note The unit of measurement for all services in the table below is per hour unless specified by an asterisk (*).

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
	Dietitian or nutritionist
	Exercise physiologist
	Music therapist
	Occupational therapist
	Physiotherapist
	Podiatry
	Psychologist
	Social worker
	Speech pathologist
Nutrition	Prescribed nutrition[4*]
Care management	Home support care management
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

Service type	Services
	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	Acupuncturist
	Chiropractor
	Diversional therapist
	Remedial masseuse
	Art therapist
	Osteopath
Respite[7, 8]	Respite care
Transport[9*]	Direct transport (driver and car provided)
	Indirect transport (taxi or rideshare service vouchers)
Assistive technology and home modifications[*]	Assistive technology
	Home modifications
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[10]
	Laundry services
	Shopping assistance
Home maintenance and repairs	Gardening
	Assistance with home maintenance and repairs
	Expenses for home maintenance and repairs[11*]
Meals[7*]	Meal preparation
	Meal delivery

Service type	Services
Note: * These services do not have a per hour unit of measure but will have a relevant unit cost (e.g., per trip, per meal or as per the cost of the consumable or product). ** Prices for nursing, allied health and other therapeutic services can have a billable unit for direct and indirect activities. For more information, refer to Support at Home prices for allied health and nursing services – fact sheet for providers. [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 a registered nurse, enrolled nurse and/or nursing assistant includes the cost of everyday nursing consumables that nurses are expected to carry (e.g., 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. [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] Providers delivering certain meal services are required to meet requirements for meals, snacks and drinks detailed under section 148-20 of the Rules. These requirements apply to providers delivering 'meal delivery' services under registration category 1 – *Home and Community Services* and the service 'community and centre-based respite' and 'cottage respite' services under registration category 4 – *Personal and care support in the home and community.* Further guidance on the requirements will be published on the department's website at Food and nutrition in aged care – regulation and compliance. [8] In the Aged Care Rules 2025, the service type 'respite' has two services 'flexible respite' and 'community and centre-based respite'. Providers will need to select one of these two services when claiming for respite. The service type 'cottage respite' can only be accessed through CHSP and is not available under Support at Home.	

Service type	Services
[9] Direct transport is the supply of a car and driver. Indirect transport is the supply of a voucher for taxi or rideshare services. Transport can be used for group and individual transport services. For group travel, the provider must apportion the cost to each participant. The price of transport excludes the purchase of a vehicle, running costs and licencing. Transport cannot be used for holiday-related travel. [10] The hourly price for general house cleaning may include cleaning consumables (e.g., mops and cleaning agents) if the participant is unable to provide the required cleaning equipment. [11] 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.	

10.2.1 Transitioned HCP care recipient and the service list

Transitioned HCP care recipients, who have not been reassessed under Support at Home, are eligible to access any service on the Support at Home service list, as well as assistive technology and home modifications, provided it meets the participant's needs.

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.

10.3 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 the commencement of Support at Home, 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 the services they deliver on the My Aged Care Service and Support Portal.

The department has published 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.

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.

10.3.1 Agreed price

An important responsibility of a provider is to charge prices that are reasonable and to charge no more for any care or service other than the amount agreed with the participant.

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

The agree price for each service must 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 should 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 entering into the service agreement.

Information about service agreements and what must be included is in section 7.2.

10.3.1.1 Variations to price

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, their registered supporter, or their active, appointed decision-maker (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 registered supporter or active, appointed decision-maker) agreement to the change(s) where the person providing agreement, or communicating the participant's agreement, is unable to physically sign the updated service agreement, pricing schedule and/or budget.

Note: A registered 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 registered supporter is also the participant's active, appointed decision-maker and they are exercising decision-making authority for the older person.

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 of the participant, or registered supporter, or their active, appointed decision-maker; or
- by email correspondence between the provider and the participant, registered supporter, or their active, appointed decision-maker; or
- in a file note record of verbal agreement between the provider and the participant, registered supporter, or their active, appointed decision-maker.

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.

Information on the process for agreement of prices for AT-HM services is in section 13.7.1.

10.3.1.2 Publishing prices on My Aged Care

Providers must publish their service prices on the My Aged Care Service and Support Portal.

Providers must list their price for each service during standard business hours to the My Aged Care website. Between 1 and 30 January, providers will be required to update their common price for each service as calculated over the previous 2-month reporting period.

Providers may indicate a price for non-standard business hours (e.g., weekends and public holidays) where this may vary from their common price. Providers can also attach their pricing schedule and must publish a full price list on their website.

Providers will need to review prices every two months to align with specific reporting periods. An example of a reporting is July to August. If a provider's price within a reporting period is different to that on My Aged Care, the price must be updated within 30 days.

Pricing information is available to older people on the My Aged Care website through the Find a provider tool.

10.4 Capped prices

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

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.

Note: Capped pricing will not apply to some services subject to market variations e.g., indirect transport, nursing care consumables and nutrition supports.

More information on capped pricing will be made available prior to 1 July 2026.

10.5 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/or 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, progress notes, clinical records 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 and meal delivery services only, an invoice may be accepted. However, even for these services, providers are encouraged to source and retain:

- For allied health - progress notes, clinical records and/or reports of individual episodes of care at the end of the treatment period.
- For meal delivery services - progress notes that evidence communication with the participant to confirm meals have been delivered and are meeting their nutritional needs.

Information on the confirmation of delivery for AT-HM services is in section 13.7.2.

For information on evidence required for claiming, refer to section 16.6.

10.6 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) for the delivery of services on the Support at Home service list.
- Sources, purchases, supplies and provides products, equipment, and assistive technology.

Note: If an organisation is only supplying a product, they are considered a supplier. A supplier does not deliver an aged care service and is not subject to worker obligations under the Act.

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. When an associated provider is delivering services, the registered provider remains responsible for ensuring services are delivered in a way that meets the requirements of the Act and the strengthened Quality Standards, where applicable.

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

10.6.1 Notification of third-party agreements

Providers must be able to demonstrate that they have specific arrangements in place to ensure the quality of service delivery with any associated provider delivering funded aged care services on their behalf.

A registered provider needs to notify the Commission about associated providers delivering services on their behalf in the following circumstances:

- During registration or renewal of registration, the application asks for relationships with any associated providers. This applies to providers in all registration categories.
- At all other times, providers in registration categories 4, 5 or 6 must notify the Commission when an arrangement with an associated provider commences or is varied, extended or ceases in relation to services provided under those categories.

More information on associated providers and notifications can be found on the Commission's website at Guidance for associated providers.

10.6.2 Family members delivering services

A provider can engage a participant's family member to deliver funded aged care services, but they should only be engaged when there are no other options available.

When making a determination to engage a family member, providers should consider whether:

- the participant is at risk of harm or neglect without the delivery of services
- the participant is located in a rural or remote region (as defined by the Modified Monash Model)
- the participant is Aboriginal or Torres Strait Islander, or from a culturally and linguistically diverse background
- the family member is appropriately qualified to deliver the specified service(s)
- the family member meets all other worker obligations under the Act.

If the above criteria are met, the provider can engage the family member as a third-party worker.

Note: The provider remains responsible for ensuring that a specific agreement is in place and that services are delivered in a way that meets the requirements of the Act and the strengthened Quality Standards.

10.7 Reimbursements

At times, the provider and participant may agree for the participant to pay for an item on the Support at Home service list, a service delivered by a third-party worker, or for assistive technology. When this is requested by the participant, the provider should consider how this arrangement can be supported.

Specific arrangements and requirements for reimbursements apply. For more information on reimbursements for:

- services on the Support at Home service list, see section 10.7.1
- services delivered by a third-party worker, see section 11.5.4
- the purchase of assistive technology, see section 13.6.1.

10.7.1 Reimbursement for items on the Support at Home service list

Providers and participants may agree on a reimbursement arrangement where it is more practical for the participant to pay for an item or service. Services on the Support at Home service list where reimbursement may be more practical include:

- nursing care consumables
- prescribed nutrition

Before a reimbursement is made to a participant, the provider must ensure the following requirements are met:

- The reimbursement is for a service or item on the Support at Home service list (for example, continence pads under the service 'nursing care consumables').
- The participant is approved to receive the service (as outlined in the participant's Notice of Decision and support plan).
- The service or item for reimbursement is outlined in the participant's care plan and the price is included in the individualised budget.
- The reimbursement arrangement has been discussed with the participant and documented.

Providers can refuse to reimburse participants for services that fall outside of the above requirements.

In addition to the above requirements, providers must follow Support at Home claiming rules and finalise claims for items and services within 60 days after the end of the funding period of the quarter.

For the provider to claim, the participant will need to provide evidence of the item that was purchased, including the price. Providers must retain and be able to provide records or evidence to support claims and ensure compliance with program guidelines.

More information on evidence requirements for claiming is in section 16.6.

10.7.2 Reimbursements and participant contributions

Participant contributions apply for all services delivered in the independence and everyday living service categories. There are no contributions for services in the clinical supports category as clinical care is fully funded by government for all participants.

The price paid by the participant at the point of purchase will include both the government subsidy and the participant contribution (if a contribution is applicable).

Providers should work with the participant to determine and document how the participant contribution will be paid under a reimbursement arrangement. The provider may choose to initially reimburse the participant for the full cost of the

service and invoice the participant for their contribution as per the usual invoice cycle. Alternatively, the provider may choose to only reimburse the participant for the government subsidy amount.

10.8 Service cancellations

A participant may cancel a scheduled service at late notice or may be a ‘no show’ (i.e., the participant was not at home or in a pre-determined location) when a worker arrives to deliver a scheduled service.

A provider will be eligible to be paid in full for a service, and a participant contribution may also be charged, if the provider:

- had committed to deliver a funded aged care service from the Support at Home service list, or
- had committed to deliver assistive technology, or home modification, and
- were prevented, at no fault of the provider, from delivering the service as the participant was deemed to be a late cancellation or ‘no show’.

A late cancellation occurs when a participant provides less than 2 business days’ notice of a cancellation to a scheduled service.

A ‘no show’ occurs when a participant is not present at the agreed place or at the agreed time of a scheduled service.

If a participant claims there were reasonable grounds for a late cancellation or ‘no show’, they should provide evidence in writing to substantiate their claim, and this should be considered by the provider. Some examples of reasonable grounds include, but are not limited to:

- the participant was in hospital
- the participant was experiencing a health incident
- the participant’s informal support arrangements changed unexpectedly.

The provider should consider each claim on a case-by-case basis. If the provider determines there are reasonable grounds for the late cancellation or ‘no show’, they can vary their claim for the service. More information on varying a claim is in section 16.7.

A registered provider should include their cancellation and no-show policies in their service agreements with participants.

10.9 Managing complaints and feedback

Providers must have a complaints and feedback system in place for participants, their registered 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, or any person supporting 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, registered supporters, carers, the workforce and others
  - use the input and feedback to inform continuous improvements for participants and the whole organisation.

The process by which a participant can make a complaint must be provided as part of the additional information for new participants.

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 registered 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 about making a complaint is on the Commission's website.

10.10 Elder abuse

Providers are responsible for identifying any risks and reporting or seeking advice if a participant's health, safety and wellbeing may be at risk. This includes identifying and reporting elder abuse.

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.

Providers have a responsibility under section 16(1) of the Act to notify the 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 all participants are treated with dignity and respect.

Providers must demonstrate that they understand the rights of participants under the Statement of Rights. The provider must have practices in place to ensure they comply with the Statement of Rights and comply with any requirements in relation to reportable incidents. Failure by the provider to demonstrate they meet these requirements may result in the Commission taking enforcement action.

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.

For more information, case studies are available on the Commission’s website.

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

11.0 Self-management

This chapter covers:

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

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 particular 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 approaches.
- Third-party arrangements need to be agreed between the participant, the provider and the third party.

11.1 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 support from their registered 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 care and services they receive (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.

Note: Providers must deliver at least one direct care management activity, to each participant, every month. This includes participants who self-manage.

11.2 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 support from their registered supporters and/or carers, may have greater involvement in self-managing than others. Some participants may choose to organise some aspects of their care while the provider organises other aspects.

Self-management activities may include:

- choosing and coordinating services in line with their assessed needs and budget
- managing their budget
- scheduling when services will be delivered and rostering workers
- communicating with their workers

- choosing their own suppliers and/or workers
- paying invoices for services delivered and seeking reimbursement from their provider
- navigating the aged care system.

The self-management approach must be agreed between a participant and their Support at Home provider. Effective communication between a participant and their provider is essential to any self-management approach.

11.3 Obligations for self-management

Providers, care partners and participants should have a sound understanding of the tasks and obligations involved in self-management. If a provider can support this approach, they should have a self-management model that outlines organisational requirements and arrangements that can be supported.

To finalise a self-management arrangement, providers and participants should mutually agree on the responsibilities and obligations of each party. The arrangement should be documented. 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 for a self-management arrangement**.

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.
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 delivered within the budget parameters.	Knowing that only approved services will be subsidised.

Provider Obligations	Shared Obligations	Participant Obligations
Support knowledge building and oversight of the budget.	Proactive communication from both the provider and participant, registered 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, engaging these workers and ensuring these workers meet all worker obligations under the *Aged Care Act 2024*.		
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.		

11.4 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. Providers must deliver at least one direct care management activity, every month to a Support at Home participant. Care management activities enable the provider to provide oversight of quality, safety, governance and compliance requirements.

Regardless of the self-management approach, 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 other participants. This funding will be retained by the government and allocated to the provider's care management account.

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

11.4.1 Care plan

All participants are required to have a care plan developed in collaboration with the care partner and participant. The self-management approach must be documented in the care plan. Providers and participants must work together to develop a care plan before or on the day care starts. A copy of the care plan should be provided to the participant for their records.

More information about the care plan is in section 8.6.

11.5 Using third-party workers

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

The Act outlines that a registered provider must engage a third-party worker either directly or through an associated provider in order to deliver funded aged care services to a participant. 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 10.6.

Providers should genuinely consider any requests by a participant to use a third-party worker. The provider should make a clear decision about the request, document the decision, and inform the participant of the outcome and the reasons if the request cannot be agreed to.

If the provider has agreed for the participant to source and select their own worker, some common activities the participant would undertake include:

- researching organisations or individual workers they want to deliver the service
- liaising with the organisation or individual worker to determine suitability to deliver the service
- negotiating a service price
- obtaining information from the organisation or individual worker to assist the provider with onboarding
- organising dates and times for the service to be delivered.

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 information is available at section 11.5.1.

11.5.1 Self-management overhead cap

Where the participant has directly sourced a third-party worker and is self-managing the service, 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)
- claiming for subsidy and paying the third party.

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.

The overhead cap should only be applied when the participant has directly sourced the third-party worker and this includes the activities outlined in section 11.5.

11.5.2 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 the self-management overhead cap and whether GST is applicable. Generally, services delivered to a participant using a third-party worker are inclusive of GST. GST should not be charged to a participant's budget, even if the provider pays GST to a third-party worker. Services delivered under the Support at Home program are GST-free for participants. Providers may claim GST credits for subcontractor invoices where applicable

More information on GST and home care is on the ATO website.

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 9.4.

11.5.3 Case study

Margaret

Self-management

Margaret would like to self-manage her care and use 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 a 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 *Aged Care Act 2024* before services commence. Margaret understands.

Self-management

- 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 are 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.

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 engages the physiotherapist to deliver the service to Margaret and creates a contract with 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.

11.5.4 Reimbursement for third-party services

When receiving services from a third-party worker, a participant may prefer to pay for the service and seek reimbursement from their provider. When this is requested by the participant, the provider should consider how this arrangement can be supported.

If the provider can support reimbursement arrangements, the provider must ensure the following requirements are met before the service is delivered:

- The reimbursement is for a service on the Support at Home service list.
- The provider is registered to deliver the service for which the participant is seeking reimbursement.
- The reimbursement must be for a service the participant is approved to receive (as outlined in the participant's Notice of Decision and support plan).
- The service for reimbursement is outlined in the participant's care plan and the cost is included in the individualised budget
- The provider must have engaged the worker to deliver the service and completed all relevant worker screening. For more information on using third-party workers, see section.

Providers can refuse to reimburse participants for services that fall outside of the above requirements. Once the reimbursement arrangement has been discussed with the participant it should be documented.

In addition to the above requirements, providers must follow Support at Home claiming rules and finalise claims for services within 60 days after the end of the quarter. To claim, the participant will need to provide evidence of the service that has been delivered and the final price of the service. This may be in the form of an invoice or receipt. The provider should retain this evidence as confirmation of service delivery and evidence requirements for claiming.

More information on confirmation of service delivery is in section 10.5.

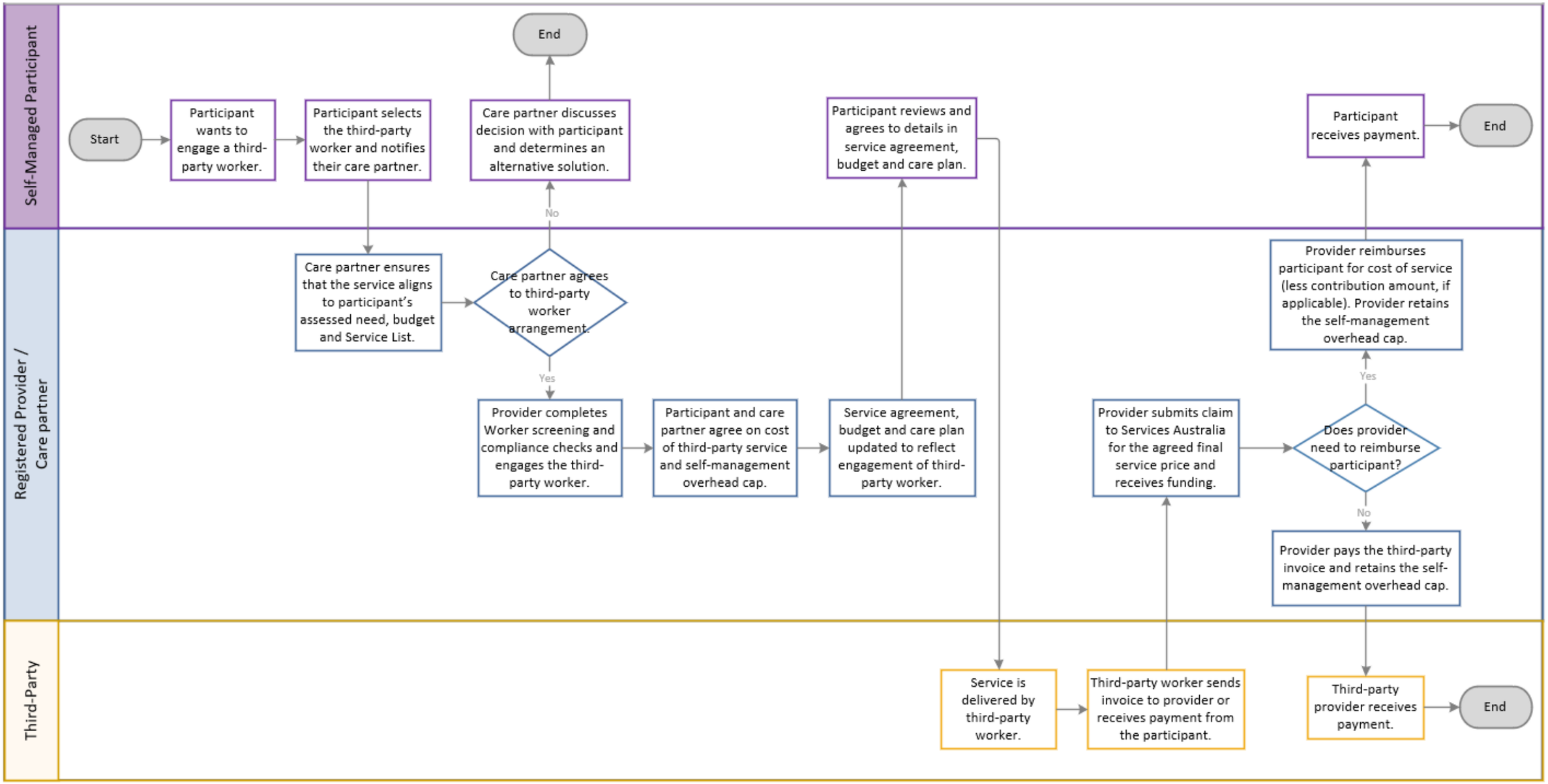
More information on evidence requirements for claiming is in section 16.6.

11.5.5 Reimbursements and participant contributions

Participant contributions apply for all services delivered in the independence and everyday living categories. For services in the clinical supports category (for example, nursing), no participant contribution is required as these services are fully funded by government.

The price paid to the third-party worker will include both the government subsidy and the participant contribution, if applicable. Providers should work with the participant to determine (and document) how the participant contribution will be paid under a reimbursement arrangement. The provider may choose to initially reimburse the participant for the full cost of the service and invoice the participant for their contribution at a later date. Alternatively, the provider may choose to only reimburse the participant for the government subsidy amount.

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



12.0 Ceasing and temporarily stopping services

This chapter covers:

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 (Home care account balance).

The *Aged Care Rules 2025*:

- Chapter 4, Part 4, Division 4 (Ceasing services).

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

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) 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.
- If changing providers, the participant should agree to the exit date with the outgoing provider.
- Providers have 60 days to finalise their claims from the date the participant exits their service.

Key points to remember

- 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 outgoing 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.

12.1 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 permanently leaving Support at Home for residential aged care. In this case, 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.

Note: A participant's funding will be reduced to zero and reallocated when a total of four consecutive quarters (one year) have passed since the end of the quarter from when the last service was delivered.

12.2 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 18.0.

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) 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 contact My Aged Care.

12.3 Changing providers

A participant can change providers for various reasons, including needing different services than what the existing provider can offer or if they change locations (e.g., 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.

Where a registered provider ceases to deliver funded aged care services to a participant, they are known as the 'outgoing provider'.

Where another registered provider starts the delivery of funded aged care services to the participant, they are known as the 'incoming provider'.

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

Note: For the AT-HM scheme, the outgoing provider should, as soon as reasonably practicable, contact the incoming provider to ensure continuity of prescription, purchase, private rental or loan of assistive technology and 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) from the last quarter of when they last received a service to enter into a new service agreement and agree a start date with another Support at Home provider. The incoming provider will need to complete and submit an entry notification (via the Aged Care Provider Portal) once the participant enters into a service agreement.

Note: If an entry notification is not received by Services Australia, the participant's funding will be discontinued and the funding will be reallocated to another person on the Support at Home Priority System.

12.3.1 Outgoing provider obligations

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

Step	Action	Details
1	Agree on cessation date	The participant and the outgoing provider should agree on the date that services will cease.
2	Notify Services Australia	Within 28 calendar days of the exit date the outgoing provider must notify Services Australia that the participant has ceased services.
3	Share information with the incoming provider	The outgoing provider must share information about services delivered with the incoming provider to assist the incoming 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. The outgoing provider must give the incoming provider the records, or copies of such records, within 28 days after the request is made.
4	Complete delivery of services and supports	The outgoing 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.

Step	Action	Details
5	Finalise claims	The outgoing 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 16.3. **Note:** This should include any AT-HM scheme claims where possible. If there are outstanding claims for assistive technology or home modifications, these will need to be transferred to the incoming provider with the agreement of the participant.
6	Calculate participant portion and Commonwealth portion of HCP unspent funds, if applicable	If the participant is a transitioned HCP care recipient, the provider will need to determine if there are HCP unspent funds. Providers need to calculate the participant portion and the Commonwealth portion of HCP unspent funds. More information is in section 12.3.3.
7	Issue final participant invoices and monthly statement	The outgoing provider must issue a final invoice for participant contributions (if applicable), as well as a final monthly statement to the participant.
8	Notify incoming provider of participant's financial balances.	Within 28 days of a participant's exit date the outgoing provider must share with the incoming provider the participant's remaining AT-HM budget and 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.
9	Refund participant portion HCP unspent funds	If the provider holds participant portion HCP unspent funds then the balance of funds must be refunded to the participant or their estate. More information is in section 12.3.3.
10	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.

12.3.2 Incoming provider obligations

To support the continuity of funded aged care services, the incoming provider may request the outgoing provider to share records relating to the participant which are necessary to ensure the continuity of funded aged care services for the individual.

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

Step	Action	Details
1	Accept the participant referral in the My Aged Care Service and Support Portal	The incoming provider must accept the participant's referral in the My Aged Care Service and Support Portal before submitting the entry notification to Services Australia.
2	Enter into a service agreement and agree on a commencement date	The incoming provider will need to discuss and enter into a service agreement with the participant. The start date for the incoming provider must be on or after the exit date.
3	Receive final budget information from outgoing provider	The incoming 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 outgoing provider, prior to the exit date. The incoming provider will receive the participant's Assistive Technology and Home Modifications budget and any transferred commitments as needed.
4	Confirm exit date with outgoing provider	The incoming provider should confirm the exit date with the outgoing provider to ensure there are no overlapping claims for services.
5	Create a care plan and quarterly budget	The incoming provider will need to work in partnership with the participant to develop a care plan and quarterly budget before or on the day care starts.
6	Notify Services Australia of participant entry	The incoming provider must submit the entry notification to Services Australia once the participant enters into a service agreement.
7	HCP unspent funds (if applicable)	Commonwealth portion HCP unspent funds will be held by Services Australia and can be used for AT-HM purchases or to top-up the quarterly budget, if this has been exhausted.

12.3.3 Transitioned HCP care recipients and transfer of HCP unspent funds

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

- Calculate the Commonwealth and participant portions of HCP unspent funds.
- Notify the incoming provider of the Commonwealth portion of HCP unspent funds.
- If the provider holds participant portion HCP unspent funds then the balance of funds must be:
    - Paid to the individual within 70 days after the cessation of services.
    - In the event the participant dies – paid to the individual's estate. This must be completed within 14 days from the date the provider has been shown the letter of administration for the estate or probate of the will or their estate.
    - Return the Commonwealth portion of HCP unspent funds to Services Australia where it will be added to the balance of the participant's home care account.

Note: Transitioned HCP care 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.

12.4 Ceasing funded aged care services

12.4.1 Participant initiated cessation of services

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

Where possible, the participant (or their registered supporter or appointed decision-maker) should notify the provider, in writing and as soon as possible, that 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 aged care will be the exit date from Support at Home. A provider has 60 days from the date a participant enters permanent residential aged care to finalise all claims for services delivered prior to entry into residential aged care.

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 aged care, agree on cessation date	Most commonly, the exit date will be the same as the entry date to permanent residential aged care. On the day of entry into permanent residential aged care the participant will be automatically exited from Support at Home.
2	In the participant has died, update My Aged Care	Providers will need to: • Update the My Aged Care Service and Support Portal with the departure code. • Call My Aged Care to update the participant record so there are no future communications issued to the participant, their registered supporters, or their family.
3	Notify Services Australia	Within 28 calendar days of the exit date, the outgoing 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 or entry into permanent residential aged care as per the claiming rules in section 16.3.
5	Calculate and transfer participant portion HCP unspent funds, if applicable	If the participant is a transitioned HCP care recipient, the provider will need to determine if there are participant portion HCP unspent funds and if so, refund these to the participant or their estate. More information is in section 12.3.3.
6	Issue final participant invoices and monthly statement	The outgoing provider must issue a final invoice for participant contributions (if applicable), as well as a final monthly statement to the participant.

12.4.2 Provider initiated cessation of services

At times, a provider may need to cease providing funded aged care services to a Support at Home participant. This is outlined in Section 149-35(2) of the Rules. The circumstances when a provider can cease providing services are:

- The participant can no longer be cared for in their home with the resources available to the provider.
- The participant no longer needs the funded aged care services delivered by the provider.
- The participant's needs, as determined through an assessment by an aged care needs assessor, can be more appropriately met by other types of funded aged care services.
- The participant has intentionally caused serious injury to an aged care worker of the provider.
- The participant has intentionally not complied with the rights of an aged care worker to work in a safe environment.
- The participant, for a reason within their control, has not paid the provider the required contribution as per their service agreement, has not negotiated an alternative payment arrangement, and does not have an application for the fee reduction supplement in place.
- The participant notifies the provider of a change of address to a location whereby the provider does not deliver Support at Home services.

Note: The circumstances that a provider may cease delivering funded aged care services must be outlined in the participant's service agreement.

If a provider needs to cease the delivery of services, the provider must notify the participant of the decision in writing at least 14 days before services end. The notice must include:

- The reason for the decision to cease Support at Home services.
- The date the provider will cease the delivery of services.
- Information about the participant's rights in relation to ceasing services, including:
    - how to make a complaint with the provider
    - other mechanisms for making and addressing complaints
    - information about independent aged care advocates (more information on aged care advocates is in section 6.3.1.4).

Note: Providers must ensure there are appropriate continuity of care arrangements in place for people receiving funded aged care services.

If the decision to cease service delivery was based on the participant's behaviour, the participant and provider may agree to continue service delivery if the behaviour

changes. If this happens, the provider must give the participant a written notice stating that the provider no longer intends to cease the delivery of services to the participant.

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

13.0 Assistive Technology and Home Modifications (AT-HM) scheme

This chapter covers:

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.

The *Aged Care Rules 2025*:

- Chapter 1, Part 3, Division 4 and 6 (Service list)
- Chapter 2, Part 3, Division 2 – 80-20, 80-25 and 80-30 (Classifications and period of effect)
- Chapter 2, Part 3, Division 3 – 81-20, 81-25 and 81-30 (Classifications and criteria)
- Chapter 4, Part 7, Division 2 – 155-40 and 155-50 (Provision of information)
- Chapter 7, Parts 3 and 4 (Subsidy for assistive technology and home modification).

Support at Home providers delivering the AT-HM scheme must be registered in Category 2 – Assistive Technology and Home Modifications and must comply with provider obligations and the Code of Conduct.

Key points to remember

- 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.
- All transitioned HCP care recipients will have a transitional approval for assistive technology and home modifications.
- 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 is in the AT-HM scheme guidelines.

13.1 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 allocated an assistive technology funding tier, a home modifications funding tier, or both.

Participants can access both assistive technology and home modifications funding tiers at the same time, if needed. This will provide access to funding for products, equipment and home modifications.

Participants will be allocated a funding tier for 12 months (in most instances) to spend their assistive technology and home modifications 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.

13.1.1 What is assistive technology?

Assistive technology includes items, pieces of equipment or products that 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 such as bedpans and commodes
- bathing devices including shower chairs and non-slip mats.

Providing assistive technology to a participant may also include services delivered by a suitably qualified health professional such as prescription, advice and wrap-around services that help to match a person, their goals and their environment with specific products and equipment.

The AT-HM list sets out the assistive technology 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 equipment that are more appropriately funded through an alternative national or state-based program (e.g., the Medical Aids Subsidy Scheme).

13.1.2 What are home modifications?

Home modifications provide changes to a participant's home environment to make it safer and more accessible.

Home modifications can include:

- grab rails in the shower or bathroom
- internal and external handrails
- ramps and stair lifts
- bathroom redesign (e.g., changing the layout to improve accessibility)
- widening doorways and passages (e.g., to allow for wheelchair access).

The AT-HM scheme does not include:

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

13.2 Accessing the AT-HM scheme

Older people will be assessed for the AT-HM scheme as part of their aged care assessment.

Assessors consider the older person's functional ability and home environment when determining whether assistive technology or home modifications are required and will recommend a funding tier based on their needs, as assessed using the Integrated Assessment Tool (IAT). A participant can be assessed as needing assistive technology or home modifications, or both.

If required, a funding tier and approval for assistive technology or home modifications will be outlined in their Notice of Decision and support plan.

Note: Funding for assistive technology and home modifications will be separate from a participant's budget for ongoing or other short-term Support at Home services.

13.2.1 Transitioned HCP care recipients and access to AT-HM

All transitioned HCP care recipients will have access to the AT-HM scheme without the need for further assessment. Participants can use their HCP Commonwealth unspent funds to access equipment, products

and home modifications from the AT-HM list. Providers must document and justify the need and reasoning for AT-HM to support the claim. More information is in the AT-HM scheme guidelines.

If a transitioned HCP care recipient has no HCP Commonwealth unspent funds and requires assistive technology or home modifications, the provider can, with consent from the participant:

- complete the AT-HM scheme data collection process to seek an appropriate assistive technology or home modifications tier or both, or
- 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 care recipient has been re-assessed under Support at Home and receives AT-HM funding, funding to access assistive technology and home modifications must be first drawn from HCP Commonwealth unspent funds before the provider can claim from the AT-HM funding account. More information on how funds are used for assistive technology and home modifications is in section 16.4.5.

Note: All provision of assistive technology and home modifications must align with the participant's needs, be agreed with the participant, be documented in their care plan and individualised budget, as well as meet any prescription requirements, where applicable.

13.2.2 Care management and AT-HM

Care management is a core service for all Support at Home participants. When delivering care management activities, the care partner should also:

- identify assistive technology or home modifications funding
- confirm the needs and goals of the participant in relation to identified needs in the support plan
- include AT-HM scheme items and services in the participant's care plan and budget
- make referrals to relevant professionals, where required (e.g. for prescription of assistive technology and home modifications)
- communicate with any relevant professionals about the participant's needs, where required.

Administration and coordination activities, that fall outside the scope of care management, can be compensated through the participant's AT-HM funding. More information on administration and coordination activities is in section 13.4.3.

More information on Support at Home care management activities is in section 8.4.

13.3 AT-HM funding

Funding for assistive technology and home modifications will be separate from a participant's budget for ongoing or other short-term Support at Home services.

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 scheme guidelines.

Funding tier	Funding allocation (up to)	Funding period
Assistive technology		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000[1]	12 months
[1] High tier assistive technology is not capped at $15,000. Participants who have assistive technology costs above $15,000 can access additional funding with evidence, such as a valid prescription.		
Home modifications		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000	12 months[2]
[2] Funding may be extended for an additional 12 months to complete complex home modifications (24 months in total) if evidence is provided to Services Australia.		
Other funding		
Assistance dog maintenance	$2,000 per year	Ongoing[3]
[3] Funding will be automatically allocated every 12 months; however, the funding cannot accrue or roll over. More information on assistance dogs funding is in section 13.5.1.		

13.3.1 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 instances). The period of funding availability commences from the date the participant enters into a service agreement with their provider. After the funding period, AT-HM funding will no longer be accessible for the participant to use. Providers will need to finalise outstanding AT-HM scheme claims within 60 calendar days of the funding 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 of the home modifications high tier will be monitored by Services Australia.

Participants who were identified at assessment with specific progressive conditions (as outlined in legislation) will automatically have access to their assistive technology funding for 24 months to meet their rapidly changing needs. They can apply for an additional 24-month extension, if required (48 months in total).

13.3.2 Supplements for AT-HM funding

The following supplements apply to participants with approved AT-HM funding:

- the remote supplement for participants living in an area in the Modified Monash Model (MMM) classification 6 or 7
- the fee reduction supplement for participants experiencing genuine financial hardship.

More information on AT-HM supplements is in section 9.3.2.

13.4 AT-HM services and activities

The AT-HM scheme includes a variety of services and activities that provide end-to-end support for the participant. These services and activities, and the participant contribution rate, are outlined below.

13.4.1 Prescription of AT-HM

Some assistive technology will benefit from prescription, and all home modifications require a prescription (made by a suitably qualified health or allied health professional). The AT-HM list outlines the types of equipment and products that will benefit from prescription and home modifications that require a prescription.

Depending on the equipment, products or home modifications 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, GPs and rehabilitation specialists
- Aboriginal and Torres Strait Islander health practitioners.

Prescribers of assistive technology and home modifications will operate within their professional scope to:

- consider any issues or problems that restrict an older person's physical, functional or cognitive abilities
- determine the type of assistive technology or home modifications support that are needed to maintain physical, functional or cognitive abilities
- identify assistive technology products or equipment that will assist an older person to maintain physical, functional or cognitive abilities
- identify modifications to the home environment to support an older person to access and move around their home safely.

Note: Participant contributions for AT-HM prescription services will have a clinical supports contribution rate of 0%.

More information on prescribing assistive technology and home modifications is in the AT-HM scheme guidelines.

13.4.2 Wrap-around services

Participants may require services to ensure their assistive technology or home modifications are fit-for-purpose and 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 can include:

- delivery or set up of assistive technology equipment
- organising building approvals for home modifications
- training and education on the safe use of assistive technology equipment and products or home modifications
- follow-up visits from a health professional to check whether assistive technology or home modifications effectively meet the needs of the participant.

Note: Participant contributions for AT-HM wrap-around services will have a clinical supports contribution rate of 0%.

If the AT-HM funding tier is insufficient to cover wrap-around services, the provider can, with consent from the participant, refer them for a Support Plan Review by an aged care needs assessor to increase the funding tier.

This option should be discussed with the participant and documented in their care notes.

More information on AT-HM wrap-around services is in the AT-HM scheme guidelines.

13.4.3 Administration and coordination activities

Providers may deliver administration (assistive technology) or coordination (home modifications) activities as part of delivering the AT-HM scheme to a participant.

Administration and coordination activities must be claimed from a participant's AT-HM funding and cannot be claimed as care management activities.

A provider's administration (assistive technology) activities may include:

- liaising with assistive technology suppliers
- purchasing low-risk assistive technology products and equipment
- organising quotes, delivery and wrap-around services.

Note: A provider's administration costs in delivering assistive technology must not exceed 10% of the cost of the item or item bundle, or up to $500 (whichever is lower).

A provider's coordination (home modifications) activities may include:

- project management activities
- seeking local government approval for structural modifications
- managing subcontractor invoices.

Note: A provider's coordination costs in delivering home modifications must not exceed 15% of the total quoted cost of a participant's home modifications or up to $1,500 (whichever is lower).

Providers can provide coordination services for home modifications or subcontract this service to a third-party.

13.4.4 Case study

Tina

AT-HM services and activities

Tina is a Support at Home participant with assistive technology funding. She uses her assistive technology funding to purchase equipment, as well as for prescription, wrap-around and administration activities.

Tina is a Support at Home participant with medium tier funding for assistive technology. Following a series of falls, Tina and her care partner identified that she may benefit from some assistive technology to support Tina to move safely around her home. Tina

consented to an appointment with an occupational therapist, which her care partner arranged.

The occupational therapist met with Tina to discuss her falls history, needs, goals and preferences. The occupational therapist suggested a shower chair, a commode chair for toileting assistance, a walking frame and a non-slip mat for the kitchen. Tina agreed with their recommendations.

The occupational therapist provided the care partner with a prescription for the assistive technology items required, the provider discussed the prescription with Tina and documented the information in Tina's care plan. The care partner commenced sourcing the items, spoke with Tina about the agreed price and worked with Tina to update her individualised budget before purchasing the items.

Once the items were delivered, the occupational therapist met with Tina to discuss how to use her new equipment. The occupational therapist showed Tina how she could use her walking frame to move between rooms and then use it to sit down when she was fatigued. The occupational therapist supervised Tina to ensure she could use the walking frame safely.

At the end of the month, the provider claims for all services delivered to Tina for the period. This includes the equipment, prescription from an occupational therapist, the wrap-around services delivered by the occupational therapist, as well as the care management provided by the care partner.

From the **assistive technology fund account**, the provider claims:

- $180.00 for the shower chair
- $150.00 for the commode chair
- $210.00 for the walking frame
- $22.80 for the non-slip mat
- $600.00 (3.0 hours) for the **prescription service** provided by the occupational therapist
- $50.00 for delivery of the items (**wrap-around service**)
- $200.00 (1.0 hour) for the follow-up appointment for education on how to use her equipment (**wrap-around service**)
- $$56.28 for the sourcing and purchasing of equipment (**administration activity**). This cost was agreed with Tina and is under the cap of 10% of the cost of the item or item bundle or up to $500 (whichever is lower) for administrative activities.

From the **care management account**, the provider claims:

AT-HM services and activities

- $60 (0.50 hours) of care management activities for the initial conversation with Tina, as well as documentation of the conversation and referral to the occupational therapist.

More information on AT-HM prescription, wrap-around services, as well as administration and coordination activities is in the AT-HM scheme guidelines.

13.4.5 Repairs and maintenance

Repairs and maintenance for assistive technology products and equipment on the AT-HM list can be funded through a participant's assistive technology funding.

In order to use assistive technology funding for repairs and maintenance, products and equipment must have been originally accessed through Support at Home or another Australian Government-funded aged care program.

If the assistive technology funding is insufficient, the funding period has expired, or the participant has no HCP Commonwealth unspent funds, the provider can refer the participant for a Support Plan Review (for repairs and maintenance only) by an aged care needs assessor to access another assistive technology funding tier.

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

13.5 AT-HM list

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

AT-HM funding may only be used for products, equipment and home modifications on this list where it optimises the participant's functioning or manages their disability or age-related functional decline.

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** – including adaptive clothing or shoes and assistive products for toileting, bathing and showering
- **mobility** – including walking frames, wheelchairs and lifting devices
- **domestic life** – including assistive products for food preparation, eating, drinking and house cleaning

- **communication and information management** – products and equipment 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 describes how participants can access each item safely and effectively. The prescription category (low risk, under advice, prescription) is the suggested level of skill or qualification required to effectively provide recommendations for the safe and effective use of assistive products or equipment or the installation of home modifications.

More information on the AT-HM list and the prescription categories is in the AT-HM scheme guidelines.

13.5.1 Assistance dogs

If a participant is not accessing the government-funded Physical Assistance Dogs Program, some of the costs associated with essential 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 their aged care assessment. Funding for assistance dog maintenance is a specified need with separate funding, capped at $2,000 per year.

Ongoing maintenance costs for assistance dogs may include:

- animal vaccinations
- deworming and flea treatments
- essential grooming
- dog food
- vet bills.

Funding does not include non-essential assistance dog maintenance costs, such as boarding kennel fees, or grooming for aesthetic reasons.

Funding for assistance dogs can be approved in isolation or in addition to an AT-HM funding tier.

Funding is ongoing, which means that funding will be automatically allocated every 12 months, but it cannot accrue or rollover.

If the participant no longer requires this specific funding, the provider must notify Services Australia through the Aged Care Provider Portal.

Assistive technology administration charges are not expected to be applicable to (Specified Needs) assistance dogs funding.

13.6 Sourcing assistive technology and home modifications

Providers are responsible for arranging and sourcing any required assistive technology and home modifications, including prescription and wrap-around services, in accordance with the participant's assessed needs.

Providers can source assistive technology products and equipment through the:

- purchase or rental of assistive technology:
  - equipment and products can be sourced and purchased from a registered provider or supplier
  - private rental as outlined in the AT-HM scheme guidelines.
- National Assistive Technology Loans scheme (AT Loans scheme):
  - a loan arrangement through the AT Loans scheme for the provision of high quality new and refurbished equipment.

There will be a staged implementation of the AT Loans scheme in states and territories from 1 November 2025, with further information provided as this becomes available.

More information on purchase or rental of equipment and the AT Loans scheme is in the AT-HM scheme guidelines.

13.6.1 Reimbursement for the purchase of assistive technology products

A participant may prefer to source and pay for an assistive technology product and seek reimbursement from their provider. When this is requested by the participant, the provider should consider how this arrangement can be supported.

If the provider can support reimbursement arrangements, the provider must ensure the following requirements are met before the purchase of a product is made:

- The reimbursement is for a product on the Support at Home AT-HM list.
- The participant is approved to receive assistive technology (as outlined in the participant's Notice of Decision and support plan) or they have approval as a transitioned HCP care recipient.
- The participant has funding available and the product for reimbursement is outlined in the participant's care plan and individualised budget.
- The reimbursement arrangement has been discussed with the participant and documented.

Providers can refuse to reimburse participants for services that fall outside of the above requirements.

In addition to the above requirements, providers must follow Support at Home claiming rules and finalise claims for items and services within 60 days after the end of the funding period. For the provider to claim, the participant will need to provide evidence of the product that was purchased, including the price. The provider should retain this as evidence to support claiming. More information on evidence requirements for claiming is in section 16.6.

13.7 Recording assistive technology and home modifications

Prices for assistive technology and home modifications may not be known at the time of developing a service agreement with a participant. To ensure transparency, accountability and participant satisfaction under Support at Home, providers must document the following in relation to assistive technology and home modifications:

- the price the participant is charged (i.e., the final agreed price)
- quotes and prescriptions, where applicable
- invoices and receipts to support claiming
- a confirmation of delivery for AT-HM items
- the participant contribution amount.

These requirements apply for all items available through the AT-HM scheme.

13.7.1 Final agreed price of AT-HM

The price charged to a participant's fund for assistive technology and home modifications should be the agreed price and no more than the invoiced cost of:

- the item
- the prescription
- wrap-around services
- administration/coordination services, capped at:
    - 10% of the cost for assistive technology or $500 (whichever is lower)
    - 15% of the cost of home modifications or $1,500 (whichever is lower).

All AT-HM costs must be agreed and documented between the provider and the participant before committing to the funds being spent. These costs can be agreed progressively during this process.

When finalising claims and payment for assistive technology and home modifications, providers must include:

- a final invoice for the AT-HM item (including GST)

- the final invoice must be itemised if there is more than one item or service for claiming
- progress payments for home modifications can be claimed over time, as needed.

13.7.2 Confirmation of delivery

Providers must keep a record confirming the delivery of AT-HM items.

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 and completed home modifications
- records created by an electronic system that demonstrate delivery and show:
  - details of items
  - the participant's name and address
  - details of delivery (including date and time)
  - photos of the AT-HM item at participant's address.

13.8 AT-HM participant contributions

Participant contribution categories apply for AT-HM services and items. AT-HM items 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 the AT-HM scheme is in section 9.4.

14.0 Restorative Care Pathway

This chapter covers:

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 Rules 2025*:

- Sections 8-75, 80-15(1), 80-55 and 81-15
- Sections 148-40 (Delivering services) and 148-81 (Care plan requirements).

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
- Standard 5: Clinical Care
    - Outcome 5.1: Clinical Governance

If the provider is delivering nursing services, they must comply with Standard 5, in full.

A provider must be registered to deliver restorative care management and allied health and therapy, to deliver the Restorative Care Pathway.

Key points to remember

- An episode of restorative care provides up to 16 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.
- Funding for restorative care management is taken from the individual restorative care budget and not care management pooled funds.
- A service agreement and goal plan must be established for each participant (this is in lieu of the 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 (evidence will be required). It can also be used to request a reassessment for other aged care services as the episode concludes, if required.

14.1 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 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, function and wellbeing.

Restorative care provides a short-term period of care of up to 16 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/or 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 supports category.

14.1.1 The Restorative Care Pathway clinical guidelines

The Restorative Care Pathway clinical guidelines are available to assist providers deliver evidence-based restorative care services.

The clinical recommendations can be generalised to provide restorative care intervention for a large range of conditions however, specific recommendations are made in relation to people:

- at risk of falls
- with frailty, sarcopenia and/or multimorbidity
- with dementia
- who require support with their mental wellbeing and social connections
- who require nutritional support
- with swallowing difficulties.

Note: Clinicians are expected to utilise their own professional judgment, experience and expertise to ensure high quality clinical outcomes to effectively deliver restorative care.

More information is in the Restorative Care Pathway clinical guidelines.

14.2 Goals of restorative care

The Restorative Care Pathway provides an intensive short-term period of care designed to:

- prevent or delay the need for ongoing in-home care services or the need to access higher levels of ongoing care
- support participants to regain their ability to carry out daily activities
- provide reablement education and skills to participants on how they can retain better function as they age, for longer independent living.
- help participants to manage new or changing age-related conditions

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.

14.2.1 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 dietitian. 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 14.9.

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.

Practical examples of the MDT approach is included in the Restorative Care Pathway clinical guidelines.

14.3 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. Services through the Restorative Care Pathway should be clinically focused and complementary to any ongoing services being delivered.

New participants to the Support at Home program being assessed to access the Restorative Care Pathway can be reviewed at the end of the episode to determine if ongoing services are required.

Note: Approval of an ongoing Support at Home classification (for a new participant) will end a participant's access to the Restorative Care Pathway. This will be amended from February 2026 so that both new and existing participants can access the restorative care episode and ongoing classification, at the same time.

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 original Support at Home classification without the need for higher level ongoing services
Intensive clinical and/or allied health	**Intensive allied health and/or nursing services** will likely address an issue that will benefit from a range of clinical professionals 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 eligible for, or have recently received, the End-of-Life Pathway • have accessed 2 separate episodes or 2 units of funding for the Restorative Care Pathway in the past 12-month period (or have finished an episode within the last 90 days) • receive, or are eligible to receive, services through the Transition Care Programme (TCP) • receive permanent residential aged care.

14.3.1 Single provider model and the Restorative Care Pathway

Under the single provider model outlined in section 6.9.1, ongoing and short-term services must be delivered by the same service delivery branch of a registered provider. Participants already accessing ongoing services will need to consider if their provider is able to deliver the Restorative Care Pathway. If the provider does not deliver the Restorative Care Pathway, the participant will need to change providers to access both restorative care and ongoing services.

Providers should ensure that participants receive services through a single service delivery branch. This includes any ongoing Support at Home services or AT-HM services being accessed concurrently.

Providers will need to make sure any request to change providers to access the Restorative Care Pathway is undertaken in a timely manner to ensure care is not impacted.

14.4 Episodes and funding

An episode of restorative care provides up to 16 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 for services.

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 16-week or less period (subject to approval by an aged care assessor).

If requiring 2 separate episodes across a 12-month period, these episodes cannot be consecutive. The participant will need to wait at least 3 months from the end of the 16 weeks period associated with 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 14.4.2.

14.4.1 Commencement of an episode

An episode of restorative care commences from the start date outlined in the participant's entry notification to Services Australia. 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 Provider Portal.

A service agreement and goal plan must be completed before, or on the day, restorative care services commence. Where a service agreement is already in place as the participant is accessing ongoing Support at Home services, a new service agreement may be developed or a variation can be progressed. The service agreement must include the start and end date of the restorative care episode.

Note: The start date on the service agreement should be the same as the commencement date on the entry notification.

More information on notifying Services Australia of entry to care is in section 7.4.

14.4.2 Additional funding for an episode

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode for services.

If the participant requires additional funding within a single 16-week episode (or less), the provider can submit a request for a Support Plan Review.

Evidence must be provided with the request demonstrating that the initial unit of funding is insufficient to meet defined restorative outcomes. In practice, this evidence can be the goal plan and individualised budget, with a written statement to indicate that the restorative care goals cannot be met as indicated in these documents.

If the participant is already receiving ongoing Support at Home services, evidence is also required indicating that adjustments to the ongoing care plan and individualised budget are also insufficient to meet the restorative outcomes.

Participants will receive a letter advising of the decision outcome. 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, this will be automatically added to the participant's Restorative Care Pathway account. Providers will not be required to submit a new start notification to Services Australia. The additional funding will cease on the same day as the episode, no extension of time is provided to utilise the additional funding. Any remaining funds do not roll over and cannot be utilised at a later date. The 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.

Note: The request for additional funding for a Restorative Care Pathway episode is not a reviewable decision.

14.5 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.

14.5.1 Restorative care management activities

Restorative care management activities should be appropriately delivered to reflect the intensive nature of the episode.

In addition to the care management activities outlined in section 8.4.1, the table below outlines a list of **care management activities that can be claimed by providers as restorative care management activities**.

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. • Establishing and reviewing service agreement (as required). • Developing and reviewing the goal plan and budget. • Identification and selection of services with a focus on applying a multi-disciplinary approach using allied health and nursing services.
Service planning and management	• Planning and management of clinical supports to ensure comprehensive, coordinated and effective delivery of funded aged care services. • Communication with the participant, their carers and those who support them, including their registered supporters about reablement progress and attainment of goals. • Communication with the multidisciplinary team and a range of relevant stakeholders. • Management of the restorative care budget. • Supporting access to the AT-HM Scheme, where required.
Monitoring, review and evaluation	• Engaging in ongoing care discussions and/or case conferencing with the participant, their registered supporter or family members and/or relevant health professionals, where required. • Internal case conferencing amongst care partners and/or the multidisciplinary team to respond to changing needs and optimise care • Evaluation of the participant's 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 delivery of services with wellness and reablement approaches. • Providing independent advice, information and resources on age-related health matters.

14.5.2 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. Restorative care partners must have the appropriate skills and knowledge for clinical coordination and oversight for short intensive periods of care.

Restorative care partners should hold qualifications in nursing or allied health, preferably at the university level to enable them to work autonomously. Other relevant clinical qualifications may be held noting providers remain obligated to meet the strengthened Quality Standards, including outcome 5.1.

The clinical scope and role 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 an AT-HM item, 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.

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 complementary 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.

14.6 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 16-week episode (or less). 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.

14.6.1 Goal plan

All participants accessing restorative care must have an individualised goal plan. The goal plan replaces the care plan which is required for ongoing Support at Home services. 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 participant, their registered supporters (if required), 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:

- Identification of the participant's needs, goals, preferences and existing supports (drawn from the support plan from the aged care assessment).
- Strategies for risk management and preventative care.
- The services that will be delivered, including frequency, volume and duration of the services.
- The dates of review and proposed exit date.

If the Restorative Care Pathway is being delivered at the same time as ongoing Support at Home services, restorative care partners must ensure services are focused on clinical supports and complement existing ongoing services.

Note: The goal plan is a requirement for the Restorative Care Pathway only.

14.6.2 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 (16-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, including weekly restorative care management activities.

Restorative Care Pathway

- 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 services and progress. Together, Georgios and Nikolas tracked progress against the documented goals.

Prior to the completion of the restorative care episode (16 weeks), 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. The Support Plan Review will be reviewed by an aged care assessor to determine if Georgios is eligible to be reassessed for in-home aged care services.

14.7 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 (allied health and nursing) designed to restore function and improve independence.

Where participants are concurrently accessing a restorative care episode and receiving ongoing Support at Home, services should be complementary. Independence and everyday living services through the Restorative Care Pathway should only be used to achieve goal outcomes and support clinical gains (e.g., transport to get to group exercise classes at the local allied health centre).

14.7.1 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 when approved for the Restorative Care Pathway. However, participants with an ongoing Support at Home classification who are already approved for the high tier home modifications will retain this approval while accessing the Restorative Care Pathway.

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.

14.7.2 Transitioned STRC clients and access to AT-HM

Transitioned STRC clients, who commenced their STRC episode prior to 1 November 2025, will have a transitional approval for all assistive technology and home modifications. Providers will need to ensure access to AT-HM complies with the AT-HM list.

People with an active STRC approval, who have not commenced an STRC episode by 1 November 2025, will be able to use their approval to access an episode of restorative care including. These participants will also have transitional approval for funding equivalent to medium tier assistive technology and medium tier home modifications (see section 13.3 for AT-HM funding).

14.8 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 up to 16 consecutive weeks.

14.9 Support Plan Review

A restorative care partner will need to refer a restorative care participant for a Support Plan Review:

- to request additional services not approved at assessment
- to request an additional unit of funding for the restorative care episode
- to get AT-HM approval or a higher AT-HM

- for a reassessment of the participant at, or the near, the completion of a restorative care episode.

If additional funding is required, the request for a Support Plan Review should be submitted with evidence to support the request (see section 14.4.2 for more information on additional funding).

Evidence is required that shows a health professional confirming that the level of funding is insufficient to meet clinical needs and restorative care goals (as per the goals outlined in the goal plan).

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 7.6.

14.9.1 Support Plan Review 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, the restorative care partner can request a Support Plan Review to request a reassessment for ongoing Support at Home services, if required.

Participants who are accessing ongoing support at home services (during a restorative care episode), will continue to access ongoing Support at Home services after their restorative care episode has ended. However, if the exit plan determines that a participant's current ongoing classification is not sufficient to meet their needs, even after the restorative care episode, the restorative care partner can request a Support Plan Review to request a reassessment.

If the participant is reassessed and approved for an ongoing Support at Home classification while undertaking the Restorative Care Pathway, the Restorative Care episode will end upon approval of the ongoing Support at Home classification.

Note: Even if a participant's function has improved following a restorative care episode, a participant cannot be reassessed to a lower classification than the one they are currently receiving. People who determine they do not need ongoing services or a higher level classification may choose to have their restorative care episode conclude without further action.

14.10 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 is in section 9.4.

14.11 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 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 items prescribed and/or received during the episode (and their status of delivery or completion).
- 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.

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.

More information on exit planning is in the Restorative Care Pathway clinical guidelines.

15.0 End-of-Life Pathway

This chapter covers:

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.

The *Aged Care Rules 2025*:

- 80-15(2) and 80-57 (Classification and maximum period)
- 81-15 (Classification and criteria).

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.

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 funding to access in-home aged care services.
- 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
  - Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator) of 40 or less.

15.1 Overview

This chapter outlines the End-of-Life Pathway and its key elements including eligibility, funding, access and care management.

Older people who have 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 provides funding to access in-home aged care services from the Support at Home service list (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).

15.2 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.

15.3 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 the End-of-Life funding period and move to an ongoing classification.

15.3.1 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 use HCP Commonwealth unspent funds (if available) up until the 16-week mark, if funding under the End-of-Life Pathway is exhausted.
- work with their provider to request a Support Plan Review (available from the 12-week mark) to move to an ongoing Support at Home classification.

15.4 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 15.4.2 and information for new participants is in section 15.4.3.

15.4.1 The End-of-Life Pathway Form

An 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 registered supporter or active, appointed 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 an aged care assessor.

The End-of-Life Pathway Form can be downloaded from the department's website.

An End-of-Life Pathway fact sheet is available to assist medical practitioners to understand the program requirements and how to complete the End-of-Life Pathway Form.

15.4.2 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 an urgent 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 an AKPS 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 returned to the participant. • Requesting an urgent 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

Existing participants: Access to the End-of-Life Pathway	
	care assessor. At this time, the completed End-of-Life Pathway Form should be uploaded. • As an alternative to the provider requesting an urgent Support Plan Review, an existing participant may contact My Aged Care who can also request a Support Plan Review.
2.	An aged care assessor undertakes a 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 Provider Portal. 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.

15.4.2.1 Single provider model and the End-of-Life Pathway

Under the single provider model outlined in section 6.9.1, ongoing and short-term services, as well as AT-HM services, must be delivered by the same service delivery branch of a registered provider. Participants already accessing ongoing services will need to consider if their provider is able to deliver the End-of-Life Pathway.

15.4.3 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 an 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 registered supporter or active, appointed decision-maker (communicating the older person's decisions or acting on their

	behalf in accordance with a Commonwealth, state or territory arrangement), may take any of the following steps to initiate 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 an 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, their registered supporter, or their active, appointed decision-maker 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. 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. **Option 3:** Contact My Aged Care on 1800 200 422 or visit an 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 an 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 assessment process, 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 Provider Portal.
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.

15.5 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 8.4. In addition to these activities, care partners must ensure there is liaison and care coordination with the participant's doctor, medical team and/or any state or territory palliative care services. It is important that the care partner seeks to understand what supports are currently in place and whether additional services or parties should be notified (for example, palliative care services if they are not already engaged). 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 under the 'Home support care management' service. 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.

15.5.1 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 8.6.

15.6 Services and resources

End-of-Life Pathway participants can access services from the Support at Home service list, determined on a needs-basis in accordance with their aged care assessment or Support Plan Review.

Participants under the End-of-Life Pathway may be approved to receive funding for assistive technology, but 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.

15.6.1 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.

Palliative care can also be provided by General Practitioners (GPs) and Palliative Care Nurse Practitioners. Participants can discuss these services with their treating health professional.

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.

For more information on state and territory based palliative care services, refer to:

- Palliative Care ACT
- Palliative Care New South Wales
- Palliative Care South Australia
- Palliative Care Queensland
- Palliative Care Victoria
- Palliative Care WA
- Palliative Care Tasmania.

15.6.2 Aboriginal and Torres Strait Islander end of life care

Aboriginal and Torres Strait Islander participants are able to access Aboriginal or Torres Strait Islander Health Practitioner and Health Workers under the Support at Home service list. Cultural support is also available.

More information on Aboriginal and Torres Strait Island services is in section 10.2.

In addition to the abovementioned services, specific resources are available to support health and aged care workers to provide culturally safe palliative care for Aboriginal and Torres Strait Islander people. These resources 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).
- Caring@home Resources for Aboriginal and Torres Strait Islander families.

15.6.3 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. Sanjeeta's medical practitioner liaises with a 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.

The medical team support Sanjeeta and her family to arrange in-home palliative care services. Sanjeeta wants her daughter Ava to talk to her Support at Home care partner about her circumstances, including her diagnosis and the new arrangements. Ava is Sanjeeta's registered supporter which means she can help communicate information for Sanjeeta in line with her will and preferences. Ava

contacts the existing Support at Home care partner to discuss Sanjeeta's circumstances.

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 AKPS score of 40 or less) would need to be met.

Following the advice from the care partner, Ava discusses the options with Sanjeeta who decides to proceed. Sanjeeta and Ava access their GP who provides Sanjeeta with a score of 40 on the 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.

At Sanjeeta's direction, Ava provides the care partner with the signed form and the care partner requests a Support Plan Review via the My Aged Care Service and Support Portal. The care partner uploads the form when applying for the Support Plan Review.

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 Sanjeeta and Ava with Hindi resources from Palliative Care Australia which they can share with 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 assistive technology.

Working closely together, Sanjeeta, 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. Ava is also included when Sanjeeta wants her to be involved.

Nine weeks after commencing the End-of-Life Pathway, Sanjeeta dies. Ava notifies Sanjeeta's provider that her mother has died and the provider then notifies Services Australia.

15.6.4 Palliative care resources for providers

The Australian Government provides funding for workforce education, experiential learning and resources in palliative and end of life 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.

The Palliative Aged Care Outcomes Program (PACOP) provides education and training to the aged care workforce to strengthen their ability to deliver high-quality palliative and end of life care.

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.

For practical resources to support health and aged care professionals provide home-based end-of-life care, caring@home is available. Caring@home provides education and resources to health and aged care professionals to support families and carers help manage practical care and symptoms at home.

Additional palliative care resources include:

- National Palliative Care Standards – Palliative Care Australia
- Palliative care education and training – Australian Government Department of Health, Disability and Ageing
- National guidelines for spiritual care in aged care.

15.7 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 9.4.

15.8 Exiting from the End-of-Life Pathway

Exiting 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 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 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 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 12.4.

Part E: Provider payment arrangements

This section covers:

- Provider claiming
- Payments to providers
- Monthly statements for participants

16.0 Provider claiming and payment arrangements

This chapter covers

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, Division 6, Subdivisions A and D.

The *Aged Care Rules 2025*:

- Chapter 4, Part 7, Division 1, Subdivision S.

The strengthened Quality Standards are relevant throughout this program manual as a whole and providers should familiarise themselves with them.

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 on the service list 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.
- Providers must keep evidence of all services and purchases to support their claims.

16.1 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.

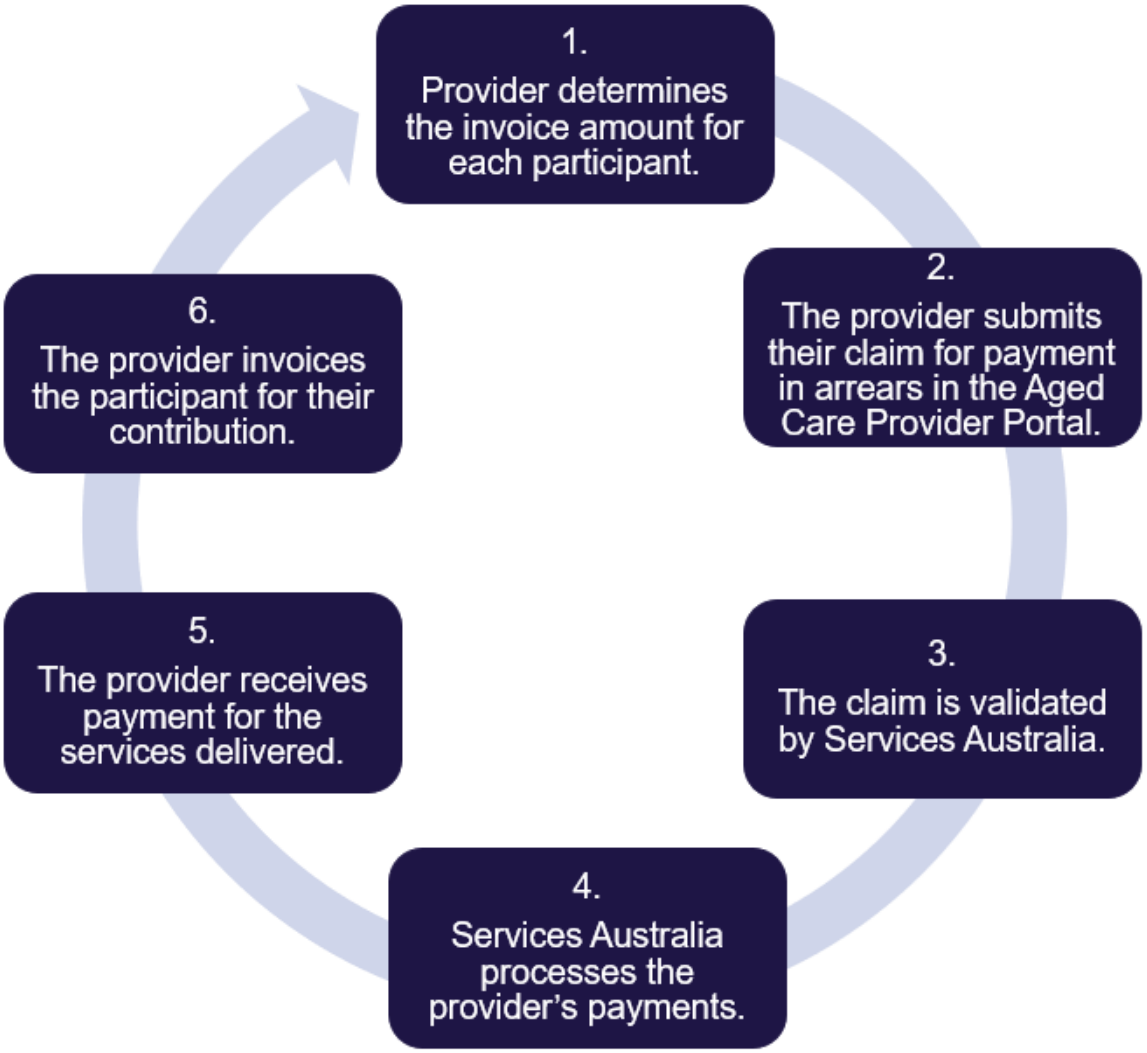
Providers must only claim for services on the service list that have been approved in the participant's Notice of Decision and support plan and must only claim for the agreed price.

To support claims, providers should keep evidence of all services and purchases.

Participant contributions will be collected by and paid directly to the provider.

16.2 Claiming process

The diagram below outlines the **process for provider claiming**.



16.3 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. When claiming, providers can make both whole-hour and part-hour claims. Part hour claims can be in 15-minute increments e.g., 15, 30, or 45 minutes. Providers can make multiple claims in a single 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. Claims can be submitted individually for a participant or as a bulk import for multiple participants.

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**. More detailed information on submitting and finalising a claim is available on the department's website at Support at Home: Claims and Payments Business Rules Guidance and Support at Home User Guide – submitting claims to the Aged Care Provider Portal.

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.

No.	Claim details
3.	Claim only for services delivered: • that the participant has been approved to receive through their aged care assessment and notice of decision, 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 entry notification or after the participant's exit date).

4.	Include the following mandatory information:
	• An identifier of the participant who received the service (for example, participant name, care recipient 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 the following claims, additional mandatory information will be required to identify the item:
	• prescription (if needed) and wrap around services provided (for claims for the AT-HM scheme)
	• expenses for home maintenance and repairs
	• expenses to maintain personal affairs
	• nursing care consumables
	• nutrition supports
	• indirect transport.

5.	Completed provider declaration.

16.4 Claiming requirements

The table below outlines the **claiming requirements for all provider claims**.

Specific requirements for care management, the AT-HM scheme, the Restorative Care Pathway and the End-of-Life Pathway are outlined in subsequent sections.

Requirement	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). **Note:** Claims for care management, for any quarter, must be finalised within 60 days from the end of the financial year.
Service date	The service delivery date being claimed for cannot be in the future.
Frequency	Claims can be submitted up to daily.
Claim amount	Providers must claim the full cost of services delivered within the quarter. The claim amount should align with what has been agreed with the participant and outlined in their care plan and budget 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 9.7.3). Outstanding amounts cannot be added to future claims unless a system error occurred.
Evidence	For most claims, providers are not required to upload evidence at the point of claiming. However, evidence requirements must be uploaded at time of claiming for specific assistive technology and home modifications claims. More information is in section 16.6.
Exits	For participants ceasing access to services, claims must be finalised within 60 days from the participant's exit date, unless an exception is approved.
Exceptions process	Providers must finalise claims for the previous quarter within 60 calendar days of the start of the new quarter (or 60 calendar days after the conclusion of short-term

Requirement	Details
	care). Claims for care management, for any quarter, must be finalised within 60 days from the end of the financial year. If a provider cannot meet this timeframe, they may request an exception to submit a late claim after day 61 of the new quarter (or 61 days the conclusion of short-term care). A request for a claiming exception will be sent to a Services Australia delegate and may be approved under the following specific circumstances: • Staff leave, including personal, sick, annual, maternity, long service, compassionate, parental, study, volunteering, training, community service and cultural leave. • Staff shortages. • IT and software issues including but not limited to system outage, system maintenance, system upgrade and power outage. • Cybersecurity and data breach issues. • Database and/or data warehouse issues including but not limited to data latency, data quality and accuracy, data integration, historical data validation, data downtime, data modelling and change management. • Subcontractors, third-party vendors, associate providers and/or participants submitting evidence late i.e., late invoicing from subcontractor. • Unforeseen, uncommon, exceptional and/or extenuating circumstances such as natural disaster, border restrictions, disease outbreak and death. • Unforeseen, unusual, exceptional, and/or extenuating circumstances regarding Aboriginal and Torres Strait Islander individuals and community such as Sorry Business, First Nations community unrest, influx of people from another community and any other extenuating circumstances. • Administrative error by the Commonwealth including but not limited to incorrect processing

Requirement	Details
	information, incorrect payment amount, incorrect advice, interface issues with different portals. • Complex home modifications where the participant dies unexpectedly in the middle of the build or has a significant health deterioration and enters residential aged care in the middle of the build. Claims may be submitted more than 60 days after the date of such events to allow for remaining works to be completed. *Note: the home modifications account will close after the final claim is submitted. In the above circumstances, home modification claims must still be finalised within the tier timeframe i.e., 12 months + 60 days or 24 months + 60 days at the latest.* • Any other circumstances that are not applicable to any of the exceptions listed above. Providers must retain evidence as to why the exception is required under any specific circumstances listed above. **Note:** for Aboriginal and Torres Strait Islander cultural leave and any extenuating circumstances regarding Aboriginal and Torres Strait Islander individuals, providers do not need to retain evidence to request claiming exceptions.
Audit or review	Provider claims may be flagged for review based on analysis of claim data at the provider, participant and transaction level to identify unusual claiming behaviour. For short term service claiming, high percentages of non-allied health or non-nursing service claims (in restorative care) or high levels of care management (for the Restorative Care Pathway or End-of-Life Pathway) may be flagged for review.
Cancellations and no shows	For participant initiated cancellation or no shows, a provider can claim for a service, provided it meets the requirements outlined in section 10.8. Providers must be able to provide evidence to support the claim and this should include the cancellation and no show policy in their service agreement.

16.4.1 Claiming for care management

The table below outlines **additional claiming requirements specific to claiming for care management services**.

Care management requirement	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 to claim for care management services. Claims for care management, for any quarter, must be finalised within 60 days from the end of the financial year. Claims against the care management account are subject to all other submission and claiming rules outlined in sections 16.3 and 16.4.

16.4.2 Claiming for AT-HM

The table below outlines **additional claiming requirements specific to claiming for AT-HM services and supports**.

AT-HM requirements	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 may also include prescription, wrap-around services, assistive technology 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.

AT-HM requirements	Details
Timeframe	Providers can submit a claim for payment at any time following the delivery of the assistive technology or home modification. All claims must be finalised 60 days after the AT-HM funding period has ended.
Prescription	Providers can submit a claim for the cost of a health/allied health professional to prescribe AT-HM. This can be claimed prior to the claim for the AT-HM product, equipment or home modification.
Price for assistive technology	The price claimed for the assistive technology items should match the invoice or other evidence provided. If a provider is required to submit a claim to access assistive technology funding 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/s and any conditions • whether the item or items are purchased or loaned.
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 **HCP Commonwealth unspent funds** account, if available. Otherwise, claims for repairs and maintenance should be claimed from the relevant Assistive Technology funding source. If no HCP Commonwealth unspent funds are available, and assistive technology funding has been exhausted, the provider can submit a request for a Support Plan Review.
Submission and rules	Claims against the Assistive Technology and Home Modification accounts are subject to all other submission and claiming rules outlined in sections 16.3 and 16.4.

AT-HM requirements	Details
Evidence	Providers must retain all invoices and/or receipts for services and products claimed under the AT-HM scheme. For prescribed AT-HM, additional evidence may be required and this is outlined in section 13.7 and section 16.6. Where quotes have been provided these should also be retained.

16.4.3 Claiming for the Restorative Care Pathway

The table below outlines **additional claiming requirements specific to claiming for the Restorative Care Pathway.**

Restorative care requirements	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: • 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	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

Restorative care requirements	Details
	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 16.3 and 16.4.

16.4.4 Claiming for the End-of-Life Pathway

The table below outlines **additional claiming requirements specific to claiming for the End-of-Life-Pathway.**

End-of-life requirements	Details
Funding source	Funding for end-of-life services will be drawn from the **End-of-Life budget account**.
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.

End-of-life requirements	Details
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 16.3 and 16.4.

16.4.5 Transitioned HCP care recipients and claiming from the HCP Commonwealth unspent funds account

Transitioned HCP care recipients who had unspent funds at the commencement of Support at Home retained these funds for use under Support at Home.

Providers will need to submit their claim for services delivered and Services Australia will automatically draw-down from a participant's HCP Commonwealth unspent funds, where required. 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.

For ongoing services, the Restorative Care Pathway and the End-of-Life Pathway, the order of funding draw-down for claiming is:

1. Participant quarterly budget or restorative care budget or end-of-life budget.
2. Provider held HCP Commonwealth unspent funds.
3. HCP Commonwealth unspent funds held in the home care account (this account is managed by Services Australia).

For AT-HM, HCP Commonwealth unspent funds must be used, if available, before AT-HM funding tiers are accessed. For AT-HM, Services Australia will automatically draw-down funding in the following order:

1. Provider held HCP Commonwealth unspent funds.
2. HCP Commonwealth unspent funds held in the home care account.
3. Assistive Technology and/or Home Modifications budget.

Services Australia will draw down on the provider held HCP Commonwealth unspent funds in the abovementioned circumstances. When this happens, a subsidy will not be paid to the provider.

Services Australia will cease draw down from the participant's HCP Commonwealth unspent funds once the respective balance of funds have been exhausted.

16.5 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. There may be circumstances where the same service may be claimed under different programs on the same date (e.g., a participant receives the service of nursing from a Support at Home provider in the morning and then also receives nursing from a residential respite provider in the afternoon). This should only occur on the entry and exit dates.
5.	Where a participant exits Support at Home and enters residential aged care on the same day, services from both programs can be claimed on the residential aged care entry date, regardless of whether they are the same services or not. Providers have 60 days after the participant enters

No	Description
	permanent residential aged care to claim for services up to, and including, the entry date. **Note:** A client may be approved to access both Support at Home and residential aged care, however a client cannot be entered into Support at Home and residential aged care at the same time.
6.	Any extra validation rules for services or service types must also be met.

16.6 Evidence requirements for claiming

While not required to be uploaded at the point of claiming, providers must retain and be able to provide records or evidence to support claims and ensure compliance with program guidelines. Providers must be able to provide documentation that demonstrates:

- that the price for care and services was agreed, for all participants (as outlined in section 10.3.1)
- confirmation of delivery of care and services, for all participants (as outlined in section 10.5)
- that the price for assistive technology and home modifications was agreed, for all participants (as outlined in section 13.7.1)
- confirmation of delivery of assistive technology and home modifications, for all participants (as outlined in section 13.7.2).

There are specific evidence requirements to support claims under the Assistive Technology and Home Modifications scheme, and these are outlined in section 16.6.1.

16.6.1 AT-HM evidence requirements for claiming

There are specific evidence requirements for claiming for assistive technology and home modifications services. These are outlined in the table below.

AT or HM funding tier	Evidence requirements
Low & medium	Evidence is not required to be uploaded at time of claiming however, should be retained as part of record keeping requirements.
High	Certain evidence is required to be uploaded at time of claiming for all high tier assistive technology and home

AT or HM funding tier	Evidence requirements
	modification claims, including prescription (where applicable).

The type of acceptable evidence includes:

- an invoice or receipt
- a prescription for assistive technology where applicable and all home modifications items
- a quote for items claimed under *home modifications products* if 'first payment for this item' is indicated in the claim.

16.7 Varying a claim

At times, a provider may need to amend or vary a claim that has already been submitted. This may occur when the original claim amount was inputted incorrectly. For example, the provider submitted a claim for a service with a price of $10 but on review, the provider realised they should have claimed a service price of $100.

Providers can vary claims through the Aged Care Provider Portal by selecting the item previously claimed and paid. The provider will need to resubmit the claim with the correct information and Services Australia will calculate the subsidy payable or recoverable, based on the variation.

17.0 Monthly statements

This chapter covers:

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*:

- Section 155.

The Aged Care Rules 2025:

- Sections 155-40 and 155-45 (Monthly statements) of the Rules

The strengthened Quality Standards are relevant throughout this program manual as a whole and providers should familiarise themselves with them.

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 services.

17.1 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 registered 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 cessation of services.

Note: For restorative care and end-of-life classifications, and where funded aged care services are still being delivered through an ongoing classification, a final monthly statement is not required. The provider will continue to deliver regular monthly statements to the participant and this should include information about services delivered under the Restorative Care Pathway or End-of-Life Pathway.

Statements 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.

17.2 Inclusions for the monthly statement

The table below outlines what information must be **itemised in the monthly statement**.

To support providers, a monthly statement template is available on the department's website at Support at Home monthly statement template.

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.
	• The total of HCP unspent funds (for transitioned HCP care recipients) including:
	  ○ the Commonwealth-held HCP Commonwealth unspent funds
	  ○ the provider-held HCP Commonwealth unspent funds
	  ○ the participant portion HCP unspent funds (held by the provider).
	
	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 home modifications funding available to the participant for the allocation (12-month) period. • The amount of assistive technology and home modifications funding available in the participant's assistive technology account and 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 assistive technology item has been ordered, it should show as a commitment for that month. • The amount of assistive technology and 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.

Inclusions	Details

Services delivered	• Itemised list of each episode of service (excluding care management) 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.
	• The number of hours or units of each service delivered.
	• The amount of government subsidy paid to the provider for each service delivered.
	• Indicate any services or items delivered by third-party suppliers.
	• Any AT-HM services or items purchased or delivered or committed.
	• For ongoing classifications, the total number of hours or units of care management delivered. For participants receiving the Restorative Care Pathway and End-of-Life Pathway, the price charged by the provider and amount of government subsidy paid to the provider for care management.

Participant contributions	• The contribution amount 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 payable by 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 for AT-HM. • Any funding that expired during the calendar month for AT-HM.

Part F: Program linkages

This section covers:

- Interactions with other programs and schemes
- Business and Workforce Advisory
- Service Development Assistance Panel

18.0 Interactions with other programs and schemes

18.1 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 govern how the Support at Home program interacts with other programs. As providers of services under the program, providers must comply with these laws.

Find more information about the participant programs on the My Aged Care website. Participants can also call the My Aged Care Contact Centre on **1800 200 422**.

18.2 CHSP and Support at Home

The Commonwealth Home Support program (CHSP) provides entry-level support to help older people continue to live safely and independently at home and in their communities. It is available to people aged 65 years and over, and Aboriginal and or Torres Strait Islander people aged 50 years and over. The CHSP is suitable for people who can live independently at home but may need small amounts of support.

The 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. However, in certain circumstances Support at Home participants may need to access specific and time-limited services through the CHSP. These circumstances and services are outlined in section 18.2.1.

CHSP providers should only provide services to Support at Home participants where they have capacity to do so without disadvantaging current or potential CHSP clients. When providing services to Support at Home participants, normal CHSP service delivery requirements and the process for getting services apply. This means:

- All Support at Home participants must be assessed through My Aged Care for approval to access the additional CHSP services.
    - HCP transitioned care recipients who have previously been approved to access CHSP social support group activities do not need to be reassessed.
- The CHSP provider must accurately report the services delivered in DEX as they would with any other client.

- CHSP providers must regularly review a client's progress against their individual goals and should refer the client to their most recent assessment organisation for a Support Plan Review or reassessment if their needs change.

More information on the CHSP is available via the Commonwealth Home Support Program (CHSP) 2025-27 Manual.

18.2.1 Access to CHSP for Support at Home participants

The table below outlines the specific circumstances where a Support at Home participant can simultaneously access CHSP services.

Circumstance		Description	Time-limited*
1	Pre-existing CHSP social support group	Support at Home participants who have transitioned from the CHSP may **continue to access their pre-existing CHSP social support group** through the social support and community engagement service type on an ongoing basis to allow the continuity of social relationships. This only applies to participants attending a pre-existing CHSP social support group service.	No
2	Hoarding and Squalor	Support at Home participants who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need, can access **Hoarding and Squalor services through the CHSP** (in addition to their Support at Home funding) via reassessment.	Yes
3	Community and centre-based respite, flexible respite and Cottage respite	Support at Home participants may access additional planned **respite services** through the home or community general respite service or Community cottage respite.	No
4	Emergency access	In emergency situations, where a Support at Home participant has an **urgent and immediate health or safety need**, and their individualised budget has been fully allocated** or they are waiting for their budget allocation, some additional CHSP services can be accessed on a short-term basis.	Yes

Circumstance		Description	Time-limited*
		These instances must be time limited, monitored and reviewed.	
5	Specialised support services (vision advisory services)	Support at Home participants may access **vision advisory services** under **Specialised Support Services** on an ongoing basis to receive the aged care supports they need.	No
*Short-term and time limited will depend on the specific circumstances and needs of each individual. As a guide, up to 2 months would be considered a short-term period. CHSP providers have a responsibility to regularly review a client's progress against their individual goals and should refer the client to their most recent assessment organisation for a Support Plan Review or reassessment if their needs change. **An individualised budget is fully allocated when a participant has **planned** to use all available funding, even if the individualised budget has not been fully expended.			

18.2.2 Cottage respite under CHSP

The service type 'cottage respite' can only be accessed through CHSP and is not available under Support at Home. However, the table in section 18.2.1 outlines that Support at Home participants can access cottage respite.

To access cottage respite as an additional CHSP service, the Support at Home participant must have a relevant referral. This can be accessed via a Support Plan Review and should include details about the need for cottage respite. Alternatively, an urgent referral for cottage respite can be issued by calling the My Aged Care Contact Centre on 1800 200 422. If approved, the participant can access cottage respite through a CHSP provider.

18.2.3 Contributions for specific CHSP services

For services outlined in section 18.2.1, Support at Home participants must pay regular CHSP client contribution fees. These client contribution rates are subject to government subsidisation. Support at Home participants will need to fund the client contribution fees themselves and cannot use their Support at Home funding allocation.

18.3 Transition Care Programme (TCP) and Support at Home

The Transition Care Programme (TCP) provides time-limited, goal-oriented and therapy-focused services to older people after a hospital stay. TCP aims to enhance

the functioning and independence of older people after their hospital episode, and where possible, delay a person's entry into ongoing funded aged care services, including residential aged care.

Support at Home participants can access TCP after a hospital stay if they are assessed and approved as eligible by an aged care assessor. Support at Home services can continue to be accessed while accessing TCP, as long as the services are not duplicative. For example, an older person may elect to continue receiving gardening services under Support at Home in order to maintain a safe home environment, while they receive other services under TCP.

It is the responsibility of the participant to notify their Support at Home provider of their intention to enter transition care. It is expected that the participant's Support at Home provider and the relevant transition care provider will discuss and coordinate care provision to ensure the participant's needs are met. During this period Support at Home providers can claim care management services for activities related to coordination and consultation with TCP stakeholders. For example, liaising with the social worker or allied health professionals regarding in-home aged care service delivery when a participant is discharged from hospital or TCP.

Note: Individuals receiving, or are eligible to receive TCP, cannot be approved to access the Restorative Care Pathway.

While a delegate can make an approval for transition care while an individual is accessing the End-of-Life Pathway, the assessor and delegate should consider the individual's circumstances as to whether accessing TCP is the right approach for the individual. If this scenario was to occur, the services delivered must not be duplicative.

More information on TCP is available on the department's website at Transition Care Programme.

18.4 Residential aged care and Support at Home

At times, Support at Home participants will need to access temporary respite in a residential care home or will move permanently to residential aged care.

Support at Home services can continue to be accessed while accessing temporary respite in a residential care home, as long as the services are not duplicative. For example, an older person may elect to continue receiving gardening services under Support at Home in order to maintain a safe home environment, while they receive other services in temporary respite.

It is the responsibility of the participant to notify their Support at Home provider of their intention to access temporary respite in a residential care home. It is expected

that the participant's Support at Home provider and the relevant residential care home provider will discuss and coordinate care provision to ensure the participant's needs are met. During this period Support at Home providers can claim care management services for activities related to coordination and consultation with the residential care home. For example, liaising with allied health professionals regarding in-home aged care service delivery when a participant returns home from temporary respite.

Permanent residential aged care services cannot be accessed at the same time as Support at Home. The only exception to this is on the participant's entry and exit day whereby Support at Home services can still be provided to ensure the participant is supported to transition from home or back to their home.

Where a participant foresees that they will need to permanently move to a residential care home, their Support at Home service provider is responsible for discussing this move with them and mutually agreeing on a cessation date. At times, entry to permanent residential aged care is unforeseen. Providers must work alongside participants to appropriately support and manage the cessation of services.

Support at Home service providers are also encouraged to create linkages with hospitals and residential aged care providers in their region to support continuity of care for the participant.

More information is available on the department's website at Residential aged care.

18.5 Multi-Purpose Service (MPS) Program and Support at Home

The Multi-Purpose Services (MPS) Program is a specialist aged care program under the Act. It provides integrated health and aged care services for older people living in small communities in rural and remote areas that cannot support stand-alone aged care and health services. MPS providers typically provide their services from a place co-located with a state or territory government hospital or other state or territory funded health service.

MPS providers delivering aged care services under the MPS Program must be able to deliver residential aged care. Some MPS providers will also provide aged care services in the home or community.

Different funding arrangements are in place for the MPS Program, with providers funded through block-funding arrangements. The contributions that an individual can be asked to make are also different.

A participant may access both the MPS and Support at Home at the same time, provided the same services are not accessed on the same day. For example, a

participant could access gardening and meals through Support at Home and nursing care via the MPS Program.

More information about the MPS Program is available on the department's website.

18.6 Aboriginal and Torres Strait Islander aged care services

The Aboriginal and Torres Strait Islander Aged Care Framework establishes a vision for older Aboriginal and Torres Strait Islander people to age well by having their spiritual, physical and mental health needs met through holistic, high-quality and culturally safe aged care.

This Framework:

- promotes wellbeing
- delivers trauma aware and healing informed responses
- empowers connection to culture, family, community and Country or Island Home
- provides a roadmap to build a more culturally safe, accessible aged care system with more First Nations providers and workers.

18.6.1 National Aboriginal and Torres Strait Islander Flexible Aged Care Program

The National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) Program is a specialist aged care program under the Act which supports the provision of culturally safe aged care to meet the needs of older Aboriginal and Torres Strait Islander peoples, allowing them to remain close to home and community.

Under the NATSIFAC Program, providers deliver a mix of residential, home and community care services in accordance with the individual's assessed care needs, and the needs of the community. Services may be provided on a permanent (ongoing) or short term (non-ongoing) basis, as well as to support emergency needs.

To support this flexible service delivery model, the NATSIFAC Program is block funded. This means individuals accessing care under the program do not have allocated budgets.

Arrangements for care recipient contributions are also variable and take into account the capacity of individuals to contribute toward the cost of the services delivered to them.

In general, in-home care services must not be provided to individuals who are receiving other similar government-subsidised services. However, individuals may

access both the NATSIFAC Program and Support at Home at the same time, provided the services accessed under the programs are different. For example, a participant could access gardening through Support at Home and personal care via the NATSIFAC Program.

More information is available on the department's website at National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

18.6.2 Elder Care Support and Support at Home

The Elder Care Support (ECS) program provides face-to-face support to assist Aboriginal and Torres Strait Islander people navigate and access aged care services and provide referrals to other services as necessary, including health and disability supports.

Aboriginal and Torres Strait Islander people wanting to access aged care services, including Support at Home services, can be assisted by a trained, culturally safe Elder Care Support worker. This support will assist them to understand aged care services that may be available to them and help them access those services.

The National Aboriginal Community Controlled Health Organisation (NACCHO) delivers this program through their partner organisations across the country.

More information about the ECS program is available via:

- the department's website Elder Care Support
- Elder Care Support organisations
- on the NACCHO website
- contacting the NACCHO Aged Care Programs team at agedcare@naccho.org.au.

18.7 Disability Support for Older Australians (DSOA) Program and Support at Home

The Disability Support for Older Australians (DSOA) Program is now closed and is no longer accepting new clients. Older people who are not current DSOA clients but are seeking disability support should contact My Aged Care to find out what programs or services may be available to them.

The DSOA program supports clients who:

- were 65 years or over when the National Disability Insurance Scheme (NDIS) commenced in their region, or
- were an Aboriginal or Torres Strait Islander person aged 50-64 years when the NDIS commenced in their region, and

- were assessed as ineligible for the NDIS, and
- were an existing client of state or territory government specialist disability services at the time the NDIS commenced in their region.

If a DSOA client is found eligible and/or accesses aged care services, it may impact their DSOA funding. Depending on the aged care service, a client's funding may be capped, or they may be required to exit the DSOA Program.

More information about the DSOA Program is on the department's website.

18.7.1 Transition between DSOA and Support at Home

The way DSOA works with the Support at Home program is the same as how it worked with the Home Care Package Program and the Commonwealth Home Support Program (CHSP). That is:

- If a client is found eligible for Support at Home, their DSOA funding will be capped.
- If a client is assigned a Support at Home classification and commences services, they will be required to exit the DSOA Program from the date aged care services commenced. These dates will be verified through My Aged Care.
- If a client commenced their Home Care Package prior to 1 July 2021, they can continue in the DSOA Program. However, their DSOA funding will remain capped.
- If a client commenced CHSP services that are available through the DSOA program, they will be required to exit the DSOA Program from the date the aged care services commenced. These dates will be verified through My Aged Care. However, if a client commenced CHSP services, that are not available via the DSOA program, **prior to 30 June 2021**, the client can continue to access these services as a grandfathered support without any impact to their DSOA funding.

18.7.2 Avoid duplication of service

If a DSOA client is assessed as eligible for Support at Home and commences services, they will be required to exit the DSOA Program from the date aged care services commenced. These dates will be verified through My Aged Care.

Further information on how aged care services work with the DSOA Program is available in the DSOA Program Manual.

18.8 Aged care volunteering

Volunteering in aged care plays a vital role in supporting older people who choose to age in place and remain living independently in their own homes. Volunteers provide meaningful support that enhances wellbeing, independence, and connection to community.

The department has developed a comprehensive suite of resources to support providers and volunteer managers to attract, onboard, train, recognise and support volunteers. The resources also include:

- Promotional materials – Free downloadable volunteer postcards and posters to help attract new volunteers
- Provider requirements – responsibilities and obligations for engaging volunteers in aged care
- Volunteer stories – inspiring accounts from volunteers and volunteer managers
- Information booklets and FAQs – resources for volunteers, including a Frequently Asked Questions flyer and a booklet on volunteering in aged care.

More information is on the department's website at Volunteering in aged care.

18.8.1 Aged Care Volunteer Visitors Scheme

The Aged Care Volunteer Visitors Scheme (ACVVS), formerly known as the Community Visitors Scheme, supports volunteer visitors to make regular visits to older people who are socially isolated or lonely, particularly those from linguistic, cultural and diverse backgrounds.

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.

Support at Home participants can access ACVVS without any impact on their service provision. Older people who are approved or on the Support at Home National Priority System can also access ACVVS.

More information about ACVVS is on the department's website.

18.9 Continence Aids Payment Scheme

The Continence Aids Payment Scheme (CAPS) is an Australian Government scheme that provides a payment to eligible people with permanent and severe incontinence to assist with a portion of the costs of their continence products.

Eligibility for CAPS has changed and Support at Home participants are not eligible for CAPS.

From 1 November 2025, there will be no **new** CAPS approvals for anyone who is a Support at Home participant. Transitioned HCP care recipients with an **existing** approval for CAPS can continue to receive CAPS funding until February 2026 as long as they are not also accessing continence aids through Support at Home.

From February 2026, CAPS eligibility will end for all Support at Home participants and they will no longer be able to receive continence products through the CAPS. Rather, providers should assist Support at Home participants to obtain continence products through state-based continence aids schemes. If state-based assistance is not available, participants can purchase continence products through their Support at Home funding.

For more information on state-based continence aids schemes, see section 18.9.1.

For more information on continence aids under Support at Home, see section 18.9.2.

18.9.1 State-based continence aids schemes

Most Australian states and territories operate continence aids schemes for their residents. There are differences in program design, funding availability and eligibility across these schemes.

Any state-based continence products schemes that can meet the needs of a participant should be used in favour of funds from their Support at Home budget, where the participant is eligible for that scheme.

If a state-based continence product aid scheme is unable to meet the needs of the participant, then Support at Home funding may be used. More information on using Support at Home funding to purchase continence aids is in section 18.9.2.

18.9.2 Continence aids under Support at Home

If a participant is eligible for nursing (as outlined on their Notice of Decision and support plan), continence aids can be purchased using the service ‘nursing care consumables’ under the service type ‘nursing’.

Transitioned HCP care recipients, who have not been reassessed under Support at Home, are eligible to access any service on the Support at Home service list. This includes the purchase of continence aids.

Reusable continence products and equipment that assists with continence management (e.g., waterproof sheets, incontinence alarms) may be accessed through the Assistive Technology and Home Modifications (AT-HM) scheme. For more information on the AT-HM scheme, see chapter 13.0.

Note: There are no participant contributions for continence aids as this falls under the clinical supports category which is fully funded by the government.

18.9.3 National Continence Helpline

A major resource of support for carers is the National Continence Helpline, run by Continence Health 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 8.00am to 8.00pm, Monday to Friday on 1800 33 00 66.

18.10 Hospital in the Home and Support at Home

Hospital in the Home (HITH) allows a range of clinical conditions to be safely and effectively managed without a person needing to be in hospital.

Participants can receive both HITH and Support at Home services at the same time or they may choose to only access HITH or only access Support at Home.

If HITH and Support at Home are accessed concurrently, services cannot be duplicated. This means that where a person is receiving nursing services through HITH, they cannot receive nursing services through Support at Home. While services cannot be duplicated, the person can access different services such as cleaning, gardening, or meal preparation through Support at Home.

The provider of each service should ensure services are not duplicated.

19.0 Additional services

19.1 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 about BWAS is on the department's website.

19.2 Service Development Assistance Panel

The Rural, Remote and First Nations Aged Care 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 about SDAP is on the department's website.

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 Worker	Refer to sections 11(4) and (5) of the *Aged Care Act 2024* for a definition of an aged care worker.
Aged Care Volunteer Visitors Scheme (ACVVS)	A Commonwealth-funded program matching a volunteer visitor to an eligible care recipient who is lonely or at risk of social isolation to provide friendship, social connection and companionship.
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 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.
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 Program (CHSP)	CHSP 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.
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, Disability and Ageing.
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.
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.
Entry notification	Submitted via the Aged Care Provider Portal, the entry notification is the process of notifying Services Australia of new participants entering care, or changes to existing participants' circumstances.

Term	Meaning
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 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 care recipients will be no worse off under the contribution arrangements for Support at Home. Also refer to the definition for *transitioned HCP care 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 • 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

Term	Meaning
	people to remain living at home. The Home Care Packages Program ceases on 31 October 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.
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.
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 national scheme that will enable eligible Support at Home participants to loan 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 care recipient will be no-worse off under Support Home and will not make higher

Term	Meaning
	participant contributions than they did under the Home Care Packages program. This applies to grandfathered HCP care 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 Home Care Package.
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 suitably qualified health professional.
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*.
Registered supporter	A person registered as a supporter of an older person under section 37 of the *Aged Care Act 2024*.
Residential aged care	This program provides high levels of care to people in a residential aged care home.

Term	Meaning
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 16 weeks of intensive allied health and/or nursing services (through a multidisciplinary team) and supports aimed to help the participant regain function.
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 who provides care management for participants in the Restorative Care Pathway.
Rules	The Rules refer to the subordinate legislation of the *Aged Care Act 2024*.
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	Refer to section 7 of the *Aged Care Act 2024* for a definition of service agreement.
Service Delivery Branch	The place of business of the registered provider through which funded aged care services are delivered to an individual. A provider must have a service delivery branch to claim for services delivered and receive subsidy from Services Australia.
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.

Term	Meaning
Specified need	Refers to participants who require ongoing assistive technology funding for the essential maintenance of their assistance dog.
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.
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 commencement of the program.
Volunteer	A person who willingly gives their time without financial gain to support older people receiving funded aged care services.

Start a conversation about aged care

Transforming aged care laws to put the rights of older people first.

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Phone **1800 836 799** (My Aged Care service provider and assessor helpline)

For translating and interpreting services, call 131 450 and ask for 1800 836 799.
To use the National Relay Service, visit nrschat.nrscall.gov.au/nrs to choose your preferred access point on their website, or call the NRS Helpdesk on 1800 555 660.