Australian Government

Department of Health, Disability and Ageing

Transition Care Program Guidelines

December 2025

Version History

DATE	Summary of Change
October 2025	V1 – New Guidelines to correlate with the new *Aged Care Act 2024* (Cth) and Aged Care Rules 2025.
November 2025	V2 – Links updated.
December 2025	V3 – Text and formatting updates.

FOREWORD

The Transition Care Program Guidelines have been developed by the Australian Government in consultation with all States and Territories.

The guidelines are a resource for the State and Territory governments, in their oversight role in managing the Transition Care Program in their respective jurisdictions, as well as registered providers delivering transition care to individuals, officers of the Department of Health, Disability and Ageing, and other interested parties.

The guidelines explain the Australian Government's policy context and operational requirements for the Transition Care Program, including the clarification of responsibilities of the State and Territory governments, and the registered providers under the *Aged Care Act 2024* and Aged Care Rules 2025 which govern the operation of the program. Users of these guidelines should be aware that State and Territory governments, may develop jurisdiction-specific operational guidelines to complement the national guidelines.

We trust you will find these guidelines a valuable tool to assist in the provision and operation of transition care.

Australian Government Department of Health, Disability and Ageing

November 2025

CHAPTER 1 ABOUT THE GUIDELINES

These guidelines provide general information about the Transition Care Program (**TCP**). The guidelines are linked to the *Aged Care Act 2024* (the **Act**) and the Aged Care Rules 2025 (the **Rules**) and, where relevant, the *Aged Care (Consequential and Transitional Provisions) Act 2024* (the **Consequential and Transitional Provisions Act**) through a Transition Care Program Agreement (**TCP Agreement**) between the Australian Government and each State or Territory government. Compliance with the guidelines is a requirement under the TCP Agreement.

The guidelines should be read in conjunction with the Act, the Rules and the Consequential and Transitional Provisions Act where relevant. Further information about the TCP or clarification of the guidelines can be sought from the Australian Government Department of Health, Disability and Ageing (the **Department**), or the relevant State or Territory governments who oversee and manage the delivery of transition care by registered providers in their jurisdiction. These guidelines do not constitute legal advice.

1.1 What the guidelines contain

The guidelines explain the Australian Government's policy context and operational requirements for the provision of transition care.

1.2 How the guidelines will be updated

The Department will update the guidelines, as required, in consultation with States and Territories, to ensure their currency and accuracy.

Please refer to the online version of the guidelines located on the Department's website to ensure you have the most recent version. The footer of each page includes the issue date of the guidelines.

1.3 Feedback

The Department and all State and Territory governments welcome any comments on the guidelines. Please provide any comments via email to TCP@health.gov.au.

CHAPTER 2 INTRODUCTION

2.1 Transition care in brief

Transition care is a **specialist aged care program** under section 7 of the Act. It provides short-term care to optimise the functioning and independence of older people after a hospital stay. Transition care is goal--oriented, time-limited and therapy focused. It provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support and/or personal care to maintain and improve physical and/or cognitive functioning.[1] Whilst available to eligible permanent residents of residential care homes, the program seeks to enable older people, where possible, to return home after a hospital stay rather than prematurely enter residential aged care.

Transition care facilitates a continuum of care for older people who have completed their hospital episode, including acute and subacute care[2] (e.g. rehabilitation, geriatric evaluation and management), and who may benefit from restorative care and more time and support to make a decision on their long-term aged care options if needed.

The program is not intended to be a "holding" program for people awaiting placement in a residential care home or a residential Multi-Purpose Service. The primary function of the program is therapeutic.

2.2 Roles and responsibilities within the Transition Care Program

Six key entities have roles and responsibilities within the program:

- the Australian Government;
- State and Territory governments;
- transition care registered providers who are nominated by State or Territory governments to deliver transition care;
- assessment organisations (who conduct aged care needs assessments for in-home aged care, specialised aged care programs, residential respite and entry into residential aged care);
- hospitals; and
- individuals receiving transition care.

The roles of the Australian Government and State and Territory governments are outlined below. For the other entities, see sections *3.3 The role of hospitals*, *3.4.1 Assessment: the roles of the clinical aged care needs assessor*, *3.5.2 The registered provider*, and *5.3 Individual responsibilities,* of these guidelines.

2.2.1 Australian Government

The Australian Government's roles and responsibilities in relation to the program are to:

- develop and implement national policies to meet the objectives of the program in partnership with the State and Territory governments;
- administer the program in partnership with the State and Territory governments, including the development of operating guidelines;
- allocate transition care places;
- provide a subsidy under the Act to each occupied transition care place, for care and services provided;
- collaborate with State and Territory governments in the evaluation of the program and reporting of transition care data; and
- provide strategic direction.

2.2.2 State/Territory governments

State and Territory Governments' responsibilities in relation to the program are broadly defined as follows:

- in partnership with the Australian Government, develop and implement policies;
- plan, manage and monitor the allocation of places within their jurisdiction;
- collaborate with the Australian Government in any review or national evaluation of the program that may occur from time to time;
- as co-funders of the program, provide proportionate funding towards the operation of the program;

[1] A detailed list of services relevant to the TCP is in the Aged Care Service List (Chapter 1 of the Aged Care Rules 2025*)* and a copy of this is provided at *Attachment A.*

[2] Definitions for acute care and subacute care are included in the glossary at the end of these guidelines.

- use reasonable endeavours to ensure that any nominated registered providers comply with the Transition Care Guidelines and Transition Care Restorative Care Requirements; and
- monitor system-level performance of the TCP to inform strategic policy advice and the management and allocation of TCP places.

2.2.3 Registered Providers

Registered providers are responsible for meeting all registered provider obligations and responsibilities under the Act and Rules. The use of sub-contractors or associated providers does not negate these legal obligations.

Registered provider responsibilities in relation to the program are broadly defined as follows:

- manage the day-to-day operation of their TCP service;
- ensure quality care is provided in accordance with the Aged Care Quality Standards under Chapter 1 of the Rules;
- manage complaints and where necessary cooperate with the Aged Care Quality and Safety Commission (**the Commission)** or the relevant complaints body in their jurisdiction;
- comply with the requirements of the Serious Incident Response Scheme (**SIRS**); and
- collect and report data to the Commonwealth as required.

Registered providers will be audited by the Commission to monitor for compliance with the Aged Care Quality Standards, as part of the Commission's ongoing and periodic audit program. Where local health networks within a State or Territory are the registered providers of TCP services, they will be subject to the site audits to be conducted by the Commission. Where services are further sub-contracted out to associated providers, registered providers will be responsible for the quality, safety and compliance of the services delivered by associated providers.

Further information on registered provider and associated provider responsibilities in relation to compliance and audits can be found on the Commission's website at Regulatory Bulletin RB 2025-1 Associated providers | Aged Care Quality and Safety Commission, and in Chapters 6 and 7.

Registered providers must maintain appropriate insurance while providing transition care services and be aware of any relevant State or Territory legislation regarding insurance requirements and standards that may affect the delivery of transition care services.

Registered providers must also comply with the provisions of any relevant statutes, regulations, by-laws and requirements of the Australian Government, State or Territory government, or local authority.

2.3 Allocation of transition care places

The Australian Government and State and Territory governments have clearly defined roles in relation to the allocation of transition care places.

The Australian Government will determine the number of places available to be allocated to entities for delivering transition care and how many of these places must be used to deliver transition care in a specified State or Territory (section 94 of the Act).

The Departmental delegate may decide whether to allocate transition care places to an entity once the Minister has determined there are places for allocation (section 95 of the Act).

The Department can invite State or Territory governments to apply on their own behalf or on behalf of another entity (the nominated entity) for an allocation of TCP places in their jurisdiction (section 95-5 of the Rules). This application must be made as per the criteria in section 95-10 of the Rules. It must specify:

- whether the application is being made on an entity's own behalf or on behalf of a nominated entity to which the place is to be allocated;
- the number of places applied for;
- the number of those places that will be used to deliver funded aged care services to Aboriginal or Torres Strait Islander persons; and
- the area or areas in which the places will be used to deliver funded aged care services.

For each area specified in the application where TCP will be delivered, the application must also specify:

- the number of persons[3] residing in the area or areas who are aged at least 70, other than Aboriginal or Torres Strait Islander persons;
- the number of Aboriginal or Torres Strait Islander persons residing in the area or areas who are aged at least 50;
- the number of persons mentioned in the above two categories, who are expected to be discharged from hospital;
- the number of persons expected to be discharged from hospital who are also expected to benefit from funded aged care services delivered under the TCP after discharge; and
- if the application is made on behalf of one or more nominated entities to which the places are to be allocated — the nominated entity or entities that will deliver funded aged care services under each place applied for.

Transition care places may be delivered flexibly in either a residential setting, a home/community setting or a combination of both. State and Territory governments have the flexibility to determine the mix of care delivery settings in line with local service capacity (including spare residential setting capacity) and individual needs.

Registered providers may assign or sub-contract out day-to-day care and service provision responsibility to other service providers known as associated providers under the Act.[4] Therefore, associated providers may manage the delivery of transition care on behalf of the registered providers. Where associated providers are assigned responsibility for the delivery of transition care, registered providers remain accountable for ensuring all requirements in the Act and the Rules are met (further information on legislative requirements is in *Chapter 6 Responsibilities of Registered Providers of Transition Care).*

Registered providers cannot exceed the number of transition care places allocated to them. For example, if a provider has been allocated 10 transition care places, it may only claim subsidy for up to ten TCP clients on any given day.

2.3.1 Notice of an allocation decision

Once a decision to allocate transition care places has been made the Department will provide each State and Territory with a notice of decision which must be given to relevant nominated registered providers within 14 days of the delegate making the decision. This will include the following:

- the specialist aged care program (in this case the transition care program) and service groups for which the nominated registered provider of the State or Territory has been allocated places;
- any condition on the allocation of the places; and
- details about when the place takes effect.

2.3.2 Reallocation of TCP places

A State or Territory may apply to the Department for TCP places within its jurisdiction to be reallocated from one nominated registered provider to another under section 97-25 of the Rules. If the State or Territory makes an application to the System Governor, the System Governor may decide to reallocate the places to the other nominated registered provider under section 95(1) of the Act and if the System Governor so decides, the places will come into effect in accordance with section 97-5 of the Rules.

2.3.3 Conditions that apply to an allocated place

An allocation of TCP places under section 99 of the Act is subject to the following conditions:

- the place must only be used by the entity once the entity has become a registered provider and the entity's registration is in effect and covers any funded aged care service delivered under the place;
- the place must only be used by the entity to deliver transition care to an individual when the place is in effect;
- the place must only be used to deliver transition care, to an individual with an access approval in effect with the relevant classification type hospital transition for the service group in which the service is included, and for which the place is allocated;
- the place must only be used to deliver transition care to an individual in the State or Territory for which the place was allocated;
- any other conditions determined by the System Governor under section 99(2) of the Act; and
- any condition prescribed by the Rules.

In accordance with section 99-5 of the Rules, States and Territories must notify the Department if it or a nominated registered provider will not be able to, or does not intend to, use places to deliver transition care for a period of 12 months or more.

[3] The number of persons for an area specified in an application is to be expressed as a whole number per thousand of the total number of persons residing in the area under section 95-10(3) of the Rules.
[4] See definition of Associated Provider under section 7 of the Act.

2.3.4 Varying conditions of allocation

States and Territories may apply to the System Governor to vary conditions of allocation which apply to one or more of their nominated registered providers under section 100 of the Act. The application must be in an approved form and meet the criteria as per section 100(3). In making a decision to vary a condition, the System Governor must consider the factors as set out in section 101 of the Act and 101-5 of the Rules. The System Governor must give notice of a decision to vary conditions, within 14 days of making the decision to the applicant.

To apply for a variation to conditions of allocation for TCP places, please email TCP@health.gov.au.

2.3.5 How to participate in delivering transition care services

Transition care is managed by State and Territory Governments within their jurisdiction, and they will have agreements or arrangements in place with the registered provider/s whom they wish to operate transition care services.

Registered providers will need to meet obligations based on the type of services they deliver. These obligations make providers accountable for the safety and quality of care they provide. Obligations are intended to be proportionate to the environment a provider operates in, the services they deliver and any risks of harm that may be present.

The Find a Provider Tool on the My Aged Care website publishes information on registered providers such as:

- registration categories;
- service types; and
- registration period.

The Commission will monitor providers to make sure their obligations are being met.

2.3.6 Registration categories

There will be six registration categories that group service types based on similar care complexity and risk. This means registration requirements, related provider obligations and regulatory oversight will be linked to these registration categories and be proportionate to the service types being offered.

Providers can register into one or more of the six categories relevant to the type of services they wish to provide or services as required by their current agreements and arrangements for delivering TCP services with the State or Territory Governments.

TCP providers nominated by State or Territory Governments to be registered providers in each jurisdiction from the commencement of the new Act, have had their registrations deemed over by the Commission under all six registration categories. While existing TCP providers will be registered in all categories, this will not require them to deliver services within each category or across all categories (including every service type within a particular category).

Following commencement of the new Act, registration across the categories can be further updated as required by TCP registered providers, for example at the time of the next registration renewal.

Further details regarding each registration category can be located at: How the new aged care regulatory model will work | Australian Government Department of Health, Disability and Ageing.

2.4 Program funding

The Australian Government and States and Territory governments jointly fund the program.

Australian Government funding for transition care is provided in the form of a subsidy for a specialised aged care program under section 247 of the Act and section 249-90 of the Rules. The amount of Australian Government transition care subsidy a registered provider can claim on a day can be found in the Schedule of Subsidies and Supplements for Residential and Transition Care | Australian Government Department of Health, Disability and Ageing. The rate is subject to change from 1 July each year in line with indexation.

Registered providers are also paid the dementia and veterans' supplement equivalent amount, in addition to the basic subsidy amount, all of which together make up the total Australian Government TCP subsidy amount. This additional funding is paid in recognition that registered providers may provide care to veterans with an accepted mental health condition and others with higher care needs associated with dementia.

This is complemented by State and Territory funding contributions which are made by additional direct funding and/or in-kind contributions. The minimum State/Territory contribution is equivalent to one third of the Australian Government's basic subsidy contribution (excluding the dementia and veterans' supplement equivalent amount), noting that some jurisdictions contribute significantly more than this.

To confirm the Australian Government and State and Territory funding contributions towards the program annually, there is an exchange of formal correspondence between the State and Territory governments' representatives and the Australian Government's representative. This is an opportunity to recognise each party's funding contributions that will go to delivering the program in each jurisdiction, taking into consideration annual increases in the Australian Government subsidy rate in line with indexation. The relative proportion of Australian Government and State/Territory funding towards the program are specified in the TCP Agreement.

Registered providers may also request fees from individuals who are able to contribute to the cost of their care (see also sections *5.7 Fees payable by individuals*).

2.5 Management of the Transition Care Program

The State and Territory governments are responsible for planning the model of transition care service delivery based on local needs. Where appropriate, the Department is to be consulted as part of this process.

States and Territories should enter into appropriate arrangements/agreements on the management of TCP service provision with their nominated registered provider/s.

Registered providers of transition care in each jurisdiction are responsible for ensuring they and any associate providers comply with the provisions of the TCP legislation and TCP Agreement.

To meet their responsibilities, registered providers should enter into agreements with any associated providers that mirror the relevant requirements of the TCP Agreement and/or other appropriate arrangements in place with the State or Territory Governments, including compliance with these guidelines.

Registered providers delivering TCP services in both a home/community setting and/or residential care setting will be required to enter into a Client Service Agreement (**service agreement**) with each TCP client. The service agreement will set out key service information including the care and services the client will receive. For existing TCP clients as at 31 October 2025, their existing agreements will be automatically deemed over under the new Act. See Chapter 3, section 3.1 for a summary of the different service types TCP clients will receive from the Aged Care Service List (as at *Attachment A*), in a home/community care setting and residential care setting.

2.6 Relevant legislation

Transition care is legislated by the Act and the Rules.

Registered providers are required to meet all the obligations and conditions specified by the legislation, the TCP Agreement and service agreements in place with TCP clients.

Throughout these guidelines, specific references are made to relevant sections of the Act and the Rules. These documents should be referred to when more detailed clarification is required.

Copies of the Act, the Rules and any amendments to the legislation can be found on the Federal Register of Legislation website.

The table below sets out the parts of the Act relevant to the program and should be read in conjunction with the Rules.

Chapter	Part
Chapter 1 – Introduction	Part 2 – Definitions of transition care program, Aged Care Service List and Aged Care Quality Standards Part 3 – Aged care rights and Aged care principles
Chapter 3 – Registered providers, aged care workers and aged care digital platform operators	Part 4 – Obligations of registered providers etc. and conditions of registration of registered providers
Chapter 4 – Funding of aged care services	Part 2 – Commonwealth contributions Part 3 – Individual fees and contributions

These guidelines should be considered in conjunction with:

- the Act and the Rules;
- the Transition Care Program Agreement;
- State and Territory agreements with any nominated registered providers;
- relevant State and Territory legislation; and
- the service agreements that registered providers enter into with individuals receiving transition care.

2.7 Additional national support

2.7.1 Translating and Interpreting Service (TIS National)

TIS National is an interpreting service provided by the Australian Government Department of Home Affairs for people who do not speak English and for agencies and businesses who need to communicate with non-English speaking clients.

TIS National provides immediate phone interpreting, pre-booked phone interpreting and on-site interpreting services for Australian Government funded aged care programs, including transition care.

TIS National has access to:

- more than 3,000 contracted interpreters across Australia; and
- interpreters speaking more than 160 languages.

TIS National's immediate phone interpreting service is available 24 hours a day, every day of the year for any person or organisation in Australia who needs an interpreter. Registered providers of funded aged care services, including transition care, can use TIS National for free when discussing care needs, fees, care plans and budgets with clients.

TIS National can be contacted through the following channels:

- Online: www.tisnational.gov.au
- General telephone enquiries: 1300 655 820
- Immediate phone interpreting: 131 450
- Email: tispromo@homeaffairs.gov.au

For information on registering with and accessing TIS National, please see the Department's website at: Translating and Interpreting Service (TIS National) for aged care service providers and older people in aged care | Australian Government Department of Health and Aged Care.

2.7.2 My Aged Care

The My Aged Care website is the entry point to access Australian Government funded aged care services and provides information about the types of aged care services available, eligibility for services, referrals to service providers that meet a client's needs, and the contributions they can be asked to pay. The My Aged Care phone line and website can be used to find information about the transition care program. The My Aged Care contact centre can be contacted on 1800 200 422 and its operating hours are:

- Monday to Friday 8am – 8pm
- Saturdays 10am – 2pm
- Sundays and national public holidays – Closed

Additional information can be found at the My Aged Care Website.

2.7.3 Services Australia

Services Australia is responsible for processing the payment of transition care subsidies.

TCP subsidy claims for individuals receiving transition care are processed in accordance with section 260 of the Act and section 260-15 and 260-20 Rules, and the TCP Agreement between the Australian Government and State and Territory governments.

Subsidy claims are lodged monthly by TCP service providers via the Aged Care Provider Portal (**ACPP**), a secure online platform managed by Services Australia.

The ACPP has integrated features which makes the platform user friendly, including quick links. It allows users to easily manage claims utilising self-service tools, with the capacity to quickly filter details in claim and event screens and to securely search for individuals and events.

Users with 'organisation' administration access can use provider self-service features to manage which users have access to claim on behalf of a registered provider and/or its services. Users can also use these features to update key provider information online in real-time.

Information regarding the ACPP, including access guidelines and user resources including claiming processes are available at these Services Australia websites:

- Aged Care Provider Portal - Health professionals - Services Australia
- Aged Care Provider Portal (ACPP) - Flexible Care - Health Professional Education Resources
- Register flexible care recipient events - Health professionals - Services Australia

For claiming and payment enquiries and assistance, registered providers are advised to contact the Services Australia online claiming helpdesk via email: aged.care.liaison@servicesaustralia.gov.au or phone: 1800 195 206.

CHAPTER 3 THE TRANSITION CARE PROGRAM

3.1 What is transition care?

On 23 April 2004, Health Ministers endorsed the definition of transition care (its role, functions and target group) developed by the Care of Older Australians Working Group. An extract of the definition is contained below under section *3.1.1 Aim/Objectives.*

3.1.1 Aim/Objectives

Transition care provides short-term support and active management for older people at the interface of the acute/subacute and residential aged care sectors.[5] It is goal-oriented, time-limited and targets older people at the conclusion of a hospital episode who require more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity, and finalise and access their care arrangements.

The potential for further recovery will vary according to the individual. Therefore, the services provided will vary from individual to individual, ranging from those that further improve physical, cognitive and psycho-social functioning thereby improving the person's capacity for independent living, to those that actively maintain the individual's functioning while assisting them and their family and carers to make appropriate long-term care arrangements.

An outcome of transition care is that inappropriate extended hospital lengths of stay and premature admission to residential aged care are minimised. However, it should be stressed that transition care's primary function is therapeutic, rather than administrative.

3.1.2 Services provided through transition care[6]

Transition care provides older people with a package of services that includes specialised restorative care therapy services such as physiotherapy and occupational therapy, as well as nursing support and personal care. Transition care must be provided in accordance with the Aged Care Service List, and the *Transition Care Program Restorative Care Requirements* (see Chapter 4).

Depending on their assessed level of need and care setting, transition care offers eligible older people the below service types from the Aged Care Service List as contained in Part 3 of Chapter 1 of the Aged Care Rules 2025. An abbreviated version of the Aged Care Service List consolidating all Service Types and Items relevant to the TCP can be found at *Attachment A.*

It is important to note that some service types are essential core program services which are provided to all TCP clients as specified below, whereas others are provided if the client needs them, also as specified below. The actual services provided to clients during their episode is based on their individual assessed needs and will be detailed in the client's care and services plan.

TCP Services for all TCP clients

- Section 8-20 – Assistance with transition care, Items 1-2
    - Item 1: Transition care management
    - Item 2: Assistance to access medical practitioner

These are core TCP services. Item 1 must be provided to all TCP clients. Item 2 must be provided on an as needs basis.

Please note that these two Items apply to all TCP clients, regardless of their care setting.

TCP in a home or community setting

- Section 8-15 - Allied Health and Therapy

This Item must be provided to all TCP clients receiving care in a home or community setting.

- Section 8-20 – Assistance with transition care, Items 3-6

[5] While the definition is accurate in terms of specifying the interface between the acute/subacute and the residential aged care sectors, and while the program applies to older people assessed as otherwise eligible for residential care, it also includes transition care provided in a home/community setting.

[6] A detailed list of services to be provided in delivering TCP is included in *Aged Care Service List* as extracted from Chapter 1 of the Aged Care Rules 2025 at *Attachment A.*

- Item 3: Transition care medication management[7]
- Item 4: Transition care emergency or after-hours assistance
- Item 5: Transition care continence management
- Item 6: Waste disposal

These four Items must be provided to all TCP clients receiving care in a home or community setting who need them.

Under Section 8-20, Item 5 – Transition care continence management, providers are required to provide as many continence aid as needed to meet the individual's needs. If, however, the individual is already receiving continence aids through other programs such as the Continence Aids Payments Scheme or Support at Home, the TCP provider would only need to top up those supplies if needed, rather than becoming the primary source of continence aids provision.

The following Items must be provided to TCP clients in a home or community setting if required to address the goals specified in the client's Support Plan developed as part of their aged care needs assessment. These items may be delivered through CHSP or existing Support at Home arrangements, provided services are coordinated and duplication does not occur.

- Section 8-35 – Domestic assistance
- Section 8-45 – Home maintenance and repairs
- Section 8-55 – Meals
- Section 8-60 – Nursing care
- Section 8-65 – Nutrition
- Section 8-70 – Personal care
- Section 8-110 – Equipment and products, Items 5, 6 & 11

Note: From the services listed under **section 8-110 Equipment and products,** TCP clients are entitled to receive those services as listed **at Item 5: Mobility items 5 (non-loan)**, **Item 6 – Mobility items (loan),** and **Item 11 – Assistive technology prescription and clinical support** according to assessed need.

The provision of loaned **equipment and products** to assist clients with mobility under section 8-110 will continue to be offered by providers. Funding for this will continue to be covered through the transition care daily subsidy rate (paid to providers). There is no need to apply for separate funding under the Assistive Technology Service Group. The provision and management of equipment under TCP is, however, determined at the discretion of each State and Territory. States and Territories may choose to provide equipment on either a permanent or loaned basis, depending on their local policies and operational arrangements.

Where some of these services are being provided through other programs such as the CHSP or Support at Home, TCP services should complement, rather than duplicate those services.

TCP in a residential care setting

Division 8 sets out the care services that must be provided to all TCP clients receiving care in a residential setting who need them.

- Section 8-140 – Residential accommodation
- Section 8-145 – Residential everyday living
- Section 8-150 – Residential non-clinical care
- Section 8-155 – Residential clinical care

Services provided as part of the program are designed to meet an individual's daily care needs and provide additional therapeutic care to enable the individual to maintain or improve their physical, cognitive and psycho-social functioning, thereby improving their capacity for independent living.

Therapeutic care will vary from person to person, ranging from services that improve an individual's capacity for independent living, to services that enable an individual to enter or remain in residential aged care at an optimum level of physical and cognitive functioning.

Some people entering transition care are likely to have dementia or be experiencing a level of cognitive confusion. Therefore, where needed, therapeutic care would include appropriate cognitive therapy to assist with restoration or stabilisation of cognitive skills.

In providing transition care, the registered providers must have systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, quality standards and guidelines relevant to transition care service provision.

[7] Medication management services as per the Aged Care Service List can be provided under the delegation and clinical supervision of a registered nurse or other appropriate health practitioners.

Transition care clients can continue to access the Pharmaceutical Benefits Scheme (**PBS**) and Medicare. Some people from overseas, however, do not have access to the PBS and Medicare and therefore will need to meet their own medical costs while accessing the program (see also section *3.2.2 Non-Australian residents and older people from overseas*).

3.2 Individuals eligible for transition care

Part 2 of Chapter 2 of the Act sets procedures for entry into the Australian Government aged care system by a person seeking aged care services. An individual is required to apply to the System Governor for access to funded aged care services under section 56 of Act. Upon receiving an application, the System Governor must decide whether to make an eligibility determination for an aged care needs assessment for the individual (section 57 of the Act).

An aged care needs assessment must be conducted by an approved aged care needs assessor once an eligibility determination has been made by the System Governor. As part of the aged care needs assessment, to be eligible for transition care, the person must be an admitted patient of a public or private hospital, receive a comprehensive assessment from a clinical aged care needs assessor and be approved for transition care by an assessment delegate. For the purposes of transition care, an admitted patient includes people receiving hospital-in-the-home or equivalent program. Other out-of-hospital in-patient programs such as rehabilitation or geriatric care in the home would also qualify the person as admitted, as long as they remain a hospital patient and haven't been discharged from hospital care.

A person must enter the program upon discharge from hospital. Transition care can be delivered in either a residential care home or in a community setting, e.g. the person's own home. It is possible to receive transition care in a residential care home first and then in a home care setting, or vice versa.

The clinical aged care needs assessor may need to assess the person in consultation with the hospital geriatric rehabilitation service or members of the multidisciplinary team treating the person (which may include the treating physician, a registered nurse, occupational therapist, physiotherapist, social worker or a health professional from another allied health discipline), as well as carers, supporters or family members as appropriate.

In assessing a person's eligibility for transition care, the clinical aged care needs assessor must use the eligibility criteria listed at section *3.4.3 Assessment process for transition care*. The assessment delegate will only approve a person for transition care if the person meets the eligibility criteria.

Once the assessment decision is made and the client has been referred to a TCP service, the following requirements will need to be met upon discharge from hospital in order to commence transition care:

- if transition care is to be delivered in a residential care setting, the person must be able to enter care immediately (within 24 hours) on discharge from hospital; or
- if transition care is to be delivered in a home/community setting, the person must be able to enter care within 48 hours of their date of discharge from hospital.

Hospitals remain responsible for ensuring safe discharge practices are followed and as such, be confident the discharging patient will be adequately supported for the period prior to entry into residential or home/community-based TCP. Registered providers should coordinate and liaise with the hospital discharge team to ensure the client has the arrangements in place to be able to enter their TCP services within the above stated timeframes from discharge.

Further eligibility specifications for the program are outlined below.

3.2.1 Older people who usually reside interstate

The eligibility provisions for transition care under the Act do not restrict provision of care based on where individuals live, or where they are assessed. Older people who are not residents of a particular State, Territory or region can access transition care services in that State, Territory, or region in particular circumstances. For example, an individual transferred to a tertiary hospital away from their usual place of residence to access specialist care can be discharged to a transition care service in another location, based on their follow-up arrangements with their family, carer and/or supporters. It is important transition care commences immediately on discharge from hospital if the person is entering transition care in a residential care setting, or within 48 hours if the person is to receive transition care in their own home (see also section *3.5.5 Movement between care settings and services*).

3.2.2 Non-Australian residents and older people from overseas

Non-Australian residents and older people from overseas can access the program if they are assessed and approved as eligible using the same criteria as other clients by a clinical aged care needs assessor. Importantly, people who are not permanent residents of Australia may not be eligible for the PBS and Medicare and would thus be responsible for meeting their own medical and pharmaceutical expenses while in transition care. There are several countries, however, with which Australia has reciprocal health agreements, and people from these countries may be eligible for Medicare and PBS medicines. Further information is available on the Services Australia website.

Where a person from overseas enters the program and decides to meet their own expenses as a result of being ineligible for the PBS or Medicare, a service may still claim the subsidy in respect of the provision of transition care for that individual. Registered providers must inform such individuals of their responsibility to meet these costs before they enter the program.

These guidelines, including section *5.7 Fees payable by individuals receiving transition care,* apply in respect of all people seeking to access TCP.

3.2.3 People under the age of 65

As of 1 November, if a person aged under 65 (who is not Aboriginal and Torres Strait Islander, homeless or risk of homelessness and aged 50+) has not commenced the process of applying for aged care services (including registering with Ability First Australia (AFA) or the National Disability Insurance Agency (NDIA) Younger People in Residential Aged Care (YPIRAC) team, they are not eligible for an assessment for aged care services.

3.3 The role of hospitals

The role of hospitals in relation to the program is to:

- provide acute and/or subacute care, including rehabilitation and clinical evaluation (including dementia/cognitive assessment as required) and management prior to referring a patient for an aged care needs assessment;
- ensure the patient is medically stable and ready for discharge before being referred for an assessment;
- ensure the clinical team treating the patient and the hospital discharge team work closely with the clinical aged care needs assessor during the assessment process; and
- work with the registered provider, the clinical aged care needs assessor, the patient and their family or carer to assist in developing a Support Plan, as part of the individual's hospital discharge planning process.

3.3.1 Referral process

Assessment organisations accept referrals from several sources. A patient in hospital may self-refer and has the right to request for referral to TCP through their multidisciplinary care team for assessment by the clinical aged care needs assessor, or may be referred by their carer or family member. The clinical aged care needs assessor, however, must not assess them until they are medically stable and ready for discharge, (see *section 3.4.3 Assessment process for transition care*). Hospital staff and the clinical aged care needs assessor should be informed about the local availability of the program and the potential benefits and services offered by the program.

To avoid disappointment, all potential TCP clients in hospital and carers or family members should be informed if transition care is available in the area where the individual wishes to access care, i.e. in their own home or in the local area of a carer or family member.

Potential TCP clients must also be made aware that access to a transition care place depends on:

- them being assessed and approved as eligible for transition care by a clinical aged care needs assessor and assessment delegate;
- availability of a vacant transition care place; and
- whether a registered provider can meet their care needs and accepts the individual into care.

3.4 Assessment and approval of individuals for transition care

Chapter 2 of the Act contains the legislative provisions on the approval of individuals for funded aged care services, and it is accompanied by the further detailed guidance materials, contained in the My Aged Care Assessment Manual for 1 November 2025.

To access transition care, older people must first be assessed by a clinical aged care needs assessor and approved by an assessment delegate requiring the particular applicable services transition care delivers from the Aged Care Service List, as contained in Chapter 1 of the Rules.

3.4.1 Assessment: role of the clinical aged care needs assessor

The role of a clinical aged care needs assessor is to conduct a holistic, comprehensive assessment of older people incorporating physical, medical, psychological, cultural, social, environmental and wellness dimensions. The assessment is facilitated by the mandatory Integrated Assessment Tool (**IAT**), which is designed to collect consistent information across these dimensions. This information is then used to develop a Support Plan focussing on the client's most important areas of concern and recommendations that address the client's current needs.

Based on the client's eligibility in accordance with the Act, clinical aged care needs assessors support the client's access to the most appropriate aged care services, including the recommendation for residential care, home care or specialist aged care services, such as transition care.

When assessing an individual for transition care, the assessment must be conducted while the client is an admitted patient of a hospital, medically stable and ready for discharge. The clinical aged care needs assessor must consult with the hospital geriatric rehabilitation service or equivalent, or members of the treating multidisciplinary team including a registered nurse, physician, occupational therapist, physiotherapist, speech therapist or social worker. The My Aged Care Assessment Manual sets out guidance for assessors in providing older people with person-centered aged care assessments and services as required under the Statement of Principes at section 25 of the Act. Under this section, the aged care system is to offer accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed 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;
- are veterans or war widows;
- are from culturally, ethnically and linguistically diverse backgrounds;
- are financially or socially disadvantaged;
- are experiencing homelessness or at risk of experiencing homelessness;
- are parents and children who are separated by forced adoption or removal;
- are adult survivors of institutional child sexual abuse;
- are care-leavers, including Forgotten Australians and former child migrants placed in out of home care;
- are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or are gender diverse or bodily diverse;
- are an individual with disability or mental ill-health;
- are neurodivergent;
- are deaf, deafblind, vision impaired or hard of hearing;
- live in rural, remote or very remote areas.

Individuals may identify across more than one group and may have a variety of special and diverse needs that will need to be recognised and taken into consideration. This includes consideration of groups not noted under the Act. Refer to Chapter 10 of the My Aged Care Assessment Manual for further guidance on the requirements for undertaking aged care needs assessments for older people with diverse needs and life experiences.

Additionally, clinical aged care needs assessor must consider the needs of clients with dementia – please refer to section 10.1.13 of the My Aged Care Assessment Manual.

After conducting a comprehensive assessment, a clinical aged care needs assessor will send their assessment findings and recommendations to the assessment delegate, within the assessment organisation, who will then make a formal decision as a delegate of the System Governor under the Act. Where a care type under the Act is identified as the most appropriate type of support to meet the client's needs, and the client meets the eligibility criteria, the clinical aged care needs assessor will recommend this to the assessment delegate.

The assessment delegate will notify the client of the decision to approve or not approve them for transition care and if approved eligible, the clinical aged care needs assessor will provide the client with information about the relevant aged care services and make the necessary referrals to an appropriate aged care service providers (or registered providers) through the My Aged Care system or by issuing a referral code to the individual. The referral code enables potential service providers to view the My Aged Care client record, accept the referral, and start organising services.

Clinical aged care needs assessors and transition care service providers should build and maintain effective working relationships to ensure assessors are aware of the transition care services that providers offer and can make appropriate and timely referrals to the most suitable provider.

Once a registered provider is found who can offer the services required, they accept/manage the client's referral in My Aged Care Service and Support Portal and enter the relevant service information.

Please note the transition care approval is valid on the date the assessment delegate signs the approval, and then for four weeks (28 calendar days) after the date of signing. The client must enter the program within this four-week approval 'entry period', and within the specified episode commencement timeframe i.e. within 24 hours upon discharge from hospital if the client is entering transition care in a residential care setting, and within 48 hours, if the person is to receive transition care in a home/community setting. Hospitals remain responsible for ensuring safe discharge practices are followed and as such be confident that the discharging patient will be adequately supported for the period prior to entry into home/community-based TCP or residential-based TCP (see also section *3.4.4 Approval for transition care*).

The clinical aged care needs assessor is also required to assess a client's need for a transition care extension and other care options as requested by the registered provider through the My Aged Care provider portal. The assessor will use the information provided by the TCP registered provider if it becomes apparent during an individual's episode of transition care that they would require an extension, and other sources such as the client and relevant health professionals as appropriate, to assess eligibility for the extension (see also section *3.5.8 Extensions* and section *3.5.9 Review of assessment extension decisions*).

During the transition care episode, the clinical aged care needs assessor should assist the registered provider, if necessary, in reviewing an individual's needs, re-assessing appropriate care options or referring to a more appropriate service if needed (see also section *3.5.2 The registered provider*).

Further information is available at: My Aged Care Assessment Manual.

3.4.2 Who should participate in an aged care needs assessment?

As with all aged care needs assessments, where appropriate, and with the individual's permission, the assessment must involve:

- the individual and their carer, family or supporters;
- an interpreter or an Aboriginal or Torres Strait Islander health worker or liaison officer as required, in accordance with the individual's preferences; and
- other health and rehabilitation professionals, as appropriate.

3.4.3 Assessment process for transition care

When considering a person's suitability for transition care, the clinical aged care needs assessor must consider the eligibility criteria and several additional factors. The assessor must determine that the person:

- is a public or private hospital admitted patient, or is receiving acute or subacute care under a hospital-in-the-home or equivalent program where the patient is classified as an admitted patient;
- has completed their episode of acute and/or subacute care, is medically stable and ready for discharge at the time of assessment;
- wishes to enter transition care;
- would otherwise be eligible for residential care;
- would have the capacity to benefit from a package of services that includes, at a minimum, low intensity restorative therapy and nursing support and/or personal care; and
- would have the capacity to benefit from goal-oriented, time-limited and therapy-focussed care necessary to:
    - complete their restorative process;
    - optimise their physical and cognitive functional capacity; and
    - assist in making long-term arrangements for their care.

In addition, the clinical aged care needs assessor must consider the following factors:

- the intent of transition care is to benefit older people through time-limited, low-intensity therapy and support immediately after a hospital episode;
- transition care is designed to improve an older person's capacity for independent living and to maintain their functioning, while assisting them and their family and carers to make appropriate long-term care arrangements if needed;
- the therapeutic care provided by the program will vary from individual to individual, ranging from services that improve an individual's capacity for independent living, to services that enable a person to enter residential aged care at an optimum level of physical and cognitive functioning;
- in consultation with the hospital geriatric rehabilitation services or equivalent, and other members of the multidisciplinary team caring for the patient, ensure the full range of clinical and/or rehabilitation support provided by the hospital has been completed before a person enters transition care; and

- the cognitive abilities of a person with dementia may fluctuate from day to day, so the extent of a person's dementia may not be immediately obvious at the initial assessment;
- entry to transition care must be:
    - immediately upon discharge from hospital (within 24 hours) if the person is entering transition care in a residential care setting, or
    - within 48 hours if the person is to receive transition care in a home/community setting.
- hospitals remain responsible for ensuring safe discharge practices are followed and as such, be confident that the discharging patient will be adequately supported for the period prior to entry into home/community-based TCP or residential based TCP;
- close co-operation and liaison between the hospital discharge planner, the clinical aged care needs assessor and the registered provider is required to ensure a transition care place is available in a timely manner, to benefit the individual;
- as part of the comprehensive assessment, the individual, and their carer and/or family as appropriate, should be fully informed of the range of other available aged care services that may be appropriate for them. The clinical aged care needs assessor should assess the person's eligibility for those options and approve them if clinically appropriate; and
- if the person is only approved as eligible for transition care at the time of the initial assessment, it is likely they will need a re-assessment before the completion of their transition care episode, to establish their long-term care requirements. Where this is necessary, the clinical aged care needs assessor should consider any changes to the person's care needs and ensure that the long-term care recommendations reflect the revised level of need and the person's preferences.

Assessment outcomes for transition care

The assessment summary, findings, and recommendations for care are outlined in a Support Plan, developed by the clinical aged care needs assessor. In terms of recommending for TCP, the assessor will recommend the Care Type: Transition Care - After Hospital Care. Once the recommendation is approved by the Clinical Assessment Delegate, the client will be approved to receive care and services via TCP under all three of the following Service Groups:

- Home Support;
- Assistive Technology; and
- Residential Care.

The clinical aged care needs assessor/Assessment Delegate does not need to select or identify specific Service Types (i.e. TCP Items in the Service List) in the Support Plan or the assessment system – approval for all TCP Service Types will automatically apply once the Support Plan is submitted and approved.

A TCP client will then be able to receive any of the TCP Service Types required to meet their determined care needs. The specific TCP Service Types under which care and services will be provided to a client, are subsequently outlined in the client's detailed care and services plan, developed by their TCP registered provider/associated provider in conjunction with the client and their supporting multidisciplinary team.

3.4.4 Approval for transition care

An aged care needs assessment approval to enter transition care is valid on the date the assessment delegate signs the approval, and then for four weeks (28 calendar days) after the date of signing. The client must enter the program within this four week 'entry period'. If the client does not enter the program within the four-week period, their approval will lapse and they will need a re-assessment for transition care, if appropriate.

As transition care places may become vacant at short notice, assessment delegates should approve eligible clients for transition care even if there is not an immediate vacancy at the time of referral.

As with all aged care needs assessment approvals, clients are to be reminded that approval does not guarantee a place, particularly if a vacancy does not present itself during the person's stay in hospital.

The result of an aged care needs assessment, and the decision to approve or not approve a person to receive transition care, must be provided to the person who has applied for the care (or their supporter) in writing. The applicant must also be provided with the reasons for the decision under section 70 of the Act. A decision to reject a person's application for transition care is a 'reviewable decision' under section 557 of the Act. The My Aged Care Assessment Manual contains further information on reviewable decisions.

3.4.5 Assessment and approval within in a short stay unit of an emergency department

Where appropriate, older people may be assessed and approved for the program by a clinical aged care needs assessor from a short stay unit or equivalent in an emergency department, provided:

- they have been admitted to hospital and are classified as an admitted patient in the emergency department ward;
- they are medically stable at the time of assessment, have had an aged care assessment, and have been approved as meeting all other eligibility criteria for transition care; and
- it is not more appropriate for the patient to receive subacute care such as rehabilitation or geriatric evaluation and management.[8]

The care provided while the individual is an in-patient of the short stay unit of an emergency department should involve discussion between the treating multidisciplinary team, geriatrician, and transition care service staff, as well as a comprehensive assessment by a clinical aged care needs assessor to ensure the person is medically stable and not identified prematurely for the TCP.

3.4.6 Hospital and assessment information for care and services plan development

For those approved as eligible for transition care, the hospital clinical teams and the aged care needs assessment are key information sources for the development of a care and services plan to guide the physical and cognitive therapy services to be delivered to an individual through transition care by registered providers. It is important that the aged care needs assessor attaches a copy of all relevant assessment documentation (assessment outcomes, delegate approval for accessing funded aged care services, etc.) from the IAT, to the individual's My Aged Care account so that this information can be given to the registered provider when the individual it put in contact with them.

3.5 Entry to transition care

An individual must enter transition care:

- Within 24 hours upon discharge from hospital if the person is entering transition care in a residential care setting; or
- within 48 hours of discharge, if the person is to receive transition care in a home/community setting.

These commencement timeframes are to ensure individuals can derive maximum benefit from a time--limited episode of low intensity therapeutic interventions by not delaying these interventions.

An assessment organisation's approval of an individual to enter transition care is valid on the date the assessment delegate signs the approval, and then for four weeks (28 calendar days) after the date of signing (see also section *3.4.4 Approval for transition care*).

Older people receiving care under a hospital-in-the-home or equivalent program cannot commence their transition care episode while still classified as an admitted patient of a hospital.

Older people who are discharged from hospital and have returned to their usual place of residence without commencing the program within the required timeframes as set out above, are no longer eligible to enter the program.

3.5.1 Duration of care

The TCP subsidy will be paid for all individuals accessing the program up to a maximum of 12 weeks. Where an extension has been granted, up to a further six weeks of TCP subsidy will be paid (see also section *3.5.8 Extensions*).

To ensure that limited resources benefit as many older people as possible, the program and length of duration should be tailored to the needs of the individual, so a '12 week program' may not be required for every individual. Therefore, while some individuals may require the maximum 12 weeks of care and an extension of up to six weeks, not all individuals will require the maximum period of care.

Additionally, where an individual transfers between one TCP setting/provider to another during an episode, they may choose to utilise some or all of their episode 'break days'. There must, however, be no gap in their ability to access care, i.e. there is no day during which the individual is not able to be provided transition care services by either their current or new service provider.

[8] A definition for subacute care is included in the Glossary at the end of these guidelines.

3.5.2 The registered provider

Registered providers manage the day-to-day operations of a transition care service. This includes:

- assisting in the admission of clients to transition care, their return to hospital if required and their transfer to their preferred long-term care option;
- liaising with the local assessment organisation and/or transition care coordinator and advising of the capacity of the service to accept new clients, and any transition care vacancies in the region;
- offering and remaining ready at any time to enter into a service agreement with eligible clients (see also section 5.2 Individual Service agreements);
- having appropriate processes in place to receive, record and resolve complaints and handle them fairly, promptly, confidentially and without retribution (see also section 7.2.1 Internal complaints processes);
- reporting (activity, financial data and quality) as per program requirements and arrangements in place with State or Territory health department; and
- ensuring their sub-contracted service providers or associated providers adhere to the strengthened Aged Care Quality Standards.

Registered providers are responsible for providing services appropriate to the needs of individuals in care for the entirety of their transition care episode. The registered provider, following consultation with the referring hospital, will make the final decision as to whether the person's care needs can be met by their service and whether they have any places available.

The 12-week duration of the program equates to 84 calendar days. As it is a time-limited program, services should be provided according to the care and services plan on a 7-day a week basis, including weekends and any public holidays falling within the transition care period.

Care planning

The registered provider must develop a care and services plan under section 148(e) of the act and sections 8-20, 148-80 and 148-85 of the Rules, which incorporates a therapeutic plan for physical and cognitive needs developed through the individual's hospital discharge planning, the aged care assessment process and in consultation with the individual, and their carer or supporters where appropriate. For older people with dementia who are unable to express their care goals, the development of a care and services plan may need to involve the person's supporters, family and/or carer.

Case management

The registered provider has a responsibility to assist in the admission of an individual into the program, in their return to hospital if required, and in their subsequent transfer to their preferred long--term care option at the end of their transition care episode. The registered provider plays a significant role in the individual's case management, including establishing community support and services and, where required, identification of residential care options.

Cooperation with Assessment Organisations

To facilitate the best outcome for the individual during and after the assessment process, registered providers should have an effective working relationship with their local assessment organisation. Specifically, registered providers:

- should liaise with the assessment organisation, and keep them informed about the capacity of their service to accept new clients, and any transition care vacancies in the region;
- may involve the clinical aged care needs assessor in reviewing the individual's needs, re-assessing appropriate care options and/or referring the individual to a more appropriate service; and
- may also identify individuals who potentially require an extension to their transition care episode and submit a transition care extension request to a clinical aged care needs assessor and assessment delegate for review (see also sections 3.5.8 Extensions and 3.5.9 Review of the assessment extension decisions).

Assessment organisations can work with Dementia Support Australia to ease the transition of clients with dementia to home or residential aged care.

The Government funds a free dementia behaviour support service delivered through **Dementia Support Australia (DSA)**, which can assist informal carers and providers when behavioural and psychological symptoms of dementia impact a person's care or quality of life. DSA offers a 24-hour helpline, accessible by calling **1800 699 799** or visiting www.dementia.com.au. As part of its service offering, DSA can review an individual's situation while they are in hospital and support their transition to residential aged care if a suitable place is found. Support can also continue after the transition to help avoid re-admission to hospital.

This service may be particularly beneficial for individuals in the TCP who are experiencing behavioural symptoms of dementia, as DSA can provide tailored support during their hospital stay, assist with planning for appropriate longer-term care, and help ensure a smoother transition to residential aged care where needed.

3.5.3 Residential based transition care

Registered providers of residential based transition care are expected to provide services that reflect the intent of the program to optimise the individual's health and independence. Residential based transition care services should be provided in a more home-like, less institutional environment, including:

- communal living space/living room environment which is separate from sleeping areas and the location of acute/subacute care provision, i.e. a space that encourages family, carers and visitors to spend time with individuals;
- a dining area and individuals to be encouraged not to eat in bed;
- individuals to be encouraged and supported to dress every day;
- facilities for individuals to prepare snacks for themselves and their visitors;
- privacy, particularly for personal care and bathing arrangements;
- space for individuals to move about, especially outdoors;
- physical arrangements which support the involvement of carers in the therapeutic activities; and
- a model of care and staff knowledge that supports the intent of the program to promote the individual's independence and health (including cognitive functioning).

Transition care services may also be provided in hospitals when appropriate. The requirements for the more home-like environment may be relaxed on a case-by-case basis in these locations, if relevant (see also the requirements set out in *Chapter 4: Transition care program restorative care requirements*).

It is not the intention that the program will reduce access to the number of allocated residential care places. Rather, transition care places are to be considered as additional to other aged care places.

3.5.4 Existing recipients of residential or home care

Existing recipients of Australian Government funded residential or home care services, including recipients of the Commonwealth Home Support Program, the Support at Home Program and residential care, may be able to access transition care following an episode of hospital care if they are assessed as eligible.

It is the responsibility of the individual to notify their residential or home care provider of their intention to enter transition care. It is expected, however, the individual's residential or home care provider will discuss the provision of care with the relevant transition care provider to coordinate care provision and ensure the individual's care needs are met.

Support at Home Program recipients

People receiving Support at Home services can access transition care after a hospital stay if they are assessed and approved as eligible by a clinical aged care needs assessor and assessment delegate. Under the Act, individuals can continue or commence to receive services under their Support at Home Program while also receiving transition care, provided there is no duplication of services between the Support at Home and TCP registered providers in service provision. In these instances, both registered providers should consult and coordinate between them the care and service provision to the individual so as to avoid any duplication of services.

Further information regarding Support at Home Program arrangements while accessing transition care is available in the Support at Home Program Manual on the Department's website at the following link: Support at Home program manual (version 3) – A guide for registered providers | Australian Government Department of Health, Disability and Ageing.

As per Section 12.2 of the Support at Home Program Manual, individuals also have the flexibility to temporarily stop receiving their Support at Home services for various reasons, including receiving transition care following a hospital stay. While services are stopped, a participant will continue to receive their Support at Home quarterly budget. In addition to their quarterly budget, participants can carry over unspent budget from a previous quarter. However, carryover unspent budget limits will apply. As outlined in Section 9.0 of the program manual, Support at Home quarterly budgets that are not fully utilised can accrue up to $1,000 or 10% of the participant's Support at Home quarterly budget (whichever is higher) and will be added to the following quarter's budget. Any unspent budget above this threshold will lapse.

There is a maximum period services can be stopped before a participant is no longer eligible for Support at Home funding. An individual'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.

Commonwealth Home Support Program (CHSP) recipients

People are entitled to receive CHSP and transition care services at the same time, provided they are assessed as being eligible for each program. There are instances where the CHSP may provide the same or similar services to transition care, such as home maintenance or assistance with meals. When planning care, transition care service providers are expected to liaise with an individual's existing CHSP provider to ensure there is no duplication of services.

Existing residential care recipients

The Australian Government has created a category of leave (where required) from residential care for existing recipients of residential care who subsequently enter the transition care program. The relevant Australian Government residential care subsidy continues to be paid to the original residential care provider during periods of leave for transition care.

Where residents of residential care homes take more than 28 consecutive days of either hospital leave or leave for transition care (which must be preceded by hospital leave), the subsidy to the existing residential care home drops by 50 per cent for residents who have a classification under the Australian National Aged Care Classification (AN-ACC) and are being paid the residential care subsidy.

When an existing recipient of residential care is accepted into the program, the individual must be provided with the full package of transition care services to be provided in a residential care setting if they are accessing the program from a residential care setting, in accordance with the services as specified from the Aged Care Service List in their access approval.

3.5.5 Movement between care settings and services

To facilitate client-centred transition care delivery, it is possible for individuals to move from one care setting to another within the same transition care episode, i.e. from a residential setting to a home/community care setting or vice versa. Individuals do not require an aged care re-assessment to enable this move.

Where available and appropriate, the step-down from residential to home-based care within a transition care episode should be encouraged in order to maximise the individual's opportunities to return to independent living in the community post exiting from the TCP.

Individuals are also able to transfer from one setting/registered provider to another (within their State or Territory, or interstate) during an episode, provided there is no gap in their ability to access care, i.e. there is no day during which the individual is not able to be provided transition care services by either their current or new registered provider.

An individual service agreement will need to be developed with the new registered provider (see *Section 5.3: Individual service agreements* below).

3.5.6 Interrupting a TCP episode – available break days

An individual can take a break from receiving care for up to seven days in total, during their transition care episode, for hospital admission or social purposes. In a residential care setting, break days are calculated by the number of nights away from the service – that is up to a maximum of seven allowable nights. In a home/community care setting, break days are calculated by the number of days without TCP services.

An individual can take break days at any time after they have commenced their episode. That is, a person must have entered the program as per the commencement requirements for at least one day, prior to taking a break.

Break days can be taken together in blocks, or individually, throughout an individual's episode.

Any break days taken will still be counted as available care days and will not extend the maximum duration of an individual's transition care episode (i.e. up to 12 weeks, with a possible extension of up to another six weeks, where approved).

A registered provider will continue to be paid subsidy for any break days taken by an individual throughout the duration of their episode. Calculation of an individual's 's contribution fee is to include any days taken as break days.

Break days only interrupt the delivery of care and services during an individual's transition care episode. The episode itself is not suspended and then recommenced. As such, providers are not required to report break days via the Aged Care Provider Portal, for the purposes of subsidy payment.

Where an individual is absent from care for more than a cumulative total of seven nights or days (as per the calculation method for residential and home/community TCP services mentioned above), their transition care episode must end.

To recommence care, the person will require a valid, current aged care needs assessment approval and must enter a new transition care episode after another hospital stay, in line with the relevant 'delivery setting' episode commencement timeframe.

Dual recipients of transition care and ongoing residential care, taking a break from their transition care episode, remain on 'leave' from their ongoing residential care home.

An individual cannot use their break days for the purpose of accessing residential respite.

Tracking and management of break day balances

Responsibility for managing an individual's break day balance sits with TCP registered providers. Providers are to ensure their services have appropriate processes and systems in place to track and manage break day balances and collate break day data.

3.5.7 Readmission to hospital from transition care

An individual's episode will cease if they are absent from care for more than a total of seven break days during their transition care episode (as per the calculation method for residential and home/community TCP services mentioned above), including if they need to re--enter hospital (see also, section *3.5.6 Interrupting a TCP episode – available break days*).

To recommence care, a person will require a valid aged care needs assessment approval and must enter their new transition care episode after another hospital stay, in line with the relevant 'delivery setting' episode commencement timeframe.

A person who is hospitalised and whose episode has ceased, is able to enter a new transition care episode without the need for an additional transition care approval, if the person is subsequently able to be discharged from hospital within their initial aged care assessment transition care approval's 28 day/four-week entry period, if clinically appropriate.

An assessment organisation's re-assessment is only required if the individual wishes to re-enter the program after the four-week entry period has expired, or where the aged care assessment is still valid but the re-admission to hospital may have changed the person's care needs significantly (as to be determined by the assessment organisation) since the last approval for transition care services.

3.5.8 Extensions

In exceptional circumstances, an individual may require an extension to a transition care episode where their care will need to exceed the 12-week maximum. To apply for an extension, the registered provider must lodge a Transition Care Extension Request through the My Aged Care Service and Support Portal with the individual (or their supporter), within the initial 12-week episode of transition care. This will be an application for an extension in the approved form under section 80-65 of the Rules. Once the provider has completed the request, it will be forwarded to the assessment organisation for review. The clinical aged care needs assessor needs to be satisfied that the client has further therapeutic care needs and wishes to continue transition care. The assessment delegate will determine whether to grant the extension and specifies the number of days of extension.

An assessment delegate should only grant extensions if individuals have further therapeutic care needs and wish to receive further transition care to achieve a better outcome. A transition care episode can only be extended by up to 42 days (6 weeks). It is possible to have more than one extension if the total number of days does not exceed 42 days (6 weeks). For example, if an assessment delegate has only granted an extension of 20 days, it is possible to grant another extension of up to 22 days.

Based on the information provided by the service provider, and other sources such as the individual and relevant health professionals, the assessment delegate will decide whether the transition care episode is to be extended and for how long.

Under section 80-65(6) of the Rules, the assessment delegate must give written notice to the registered provider of a decision for extension within 28 days after the application was made. The extension decision does not need to be signed by the same clinical aged care needs assessor who undertook the initial assessment for eligibility for transition care.

It is not necessary for a clinical aged care needs assessor to comprehensively re-assess an individual if the registered provider has identified that the person requires an extension and provides the following information:

- reasons why goals were not achieved in 12 weeks;
- physical, cognitive and psycho-social goals the individual would be working on during the extension;
- team action required to achieve individual goals and discharge;
- action required by external services to achieve individual goals and discharge;

- relevant information from other sources such as the individual (or supporters) or health professionals; and
- the proposed number of days of extension.

The clinical aged care needs assessor may undertake a comprehensive re-assessment of the individual if they are not satisfied with the information provided by the registered provider.

To avoid delays in processing extension requests within the 12-week Transition Care Program episode, the registered provider must ensure that the application for extension includes the individuals *My Aged Care reference number*, the proposed extension start and end dates and a clear explanation and aged care requirements that justify the extension. The application should be submitted with sufficient time to allow the clinical aged care needs assessor to review the status of the individual. This is particularly important if a more comprehensive re-assessment is required to support the extension.

Further advice and information can be located through the My Aged Care Services and Support Portal at: My Aged Care Service and Support Portal | Australian Government Department of Health, Disability and Ageing

The portal can assist providers of aged care to:

- enter and manage information about your services
- see your service's care minutes target
- manage referrals
- update client records
- generate reports
- ask assessors to review a client's support plan.

Updates, including resources and help on how to use the portal can be located at: My Aged Care for providers.

The My Aged Care service provider and assessor helpline can be contacted on 1800 836 799 from 8 am to 8 pm Monday to Friday or 10 am to 2 pm Saturday.

3.5.9 Review of the assessment extension decisions

A decision to extend or not extend an individual's episode of transition care is not a 'reviewable decision' under the Act. The Department does, however, offer a right of review to any person whose request for an extension is denied. In the first instance, the decision should be discussed with the clinical aged care needs assessor. If after discussing a decision not to extend an episode of transition care with the clinical aged care needs assessor, an individual wishes to seek further review of an extension denial, they should write to:

The Secretary

Department of Health, Disability and Ageing

Attn: Single Assessment System Program

GPO Box 9848

ADELAIDE SA 5001

3.5.10 Accessing ongoing residential care during/after transition care

A person entering residential care permanently after the completion of their transition care episode may take up to seven days 'pre-entry leave' to secure their place in their new residential care home. The only fee that can be charged during pre-entry leave from residential care is the basic daily fee. No subsidy is payable to the residential care home as a registered provider, for pre-entry leave (see also *section 5.7.1 Determining care fees*).

Residential care homes cannot claim pre-entry leave for an existing recipient of residential aged care who is on leave from residential care for the purposes of receiving transition care.

CHAPTER 4 TRANSITION CARE PROGRAM RESTORATIVE CARE REQUIREMENTS

This chapter outlines the restorative care requirements that service providers must comply with when delivering transition care to individuals.

4.1 Optimising Independence and Wellbeing – Requirement 1

The transition care service optimises the independence and wellbeing of its care recipients.

4.1.1 Assessment processes:

- allow care recipients or their supporters, assisted by carers and families as appropriate, to make informed choices between transition care service options to define and set their goals to optimise their independence and wellbeing;
- include an assessment of care recipients' physical and cognitive independence, as well as their psycho-social needs; and
- consider special needs groups, including people from Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds, and people who have a physical or cognitive impairment.

4.1.2 Care planning is focussed on optimising independence and wellbeing and includes a goal-oriented care plan for the care recipient that:

- responds to the identified needs of the individual and targets those goals which optimise independence while taking into consideration the cognitive and psycho-social needs of the individual;
- provides the individual with required physical and cognitive therapies and treatments designed to teach the individual to achieve their own goals; and
- improves the individual's functioning by promoting independence and monitoring improvement, in consultation with the individual and/or their supporters, carers and families, clinicians, and therapists.

4.1.3 The transition care registered provider demonstrates that its service:

- provides a coherent and integrated case management process that enables individuals to meet their goals and takes into consideration the psycho-social situation of the individuals;
- actively promotes self-management and self-sufficiency by providing interventions to support the individual to make the most of their own capacity and achieve their full potential;
- encourages individuals to seek support from carers and families, community groups and others to foster their independence when required;
- assists individuals to achieve an optimum level of independence and wellbeing so that care needs are minimised over the longer term;
- provides facility-based residential transition care services in a more home-like, less institutional environment. This may include:
    - a communal living space/living room environment which is separate from sleeping areas and the location of acute/subacute care provision, i.e. a space that encourages carers, families and visitors to spend time with individuals;
    - a dining area, and individuals are encouraged not to eat in bed;
    - individuals being encouraged and supported to dress every day;
    - facilities for individuals to prepare snacks for themselves and their visitors;
    - privacy, particularly for personal care and bathing arrangements;

- space for individuals to move about, especially outdoors;
- physical arrangements which support the involvement of carers and family in the therapeutic activities; and
- a model of care and staff knowledge that supports the intent of the Transition Care Program to promote the individual's health and independence.

Note: Transition care services may also be provided in hospitals where appropriate. The requirements for a more home-like environment may be relaxed on a case-by-case basis in these locations, if relevant.

4.2 Multidisciplinary Approach and Therapy Focused Care – Requirement 2

The transition care service provides individuals with high quality, evidence-based therapeutic services focussed on maintaining or improving function in line with established goals.

4.2.1 Assessment processes:

- assess the individual's transition care needs via a multidisciplinary team (MDT) at the beginning of the transition care episode;
- use validated assessment tools deemed appropriate by clinicians/therapists;
- include a dementia assessment;
- include measurement of a baseline level of functioning using validated assessment tools, and reassessment of functional performance at pre-determined intervals; and
- include evidence of discharge planning throughout the transition care episode.

Note: The use of the Modified Barthel Index for assessments by the transition care registered providers at entry to and exit from the TCP is mandatory for Australian Government subsidy payments.

4.2.2 Care planning processes demonstrate that:

- a goal-oriented physical and cognitive therapy program is developed by the registered provider in consultation with the individual or supporter, carer, and family prior to the commencement of therapy or treatment, with input from the MDT of the transferring hospital and the clinical aged care needs assessor;
- the therapy program duration is estimated and informs planning for the individual's discharge;
- hospital discharge information is incorporated into the initial care planning process;
- care provision is responsive to the identified needs and goals of the individual;
- physical and cognitive therapy goals agreed with the individual, or their supporter/carer, are documented and prioritised;
- the individual receives timely and appropriate access to therapy, care and equipment during the transition care episode. This is demonstrated by:
  - ensuring aids, appliances, equipment and services required for an individual's therapy are provided in a timely manner;
  - providing a broad range of services tailored to meet the individual's therapeutic goals to improve or maintain function;
  - providing the individual with restorative care therapy from appropriately qualified staff to achieve their individual documented goals; and
  - actively encouraging the individual, and/or their supporter, carer and family to participate in all aspects of transition care service provision;

- the individual's progress against therapy goals is regularly evaluated throughout their transition care episode and on exit, with changes in physical and cognitive function measured and recorded to demonstrate achievement of the individual's goals;
- the individual's changing needs are reflected as they move between care settings; and
- individual goals are delivered in accordance with the care plan, using an integrated case management approach.

4.2.3 The MDT approach to the planning and review of individual care demonstrates that:

- documented procedures and protocols are available to support the MDT in the care and review of individuals, including processes for communicating information about individuals to relevant health professionals;
- care planning is carried out by members of the MDT with relevant clinical experience in goal-oriented, low intensity therapy;
- care plan reviews/case conferencing include those members of the MDT involved in the individual's treatment and occur at predetermined intervals;
- care is informed by discussions with and between the relevant geriatrician and the individual's GP, where possible, and/or other appropriate medical input;
- MDTs have integrated individual records;
- the MDT comprises an appropriate mix and level of staff, enabling the provision of effective services to individuals; and
- a coordinator/case manager is in place to provide oversight and promote effective MDT and interagency working.

4.3 Seamless Care – Requirement 3

The transition care service uses a collaborative service delivery model to deliver seamless care.

4.3.1 Assessment processes:

- follow agreed protocols for the effective transfer of individual information between primary, community, acute and aged care services;
- recognise and incorporate hospital assessment, care planning and discharge arrangements, including an aged care needs assessment and approval recommendations;
- enable staff of the receiving transition care service to meet and assess the individual's care needs and the transition care service's ability to meet these care needs prior to the individual's admission into the service, where possible; and
- provide for a verbal as well as a written handover of individual information and status whenever the individual moves between or within services, where practical.

4.3.2 The transition care service works within an integrated system of care with other organisations by:

- establishing relationships and communication strategies that govern collaboration between acute/subacute, aged, and primary care services, promoting a clear understanding of each other's roles, responsibilities, and admission criteria;
- establishing systems for the secure, timely and effective transfer of transition care and individual-related information between service providers;
- strengthening partnerships with GPs and other transition care support services;
- facilitating effective interagency case conferences;

- facilitating the individual's entry to and exit from transition care so the individual experiences a seamless move;
- effectively coordinating the individual's needs and goals between services;
- keeping the individual and/or their supporters well informed prior to moving to a new service;
- facilitating education, training, networking and support across sectors and service boundaries in the broader health and aged care community where appropriate; and
- facilitating access to ongoing care and service provision post discharge from the program, as required.

4.3.3 The transition care service develops systems for the safe discharge of individuals that help prevent re-admission, including:

- providing transition care service discharge plan information to any subsequent care organisation; and
- providing appropriate discharge documentation to the individual, specifying:
    - length of stay in transition care;
    - destination post transition care;
    - goals which the individual agrees has or has not been achieved (with reasons for non-achievement);
    - individual physical and cognitive functional levels on discharge from transition care, assessed using the same validated instrument used on admission;
    - individual and/or supporter, carer and family education and support to improve functioning following discharge;
    - where appropriate, all services and equipment to be provided to the individual on discharge from transition care, with key supplier contact details;
    - an up-to-date list of prescribed discharge medications; and
    - other follow-up arrangements/referrals such as information for the individual's GP, which are the responsibility of the individual and/or their supporters.

CHAPTER 5 INDIVIDUALS RECEIVING TRANSITION CARE

5.1 Aged Care Statement of Rights

The Act includes a Statement of Rights for older people accessing aged care services. The Statement of Rights, contained in Part 3 of Chapter 1 of the Act, replaces the Charter of Aged Care Rights from 1 November 2025 and explains what rights older people have when accessing aged care services funded by the Australian Government.

Under section 155-15 of the Rules, registered providers must explain and provide a copy of the Statement of Rights to individuals accessing or seeking to access transition care.[9] Registered providers are also required to assist individuals to understand the information contained in the Statement of Rights.

The Statement of Rights is designed to ensure individuals accessing government funded aged care service are put at the centre of their aged care journey. The Statement gives individuals the right to:

- make their own decisions about their own life;
- have their decisions not just be accepted, but respected;
- get information and support to help them make decisions;
- communicate their wishes, needs and preferences;
- feel safe and respected;
- have their culture and identity respected;
- stay connected with their community.

5.1.1 Provider responsibilities in relation to the Statement of Rights

It is a requirement under section 24 of the Act that registered providers delivering transition care services to individuals must take all reasonable and proportion steps to act compatibly with the Statement of Rights and balance this responsibility with the following factors:

- competing or conflicting interests;
- the rights and freedoms of other individuals, including aged care workers of the registered provider and other individuals accessing funded aged care services; and
- compliance with other laws of the Australian Government or of a State or Territory, including the *Work Health and Safety Act 2011* (Cth).

Under *Aged Care Quality Standard 1 – The Individual*, contained within Part 6, Chapter 1 of the Rules, registered providers are required to demonstrate they understand the rights of individuals under the Statement of Rights and they must have practices in place to ensure that they act compatibly with the Statement of Rights.

5.1.2 Resources

To assist providers and individuals receiving transition care understand the requirements in the Statement of Rights, the Department has developed a fact sheet which provides a summary of how the rights apply for individuals when accessing aged care services: A new rights-based Aged Care Act. The fact sheet is available in English and a number of other languages to download from the Department's website. Other resources to support the sector are available on the Department's website and the Older Persons Advocacy Network website.

5.2 Individual Service Agreements

Registered providers of TCP services are required to enter to service agreements with individuals accessing transition care under section 148-65 of the Rules, on or before the client's start day.[10] If the start date changes, the service agreement should be updated, with the agreement of the client, to reflect that.

A registered provider must ensure the following in relation to the service agreement:

- the individual is involved in the development and negotiation of the service agreement;
- if requested by the individual, a supporter, family member, carer or advocate of the individual, or any other person significant to the individual, is present during the development and negotiation of the service agreement;
- the service agreement is expressed in plain language and is readily understandable by the individual; and

[9] Registered provider must retain records relating to the Statement of Rights given to individuals under section 155-15 of the Rules.
[10] 'Start day' is defined in the Act at section 7, as the date the registered provider *starts delivering* funded age care services to the individual.

- the individual is helped to understand the terms of the service agreement.

There is a cooling off period for service agreements under section 148-65(3)-(4) of the Rules which allows individuals to withdraw from their service agreements by giving notice.

Service agreements are also required to state how they will be varied (section 148-65(5) of the Rules). This section provides that variation to a service agreement may be made following adequate consultation and mutual consent of the individual and the registered provider. Any variations to the agreement must be clearly documented in the individual's records and not be varied in a way that is inconsistent with the *New Tax System (Goods and Services Tax) Act 1999* (Cth) and the Act. Service Agreements can be varied at any time during a TCP episode. When a TCP episode is extended beyond the initial 12-week period up to a maximum to 18 weeks (further to an extension request application through an Assessment Delegate), this should also be recorded as a variation to the TCP episode length details in the service agreement.

The required specific contents of service agreements are set out in section 148-70. Service agreements for the provision of TCP must include the following:

- a statement setting out the parties to the agreement, including the contact details of the individual;
- the name of the provider;
- the contact details of the provider;
- the contact details of the supporters of the individual (if any);
- a copy of the individual's access approval (including Support Plan) from the assessment delegate;
- the approved residential care home (if any) in or from which the provider will deliver transition care to the individual;
- the date when the service agreement commences;
- the start day of care for the individual;
- when the provider will cease delivering care and services to the individual (this includes providing an exit strategy planned for the individual, for instance where the individual is expected to be discharged to, support services to be arranged, and carer briefings);
- the date when the service agreement ends; and
- which fees or contributions (if any), referred to in Division 3 of Part 3 of Chapter 4 of the Act, the provider will charge the individual, including copies of any policies and practices used to set fees, and information about what happens if an individual does not pay any agreed fees.

In addition, the service agreements are required to state the range of services, particularly physical and/or cognitive therapies, the individual has been assessed as requiring as per their Support Plan. Further to this, registered providers must adhere to the requirements for developing care and services plans for individual entering a TCP episode under Subdivision D, Division 3, Part 4, Chapter 4 of the Rules. Further information on care and services plans is in the next section. Registered providers are also required to state in the service agreement that the individual (or their supporter) is entitled to make, without fear of reprisal, any complaint about the provision of transition care and state the mechanisms for making a complaint. This refers to both internal and external complaints mechanisms (see *section 7.2 Complaints*).

Service agreements entered into under the new Act must be signed by the individual and should state any other matters to be agreed to between the parties such as any conditions under which either party may terminate the agreement. Responsibility for facilitating signing of the service agreement lies with the registered provider. Either the registered provider or their associated provider is able to sign the agreement, noting arrangements will be up to the jurisdictions and what works best in their respective TCP service delivery models.

As indicated in *Section 3.5.5 – Movement between care settings and services*, if an individual moves to a new registered provider during their transition care episode, a new service agreement must be developed with the new registered provider.

New service agreements do not need to be entered when moving between different associated providers who are sub-contacted by the registered provider, who has signed the initial service agreement with the TCP client. The initial service agreement that the registered provider signs, may indicate the associated providers that will be involved in the provision of care. If this changes during the course of an individual's TCP episode, this may be recorded as a variation to the initial service agreement signed with the registered provider.

Please see *Attachment B* for a Client Service Agreement Template which jurisdictions may choose to use or modify for use as they see fit. It is not compulsory to use this template if jurisdictions would like to develop their own based on the legislative requirements and their respective TCP operating models. The Client Service Agreement Template also assists with setting client expectations in terms of noting that the specific care and services clients will receive under

TCP will be those required to meet their assessed needs and goals, which will be detailed in the care and services plan their provider will develop for them.

5.3 Individual Care and Services Plans

A care and services plan must be developed for the TCP client on or before their start day under section 148-80 and 148-85 of the Rules. The care and services plan will be based on the client's needs assessment and accompanying Support Plan as signed off by the assessment delegate, which lists the client's goals in accessing transition care. The Support Plan will list that an individual is eligible for all the relevant transition care service groups and service types from the Aged Care Service List but the actual services that the client will receive from that complete list will be based on their individual needs as assessed by the a multidisciplinary care team of the registered provider (including associated providers), as they are commencing their TCP episode.

The care and services plan will primary have a therapeutic focus based on the individual's goals and will specify the type and level of available therapeutic services a TCP client is to receive, which incorporates a therapeutic plan for physical and cognitive needs developed through the individual's hospital discharge planning, the aged care assessment process and in consultation with the individual, and their carer or supporters where appropriate.

As is currently the case, when developing a client's care and services plan, TCP providers must comply with the TCP Restorative Care Requirements, which are detailed in these guidelines at Chapter 4. These are not changing during the transition to the new Act. Their core requirements remain:

- Requirement 1 – Optimising Independence and Wellbeing;
- Requirement 2 – Multidisciplinary Approach and Therapy Focussed Care; and
- Requirement 3 – Seamless Care.

As the client's TCP episode progresses, it is expected the care and services plan will be regularly reviewed or updated as required with detailed care plan information and progress notes from the registered provider's care team (these teams may also be engaged as associated providers). Any updates to the care and services plan is to be based on monitoring of changes in the client's condition and ongoing communications between the client, their supporters and care team.

TCP clients will not need to be reassessed by an Aged Care Needs Assessor if their condition, or TCP care setting changes through the course of their TCP episode.

Clients should be provided with a copy of the care and services plan when it is initially developed and any time it is updated, and also provided information on the full list of TCP service types that may be made available to them under the program. The Client Service Agreement Template developed by the Department at *Attachment B* includes an attachment with the full list of TCP service types.

5.4 Individual responsibilities

As well as having rights that must be respected, individuals receiving TCP services, or their supporters where appropriate, have responsibilities to the registered provider, care staff, other individuals in care and themselves.

The Department expects that responsibilities of individuals will be agreed between both parties and not be inconsistent with any requirements of the Act and the Rules. These responsibilities are to be clearly articulated in the service agreement between the registered provider and the individual.

In the spirit of the individual and the TCP registered provider having reciprocal responsibilities, the individual's responsibilities include the following:

- respecting the rights of staff and the provider to work in a safe and healthy environment free from harassment;
- respecting the rights and needs of other individuals (for transition care delivered in a residential setting);
- caring for their own health and well-being, as far as they are capable;
- working to achieve the goals articulated in their agreed individual care and services plan;
- informing the registered provider about any required changes to the care and services plan or service agreement;
- providing information to the registered provider about their wants and needs;
- notifying the registered provider of any special requirements;
- providing constructive feedback to the registered provider about the service's performance; and
- contributing to the cost of care where appropriate.

5.5 Advocacy

Registered providers should present information to individuals on the role of advocates.

An individual has the right to call on an advocate of their choice to represent them as required in the management of their care, including establishing or reviewing their service agreement, negotiating the fees they may be asked to pay and in presenting any complaints they may have.

If an individual requires assistance, the National Aged Care Advocacy Program (**NACAP**) provides free, independent and confidential advocacy support, education and information. NACAP is provided Australia-wide by the Older Persons Advocacy Network (**OPAN**). OPAN can be contacted between 8am to 8pm from Monday to Friday and between 10am to 4pm on Saturday on 1800 700 600 (free call) or at www.opan.org.au. An advocate can help an individual to make informed decisions and support them in raising concerns and working towards a resolution.

5.6 Privacy/confidentiality

Under section 168 of the Act, registered providers of TCP must ensure the protection of personal information, relating to an individual to whom the registered provider delivers TCP services. The personal information must not be used other than:

- for a purpose connected with the delivery of a funded aged care service to the individual; or
- for a purpose for which the personal information was given to the registered provider.

Except with the consent of the individual, the personal information must not be disclosed to any other person other than:

- for a purpose connected with the delivery of TCP services to the individual by the registered provider;
- for a purpose connected with the delivery of TCP services to the individual by an associated provider of the registered provider, or another registered provider; or
- for a purpose for which the personal information was given; or
- for the purpose of complying with an obligation under the Act.

The personal information must be protected by security safeguards that it is reasonable in the circumstances to take by registered providers against the loss or misuse of the information. The obligations in section 168, however, do not prevent personal information being given to a court, or to a tribunal, authority or person having the power to require the production of documents or the answering of questions, in accordance with a requirement of that court, tribunal, authority, or person.

Chapter 7 of the Act outline the responsibilities relating to the protection of personal information by the Australian Government. Section 538 outlines unauthorised use and disclosure of protected information by officers of the Australian Government. Protected information is defined under section 21 of the Act as personal information or information (including commercially sensitive information) the disclosure of which could reasonably be expected to found an action by an entity (other than the Australian Government) for breach of a duty of confidence.

Sections 537 – 542 authorises the use and disclosure of protected information and relevant information by the Australian Government and its representatives/officials in various circumstances. Some of the circumstances prescribed in these sections of the Act are as follows:

- use or disclosure in performing functions or exercising powers under the Act;
- use or disclosure for purposes of proceedings;
- use or disclosure required or authorised by another Australian law;
- disclosure to an entity to whom the information relates; and
- use or disclosure of information that has already lawfully been made public.

It is the responsibility of each registered provider to ensure that it protects the privacy of the individuals in their care and complies with all applicable laws relating to the use of personal information or protected information.

Registered providers should also determine how they meet the Australian Privacy Principles in the *Privacy Act 1988* (Cth) and/or similar obligations contained in State or Territory privacy laws.

5.7 Fees payable by individuals receiving transition care

Section 286 of the Act and section 286-10 of the Rules sets out the requirements for the charging of client fees by registered providers of TCP services (this fee is referred to as a *specialist aged care program fee* under the Rules) and the maximum amount that can be charged to individuals.

Registered providers may ask individuals to pay a care fee as a contribution to the cost of their care. Any fees must be fully explained to the individual and the amount charged forms part of the service agreement between the individual and registered provider.

The maximum amount that can be charged as per section 286-10 of the Rules is:

- if TCP is delivered through the residential care service group —the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis); or
- if TCP is delivered in a community/home setting and is delivered through the home support, or assistive technology service groups — the amount obtained by rounding down to the nearest cent the amount equal to 17.5% of the basic age pension amount (worked out on a per day basis).

An individual's access to transition care should not be affected by their ability to pay fees but should be decided based on their need for care and the capacity of the registered provider to meet that need.

Decisions on whether to charge fees are entirely at the discretion of each State and Territory. The Australian Government recommends that fees be waived for financially disadvantaged individuals.

Information on the cost of transition care for individuals is outlined on the My Aged Care website.

5.7.1 Determining care fees

The process of setting fees should be as simple and unobtrusive as possible, respecting the individual's right to privacy and confidentiality.

To ascertain an individual's ability to contribute to the cost of their transition care, the service provider may only request information that is reasonable to request under the circumstances (i.e. the individual is an in-patient of the hospital before entering transition care).

In determining an individual's capacity to pay fees, the service provider should consider any exceptional and unavoidable expenses incurred by the individual.

Where an individual enters a TCP episode, while receiving other forms of funded aged care services, registered providers should consider the interaction of the TCP with these other services in determining the capacity of individuals to pay fees. For instance, Support at Home services can continue to be accessed while accessing TCP, as long as the services are not duplicative. It is expected that the individual's Support at Home provider and the relevant transition care provider will discuss and coordinate care provision to ensure the individual's needs are met. During this period, Support at Home providers can claim subsidies for care management services for activities related to coordination and consultation with TCP stakeholders. Further information can be found in the Support at Home Program Manual.

Similarly, residents who were in residential aged care before entering hospital may continue to be charged fees by their original residential care service whilst receiving transition care services, which may impact on their capacity to pay fees for transition care.

Each March and September when new pension rates are announced, the Department notifies the registered providers of any variations in the rate of the maximum fees for transition care. The approved providers should then notify all associated providers of the new rate. These rates are published on the Department's website at: Schedule of Fees and Charges for Residential and Home Care.

5.7.2 Payment of fees in advance

Service providers may ask for fees up to one month in advance under section 286(3) of the Act. If the individual dies or stops accessing TCP services, any amounts paid in advance for a day occurring after the individual dies or stops accessing those services must be refunded under the requirements as set out in section 285-17 of the Rules.

5.7.3 Waiving Fees (Financial Hardship)

Transition care registered providers are required to have a financial hardship policy in place and publicly available and under such a policy, can waive or reduce the *specialist aged care program fee* payable by individuals in circumstances where an individual is experiencing financial hardship. The individual will need to apply for a waiver or reduction of the fee. Individuals should discuss their financial circumstances with the transition care registered provider at the time of entering into the service agreement and also during the episode if any financial circumstances change and they are experiencing financial hardship (see section 286-20 of the Rules and *Section 5.7.1 Determining care fees* above).

CHAPTER 6 RESPONSIBILITIES OF REGISTERED PROVIDERS

Part 4 of Chapter 3 of the Act sets out the responsibilities of the registered providers of all funded aged care services including the TCP.

6.1 Compliance with the legislation

Registered providers are assessed and registered by the Commission as per functions given to the Commission under the Act and therefore must comply with the requirements set out in the Act and the Rules. This chapter identifies the key responsibilities of registered providers of the TCP under the Act and Rules.

While these guidelines provide additional advice on responsibilities of the registered providers and a measure of policy interpretation, it is strongly recommended that registered providers and their sub-contracted service providers become familiar with the Act and the Rules to be fully aware of their responsibilities in all aspects of transition care.

The Department has developed an online search tool, Aged Care Provider Requirement Search, to assist registered providers navigate and understand their obligations under the Act and Rules. This can be access at Aged Care Provider Requirements Search.

6.1.1 Failure to comply

Chapter 6 of the Act outline the regulatory functions and powers available to the Commission, Complaints Commission and the System Governor, including the regulatory responses available for non-compliance by registered providers.

Failure to meet responsibilities under the Act can lead to the imposition of civil penalties and a range of other compliance actions such as injunctions, enforceable undertakings, and compliance notices on a registered provider under Chapter 7 of the Act. Most instances of non-compliance can be resolved without the registered provider incurring pecuniary penalties.

If, however, the registered provider does not remedy the non-compliance, one or more enforcement actions may be imposed. A decision to impose various enforcement actions under Chapter 6 of the Act are 'reviewable decisions' and must be subjected to an internal review, as required, before it is referred to the Administrative Review Tribunal for an external review.

Where registered providers sub-contracts out TCP service provision to associated providers, the registered providers will continue to be responsible for how their associated providers are delivering TCP services and whether it is in compliance with the legislative requirements. If there is a regulatory issue with the service delivery of a registered provider, the Commission will always work with the registered provider even when the service is being delivered by an associated provider. For example, where a registered provider (Provider A) is sub-contracting to an associated provider who may also be a registered provider (Provider B) and there is a regulatory issue with the service Provider B delivers as a registered provider, as well as what they deliver for Provider A, the Commission will work with Provider B to remedy the concern at a provider level but also work with Provider A to remedy (e.g. through the contractual arrangements with Provider B) any concerns related to the service delivery they are sub-contracting through Provider B.

6.1.2 Serious and immediate health and safety risk management and reporting

The Serious Incident Response Scheme (**SIRS**) commenced on 1 April 2021 for residential care and transition care delivered in a residential setting. From 1 December 2022, the SIRS also applied to home care and transition care delivered in home and community settings. SIRS aims to reduce abuse and neglect in aged care by increasing the transparency of serious incidents and providing a means by which the Commission can respond to such incidents.

TCP registered providers must comply with the incident management and reporting requirements under the Act (sections 164 and 165) and the Rules (Chapter 4, Part 10, Division 1 and Chapter 5, Part 2, Division 2). The information below provides a high-level summary of the SIRS requirements. Registered providers should refer to the legislation for information on detailed requirements and check the Commission's website at aged care quality.gov.au/sirs for further SIRS information, including provider resources. Alternatively, the Commission can be contacted by emailing sirs@agedcarequality.gov.au or calling on 1800 081 549.

Incident management system

The SIRS requires every registered provider to have in place an effective incident management system – a set of protocols, processes, and standard operating procedures that staff are trained in and expected to use when reporting and responding to incidents. Responsibility to establish an incident management system and notify the Commission of any reportable incident, sits with the registered provider through their accounts in the My Aged Care portal. The

registered provider is also responsible for determining how information about an incident moves from any sub-contracted TCP service or associated providers to the registered provider and/or the Commission. As registered providers are responsible for reporting incidents through their My Aged Care accounts, they should liaise and agree with any associated providers about how they will obtain information about incidents occurring when associated providers are delivering a TCP service and also to what extent, associated providers, will bear responsibility for reporting via the My Aged Care portal, given this may require system access to be arranged by registered providers for their associated providers.

Managing and responding to incidents

Under the SIRS, registered providers need to manage incidents and take reasonable steps to prevent incidents with a focus on the safety, health and wellbeing of individuals.

Consistent with the incident management system arrangements, these responsibilities relate to a range of incidents that occur, or are alleged or suspected to occur, in connection with the delivery of aged care services, that either have caused, or could reasonably have been expected to have caused, harm to an individual in care or another person.

As part of these responsibilities, registered providers must respond to incidents by assessing and providing support and assistance to persons affected by incidents to ensure their health, safety and wellbeing. Registered providers should use an open disclosure process and make sure to involve persons affected by incidents in the management and resolution of the incident.

For more information refer to the SIRS guidance for providers on the Aged Care Quality and Safety Commission website.

Reportable incidents

SIRS reporting is facilitated through the My Aged Care Provider Portal. Specific guidance and resources for providers on reporting incidents through the My Aged Care Provider Portal, can be found by visiting the resources page on the Department of Health and Aged Care website.

Under SIRS, certain types of incidents must be reported to the Commission, referred to as reportable incidents. This can include both incidents that occur or are alleged or suspected to have occurred and may also include incidents involving individuals with cognitive or mental impairment (such as dementia). There are 8 types of reportable incidents involving individuals that must be reported to the Commission. If the incident is of a criminal nature, it must also be reported to the police.

The table below sets out the differences in the definitions of what is considered to be a reportable incident for residential care settings and home and community settings.

Residential setting	Home or community setting
Unreasonable use of force – includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force. It does not include gently touching an individual for the purposes of providing a service, to attract their attention, to guide them, or to comfort them when distressed.	*Same as the residential setting*
Unlawful sexual contact or inappropriate sexual conduct – includes, where the contact or conduct is inflicted by an aged care worker: any conduct or contact of a sexual nature inflicted on the individual; any touching of an individual's genital area, anal area or breasts in circumstances where this is not necessary to deliver a service. For conduct by any person, it includes any non-consensual contact or conduct of a sexual nature, an act of indecency, and the sharing of intimate images of the individual, or engaging in conduct with the intention of making it easier to procure the individual to engage in sexual contact or conduct.	*Same as the residential setting*

Residential setting	Home or community setting
It does not include consensual contact or conduct of a sexual nature between the individual and a person who is not an aged care worker. It also does not include consensual contact or conduct of a sexual nature between the individual and an aged care worker, if the contact or conduct occurs other than while that person is delivering services to the individual.	
Psychological or emotional abuse – includes conduct that has caused the individual psychological or emotional distress, or which could reasonably have been expected to have caused an individual psychological or emotional distress. Examples include taunting, bullying, harassment, intimidation, threats of maltreatment, and humiliation.	*Same as the residential setting*
Stealing or financial coercion by a staff member – includes stealing from the individual by an aged care worker, as well as conduct by an aged care worker that is coercive or deceptive in relation to the individual's financial affairs or which unreasonably controls the individual's financial affairs.	*Same as the residential setting*
Neglect of an individual – circumstances in which a registered provider, aged care worker, or responsible person of the registered provider: • has been reckless or intentionally negligent in delivering a service; • has caused or contributed to a significant failure to deliver services or a systematic pattern of conduct; • has delivered a grossly inadequate service to an individual; • has delivered a service to an individual that exposes the individual to a risk of serious injury or illness.	Same as the residential setting
Unexplained absence from care – an absence of the individual from the home where there are reasonable grounds to report the absence to the police.	**Unexplained absence from care** – an absence of the individual from the setting during the delivery of a service to the individual in circumstances where there are reasonable grounds to report the absence to the police.
Unexpected death – includes deaths where: • the death resulted from services delivered by the registered provider, or a failure by the registered provider to deliver services.	**Unexpected death** – includes deaths where: • the individual was accessing services in a residential care home and reasonable steps were not taken to prevent the death; • the death resulted from services delivered by the registered provider, or a failure by the registered provider to deliver services.
Inappropriate use of restrictive practices – where a restrictive practice is used in relation to an individual and this use is not in accordance with the requirements for use of a restrictive practice set out in the Act and Rules. See in particularly clause 16-15 of the Aged Care Rules 2025.	**Inappropriate use of restrictive practices** – where a restrictive practice is used in relation to an individual and this use is not in accordance with the requirements for use of a restrictive practice set out in the Act and Rules. See in particular Chapter 4, Part 9 of the Rules.

For more detail on what is a reportable incident and examples for each care setting, please review guidance on the Commission's website.

Reporting timeframes

All **'Priority 1**' reportable incidents must be reported to the Commission, and the police where the incident is of a criminal nature, by the registered provider within **24 hours** of the provider becoming aware of the incident. There are certain types of reportable incidents that must always be reported as a Priority 1 reportable incident:

- an incident that has caused an individual physical or psychological injury or discomfort that requires medical or psychological treatment to resolve;
- where there are reasonable grounds to report that incident to the police;
- the unexpected death of an individual;
- an individual's unexplained absence from the service; or
- unlawful sexual contact or inappropriate sexual conduct.

All **'Priority 2'** incidents must be reported to the Commission within 30 days of becoming aware of the incident. Priority 2 incidents include all other reportable incidents that do not meet the criteria for a 'Priority 1' incident. The SIRS decision support tool helps providers to quickly and easily determine the difference between 'Priority 1' and 'Priority 2' reportable incidents.

While the 24-hour timeframe to report Priority 1 incidents to the Commission and the police commences from the point in time the registered provider is aware of the incident, staff members of registered providers (any individual who is employed, hired, retained or contracted by the registered provider or a TCP service provider, whether directly or through an employment or recruiting agency, and including volunteers) who are aware of a reportable incident, must notify the registered provider as soon as possible. For example, if a person working for a third-party organisation is caring for a person in bed-based TCP and there is an unexpected death (SIRS incident category) of that person on a Friday night, that person must notify the registered provider's key personnel as soon as possible. If the registered provider becomes aware on Friday night, they will still need to comply with timeframes and report the incident to police and the Commission within 24 hours (i.e. by Saturday night).

Protection against disclosure

Registered providers will also have to provide certain protections to persons who make disclosures about reportable incidents in accordance with the Act (Part 5, Chapter 7 – Whistleblower protections).

6.1.3 Minimising the use of restraints

Legislative requirements regarding the use of physical and chemical restraints are contained in section 17-18 and sections 162-163 of the Act. These requirements also apply to registered provider of TCP services. TCP providers should familiarise themselves with the restraint requirements and continue to apply the guidance contained in the Decision-Making Tool: Supporting a Restraint Free Environment in Community Aged Care and Residential Aged Care, available on the Commission's website at Restrictive practices provider resources | Aged Care Quality and Safety Commission.

6.2 Specific legislative requirements

The responsibilities of registered providers are generally set out in Part 4 of Chapter 3 of the Act – Obligations of registered providers and conditions on registration of registered providers. Some specific legislative requirements are outlined below.

6.2.1 TCP subsidy

Section 248 of the Act states the requirements which must be satisfied to claim the TCP subsidy, and the basis on which it will be paid to registered providers. To be eligible for a TCP subsidy, registered providers must be:

- registered as an aged care provider with the Aged Care Quality and Safety Commissioner; and
- allocated Places that are:
    - able to be used to deliver funded Aged Care Services; and
    - in effect under the Act and that meet any conditions of allocation that apply to those places.

The TCP subsidy rate is stated in section 249-90 of the Rules. Section 260 sets out requirement for claims and payment of TCP subsidies. It is a condition on which subsidy is paid to a registered provider under that section that the subsidy is used by the registered provider only for the purpose of delivering funded aged care services to individuals in circumstances where all of the following apply:

- the services are delivered to the individual by the registered provider under a place that is in effect under section 97 of the Act for the program and service group;
- all conditions on those places under section 99 have been complied with;
- the registered provider's registration is in effect and covers the delivery of each of those services; and
- each of those individuals has an access approval in effect that covers each of the services being delivered to the individual.

The Australian Government can recover amounts paid in circumstances where a registered provider breaches the above condition under section 514 of the Act.

6.2.2 Record keeping

Section 543 of the Act and section 543-5 of the Rules cover the records former registered providers are required to keep in relation to the administration of TCP services. Part 15 of Chapter 6 of the Act also cover the provision of false or misleading information under the Act and the penalties that may apply. Registered providers should also ensure they maintain the health records of individuals in accordance with the local State or Territory legislation and policy guidelines, as appropriate.

6.2.3 Quality of care

Section 146 of the Act outlines the condition of registration that registered providers must conform with the Aged Care Quality Standards. Registered providers are required to ensure they and their associated providers have a workforce that is sufficient, and appropriately skilled to provide safe, respectful, quality care and services. Further, section 147 of the Act and section 147-5 and 147-10 of the Rules set the condition of registration that a registered providers of TCP must demonstrate the capability for, and commitment to, continuous improvement towards the delivery of high quality care. It is a condition of registration under these sections that a registered provider of the TCP must have a continuous improvement plan.

6.2.4 Aged care workers

Subject to a staged implementation and transition requirements, section 152 of the Act sets out the condition of registration relating to aged care workers including that a registered provider must comply with the worker screening requirements prescribed by the Rules and ensure that aged care workers meet any qualifications and training requirements. An aged care worker and responsible persons of a registered provider must comply with the Aged Care Code of Conduct as specified in Part 5 of Chapter 1 of the Rules (see sections 173 and 174 of the Act).

6.2.5 Notification of a change of circumstances including changes in responsible persons

A registered provider must give notice to the Commissioner of any change in its circumstances as prescribed in the Rules (see section 167 of the Act). The changes may include:

- a change of circumstances or an event that materially affects the provider's suitability to be a registered provider taking into account the matters referred to in section 109(1)(b) of the Act (which deals with suitability of registered providers);
- a change of circumstances that relates to a suitability matter in relation to a responsible person of the provider;
- a change in the responsible persons of the provider;
- a significant change in the organisation or governance arrangements of the provider;
- a significant change in the scale of the provider in relation to the funded aged care services delivered;
- a change in the service types delivered by the provider;
- specified changes relating to the associated providers of the provider;
- specified changes to an approved residential care home; or
- specified financial and prudential matters.

A notice under subsection section 167 must be given within 14 days after the registered provider becomes aware of the change in circumstances, be in an approved form and include any information prescribed by the rules in relation to a change of circumstances.

Responsible persons

The Act and Rules places obligations on 'responsible persons' of registered providers of transition care including to have the required worker screening checks done (section 152 of the Act; 152-15 and 152-25 of the Rules) and report any change of circumstances or suitability to be a responsible person to the Commission (section 167-25 and 167-30 of the Rules). Responsible persons are also required to comply with the Aged Care Code of Conduct (section 174 of the Act).

The Act defines responsible person in section 12 as each of the following:

- if the registered provider is not a government entity—any person who is responsible for the executive decisions of the registered provider;
- if the registered provider is not a government entity—any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the registered provider;
- for any registered provider (including a government entity)— if the registered provider delivers, or proposes to deliver, a funded aged care service:
    - any person who has responsibility for overall management of the nursing services delivered by the registered provider, or overall management of the nursing services delivered at an approved residential care home of the registered provider, and who is a registered nurse; and
    - any person who is responsible for the day-to-day operations of an approved residential care home or service delivery branch of the registered provider.

The obligations placed on responsible persons are enforceable by the Commission and compliance action can be taken for non-compliance.

Due to the different structures and governance arrangements of registered providers who are government entities, the definition of responsible person allows government registered providers to nominate a responsible person of at least one sub-contractor entity (associate providers) who would be responsible for the day-to-day operations of the sub-contracting entity as a service delivery branch of the government registered provider. If a State or Territory Government's local health networks are the registered providers of TCP and the networks further sub-contract out services provision to other services, who are associated providers, then personnel of these associated providers can also be nominated as responsible persons. Please see *Attachment C* for more detailed guidance on responsible persons.

In recognition of the responsible person arrangements for government entities above, the Commission will require government registered providers of TCP (that is the State or Territory Department of Health) to nominate a key contact from their Department for the Commission to be able to contact about matter relating to their registration, complaints and compliance matters.

See the process steps below for updating registered provider responsible person details:

Step 1	Register the new responsible person on PRODA (Provider Digital Access system). PRODA is the online identity verification and authentication system, needed to access the Aged Care Provider Portal www.servicesaustralia.gov.au/organisations/business/services/proda-provider-digital-access
Step 2	Submit a notification form relating to a change of circumstances to the Aged Care Quality and Safety Commission (as part of its notification processing, the Commission will update GPMS) Process and requirement information: https://www.agedcarequality.gov.au/providers/notifying-material-changes-approved-providers. Form: here
Step 3	Submit a *Register, amend or remove users for Aged Care Provider Portal* form (AC004) to Services Australia to enable updates to the Aged Care Provider Portal (and the payments system). Information and form link: here
Step 4	If required, update the My Aged Care provider portal with new user details and deactivate previous users – see section 2.5 of the My Aged Care Provider Portal User Guide Part 1: Administrator Functions

6.2.6 Notification of deceased TCP recipient

Where a current TCP recipient passes away, the responsible TCP registered provider is to update the client's record in the My Aged Care system. Several processes are triggered to inactivate a client record when the client's status is marked as deceased and will prevent the client or their supporters from receiving further correspondence from My Aged Care (which can understandably be upsetting when the client has passed away).

This is in addition to the standard requirements in respect to ensuring accurate claims reporting, including selection of the 'deceased' discharge code.

In the unfortunate instance that a TCP registered provider or associated provider is first to discover an individual is deceased when delivering care and services, it is expected that they follow their own guidance protocols in relation to notifying emergency services and the appropriate key contact person for the individual, and the SIRS reporting obligations as mentioned above.

CHAPTER 7 QUALITY ASSURANCE AND COMPLAINTS IN TRANSITION CARE

7.1 Aged Care Quality Standards

The Aged Care Quality Standards (see Chapter 1 of the Rules) which have been reviewed and strengthened as part of the aged care reforms, commence with the Act from 1 November 2025. The Aged Care Quality Standards apply to providers registered in categories 4, 5 and 6, including where they are delivering relevant funded aged care services through a specialist aged care program. Further information on the different registration categories can be found on the Department's website here.

The Aged Care Quality Standards set the standard for the safety and quality of aged care accessed by older people in Australia. This makes it easier for individuals, their families, carers and supporters to understand what they can expect from a service. It also makes regulation simpler for providers working across multiple aged care services, and encourages innovation, excellence and continuous improvement.

The Aged Care Quality Standards, including information for individuals and specific guidance and resources to assist registered providers and aged care services with implementing and maintaining conformance with the standards, are available on the Commission's website at Strengthened Quality Standards | Aged Care Quality and Safety Commission.

7.2 Quality Monitoring and Reviews

From 1 November 2025, the new regulatory model will commence as part of the Act. This means the Commission will have the legal authority to review and monitor registered providers, against all applicable requirements under the Act and the Rules (which include the Aged Care Quality Standards).

7.2.1 How does the Commission regulate aged care services?

Regulating aged care requires clarity about the risks being addressed. The Commission applies a responsive, risk-based and proportionate approach to regulation. This means the focus of its activities is on the areas of greatest risk to the safety, health and well-being of individuals accessing aged care, and where care and services fall short of legislated standards.

The Commission will modify its program and direct its resources in response to the nature of risks to the safety, health, well-being and quality of life of individuals, and the circumstances and behaviours of the providers of the services that are regulated.

The Commission looks for evidence of what works in aged care practice and draws the sector's attention to this as appropriate. It uses education, information and targeted communications to support its regulatory objectives, including publishing outcomes of regulatory activities to support greater transparency and accountability.

The Commission identifies sector-wide risks through research, sector trend analysis and strategic conversations with individuals accessing aged care and providers.

Details of specific regulatory functions and activities are published on the Commission's website.

7.2.2 Audit process for TCP service provision

The Commission conducts audits to assess whether registered providers are delivering services in accordance with the Aged Care Quality Standards to inform the registration or renewal process.

This includes where those services are being delivered under the TCP, unless alternative audit arrangements are in place (see section 7.2.4 below)

Where a provider is registering for category 6 – residential care, this process will include an assessment of the residential care homes included in the provider's registration.

The Commission has developed updated audit guides in line with the requirements of the new regulatory model under the new Act, which can be accessed on its website:

- Registration audit guide | Aged Care Quality and Safety Commission
- Renewal of registration audit guide | Aged Care Quality and Safety Commission
- Variation of registration audit | Aged Care Quality and Safety Commission
- Pre-audit readiness checklist | Aged Care Quality and Safety Commission.

During the audit, the Commission's audit team will review individual consumer records and other relevant documents such as policies, procedures and registers. Individuals, representatives, staff and management are interviewed about their systems, processes and practices and activities, and interactions with individuals are observed.

A preliminary audit report is then drafted, which documents the provider's performance against the Aged Care Quality Standards. The provider is then invited to respond to the information in the preliminary audit report, before a final audit report is prepared. The Commission will prepare audit gradings in the final audit report, considering the preliminary audit report, any response made by the provider and any other relevant matters.

Where non-conformance with the Aged Care Quality Standards is identified, the Commission's response will be risk based and proportionate to ensure the service returns to conformance and addresses any risks to the safety, health and well-being of individuals accessing aged care.

7.2.3 Managing non-compliance through continuous improvement

The Aged Care Quality Standards require registered providers to have effective organisation wide governance systems, including for continuous improvement (Standard 2 and the condition of registration related to continuous improvement in sub-section 147(1) of the Act). The governing body is expected to drive and monitor improvements to make sure the organisation is committed to quality care and services, and the best interests of individuals.

Evidence of continuous quality improvement also supports conformance with a number of other standards, such as those relating to risk management (Standard 2 – Outcome 2.4), and feedback and complaints (Standard 2 – Outcomes 2.6a and 2.6b).

Risk-based monitoring and management of non-compliance is determined by the Commission based on:

- the nature of non-conformance;
- the level of risk to individuals;
- what is known about the provider; and
- the information in the provider's revised plan for continuous improvement or remediating any non-conformance outcomes.

Where a risk is assessed as low or medium, the Commission may issue to the provider a direction to revise the plan for continuous improvement for the service. The revised plan must be given to the Commission. If the Commission is not satisfied that necessary improvements are being made to conform to the Aged Care Quality Standards as outlined in the plan for continuous improvement, then the Commission may escalate regulatory action.

Further information is available on the Commission's website at https://www.agedcarequality.gov.au/.

7.2.4 Alternative audit arrangements and the Integrated Health and Aged Care Services (IHACS) Module

As noted above, all registered providers must meet their obligations under the Aged Care Quality Standards where applicable from 1 November 2025. This includes providers who deliver services under TCP and who also deliver health services.

The Department is, however, working with the Commission and the Australian Commission on Quality and Safety in Health Care (**ACQSHC**) to implement expanded streamlined accreditation arrangements for some government providers who deliver integrated health and aged care services from 1 November 2025. These arrangements are designed to reduce duplication for providers who currently need to be separately audited under both health and aged care regulatory schemes.

These new arrangements will only apply to government providers who 'opt in' and are already accredited against the National Safety and Quality Health Service Standards **(NSQHS)**, and who deliver health services out of an approved residential care home in rural or remote locations (MM 3-7).[11] These providers can be accredited under the Australian Health Services Safety and Quality Accreditation (**AHSSQA**) Scheme, after being assessed against both the NSQHS Standards and the Integrated Health and Aged Care Services Module (**IHACS Module)**.

The IHACS Module is based on the Aged Care Quality Standards and covers those parts of the Aged Care Quality Standards which do not overlap with the NSQHS Standards. Further information on the IHACS Module can be found on the AHSSQA website.

Participating providers will be able to provide their AHSSQA assessment reports to the Commission, avoiding the need for a separate aged care audit to be completed by the Commission.

[11] Modified Monash Model (MMM) Modified Monash Model | Australian Government Department of Health, Disability and Ageing.

Note:

- These arrangements do not cover TCP providers who:
    - deliver services in a standalone residential aged care home or in a home and community setting (i.e. at or through a location that does not also deliver one or more health services), or
    - are not government entities or are located in a metropolitan or regional area (MM 1-2).
- Accreditation against the NSQHS standards and the IHACS Module also only applies to the residential care homes delivering the integrated health and aged care services – if a provider has other residential care homes that don't deliver integrated health and aged care, or are in MM 1 or 2, these will still need to be audited by the Commission.
- A further staged expansion of the IHACS Module arrangements will be considered from 2026 to cover other types of integrated health and aged care providers, including those that operate in the context of the TCP in an effort to further reduce duplication and administrative burden on providers.

7.2.5 Approach to regulation in transitioning to the Aged Care Act 2024

Both the Department and the Commission recognise the substantial undertaking required of States and Territories and all registered providers delivering aged care services, to integrate, embed and ensure full compliance with the requirements of the Act by the commencement date of 1 November 2025.

To further confirm the Commonwealth's and Commission's intended regulatory approach in this period of transition to the new arrangements, the Australian Government released a Statement of Expectations in June 2025 and the Commission has responded to this statement with its Statement of Intent. These documents set out an approach focused on support, collaboration and education to assist aged care providers (including jurisdictions in their capacity as registered providers for the purposes of TCP) to achieve full compliance, rather than one reliant on immediate recourse to punitive measures for identified non-compliance.

As outlined in the Commission's Statement of Intent, the Commission's regulatory approach will be consistent with its Regulatory Strategy. It will:

- always prioritise the health, safety, wellbeing and quality of life of older people receiving funded aged care and services, including by upholding their rights under the Statement of Rights.
- promote transparency and accountability by being:
    - fair – we remain objective and transparent in our decision making as we engage with older people, providers and workers in the collaborative task of upholding older people's rights.
    - balanced – our decisions and actions are consistent, based on assessed evidence and expert advice.
    - effective – we take the right actions to hold providers and workers accountable and everything we do is focused on outcomes to improve care and uphold older people's rights.
- recognise where providers are making efforts to comply with their legislative obligations, and engage these providers with an emphasis on continuous improvement toward the delivery of high-quality care.
- recognise providers who are getting it right and exceeding expectations in the quality of the care they provide.
- monitor compliance with obligations through supervision, incentivising providers to fix problems quickly and improve their performance.
- take swift and effective action, including enforcement actions, where a provider is unwilling to comply with their obligations or is putting older people at risk, to deter the provider from repeating the same behaviour in the future and to put other providers on notice that such conduct will not be tolerated.

7.3 Complaints

It is a condition of registration for registered providers that they implement and maintain a complaints and feedback management system under section 165 of the Act and associated rules. This includes informing individuals (or their supporters) in the service agreement of internal and external mechanisms for addressing complaints made by, or on behalf of, the individual.

Providers registered in registration categories 4, 5 and 6 are also required to meet the feedback and complaints requirements under Aged Care Quality Standard 2 (Outcomes 2.6a and 2.6b).

7.3.1 Internal complaints processes

If individuals have concerns about the provision of care and services under the TCP, they are to be encouraged to approach the service provider (this could be the registered provider themselves or an associated provider providing TCP on behalf of the registered provider) in the first instance. In most cases, the service provider is best placed to

resolve complaints and alleviate the concerns of individuals. Service providers must handle any complaints fairly, promptly, confidentially and without retribution.

Complaints should be used positively to monitor and improve the quality of services provided. Actively encouraging individuals to provide feedback, both positive and negative, and duly considering this feedback will improve services and provide opportunities for continuous improvement.

TCP registered providers and associated providers must also provide information in service agreements about external complaint mechanisms and relevant contact information, such as telephone numbers of State/Territory or Australian Government complaints bodies.

7.3.2 External complaints processes

If individuals (or their supporters) cannot resolve their dispute with the transition care registered provider, they may choose to direct their complaints to either the Commission (see *section 7.3.3 The Aged Care Quality and Safety Commission*), or alternatively, the relevant State/Territory 'Health Complaints Agency' outlined in the table below.

Jurisdiction	Health Complaints Agency
New South Wales	Health Care Complaints Commission
Victoria	Health Complaints Commissioner
Queensland	The Office of the Health Ombudsman
South Australia	Health and Community Services Complaints Commissioner
Western Australia	Health and Disability Services Complaints Office
Tasmania	Health Complaints Commissioner Tasmania
Northern Territory	Health and Community Services Complaints Commissioner
Australian Capital Territory	ACT Human Rights Commission

7.3.3 The Aged Care Quality and Safety Commission (the Commission)

The Aged Care Quality and Safety Commission replaced the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner on 1 January 2019. The Commission's role as the Australian Government regulator of aged care service provision is to protect and enhance the safety, health, well-being, and quality of life for people receiving aged care. The Commission provides a free service that handles concerns or complaints about service providers and can also provide support with information and options to resolve aged care concerns and complaints.

The Commission can be contacted as follows:

Free Call: 1800 951 822 9am – 5pm Monday to Friday

Mail: Aged Care Quality and Safety Commission
GPO Box 9819
In the capital city and State/Territory transition care is being provided

Email: info@agedcarequality.gov.au

CHAPTER 8 TCP ADMINISTRAITON

8.1 Transition Care Program Agreement

Section 247(1)(b) of the Act sets out the requirements for a TCP Agreement to be in place between the Australian Government and each State and Territory government.

Adherence to the TCP Agreement forms one of the conditions of allocation of transition care places to States and Territories or their nominated registered providers. The TCP Agreement sets out how the TCP program will be managed nationally and the administrative arrangements and responsibilities of the Australian Government and the States and Territories in relation to the program.

8.2 Annual Accountability Reporting by Registered Providers

As set out in section 166-745 of the Rules, TCP registered providers are required to provide an Annual Accountability Report (AAR) to the System Governor each financial year.

In accordance with the preference of the State or Territory, Transition Care Annual Accountability Reports must be either:

- collated by the State or Territory as registered provider and provided to the Department; or
- collated by the State or Territory on behalf of their nominated registered providers and provided to the Department; or
- provided to the Department directly by nominated registered providers, who must ensure the State or Territory is copied into this correspondence.

ATTACHMENT A – AGED CARE RULES – CHAPTER 1 – CONSOLIDATED TCP SERVICE LIST

Division 2 – Home support service types

8-15 Allied health and therapy

(1) A service listed and described in an item of the following table is in the service type allied health and therapy.

(2) The service requirements for a service listed and described in an item of the following table are that:

(a) the service is for the individual to regain or maintain physical, functional or cognitive abilities that support the individual to remain safe and independent at home; and

(b) the service is within the parameters specified in subsection (3); and

(c) the service is for the management of conditions related to age-related disability or decline.

(3) For the purposes of paragraph (2)(b), the parameters for a service are the following:

(a) the service may include clinical intervention, expertise, care and treatment, review, education (including techniques for self-management), and advice and supervision to improve capacity;

(b) the service aims to give the individual the skills and knowledge to manage their own condition and promote independent recovery where appropriate;

(c) the service may be delivered in person or via telehealth, as appropriate;

(d) the service may be delivered individually or in a group-based format (such as clinically supervised group exercise classes), as appropriate;

(e) for a service other than the services listed and described in items 6 and 7 of the following table—the service may be delivered:

(i) directly by a registered health practitioner or allied health professional (as applicable); or
(ii) by an allied health assistant or aged care worker, under the supervision of a registered health practitioner or allied health professional where safe and appropriate to do so;

(f) for the service listed and described in item 6 of the following table—the service may be delivered:

(i) directly by an Aboriginal or Torres Strait Islander Health Practitioner; or
(ii) by an allied health assistant or aged care worker, under the supervision of an Aboriginal or Torres Strait Islander Health Practitioner, where safe and appropriate to do so;

(g) for a service listed and described in item 7 of the following table—the service may be delivered:

(i) directly by an Aboriginal or Torres Strait Islander Health Worker; or
(ii) by an allied health assistant or aged care worker, under the supervision of Aboriginal or Torres Strait Islander Health Worker, where safe and appropriate to do so.

Services in the service type allied health and therapy		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Allied health assistance	Allied health therapy assistance that meets the service requirements specified in subsection (2)
2	Podiatry	Podiatry that meets the service requirements specified in subsection (2)
3	Social work	Social work activities that meet the service requirements specified in subsection (2)
4	Speech pathology	Speech pathology that meets the service requirements specified in subsection (2)
5	Diet or nutrition	Assistance with diet or nutrition that meets the service requirements specified in subsection (2)
6	Aboriginal or Torres Strait Islander Health Practitioner assistance	Assistance provided by an Aboriginal or Torres Strait Islander Health Practitioner that meets the service requirements specified in subsection (2)
7	Aboriginal or Torres Strait Islander Health Worker assistance	Assistance provided by an Aboriginal or Torres Strait Islander Health Worker that meets the service requirements specified in subsection (2)
8	Physiotherapy	Physiotherapy that meets the service requirements specified in subsection (2)
9	Psychology	Psychology that meets the service requirements specified in subsection (2)
10	Exercise physiology	Exercise physiology that meets the service requirements specified in subsection (2)
11	Occupational therapy	Occupational therapy that meets the service requirements specified in subsection (2)
12	Counselling or psychotherapy	Counselling or psychotherapy that meets the service requirements specified in subsection (2)
13	Music therapy	Music therapy that meets the service requirements specified in subsection (2)

8-20 Assistance with transition care

Each service listed and described the following table is in the service type assistance with transition care.

Services in the service type assistance with transition care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Transition care management	Initial and ongoing assessment, planning and management, and coordination and monitoring, of the individual's movement from hospital, through the TCP and back into the community or into a residential care home, including the following: a) ensuring that: (i) the individual's care and services plan is carried out; and (ii) progress against the care and services plan goals is monitored; b) acting as a central point of contact; c) liaising with and organising all care requirements provided by external service providers (including registered health practitioners and allied health professionals); d) administration and operation of the TCP, including documentation relating to the individual; e) arranging for another aged care assessment if needed prior to the completion of the individual's transition care episode; f) managing the individual's transition into their post transition care arrangements, including a comprehensive written and verbal handover Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
2	Assistance to access medical practitioner	Transport for the individual to visit a medical practitioner, or assistance in arranging a home visit by a medical practitioner
3	Transition care medication management	The following: (a) implementation of a safe and efficient system to manage prescribing, procuring, dispensing, supplying, packaging, storing and administering of both prescription and over-the-counter medicines; (b) administration of, and monitoring the effects of, medication (including injections), including supervision and physical assistance with taking both prescription and over-the-counter medication under the delegation and clinical supervision of a registered nurse or other appropriate registered health practitioner
4	Transition care emergency or after hours assistance	Having at least one suitably skilled employee of the registered provider or an appropriate agency and continuously on call to give emergency assistance when needed
5	Transition care continence management	The following: (a) assisting the individual to: (i) maintain continence or manage incontinence; and (ii) use aids and appliances designed to assist continence management; (b) the supply of aids and appliances designed to assist continence management to meet the individual's needs, including the following:

Services in the service type assistance with transition care		
Item	**Column 1** **Service**	**Column 2** **Description**
		(i) commode chairs, over-toilet chairs, bed-pans, uridomes, and catheter and urinary drainage appliances; (ii) as many continence aids (such as disposable urinal covers, pants, pads, chair pads and enemas) as are needed to meet the individual's needs
6	Waste disposal	Safe disposal of transition care related organic and inorganic waste material

8-35 Domestic assistance

A service listed and described in an item of the following table is in the service type domestic assistance.

Services in the service type domestic assistance		
Item	**Column 1** **Service**	**Column 2** **Description**
1	General house cleaning	The following: a) the provision of, or assistance with, light household cleaning, including mopping, vacuuming, washing dishes, and general tidying of surface areas, that ensure the individual remains safe at home; b) the supply of equipment or consumables required for cleaning mentioned in paragraph (a); but not including professional cleaning that would usually be paid for by an individual (such as carpet cleaning, pest control, dry cleaning or pet care)
2	Laundry services	The following: a) provision of, or assistance with, laundry activities including but not limited to the laundering of clothing and bedding and the ironing of clothing; b) the supply of consumables required for laundry activities mentioned in paragraph (a); but not including dry cleaning
3	Shopping assistance	The provision of shopping, or assistance with shopping activities, including developing a shopping list, online shopping, driving to a shop and assisting with the collection of shopping, but not including the cost of the shopping

8-45 Home maintenance and repairs

A service listed and described in an item of the following table is in the service type home maintenance and repairs.

Services in the service type home maintenance and repairs		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Gardening	The provision of, or assistance with, maintenance of a residential garden, including essential light gardening such as mowing lawns, pruning shrubs and clearing yards that contribute to maintaining the individual's home in a safe and habitable condition, but not including the following: a) professional gardening services that would usually be paid for by an individual (such as tree removal, landscaping or farm or water-feature maintenance);

Services in the service type home maintenance and repairs		
Item	**Column 1** **Service**	**Column 2** **Description**
		b) gardening services that relate to visual appeal rather than safety or accessibility (such as installing and maintaining plants, garden beds and compost); c) services that are the responsibility of other parties (such as landlords or government housing authorities)
2	Assistance with home maintenance and repairs	Essential minor repairs and maintenance: a) that the individual used to be able to do themselves, or that are required to maintain safety (such as cleaning gutters, replacing lightbulbs and repairing broken door handles); or b) that are required to address an imminent age-related safety risk (such as repairing uneven flooring that poses a falls risk or a section of carpet damaged by a wheelchair); but not including the following: c) professional maintenance and repair services that would usually be paid for by an individual (such as professional pest extermination, installing cabinetry or replacing carpets due to usual wear and tear); d) services that are the responsibility of other parties (such as landlords or government housing authorities)
3	Expenses for home maintenance and repairs	a) The supply of equipment or consumables required for that service

8-55 Meals

A service listed and described in an item of the following table is in the service type meals.

Services in the service type meals		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Meal delivery	Preparation, packaging and delivery of pre-prepared meals, but not including the following: a) the cost of ingredients; b) takeaway food delivery; c) meal delivery for other members of the household
2	Meal preparation	Support to prepare meals in the home or community, but not including the cost of ingredients

8-60 Nursing care

(1) A service listed and described in an item of the following table is in the service type nursing care.

Clinical care matters

(2) For items 1 to 3 of the following table, the clinical care matters are the following:

(a) the assessment, treatment and monitoring of clinical conditions;

(b) administration of medications;

(c) wound care;

(d) clinical continence management;

(e) management of skin integrity;

(f) education;

(g) specialist service linkage.

Services in the service type nursing care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Registered nurse clinical care	Clinical care provided by a registered nurse, including but not limited to the clinical care matters specified in subsection (2)
2	Enrolled nurse clinical care	Clinical care provided by an enrolled nurse, including but not limited to the clinical care matters specified in subsection (2)
3	Nursing assistant clinical care	Clinical care provided by a nursing assistant, including but not limited to the clinical care matters specified in subsection (2)
4	Nursing care consumables	The supply of consumables used in delivering the clinical care mentioned in items 1 to 3, including oxygen and specialised products for wound care, continence management and skin integrity

8-65 Nutrition

A service listed and described in an item of the following table is in the service type nutrition.

Services in the service type nutrition		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Nutrition supports	The supply of: a) supplementary dietary products (enteral and oral); and b) aids; that are: c) required for conditions related to age-related functional decline or impairment; and d) prescribed by a dietitian or registered health practitioner

8-70 Personal care

A service listed and described in an item of the following table is in the service type personal care.

Services in the service type personal care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Assistance with self-care and activities of daily living	Attendant care to meet essential and ongoing needs (such as mobility, eating and hygiene), but not including professional services that would usually be paid for by an individual (such as waxing or hairdressing)
2	Assistance with self-administration of medications	Assistance with self-administration of medications, including arranging for medications to be dispensed by a pharmacist, but not including prescribing or administering medications
3	Continence management (non-clinical)	Attendant non-clinical care to manage continence needs (such as support to access advice or funding, or assistance changing aids)

Division 3 – Other specified matters for home support service types

8-95 All service types must be delivered in a home or community setting

All service types in the service group home support must be delivered in a home or community setting.

8-100 Other specified matters—service types that can only be delivered under specialist aged care programs

A service type mentioned in column 1 of an item of the following table:

(a) is in the service group home support; and

(b) can only be delivered under a specialist aged care program mentioned in column 2 of the item; and

(c) can be delivered under a provider registration category mentioned in column 3 of the item.

Other specified matters			
Item	**Column 1** **Service type**	**Column 2** **Specialist aged care programs**	**Column 3** **Provider registration categories**
1	Assistance with transition care	TCP	Nursing and transition care

8-105 Other specified matters—other service types

Service group, specialist aged care programs and provider registration categories

(1) A service type mentioned in column 1 of an item of the following table:

(a) is in the service group home support; and

(b) can be delivered under a specialist aged care program mentioned in column 2 of the item; and

(c) can be delivered under a provider registration category mentioned in column 3 of the item.

~~*Means testing categories*~~

~~(2) The means testing category for a service in a service type mentioned in column 1 of an item of the following table is the means testing category mentioned in column 4 of the item.~~

Other specified matters				
Item	**Column 1** **Service type**	**Column 2** **Specialist aged care programs**	**Column 3** **Provider registration categories**	**Column 4** **Means testing category**
1	Allied health and therapy	a) CHSP; b) MPSP; c) NATSIFACP d) TCP	Personal and care support in the home or community	Clinical supports
3	Domestic assistance	a) CHSP; b) MPSP; c) NATSIFACP;	Home and community services	Everyday living

Other specified matters				
Item	**Column 1** **Service type**	**Column 2** **Specialist aged care programs**	**Column 3** **Provider registration categories**	**Column 4** **Means testing category**
		d) TCP		
4	Home maintenance and repairs	a) CHSP; b) MPSP; c) NATSIFACP; d) TCP	Home and community services	Everyday living
6	Meals	a) CHSP; b) MPSP; c) NATSIFACP; d) TCP	Home and community services	Everyday living
7	Nursing care	a) CHSP; b) MPSP; c) NATSIFACP; d) TCP	Nursing and transition care	Clinical supports
8	Nutrition	a) MPSP; b) NATSIFACP; c) TCP	Personal and care support in the home or community	Clinical supports
9	Personal care	a) CHSP; b) MPSP; c) NATSIFACP; d) TCP	Personal and care support in the home or community	Independence

Division 4 – Assistive technology service types

8-110 Equipment and products

(1) A service listed and described in an item of the following table is in the service type equipment and products.

Means testing category

(2) For a service listed and described in any of items 1 to 10 of the following table, the means testing category is independence.

(3) For the service listed and described in item 11 of the following table, the means testing category is clinical supports.

Services in the service type equipment and products		
Item	**Column 1** **Service**	**Column 2** **Description**
5	Mobility items (non-loan)	A service: a) that consists of the sourcing, supply and provision to the individual, other than on loan, of included mobility items; and b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies
6	Mobility items (loan)	A service: a) that consists of the sourcing, supply and provision to the individual, on loan, of included mobility items; and b) to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies

Services in the service type equipment and products		
Item	**Column 1** **Service**	**Column 2** **Description**
11	Assistive technology prescription and clinical support	c) The following, delivered by a registered health practitioner or an allied health professional: (i) identifying an issue or problem that restricts the individual's physical, functional or cognitive ability; (ii) assessing the level of assistive technology needed for the individual to regain or maintain physical, functional or cognitive ability; (iii) identifying included AT~~-HM~~ items and conditionally included AT~~-HM~~ items ~~(other than included home modifications items)~~ that will assist the individual to regain or maintain physical, functional or cognitive ability;

Division 5 – Other specified matters for assistive technology service types

8-115 All service types must be delivered in a home or community setting

All service types in the service group assistive technology must be delivered in a home or community setting.

8-120 Other specified matters for assistive technology service types

The service type equipment and products:

(a) is in the service group assistive technology; and

(b) can be delivered under any of the following specialist aged care programs:

(i) CHSP;
(ii) MPSP;
(iii) NATSIFACP;
(iv) TCP; and

(c) can be delivered under the provider registration category assistive technology and home modifications.

Division 8 – Residential care service types

8-140 Residential accommodation

Each service listed and described in the following table is in the service type residential accommodation.

Services in the service type residential accommodation		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Accommodation	The following: a) capital infrastructure costs and depreciation of buildings and grounds used by individuals; b) communal areas for living, dining and recreation, as well as personal accommodation in either individual or shared rooms; c) refurbishments and replacements of fixtures, fittings and infrastructure; d) maintenance, of buildings and grounds used by individuals, to address normal wear and tear

Services in the service type residential accommodation		
Item	**Column 1** **Service**	**Column 2** **Description**
2	Accommodation administration	Administration relating to the general operation of the residential care home, including accommodation agreements, accommodation bond agreements and accommodation charge agreements

8-145 Residential everyday living

Each service listed and described in the following table is in the service type residential everyday living.

Services in the service type residential everyday living		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Operational administration and emergency assistance	The following: a) administration relating to: (i) the delivery of the other services listed and described in this table; and (ii) service agreements; b) emergency assistance, including: (i) at all times, having at least one suitable employee of the registered provider onsite and able to take action in an emergency; (ii) if an individual is in need of urgent medical attention—providing emergency assistance in accordance with the registered provider's protocol for providing such assistance; (iii) activation of emergency plans in the case of fire, floods or other emergency; (iv) contingency planning for emergencies; (v) staff training for emergencies
2	Communication services	Access for individuals to an external telecommunications mechanism in the residential care home (and in individual's rooms if requested), such as telephone, internet or Wi-Fi services, but not including any usage charges or device costs
3	Utilities	The following: a) utility running costs for the residential care home (such as electricity, water and gas); b) heating and cooling for bedrooms and common areas to a comfortable temperature; c) testing and tagging of all electrical equipment provided by the registered provider; but not including electrical equipment brought into the residential care home by individuals
4	Cleaning services and waste disposal	The following: a) cleanliness and tidiness of the entire residential care home, including the individual's personal area unless the individual chooses to and is able to maintain their personal area themselves; b) safe disposal of organic and inorganic waste material
5	Communal furnishings	Fit-for-purpose communal lounge and dining furniture, including the following: a) televisions;

Services in the service type residential everyday living		
Item	**Column 1** **Service**	**Column 2** **Description**
		b) if the residential care home has a communal outdoor space—outdoor furniture
6	Bedroom and bathroom furnishings	The following (other than bedroom and bathroom furnishings that are customised or that the individual chooses to provide): a) a bed and a mattress that meet the individual's care, safety and comfort needs, including, if required, a bed that is adjustable to cater for the individual's needs and accommodates the individual's height and weight; b) equipment or technologies used to ensure the safety of the individual in bed and to avoid injury to the individual and to aged care workers; c) pillows (including, if required, pressure cushions, tri pillows and wedge pillows); d) a bedside table, bedside locker or bedside chest of drawers, wardrobe space, draw screens (for shared rooms), a visitor chair (if required) and an over bed table (if required); e) a fixture or item of furniture where the individual can safely lock and store valuables, if this is not provided by the furniture items mentioned in paragraph (d); f) a chair, with arms, that meets the individual's care, safety and comfort needs, including, if required, a chair with particular features, such as an air, water or gel chair; g) a shower chair (if required), containers for personal laundry, and waste collection containers or bins for bedrooms and bathrooms; h) bed linen, blankets or doonas, air or ripple mattresses (if required), absorbent or waterproof covers, sheeting and bed pads (if required), bath towels, hand towels and face washers; i) laundering of all products mentioned in paragraph (h)
7	Toiletry goods	The supply of the following goods (or substitutes if needed to meet the individual's medical needs, including specialist products for conditions such as dermatitis) but not including alternative items requested on the basis of the individual's personal preferences: a) facial cleanser (or alternatives such as facial wipes), shower gel or soap, shower caps, shampoo and conditioner; b) toothpaste, toothbrushes and mouthwash; c) hairbrush or comb, shaving cream and disposable razors; d) tissues and toilet paper; e) moisturiser and deodorant; f) cleaning products for dentures, hearing aids, glasses and artificial limbs (and their storage containers)
8	Personal laundry	The following: a) laundering (other than by a special cleaning process such as dry cleaning or hand washing) items that can be machine washed, using laundry detergents that meet the individual's medical needs, such as skin sensitivities; b) if requested, ironing of machine washed clothes (other than underwear and socks);

Services in the service type residential everyday living		
Item	**Column 1** **Service**	**Column 2** **Description**
		c) a labelling system for the individual's clothing, but not including alternate labelling systems requested on the basis of the individual's personal preferences; d) return of personal laundry to the individual's clothing storage space
9	Meals and refreshments	The following: a) at least 3 meals served each day (including the option of dessert with either lunch or dinner) plus morning tea, afternoon tea and supper, of adequate variety, quality and quantity to meet the individual's nutritional and hydration needs; b) special diets where required to meet the individual's medical, cultural or religious needs, including but not limited to enteral feeding, nutritional supplements, texture modified meals and thickened fluids, diets to address food allergies and intolerances, and vegetarian, vegan, kosher and halal diets (but not for meeting the individual's social preferences on food source such as non-genetically modified and organic); c) reasonable flexibility in mealtimes, if requested, so the individual can exercise choice; d) a variety of non-alcoholic beverages available at all times (such as water, milk, fruit juice, tea and coffee); e) eating and drinking utensils and eating aids if needed; f) snack foods of adequate variety, including fruit and options suitable for texture modified diets, available at all times in the residential care home

8-150 Residential non-clinical care

Each service listed and described in the following table is in the service type residential non-clinical care.

Services in the service type residential non-clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Care and services administration	Administration related to: a) the delivery of the other services listed and described in the other items of this table; and b) the delivery of the services in the service type residential clinical care
2	Personal care assistance	Personal assistance, including individual attention, individual supervision and physical assistance, with the following: a) bathing, showering, personal hygiene and grooming (other than hairdressing); b) dressing, undressing and using dressing aids; c) eating and drinking, and using utensils and eating aids (including actual feeding if necessary); d) cleaning of personal items (and their storage containers) needed for daily living, including dentures, hearing aids, glasses, mobility aids and artificial limbs

Services in the service type residential non-clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
3	Communication	Assistance with daily communication, including the following: a) assistance to address difficulties arising from impaired hearing, sight or speech, cognitive impairment, or lack of common language (for example, visual aids such as cue cards, paper-based photo or alphabet spelling communication boards or books, photo based easy language written information, and menu and activity choice boards or learning of key phrases); b) fitting sensory communication aids and checking hearing aid batteries
4	Emotional support	The following: a) if the individual is experiencing social isolation, loneliness or emotional distress—ongoing emotional support to, and supervision of, the individual (including pastoral support); b) if the individual is new to the residential care home—assisting the individual to adjust to their new living environment; c) provision of culturally safe supports that have been determined in consultation with the individual and their supporters (if required)
5	Mobility and movement needs	The following (other than the provision of motorised wheelchairs, electric mobility scooters, customised aids, or mobility aids requested on the basis of the individual's personal preferences): a) assisting the individual with moving, walking and wheelchair use; b) assisting the individual with using devices and appliances designed to aid mobility; c) the fitting of artificial limbs and other personal mobility aids; d) supply and maintenance of crutches, quadruped walkers, walking frames, wheeled walkers, standing walkers, walking sticks, wheelchairs, and tilt-in-space chairs; e) aids and equipment used by aged care workers to move the individual, including for individuals with bariatric needs; taking into account: f) the individual's care, safety and comfort needs; and g) the individual's ability to use aids, appliances, devices and equipment; and h) the safety of other individuals and of aged care workers and visitors to the residential care home
6	Continence management	The following: a) assisting the individual to: (i) maintain continence or manage incontinence; and (ii) use aids and appliances designed to assist continence management; b) the supply of aids and appliances designed to assist continence management to meet the individual's needs, including the following: (i) commode chairs, over-toilet chairs, bed-pans, uridomes, and catheter and urinary drainage appliances;

Services in the service type residential non-clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		(ii) as many continence aids (such as disposable urinal covers, pants, pads, chair pads and enemas) as are needed to meet the individual's needs
7	Recreational and social activities	Tailored recreational programs and leisure activities (including communal recreational equipment and products) aimed at preventing loneliness and boredom, creating an enjoyable and interesting environment, and maintaining and improving the social interaction of the individual. These programs and activities must include the option of: a) at least one recreational or social activity each day that is not screen-based, television-based or meal-based; and b) regular outings into the community (but not including the cost of entry tickets, transport or purchased food and beverages associated with the outings)

8-155 Residential clinical care

Each service listed and described in the following table is in the service type residential clinical care.

Services in the service type residential clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
1	Care and services plan oversight	Ensuring that: the individual's care and services plan is carried out; and (b) progress against the care and services plan goals is monitored Note: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
2	Allied health, rehabilitation and therapeutic exercise therapy programs	Allied health, rehabilitation and therapeutic exercise therapy programs that are: a) designed by: (i) appropriate registered health practitioners; or (ii) appropriate allied health professionals; or (iii) appropriate registered health practitioners and appropriate allied health professionals; and b) designed in consultation with the individual and their supporters (if required); and c) delivered in individual or group settings; and d) delivered by, or under the supervision, direction or appropriate delegation of: (i) registered health practitioners; or (ii) allied health professionals; or (iii) registered health practitioners and allied health professionals; and e) aimed at maintaining and restoring the individual's physical, functional and communication abilities to perform daily tasks for themselves, including through: (i) maintenance therapy that is designed to provide ongoing therapy services to prevent reasonably avoidable physical and functional decline and maintain and improve levels of independence in everyday living; and

Services in the service type residential clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		(ii) if required, more focused restorative care therapy on a time-limited basis that is designed to allow the individual to reach a level of independence at which maintenance therapy will meet their needs; but not including the following: f) intensive, long-term rehabilitation services required following (for example) serious illness or injury, surgery or trauma; g) allied health services and appointments made for or by the individual or their supporters, that are in addition to those required to meet the individual's care needs under programs covered by paragraphs (a) to (e)
	Medication management	The following: a) implementation of a safe and efficient system to manage prescribing, procuring, dispensing, supplying, packaging, storing and administering of both prescription and over-the-counter medicines; b) administration and monitoring of the effects of medication (via all routes (including injections)), including supervision and physical assistance with taking both prescription and over-the-counter medication, under the delegation and clinical supervision of a registered nurse or other appropriate registered health practitioner; c) reviewing the appropriateness of medications as needed under the delegation and clinical supervision of a registered nurse, or other appropriate registered health practitioner; but not including the cost of prescription and over-the-counter medications
4	Nursing	Services provided by or under the supervision of a registered nurse, including but not limited to the following: a) initial comprehensive clinical assessment for input to the care and services plan for the individual, carried out: (i) in line with the individual's needs, goals and preferences; and (ii) by a registered nurse; and (iii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals; b) ongoing regular comprehensive clinical assessment of the individual, including identifying and responding appropriately to change or deterioration in function, behaviour, condition or risk, carried out: (i) in line with the individual's needs, goals and preferences; and (ii) by a registered nurse, or an enrolled nurse under appropriate delegation by a registered nurse; and (iii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals; c) all other nursing services, carried out: (i) by a registered nurse, or an enrolled nurse under appropriate delegation by a registered nurse; and (ii) if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or

Services in the service type residential clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		appropriate registered health practitioners and appropriate allied health professionals Note 1: Examples of services include (but are not limited to) the following: (a) ongoing monitoring and evaluation of the individual, and identification where care may need to be escalated or altered due to the changing health or needs of the individual; (b) maintaining accurate, comprehensive, and up-to-date clinical documentation of the individual's care; (c) assistance with, or provision of support for, personal hygiene, including oral health management and considerations for bariatric care needs; (d) chronic disease management, including blood glucose monitoring; (e) if the individual is living with cognitive decline—support and supervision of the individual; (f) if the individual is living with mental health decline—support and supervision of the individual; (g) establishment and supervision of a pain management plan, including the management and monitoring of chronic pain; (h) medication management (as listed and described in item 3 of this table); (i) insertion, maintenance, monitoring and removal of devices, including intravenous lines, naso-gastric tubes, catheters and negative pressure devices; (j) if the individual has identified feeding and swallowing needs—support for the individual; (k) skin assessment and the prevention and management of pressure injury wounds; (l) establishment and supervision of a continence management plan; (m) stoma care; (n) wound management, including of complex and chronic wounds; (o) provision of bandages, dressings, swabs, saline, drips, catheters, tubes and other medical items required as a part of nursing services; (p) assistance with, and ongoing supervision of, breathing, including oxygen therapy, suctioning of airways and tracheostomy care; (q) required support and observations for peritoneal dialysis treatment; (r) assisting or supporting an individual to use appropriate healthcare technology in support of their care, including telehealth; (s) risk management relating to infection prevention and control; (t) advance care planning, palliative care and end-of-life care. Note 2: For requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of this instrument. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of this instrument.
5	Dementia and cognition management	If the individual has dementia or other cognitive impairments: a) development of an individual therapy and support program designed and carried out to: (i) prevent or manage a particular condition or behaviour; and (ii) enhance the individual's quality of life; and (iii) enhance care for the individual; and b) ongoing support (including specific encouragement) to motivate or enable the individual to take part in general activities of the residential care home (if appropriate)
6	General access to medical and allied health services	The following: a) making arrangements for registered health practitioners to visit the individual for any necessary registered health practitioner appointments (but not the cost of the appointments or any gap payments charged for the appointments); b) making arrangements for the individual to attend any necessary registered health practitioner appointments (but not the cost of

Services in the service type residential clinical care		
Item	**Column 1** **Service**	**Column 2** **Description**
		the appointments or any gap payments charged for the appointments, or transport or escort costs); c) if required, making arrangements for allied health professionals to visit the individual, or for the individual to visit an allied health professional, for any services or appointments mentioned in paragraph (f) of item 2 of this table (but not the cost of the appointments or any gap payments charged for the appointments, or transport or escort costs); d) if required, provision of audio-visual equipment for use with telehealth appointments; e) arranging for an ambulance in emergency situations

ATTACHMENT B – CLIENT SERVICE AGREEMENT TEMPLATE

Transition Care Program (TCP) – Client Service Agreement – Template

Overview:

Under the *Aged Care Act 2024* (the Act) and the Aged Care Rules 2025 (the Rules), it is a condition of registration that a registered provider delivering services under the TCP must have an agreement with each individual accessing funded aged care services (a ***service agreement***). This agreement must comply with any applicable requirements prescribed by the Rules. This is outlined in paragraph 148(c) of the Act, and sections 148-65 and 148-70 of the Rules.

The TCP Client Service Agreement Template (the Template) can be used by providers to enter new service agreements. It is not mandatory to use the Template, and providers may develop their own service agreements in accordance with the requirements of the legislation.

Providers are free to include contextual information in service agreements that goes above the minimum requirements in the Template. They are encouraged to do so where it will assist individuals to understand the funded aged care services you will deliver to them and how you will deliver them.

It will be the responsibility of providers to implement required procedures to amend / vary a signed service agreement where detail is subsequently changed – for example, if the identified TCP episode start and end dates require amendment post the service agreement being signed.

Important:

- This Template also includes a checklist of information registered providers are required to give to an individual accessing aged care services under section 155 of the Act, where that information should be provided before, or when, you start delivering services to an individual, or soon after. It does not cover all requirements on providers under this section. **Note:** This information may also be required to be given to a supporter of an individual (see section 29 of the Act).
- Where required under section 148(e) of the Act, providers will also need to prepare a *Care and Services Plan* for a person to whom they are delivering services. This Template, as drafted, does not cover these provider obligations. Providers should create these documents separately where required, or combine with this document where considered appropriate.
- If an older person seeks to access your service for the first time **after 1 November 2025** and refuses to enter into a service agreement, you cannot provide Australian Government funded TCP services to them. This agreement should be signed by both parties.
- If an older person starts accessing your service **before 1 November 2025** this template does not apply to them.

Disclaimer:

The Template and the attached information sheet is **not** a substitute for legal advice.

The Commonwealth of Australia as represented by the Department of Health, Disability and Ageing (the Department) is **not** providing any legal advice to your organisation when making the Template available to your organisation.

Before any action or decision is taken by your organisation to use this Template, your organisation should obtain, and rely on, appropriate independent legal advice to understand the legal rights and obligations your organisation will have and whether the Template is suitable for use by your organisation.

Use of the Template is entirely at your own risk. The Template is provided to your organisation as a free resource and is general in nature. It does **not** take into account your particular circumstances or specific legal requirements. To the maximum extent permitted by law, the Department excludes all liability and accepts no responsibility for any damage or loss arising directly or indirectly from your organisation's use of the Template.

Transition Care Program (TCP) – Client Service Agreement

To be able to access funded aged care services, a person must enter into a **Client Service Agreement** with their registered aged care provider.

This Client Service Agreement is to be developed and negotiated in partnership with your Transition Care Program (TCP) registered provider, yourself and, if requested, your supporter, family member, carer, advocate or other significant person.

It is to be written in plain language that is easy for you to understand. As your Transition Care registered provider, we will also help to explain all of the details and any terms outlined in this agreement.

1. Your details		
Name		
Address		
Phone		
Email		
Date of birth		
2. Our details		
Transition Care Registered Provider		
Approved Transition Care service/s which will be providing your Transition Care services		
Service Provider Address		
Service Provider Phone		
Service Provider Email		
3. Making sure you are involved in decisions about your care		
How your Transition Care provider will involve you, and if you request it, your supporter, a family member or carer, in decisions about how, when and by whom your transition care services are delivered: *[Provider to outline details]*		
4. Services to be delivered		
Transition Care Access Approval	Date Transition Care Access Approval received: [enter date] ☐ **Copy of Transition Care Access Approval attached** Your Transition Care Access Approval is provided as part of your approved aged care assessment.	☐ **I have provided a copy of my Transition Care Access Approval to my provider**
Services to be Delivered	*[Note to Registered Provider: Provide a brief summary of the types of care and services to be delivered as per the client's access approval. Suggested general text for inclusion in this section is outlined below. A summary of the full list of approved TCP Service Types is available as an attachment and should be provided to all clients along with their Service Agreement].* You have been approved for care through the TCP. Transition Care is a short-term program of no more than 12-weeks, which is designed to improve your health following a	☐ **I understand the types of care and services I am to receive**

	hospital episode. The package of care and services you will receive will be a mixture of **low intensity therapy services, nursing support, and personal care supports**, tailored to meet the restorative care goals identified in your Access Approval. We will explain to you in detail **the identified services and supports that will be delivered to you**. These are to be based on your assessed restorative goals and needs, and also what care setting you are to receive Transition Care in. The specific types and levels of services you are to receive will be outlined in your individual detailed client **Care and Services Plan** (see below for more information) which we will develop in consultation with yourself. Your supports and services may vary over the course of your Transition Care episode, depending on what is best suited to meet your needs.	
Client Care and Services Plan	An initial client **Care and Services Plan** is to be developed by your care team in consultation with you, on or before the start date of your Transition Care episode. Your initial client Care and Services Plan is attached to this Service Agreement. It will detail the specific services and therapeutic supports you will receive to help you achieve the goals outlined in your Access Approval. Your initial client Care and Services Plan will **continue to be developed and finalised** by our care team in consultation with you, when we have further assessed how to best meet your needs once you have commenced your care episode. It will also be subject to review as you progress through your time in Transition Care. An amended copy will be made available to you whenever it is updated. Importantly, your client Care and Services Plan will also include information about your ongoing care needs and options, once your Transition Care episode concludes.	☐ **I confirm my client Care and Services Plan is attached to this Service Agreement.**
Care Delivery Setting	*[Note to Registered Providers: Include specific details about the care setting here – whether residential or home/community or a combination of both during the transition care episode, as per the goals listed on the access approval – suggested general text below].* To begin with, your Transition Care episode will commence and you will receive services and supports in the following care delivery	☐ **I understand what care setting/s I am to receive Transition Care services in.**

	setting: *[Provider to tick relevant box]* ☐ **Transition Care to be delivered in a residential aged care setting** ☐ **Transition Care to be delivered in a home or community setting** We may deliver Transition Care services to you using a combination of both home/community and residential aged care settings, as needed. Further details about your care delivery setting arrangements will be outlined in your Care and Services Plan.	
5. When Transition Care services will start and end		
Start date of Transition Care episode	[enter date] *[Provider to complete]* *[Note to Registered Provider: A reminder this is the TCP episode commencement date, which can be different from the commencement date of this Service Agreement which is the date it is signed and executed by both parties].*	
Expected end date of Transition Care Episode (noting this may vary depending on your recovery)	[enter date] *[Provider to complete]* *[Note to Registered Provider: should be up to 12 weeks from start date].*	
Extensions to Transition Care episode (where agreement to be updated if any extensions are subsequently applied for and approved)	[add extension details] *[Provider to record details of any extension application made to an Assessment Organisation and outcomes of those applications.* *[Note to Registered Provider: Any extensions granted will require a variation to this Client Service Agreement – that is to vary this section to include details of the extension(s) granted. More than one extension can be granted for a maximum of up to 6 weeks in addition to the initial 12 weeks TCP episode timeframe].*	

6. What you must pay – applicable client program fees		
Client fees	*[Note to Registered Providers: registered provider should have a fees policy if they will be charging a program fee and the fees policy should be explained to the client before they sign this Agreement. Providers are also required to have a financial hardship policy in place].* *[Provider, please tick relevant box]* ☐ **No client Transition Care fees to be charged** ☐ **Client Transition Care fees to be charged** *[Provider, if charging fees, add in amount in relevant setting box or delete if not applicable].* **Client fee rate:** Transition Care in a residential care setting **$ [enter amount] per day** **Client fee rate:** Transition Care in a home/community setting **$ [enter amount] per day** The maximum client fee amount that can be charged for the provision of Transition Care under the *Aged Care Act 2024* is: - in a residential care setting = 85% of the basic age pension amount (worked out on a per day basis); or - in a community/home care setting = 17.5% of the basic age pension amount (worked out on a per day basis). Transition Care fees may increase every year in line with changes to the basic aged care pension. **By signing this Client Service Agreement, you agree to pay the above contributions for the Transition Care funded aged care services we deliver to you.**	☐ **I have read and agreed to the information about client fees**

7. Cooling off period
There is a cooling off period where you may withdraw from this agreement by notifying us verbally or in writing **within 14 days of signing**. You can withdraw as long as we have not started delivering Transition Care services to you. If you decide to withdraw from this agreement during the cooling off period, the Client Service Agreement will have no effect. (See detail under 'Terminating Your Service Agreement' below if you decide you want to end this agreement once your Transition Care episode has already commenced).

8. Varying your agreement
You can approach us to vary this agreement at any time. There may also be times when we request a variation. We will only vary the agreement if we both agree.

Any variations must comply with the *Aged Care Act 2024* and *A New Tax System (Goods and Services Tax) Act 1999.* We may also vary this agreement where this is necessary so that it complies with the *A New Tax System (Goods and Services Tax) Act 1999.* When this occurs, we will provide you with reasonable notice in writing.		
9. Terminating this agreement		
You can terminate this agreement if you notify us in writing that: *[Provider to include detail of process]* **We** can terminate this agreement if we notify you in writing that: *[Provider to include detail of process]*		
10. Third Party Authority: People we can contact about your Client Service Agreement		
Contact person/registered supporter/guardian #1	Name	
	Address	
	Phone	
	Email	
	Relationship	
	Authority Detail	Date authority to commence: [enter date] What matters they can be contacted for: [enter information]
Contact person/registered supporter/guardian #2 (where applicable)	Name	
	Address	
	Phone	
	Email	
	Relationship	
	Authority Detail	Date authority to commence: [enter date] What matters they can be contacted for: [enter information]
11. Further information and support / Complaints		
Further information and Support	You can ask for assistance from a registered supporter or an unregistered friend or family member. In addition, you can seek legal and financial advice or seek the services of the Older Persons Advocacy Network on 1800 700 600 or by visiting www.opan.org.au.	
Complaints	If you have a complaint that you have not been able to work through with your Transition Care provider, you are able to raise it with: The **Aged Care Quality and Safety Commission** phone: 1800 951 822 or via their website at What to do if you have a complaint | Aged Care Quality and Safety Commission Or [insert relevant state or territory health body]	
12. Important information you need to understand about your care		

I have been provided a copy of key documents that relate to my care and I understand what my rights are.

- ☐ a copy of the Statement of Rights and information about my rights
- ☐ a copy of the Aged Care Code of Conduct
- ☐ information about how I can make a complaint or provide feedback
- ☐ information about how my personal information will be protected
- ☐ information about any 'policies or protocols' that are relevant to the individual *[Provider, delete if not applicable]*
- ☐ information relating to client fees and financial hardship policies.

13. Development of this agreement

This agreement has been developed in partnership with me, and I understand all parts of the agreement.

☐ **I agree that this Client Service Agreement has been developed following discussion and in partnership with me. I have had opportunity to ask questions, and I understand what I am agreeing to.**

Signing Section

Please sign below if:

- you would like to access the Transition Care Program services as outlined;
- you agree, to the best of your knowledge, that the above information is accurate; and
- you agree to the conditions in this document.

As your Transition Care provider, we will also sign this agreement.

You may wish to obtain independent legal or financial advice before signing. You can also seek assistance from:

- a supporter, family member, carer, advocate, or other significant person; and/or
- a translation service if needed (the Translating and Interpreting Service (TIS) National is a free service provided by the Australian Government for immediate phone interpreting relating to Australian Government funded aged care programs, available 24 hours a day, and can be contacted on 1300 655 820 for general enquiries, or 131 450 for immediate phone interpreting).

Transition Care Program Client Service Agreement for [insert client name]

Date this Client Service Agreement will commence: **[enter date]**

Date first service will be delivered: **[enter date]**

Cessation date: **[enter date]** *[Note to Registered Provider - add only if needed]*

[Provider, insert your PROVIDER SIGNATURE BLOCK here]

[Note to Registered Provider: an Associated Provider of a Registered Provider may sign the client service agreement on behalf of the Registered Provider, if the Registered Provider chooses to delegate this responsibility to its Associated Providers. If so, this is a matter relating to the commercial practices of Registered Providers and is subject to an agreement or commercial arrangements to do so between the Registered Provider and Associated Provider].

[Provider, insert the CLIENT SIGNATURE BLOCK here]

[Note to Registered Provider: If signed by an authorised representative, please specify their name and authority to enter into this agreement on behalf of the participant (e.g. power of attorney/guardian or your authorised guardian), and the date the authority has been enacted].

Transition Care Program: Full List of Approved Service Types

The new *Aged Care Act 2024* and its subordinate legislation (the *Aged Care Rules 2005*) include a consolidated list of **approved service types**, including specific approved care and service items, able to be delivered under all funded Commonwealth Aged Care Programs. The full list of service types approved for delivery under the Transition Care Program (TCP) are listed below. Detailed information on the service items and supports that sit under each service type can be viewed in the Rules.

The specific type and level of approved TCP services and supports a TCP client is to receive will be determined by what is required to meet the client's individual assessed goals and needs.

The exact package of approved services and supports to be received throughout a client's TCP episode will be outlined in the client's detailed Care and Services Plan.

TCP Delivery Setting	TCP Service Types

For All TCP Clients regardless of setting	• Assistance with transition care
	  ○ Item 1 – Transition care management
	  ○ Item 2 – Assistance to access medical practitioner
	Items 1-2 must be provided to all TCP clients regardless of their care setting.
	  ➢ Item 1 must be delivered to all TCP clients.
	  ➢ Item 2 must be delivered to TCP clients on an as-needs basis.

For TCP Delivered in a Home/Community Setting	• Allied Health and Therapy
	This Item must be delivered to TCP clients in a home or community care setting.
	• Assistance with transition care
	Items 3-6 under this service type must be provided to all TCP clients receiving care in a home or community setting who need them:
	  ○ Item 3 – Transition care medication management
	  ○ Item 4 – Transition care emergency or after-hours assistance
	  ○ Item 5 – Transition care continence management
	  ○ Item 6 – Waste disposal
	The following Service Types must be provided to TCP clients in a home or community setting if required to address their specified goals and needs:
	• Domestic Assistance
	• Home Maintenance and Repairs
	• Meals
	• Nursing Care
	• Nutrition
	• Personal care
	• Equipment and products
	  ○ Mobility items
	  ○ Assistive technology prescription and clinical support

For TCP Delivered in a Residential Aged Care Setting	The following Service Types must be provided to all TCP clients receiving care in a residential aged care setting who need them: • Residential accommodation • Residential everyday living • Residential non-clinical care • Residential clinical care

ATTACHMENT C – RESPONSIBLE PERSONS FOR GOVERNMENT ENTITIES

Who is a responsible person?

Section 12 of the *Aged Care Act 2024* defines 'responsible persons' as follows:

(1) Each of the following is a responsible person of a registered provider:

> *(a) if the registered provider is not a government entity—any person who is responsible for the executive decisions of the registered provider;*
>
> *(b) if the registered provider is not a government entity—any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the registered provider;*
>
> *(c) for any registered provider (including a government entity)—if the registered provider delivers, or proposes to deliver, a funded aged care service:*
>
> > *(i) any person who has responsibility for overall management of the nursing services delivered by the registered provider, or overall management of the nursing services delivered at an approved residential care home of the registered provider, and who is a registered nurse; and*
> >
> > *(ii) any person who is responsible for the day-to-day operations of an approved residential care home or service delivery branch of the registered provider.*
>
> *(2) Without limiting paragraph (1)(a), a person who is responsible for the executive decisions of a registered provider includes a member of the governing body of the provider.*

Sub-sections 12(c)(i) and 12(c)(ii) are meant to be read separately as a registered provider can have multiple responsible persons. We want to capture both persons who are in charge of nursing and those in charge of day-to-day operations.

The *Aged Care Act 2024* explanatory memorandum (lodged before the amendment carving out government entities from 12(1)(a) and (b)) goes to the definition of responsible persons on page numbers 66 and 67. There is also a supplementary explanatory memorandum which on page numbers 6 and 7 goes into the amendment to the Act around government entities. These documents are intended to aid with the interpretation of the Act and provide further context for this guidance on responsible persons.

Amendments (6) and (7) amend the definition of responsible person in clause 12 by inserting into 12(1)(a) and 12(1)(b), "if the registered provider is not a government entity —" before "any". These amendments address concerns raised by stakeholders that there may be difficulty in applying paragraphs 12(1)(a) and 12(1)(b) to government providers due to their different structures and governance arrangements, and the ability to identify with precision which individuals would meet the definition of responsible person under paragraphs 12(1)(a) and 12(1)(b). These amendments remove any possible ambiguity which may have arisen across provisions in the Bill regarding application of certain provisions to responsible persons of a government provider. Amendment (8) amends paragraph 12(1)(c) and inserts "for any registered provider (including a government entity) —" before "if" to make clear that this paragraph includes government entities.

Further, amendment (9) amends subparagraph 12(1)(c)(ii) to limit the scope of the definition of responsible person in relation to any persons who are responsible for the day-to-day operations of a registered provider, by inserting "of an approved residential care home or service delivery branch" after "operations". This clarifies that subparagraph 12(1)(c)(ii) is intended to cover any persons who are responsible for the day-to-day operations of an approved residential care home or service delivery branch, rather than of the registered provider more generally. This also helps to remove ambiguity across a number of provisions and ensures that government entities will still have at least one responsible person.

People engaged or employed by an **associated provider** may also meet the definition of a responsible person under the Act (for example, directors of nursing or facility managers) and be subject to additional obligations as a result.

What requirements are related to responsible persons?

Some key items are summarised below:

- The Commissioner will consider suitability matter (outlined in section 13) as part of registration and renewal (subsection 109(1)(d)).

- A registered provider must notify changes in responsible persons or changes in the responsible person suitability (outlined in subsection 167(3)(b) and(c) and the associated rules including 167-25 and 167-30).
- The registered provider must consider suitability every 12 months (section 172).
- The responsible person must notify the registered provider of a change in circumstances relating to suitability (section 169).
- The Commissioner may make a determination about a responsible person's suitability and the registered provider must comply (sections 170 and 171).
- Responsible persons must meet worker screening requirements (section 152 and associated rules) and the Aged Care Code of Conduct (section 174).
- There is a statutory duty for certain responsible persons (section 180) – those who meet 12(1)(a) or 12(1)(b) – government entities don't have to comply with these requirements as they do not have responsible persons under these subsections of the definition.
- Responsible persons may be subject to banning orders from the Commission.

GLOSSARY

Term	Meaning
Act	The *Aged Care Act 2024* (Cth).
Acute Care	Acute care in the context of transition care is care provided to hospital in-patients where the clinical intent or treatment goal is to: • cure illness or provide definitive treatment of injury; • perform surgery; • relieve symptoms of illness or injury (excluding palliative care); • reduce severity of an illness or injury; • protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; or • perform diagnostic or therapeutic procedures.
Advocacy Service	An advocacy service is an independent, confidential service provided free of charge in each State and Territory. If a person receives Australian Government subsidised aged care services, advocacy services can help them exercise their rights by representing them, and providing information, advice and support to them, their carer, family or friends. See the Older Persons Advocacy Network (OPAN) website.
Advocate	A person who acts on behalf of another party. In the absence of a carer, an independent advocate could be a general practitioner, legal representative, person appointed by a guardianship board or another person who can represent the interests of the individual adequately.
Aged Care (Consequential and Transitional Provisions) Act 2024	The Australian Government legislation that applies to individuals who have entered an episode of transition before the commencement of *the Aged Care Act 2024* on 1 November 2025.
Aged Care Quality and Safety Commission (the Commission)	The Commission is the national regulator of the provision of aged care services. The Commission's role is to protect and enhance the safety, health, well-being and quality of life of people receiving aged care. In fulfilling this role, the Commission provides a free service that handles concerns or complaints that have not been resolved by talking to the registered providers of Australian Government funded aged care services. The Commission can provide support, with information and options, to resolve aged care concerns with service providers.
Aged Care Service	Means an Australian Government *funded aged care service* as defined in subsection 9(1) of the Act, and included in the Aged Care Service List as contained within Chapter 1 of the Aged Care Rules 2025.
Assessment Organisation	An entity engaged by the Department to provide aged care needs assessment services and/or residential aged care funding assessment services.
Associate Provider	Is defined in subsection 11(6) of the Act. They deliver funded aged care services on behalf of the registered providers and are sub-contracting organisations to registered providers.
Australian Commission on Safety and Quality in Health Care (ACSQHC)	The ACSQHC leads and coordinates key improvements in safety and quality in health care across Australia in partnership with patients, clinicians, the Australian Government, State and Territory governments, the private sector, and health care organisations. The ACSQHC's functions include: • developing national safety and quality standards; • developing clinical care standards; • coordinating work in specific areas to improve outcomes for patients; and • providing information, publications and resources about safety and quality.
Australian National Aged Care Classification (AN-ACC)	AN-ACC is the funding model underpinning the payment of subsidies to Australian Government funded residential aged care services. The AN-ACC is used to assess core care needs as a basis for allocating funding.

Term	Meaning
Australian Privacy Principles (APPs)	The APPs took effect from 12 March 2014 as a result of changes to the *Privacy Act 1988* (Cth). These principles relate to the National Privacy Principles and the Information Privacy Principles (IPPs) (except for ACT agencies who continue to be covered by the IPPs). The APPs: • deal with all stages of the processing of personal information, setting out standards for the collection, use, disclosure, quality and security of personal information; and • place obligations on agencies and organisations subject to the *Privacy Act 1988* concerning access to, and correction of, an individuals' own personal information.
Care and Services Plan	A plan developed by the transition care service provider in consultation with the individual as required under section 148 of the Act and section 148-75 to 148-85 of the Rules. The plan describes the goals of transition care agreed with the individual, the type of services to be provided, the frequency and hours of actual service provision, the location at which the service will be provided and the respective responsibilities of the service provider (registered providers/associated providers), its staff and the individuals in care. The care and services plan for transition care should be informed by the hospital geriatric rehabilitation service and the clinical aged care needs assessor.
Carer	Is defined in section 7 of the Act and refers to a person who provides personal care, support and assistance to an older individual, and that person does not do so as an aged care worker, volunteer or student.
Clinical Aged Care Needs Assessor	A clinically trained assessor who meets the qualification and training requirements outlined in the assessment organisation's contractual agreement with the Australian Government and in the My Aged Care Workforce Learning Strategy 2024 (or subsequent versions). A clinical assessor undertakes complex (comprehensive) aged care needs assessments with older people and will be required to exercise clinical judgement.
Commonwealth Home Support Program (CHSP)	The Commonwealth Home Support Program provides a broad range of entry-level support services to assist older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) to live independently in their homes and communities. From 1 November 2025, the CHSP comes under the *Aged Care Act 2024*.
Comprehensive Assessment	An assessment type for people with more complex needs. Comprehensive assessments are undertaken by clinical assessors.
Dementia	Dementia is an umbrella term describing a syndrome associated with more than 100 different diseases characterised by the impairment of brain functions, including language, memory, perception, personality and cognitive skills. Although the type and severity of symptoms and their pattern of development varies with the type of dementia, it is usually of gradual onset, progressive in nature and irreversible.
Department	The Australian Government Department of Health, Disability and Ageing.
Departmental Delegate	A departmental employee whose position has been delegated powers and functions under a section of the *Aged Care Act 2024* (Cth) by the System Governor.
GP	General Practitioner.
Individual	Means individuals approved to access Australian Government funded Aged Care Services under Chapter 2 of the Act.
In-Patient Hospital Episode	In relation to an individual, means a continuous period during which the individual: a) is an in-patient of a hospital; and b) is provided with acute care or subacute care or both.
Integrated Assessment Tool (IAT)	The Integrated Assessment Tool (IAT) is an online assessment tool for older Australians who are seeking to access government subsidised aged care services. The IAT has been designed to support skilled assessors to determine a client's aged care needs. It comprises questions across the social, physical, medical, cognitive, and

Term	Meaning
	psychological domains as well as home and personal safety, risk of vulnerability and support considerations. The IAT's triage and assessment components feature specific questions that trigger additional questions, allowing for more in-depth exploration of flagged concerns. My Aged Care Integrated Assessment Tool : My Aged Care – Integrated Assessment Tool (IAT) User Guide | Australian Government Department of Health and Aged Care My Aged Care Assessment Manual: My Aged Care Assessment Manual | Australian Government Department of Health, Disability and Ageing
Integrated Health and Aged Care Services Module (IHACSM)	Means a module developed by the ACSQHC, which addresses requirements in the Aged Care Quality Standards not covered in the NSQHS Standards.
Low Intensity Therapy	In relation to an individual, means therapy that: a) maintains the individual's physical and cognitive functioning; and b) facilitates an improvement in the individual's capacity in relation to activities of daily living. Examples include: 1. Occupational therapy; 2. Physiotherapy; 3. Osteopathy. The therapy services that transition care service providers must be able to provide, if required by an individual, are detailed in the Aged Care Service List, Chapter 1 of the Rules.
Minister	The Australian Government Minister with portfolio responsibility for Health, Disability and Ageing.
Multidisciplinary Team (MDT)	An MDT is a care team made up of three or more health care disciplines, e.g., general practitioner, geriatric, nursing, pharmacy, physiotherapy, dental, podiatry, nutrition, optometry, psychology, occupational therapy, social work, and speech pathology.
National Safety and Quality Health Service Standards (Second Edition) (NSQHS Standards)	The NSQHS Standards provide a nationally consistent statement about the level of care people can expect from health services.
Nominated Registered Providers	Are entities who have been registered under the Act as registered providers and nominated by the State or Territory governments to provide transition care services on their behalf.
Older People	For the purposes of aged care planning, older people are regarded as those aged 65 years and over, or 50 years and over if Aboriginal and Torres Strait Islander people.
Older Persons Advocacy Network (OPAN)	OPAN is an Australia-wide network that provides free advocacy services for individuals, their families and carers in relation to Australian Government funded aged care services, including transition care. OPAN can be contacted on 1800 700 600 between 8.00am and 8.00pm from Monday to Friday. Further details about OPAN are available at www.opan.com.au.
Registered Provider	Is defined in section 11 of the Act to mean an entity that is registered as a registered provider where the registration period has not ended and registration has not been revoked under a provision of Part 3 of Chapter 3 of the Act.
Rehabilitation	Rehabilitation, in the context of transition care, is a form of subacute care – see 'Subacute Care' below. Transition care is not a substitute for rehabilitation and must only commence after completion of the individual's rehabilitation care episode.
Residential Care Home	A residential care home means a place that is the place of residence for individuals who, by reason of sickness, have a continuing need for aged care services, including nursing services and it is fitted, furnished and staffed for the purpose of providing

Term	Meaning
	those services. See section 10(2) of the Act.
Rules	The Aged Care Rules 2025 (Cth).
Secretary	The person filling, or temporarily filling, the position of Secretary of the Department of Health, Disability and Ageing.
Service Agreement	An agreement between an individual receiving funded aged care services, including transition care, and a registered provider of transition care which details the care and services to be delivered by the registered provider and/or its associated providers, any charges payable by the individual to the registered and/or associated providers, the external complaint mechanisms and how to access these and other arrangements.
Subacute Care	Medical or related care or services provided to an individual who is not in the acute phase of an illness. Examples include: 1. Rehabilitation; 2. Palliative care; 3. Psychogeriatric care; and *4.* Geriatric evaluation and management. Note: To be eligible for transition care, an individual must have completed their acute and/or subacute episode of care.
Support at Home Program	The Support at Home Program replaced the Home Care Packages (**HCP**) Program and the Short-Term Restorative Care (**STRC**) Programme from 1 November 2025 and is aimed at supporting people to remain living at home. Support at Home registered providers must be guided by the Statement of Rights that underpin the Support at Home Program and should apply wellness and reablement approaches.
TCP Subsidy	The Australian Government subsidy payable to a registered provider, who meets the eligibility requirements under section 248 of the Act, on a day in relation to funded aged care services delivered through a service group under the transition care program as a specialist aged care program, and is the amount prescribed by the Rules at section 249-90.
Support Plan	A Support Plan is an important and ongoing document developed as part of an aged care needs assessment under the Act, for the older person that can be updated as an older person's needs change. It details the outcomes of discussions with, and assessments of, the older person, including what the older person would like to improve and achieve (their goals), and agreed actions to be taken. It is a continuous document (i.e. an older person only has one Support Plan).
Supporter	Means a person registered as a supporter of the individual under section 37 of the Act. Supporters may be registered to assist individuals with navigating the system and are required to act in accordance with principles that promote supported decision making.
System Governor	Is defined in section 7 of the Act to mean the Secretary of the Department of Health, Disability and Ageing.
Transition Care Program	Is defined in section 7 of the Act to mean a specialist aged care program given effect through one or more agreements entered into by the Commonwealth under paragraph 247(1)(b) of the Act for the purpose of the delivery of funded aged care services to individuals with access approvals in effect for the classification type hospital transition for a service group.
Transition Care Program Agreement	An agreement between the Australian Government as represented by the Department of Health, Disability and Ageing and each State and Territory government specifying responsibilities of the Australian Government and State and Territory governments in the delivery and overall management of the Transition Care Program.