FOI 27-3598 - Document 3

is no coverage for hoarding and squalor assistance, the eligible older person can be referred to CHSP services such as social work and other services targeted at avoiding or reducing the impact of hoarding and squalor situations (see section 6.5.3 Hoarding & squalor assistance).

All Care Finder and Elder Care Support Program clients seeking aged care services must be assessed by My Aged Care via the assessment services to determine eligibility and the need to receive additional CHSP services. People receiving assistance through the Care Finder program or Elder Care Support program may be eligible to access CHSP services targeted at avoiding homelessness or reducing the impact of homelessness. Any entry level CHSP services made available to a Care Finder or Elder Care Support Program older person between the age of 50 and 65 must be targeted at avoiding homelessness or reducing the impact of homelessness.

My Aged Care system function – linking support

The linking support function on My Aged Care provides assessors with the opportunity to record activities for older people identified as benefiting from linking support. The function allows assessors to make changes to the older person's Support Plan during the linking support period. Users accessing the older person's record, such as older people, contact centre, ACSOs and service providers, will be informed that the older person is undergoing a period of linking support. The department's expected proportion is that assessment organisations deliver linking support to a minimum of 2.5% of older people.

The function is designed so that the Support Plan can be finalised and kept open for the support period and the timeliness KPI will not be impacted. The timeliness KPI ends at the 'Finalise Support Plan & keep open for support period.'

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5.11. Vulnerable older people relating to aged care services

Where the assessor wishes to monitor the older person's access to aged care services more closely, they can elect (or at the older person or appointed decision maker's request) to be notified of correspondence sent to the older person. This particularly applies to vulnerable older people who need assistance with the process of finding a suitable provider, and do not have support to assist them. Only one person from an assessment outlet can be selected to receive this notification. This person's contact details will also appear on all correspondence with the older person.

An assessor should also consider whether a person can access support through the Care Finder and Elder Care Support Program.

This notification can be enabled from any tab in the older person's Support Plan or on the 'Approvals' tab in the older person record. The notification link will only be enabled if the older person has been marked as 'seeking services,' or a recommendation has been made.

Where an assessor is receiving Support at Home notifications for a vulnerable older person who has been approved to access funded aged care services, the assessor is able to extend an older person's acceptance period for ongoing services beyond the 56-day entry period and extend the older person's time to select provider for an additional 28 days through the extension process on My Aged Care.

FOI 27-3598 - Document 3

Care finder program | Australian Government Department of Health, Disability and Ageing

Elder Care Support | Australian Government Department of Health, Disability and Ageing

The assessor must carry out the following steps and activities:

- Consider if linking support is required – particularly if the older person presents with two or more complexities (and/or risk of vulnerability) – and may have been further confirmed through the support considerations process.
- If identified as 'vulnerable,' with the older person's agreement, the older person will be provided with linking support. If not applicable, check an appropriate plan is in place. Therefore, the IAT and/or the Support Plan evidences the complexity or risk of vulnerability support has been considered and documented. If linking support is applicable, develop the Support Plan to include linking support, recommending the period of linking support and the planned activities. Action the recommended activities, monitor progress and record the outcomes (using the linking support function).
- Consider all available care and support options appropriate to the needs of the older person and facilitate the provision of services to the point of effective referral.
- Liaise, consult, and work collaboratively with all stakeholders and service providers in a multidisciplinary approach across service sectors to support individual older person needs. For example:
    - Contact relevant experts and service providers to discuss the older person's current situation and Support Plan moving forward, and to assist with the co-ordination of the older person's care whilst receiving linking support (e.g., care finders, CHSP Hoarding and Squalor providers, health, housing and legal services, community Geriatric Evaluation and Management teams, advocates, social, case management and/or mental health workers and local councils).
    - With older person's consent, obtain the necessary older person information from various sources and organisations.
    - Maintain regular contact with the older person, providers, and those co-ordinating services during the period of linking support.
    - Assist older people with issues relating to transition to alternate service options.
    - In consultation with the older person, determine when the linking support period should be finalised, and what ongoing support (if any) may be required for the older person
    - If aged care service access is not approved, consider referral to a support service outside of aged care and if relevant a support service which provides a coordination or case management function.
- Offer the information in a variety of formats to promote equitable access (e.g., paper-based, electronic, face-to-face, over the phone, etc.) and where appropriate, include information to self-refer to the identified services and supports and information on rights, responsibilities, and mechanisms for complaints.

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FOI 27-3598 - Document 3

5.12. Recommending aged care services

Note: Providers will not be able to deliver or claim for any services for an individual that are not approved in the support plan (even if there is an immediate need).

Once the IAT has been finalised, an assessor will assess an older person's need for aged care services as defined in **Sections 66 to 68** of the *Aged Care Act 2024*.

If ongoing Support at Home, Restorative Care Pathway or End-of-life Pathway, are recommended assessors will be taken directly to the 'Add Home Support services' page. On this page specific services are grouped by service type. These service types relate to the services in the *Aged Care Rules 2025*.

Under each service type, specific services will appear (known as service levels). For example, under the service type *Domestic Assistance*, services such as general house cleaning, laundry service, shopping assistance etc. will display. All services are pre-selected, except for services in the 'prescribed' service types *Allied health and Therapy* and *Therapeutic Services for Independent Living*. This is due to the specific nature of these services and should only be recommended if an older person has a need for them.

Important:

For any service type other than *Allied health and Therapy* and *Therapeutic Services for Independent Living* (the 'non-prescribed' service types), if you think the older person needs any service in the service type, then you need to select all services in the service type.

This is because, for the non-prescribed service types under the Act, an older person is approved for access *at the level of service type only*. This applies to service recommendations for Support at Home classifications and CHSP.

Under Section 65 of the *Aged Care Act 2024* an older Aboriginal and Torres Strait Islander person only needs an approval at the level of service group and classification type to receive aged care services. This means that if the older person is approved for a service group, they are automatically approved for *all service types and services* in that group.

In the system, however, for the *home support* service group you must ensure all service types and services are selected in the 'Add home support services' page, if the older person is Aboriginal or Torres Strait Islander. If you add Assistive Technology, Home Modifications or residential aged care to the support plan, there is no need for you to select specific services.

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On the *Add Home Support services* page, assessors can also:

- recommend the frequency and intensity of services
- link the older person's concerns and goals to the services that have been selected.

Care types and services that are not part of Support at Home can be recommended by clicking 'Add a Service Recommendation' or 'Add a care type for delegate decision' under *other recommendations* in the *Goals & recommendations* tab. This applies to MPSP and NATSIFACP services, Residential Care, Transition Care and CHSP.

5.12.1. Making service recommendations

There are two types of recommendations that can be made on the Support Plan:

a) **Service recommendations** represent referrals that can be made through the Assessor Portal to Commonwealth-subsidised aged care services.
b) **General recommendations** relate to a type of support that is non-government funded or where a referral is made outside of the Assessor Portal. All recommendations – whether government-funded services, specialist programs, linking support, or general actions – must be clearly documented in the Support Plan.

Recommendations for aged care services must be aligned to an older person's current needs. If multiple services are recommended, the assessor must clearly link each service to a relevant concern and goal. If there are no recommendations as a result of the assessment, the assessor must provide clear reasons for the outcome within the Support Plan and communicate clearly to the older person.

Assessors must clearly articulate the service recommendation details – service type and services (if applicable), start, end and review dates (if applicable), frequency, intensity, priority, and outcome,

- The frequency and intensity of the services may be recorded if indicated, however may be decided at a later point by the service provider with the development of the Care Plan. Example: Two times weekly.
- The priority for the service recommendations is based on the older person's needs and urgency for services. The determination of urgency for services is based on the older person's circumstances, such that there is an urgent need for services which, if not met immediately, may place the older person's health and safety at risk.
- Include CHSP service (short-term or ongoing) information in the assessment summary (see previous sub-section: Assessment Summary).

Note: If a non-clinical assessor is recommending services other than CHSP, they must seek the supervision of a clinical assessor to assist with providing recommendations for those services e.g. Support at Home ongoing, residential care and AT-HM.

If clinical attendance occurred during the assessment, this supervision should be given by the clinical assessor who provided this attendance.

If services that are not CHSP services are recommended and clinical questions were not triggered in the IAT, the non-clinical assessor will need to seek the supervision of a clinical assessor upon converting the assessment to a comprehensive assessment.

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FOI 27-3598 - Document 3

Detail all care options agreed with the older person, ensuring general and service recommendations:

- Are evidence-based, defensible and are clearly drawn from and linked to the older person's goals and needs/area of concern. For example: a recommendation for respite, links to information on the older person/carer relationship, dementia support, and any difficulties or concerns that are experienced to reduce carer stress and support the care relationship.
- relate to the older person's current unmet needs and are supported by the assessment.
- take into account their identified support considerations when recommending options for support.
- consider the availability and capability of services and supports to meet the older person's care needs including:
- services in and outside of aged care
- informal supports, what family, friends and neighbours contribute (including the sustainability of these)
- General recommendations include responsibility to action (older person/other).
- In some instances, Aboriginal and Torres Strait Islander assessment organisations may also be an aged care provider. It is critically important that clients are provided with choice and control over service providers from whom they would like to receive aged care services. Assessors should discuss all the options with the older person.

Important: If a person can access some services from an MPSP or NATISFACP provider, you must add an MPSP or NATISFACP service recommendation. See Chapter 6 for more information.

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5.12.2. Setting the 'service seeking' preference for prioritised services under the Support at Home program

Access to ongoing Support at Home (SaH) classifications and AT-HM under the Support at Home program (the AT-HM scheme) is managed through three independent priority systems:

- the Support at Home Priority System – for the ongoing SaH classifications
- the Assistive Technology Priority System – for AT under the SaH program
- the Home Modifications Priority System – for HM under the SaH program.

As part of the assessment process, it is important for assessors to have a clear conversation with the individual about whether they are seeking to receive these services through the Support at Home program.

There is a separate 'seeking services' preference field in the Support Plan section of the Assessor Portal for each of these recommendations (ongoing SaH classification, AT and HM). Assessors must record if the client is 'seeking services' or 'not seeking services' through the Support at Home program for each of the recommendations, in line with the following guidance:

- For clients seeking these services through the Support at Home program, the assessor should set the relevant service seeking preference to 'seeking services.' This ensures that the older person is placed on the appropriate priority system(s).

FOI 27-3598 - Document 3

- For clients not seeking these services through the Support at Home program, the assessor should set the relevant service seeking preference to 'not seeking services.'
- This option makes sure the client **does not** enter the relevant priority system(s) and will not be allocated funding under the Support at Home program. Relevant circumstances include when:
    - the client has chosen to access services through NATSIFACP or MPSP and so they do not require services from a SaH provider (or funding from the SaH program)
    - the client does not want to access the recommended services at this time.

If the older person later wants to access one of these services through the Support at Home program, they can change their preference and enter the relevant priority system. Older people wanting to enter the AT or HM Priority System will need to be a Support at Home participant (for ongoing home support) to do this. For all three priority systems, wait time is always counted from the original access approval date of effect. That is, for older people who enter any of these priority systems at a later time, it will be as if they had stayed in the queue from their first approval.

An older person can change their service seeking preference by:

- contacting My Aged Care
- using their My Aged Care Online Account.

5.13. Review of Support Plan

A review date can be entered on the Support Plan and reason for the review for example "12-month review for CHSP ongoing service recommendation". Linking support and reablement start and end dates and review dates are displayed on the Support Plan. The 'Associated People' section of the Support Plan helps assessors identify the people who will be helping the older person meet their goals, or who may be providing support. It also assists in checking whether the older person consents to the associated person receiving their Support Plan.

A review date of no longer than 12 months should be set for older Aboriginal and Torres Strait Islander people to ensure the services still meet their needs.

5.13.1. Scheduling a support plan review for Aboriginal and Torres Strait Islander assessment organisations

Acknowledging that it may take a longer time to accurately identify the holistic aged care needs of an older Aboriginal and Torres Strait Islander person, following an initial assessment, an SPR should be scheduled to ensure the Support Plan remains responsive to the client's needs at the time of the assessment. The date should be:

- no later than 12 months after the assessment, and
- sooner if appropriate.

This approach enables the older person to access aged care services while enabling adjustments to the Support Plan if more needs are identified over time (most likely identified by the service provider) at the review date.

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FOI 27-3598 - Document 3

5.14. Assessment wrap-up

At the end of the assessment, an assessor should inform the older person of the next steps so they have a realistic expectation of what will occur following the assessment. This will help the older person to feel more assured and increase their satisfaction in the overall assessment experience. There are a variety of resources an assessor might leave with an older person at the conclusion of an assessment that are also available in many languages other than English (see section 13.6 Aged care resources for older people).

An assessor must:

- Inform the older person on the next steps, such as:
  - who to contact and in what instance (e.g., if the older person has chosen to be referred to service providers, they will be contacted by these providers to discuss details of the service being requested; if the older person has chosen to receive a referral code, they will need to take the code to the provider of their choice to access the service)
  - the actions they, or others identified in the Support Plan, are responsible for (e.g., visiting providers, organising a check-up with a GP/specialist)
  - identify the older person's preferred referral method to action service referrals to providers and specialist assessment (e.g., allied health, occupational therapy assessment or vision services)
- Consider the older person's information preferences (e.g., hardcopy or electronic copy) and their communication needs.
- Provide contact details to the older person on who they should contact in the future [e.g., the My Aged Care, the assessment organisation (name and contact details of the assessor), and one or more service providers].
- explain that the assessor recommendations will be submitted to the assessment delegate for approval and the older person will be contacted about the outcome.

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5.14.1. Aboriginal and Torres Strait Islander Assessment Organisations assessment wrap-up

Due to the higher likelihood of older Aboriginal and Torres Strait Islander people being vulnerable and require additional support to access services, it is best practice to routinely follow up with the client (or their support network) post assessment, particularly for those who:

- have complex social need;
- have limited family or community support;
- have experienced recent changes in health, housing, or care arrangements;
- have communication or cognitive difficulties that may impact understanding of the assessment;
- have referrals rejected/not actioned;
- have experience difficulties with accessing services;
- work on short-term goal(s) in line with the length of time stipulated in the Support Plan;
- need linking support and require short-term linking assistance for the purpose of implementing the Support Plan;
- have expressed uncertainty or concern about the process or services recommended; and/or

FOI 27-3598 - Document 3

- are at risk of disengaging from services due to past negative experiences or systemic barriers.

Follow up may include, but not limited to:

- monitoring of referrals to services or negotiating with service providers for the provision of alternative services if necessary;
- discussion with the service provider and give advice to client on any follow up actions taken; and/or
- explaining any notifications/notices the older person may have received from My Aged Care.

Resources | My Aged Care

5.14.2. Providing an assessment report for approval

Once the assessor has finalised the assessment, they must submit it for approval by an assessment delegate.

Under the *Aged Care Act 2024*, assessors are required to provide the System Governor with a report of the assessment as soon as practicable after the assessment has been completed. This report is the support plan. System Governor functions at this stage of the assessment process are performed by (delegated to) Assessment Delegates. The assessor portal will support assessors to recommend the following to the assessment delegate for approval:

- **service groups**,
- the **classification type** (short-term, ongoing or hospital transition) for each recommended service group;
- the **classification level**
- any **service types** or **services**
- the **priority category** if required.

For older Aboriginal and Torres Strait Islander people, an assessment delegate only required to approve services at the service group level. This means the clients are automatically approved for all the service types and individual services within any service group they are approved for.

Assessors must also include in the support plan any information to support the Assessment Delegate to decide that the individual meets the relevant criteria (in the Act and its related rules) for the recommended approvals.

Assessors must ensure all information generated during the assessment is uploaded to the older person's My Aged Care Record following the completion of an assessment.

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FOI 27-3598 - Document 3

6. Chapter 6: Aged care programs

What you'll find in this chapter

This chapter includes important information about the aged care programs that can be recommended by assessors to meet an older person's assessed needs and goals. It includes information about:

- Support at Home (Ongoing 1 – 8)
- Support at Home (Restorative Care Pathway)
- Support at Home (End-of-Life Pathway)
- Support at Home (Assistive Technology and Home Modifications (AT-HM scheme
- Commonwealth Home Support Program (CHSP)
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)
- Multi-Purpose Service Program (MPSP)
- Transition Care Program (TCP)
- Permanent residential care
- Residential respite

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6.1. Support at Home - ongoing classifications 1-8

Support at Home improves on the four Home Care Package levels and consists of 8 ongoing classifications (1 – 8) with increasing levels of funding based on varying need in terms of the frequency and intensity of those services.

Funding amounts for each Support at Home classification are outlined below. Note that these amounts include the funding for care management, are indicative and are subject to indexation revisions.

In addition, there are 3 short-term pathways which are part of the Support at Home program, and these are defined as stand-alone service groups under the Act:

1. Restorative Care Pathway
2. End-of-Life Pathway
3. The Assistive Technology and Home Modifications (AT-HM) scheme.

FOI 27-3598 - Document 3

Table 24. Approximate budgets for Support at Home classifications

The budget and annual amounts below are indicative, as indexation will occur on 1 July and 1 August 2026. For the latest budget information, please go to: Schedules of Subsidies and Supplements for Aged Care | Australian Government Department of Health, Disability and Ageing

Classification	Quarterly Budget	Annual Amount
1	$2,682.75	$10,731.00
2	$4,008.61	$16,034.45
3	$5,491.43	$21,965.70
4	$7,424.10	$29,696.40
5	$9,924.35	$39,697.40
6	$12,028.58	$48,114.30
7	$14,537.04	$58,148.15
8	$19,526.59	$78,106.35
Restorative Care Pathway	$6,011.04 (up to 16 weeks) May be increased to $12,000 when eligible and if units of funding are available	
End-of-Life Pathway	$25,035.36 (up to 16 weeks)	
Assistive technology short-term (12months)	Low ($500), medium ($2,000) and high ($15,000) funding tiers based on assessed need. A higher amount maybe approved with a valid prescription from a suitably qualified health professional. For progressive condition bundles, funding is available for 24 months (may be extended for another 24 months if required with declaration).	
Assistive technology On-going	Assistance dogs $2,000 per year	

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Classification	Quarterly Budget	Annual Amount
Home modifications Short-term (12 months)	Low ($500), medium ($2,000) and high ($15,000) funding tiers based on assessed need. Providers may apply for a funding tier time extension of an additional 12 months for HM high tier (24 months in total).	

A participant's annual Support at Home budget is divided into quarterly (3-monthly) budgets. Older people receiving Support at Home (known as participants) can carry over unspent funds of up to $1,000 or 10% of the quarterly budget (whichever is greater) from one quarter to the next.

These budgets are segmented into quarterly allocations to provide tailored support based on the participant's classification.

Ten percent (10%) will be deducted from each participant's quarterly budget for care management delivered by their service provider. Care management involves:

- planning and coordinating services
- checking in with participants to ensure they are being well supported
- clinical advice and practical support to address any changes in need or issues that arise
- providing support and education where needed.

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Support at Home funding and finding a provider

Participants will receive a letter notifying them when funding (including interim funding) becomes available and is allocated. Participants have 56 calendar days from the date their funding was allocated to find a provider and enter a service agreement. They can contact My Aged Care to request a 28-day extension if required, giving them a total of 84 calendar days to enter a service agreement.

A participant's Support at Home funding will be withdrawn if they have not entered a service agreement within 56 calendar days (or 84 days with an extension). This means funding for their classification is no longer available and providers cannot provide government-funded services.

If the participant later decides they want to receive Support at Home services, they need to re-join the Support at Home Priority System by contacting My Aged Care. People who re-join the Support at Home Priority System will have their date of entry recorded as the date they were originally approved for Support at Home. Refer to Page 54 of the Support at Home program manual for more information.

Support at Home Program Manual

FOI 27-3598 - Document 3

Note: An Assessor's role in budget planning and contributions

Assessors are not expected to develop detailed budget plans or explain contributions with Support at Home participants. The assessor may wish to give a high-level overview based on the information in this guidance document and direct their client to the Support at Home fee estimator tool.

A full fee estimator is available via the department's website myagedcare.gov.au/support-at-home-fee-estimator. This tool will allow people to plan budgets and estimate their contributions.

The assessor should emphasise that there will be an opportunity to discuss contributions further with their registered provider's care partner. A budget must be developed between the participant and their provider alongside the development of the care plan. The budget must outline how funding for participant's ongoing and/or short-term services will be spent in relation to the types and frequency of services outlined in their care plan, as well as any contributions for services to be delivered.

6.1.1. The Support at Home Priority System

An older person approved for Support at Home classifications 1 to 8 will enter the Support at Home Priority System in one of its four priority categories:

- Urgent
- High
- Medium
- Standard

An older person's priority category is determined using a prioritisation algorithm. The prioritisation algorithm uses a standardised set of seven criteria from the IAT and the client's record to place an older person in one of the four priority categories. The amount of time the older person waits to receive their funding will depend on the priority category they are given. The priority category will be displayed under 'Approvals for a Client' in the Assessor Portal.

The system will automatically recalculate an older person's priority category (if required) when changes are made to the following fields in their client profile:

- Accommodation type
- No fixed address
- Lives with
- Aboriginal and Torres Strait Islander Status

An older person can request to be set as 'seeking services' or 'not seeking services' at any point. This can be done by contacting My Aged Care, or by using the My Aged Care Online Account.

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FOI 27-3598 - Document 3

6.2. Support at Home - Restorative Care Pathway

The Restorative Care Pathway (RCP) is designed to provide early intervention support to older people by:

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

The RCP can be provided in a home or community setting, or a combination of both. An older person can receive up to a maximum of two units of RCP in any 12-month period. The RCP cannot be undertaken consecutively and must allow a minimum 90-day period between episodes.

The RCP can be delivered for up to a duration of 16 weeks. Participants may have a shorter RCP episode, for example, where they reach their goals earlier.

The RCP may also be accessed in addition to a participant's ongoing Support at Home budget. A participant with an ongoing Support at Home budget who is approved for RCP, can continue to access their ongoing services while undergoing the RCP. Restorative care partners will need to ensure that services are complementary.

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Important:

An approval for RCP is equal to 1 unit of RCP funding (approximately $6,000). RCP units are capped to 20,000 units of funding annually (managed as 5,000 units of funding per quarter) across Australia.

System-based visibility of RCP caps is not available.

Weekly reports of allocations are generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

Assessors and Assessment Delegates should remain aware of any communication from the Department's Assessment Delivery Section regarding RCP units.

6.2.1. Assessing for the Restorative Care Pathway

RCP provides a coordinated, multidisciplinary package of allied health and/or nursing services. An individual must require a range of different allied health and/or nursing interventions to be eligible for the RCP. For example, an individual only requiring physiotherapy, domestic assistance and gardening is not eligible as they do not meet the requirements for a multidisciplinary allied health and/or nursing team.

FOI 27-3598 - Document 3

Supporting people to regain independence and function to facilitate less reliance on higher levels of care is a critical objective of RCP. The intent of the RCP is not for an older person to receive passive 'care' services but to be an active participant to safely regain lost independence based on their individual circumstances.

A reablement approach underpins the Support at Home RCP, aiming to restore capability and keep people as independent as possible.

A person is eligible to receive RCP only if they meet all of the following criteria:

- The person is assessed as experiencing functional decline that is likely to be reversed through frequent, multidisciplinary allied health and/or nursing interventions over a short period of time
- The person has goals which align with restorative care outcomes (improve function, want to be independent, rely less on others' help, regain previous levels of function, etc)
- The person demonstrates motivation through willingness and capacity to engage and actively participate in short-term clinical interventions to increase independence (for example, willing to attend frequent allied health appointments, engage in exercise and/or nutrition classes, learn how to apply techniques to regain independence, increase health literacy and education, etc)
- The person has received an ongoing SaH classification through the IAT Outcome (more information is included under section 6.2.3)
- The person is not receiving or, eligible for, the Transition Care Program (they should also not be in hospital at the time of assessment)
- The person is not in permanent residential care
- The person is not eligible for, or has recently received, the End-of-Life Pathway
- The person has not been approved for more than two units of RCP funding in any 12-month period and/or at least 90 days have passed from the end of the 16 weeks period associated with the original episode.

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Assessors must only recommend the RCP if all the above eligibility criteria are met.

Assessors may consider contacting the older person to discuss alternative supports for recommendation if the RCP units are near exhaustion.

FOI 27-3598 - Document 3

Case Study: Omar, age 66

Omar is 66 and lives with his wife, Barbara. He recently had a fall which has left him with a few small issues but has severely impacted his confidence. He is after some help around the home, so he doesn't fall again. After talking to both Omar and Barbara, the assessor suggests he might like to consider Restorative Care Pathway (RCP) as:

Omar still has quite good mobility but needs some help building up his balance and strength to restore his confidence.

Omar has the support of Barbara and family who are keen to help him stay independent .

Omar initially had some concerns about undertaking the RCP but after discussion with the assessor, he is willing to try it as he would like to remain independent at home.

Omar's restorative care provides:

Biweekly strength classes which start as individual classes at Omar's home with an exercise physiologist but, as his confidence increases, transitions into group exercise classes at the allied health centre. This also provides opportunity for Omar to connect with others while supporting increases in physical and mental function.

Nutritionist support which provides insight and education into nutritional requirements to support his increased activity and support good health (plus meeting any cultural food requirements).

Two podiatrist appointments to assess for issues with his feet which are impacting his balance.

A restorative care partner who works with him on his goals and continues to support Omar, checking in periodically, monitoring his progress and continuing to discuss how problems achieving his goals can be resolved to help restore his confidence with the multidisciplinary team (MDT).

Outcomes

Omar regains confidence in his mobility. He teaches Barbara what he learns during his time receiving RCP services. They start attending strength building classes together at the local gym and join a walking group. After discussion with Omar and Barbara, the exit plan recommends no ongoing services are needed.

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Case study: John, age 55

John is a 55 year old Aboriginal man. He currently receives Support at Home classification 1 to help support him at home. He has several chronic health conditions and lives with his wife and adult son. His GP has recommended he be reassessed to help him manage his health conditions. After yarning to John and his family, the assessor recommends the Restorative Care Pathway (RCP). This is because services and education on how he can remain independent at home could help the household which is a good outcome for everyone. John knows he can manage his health conditions if given the support to do so.

His goals support restorative care outcomes (to regain function, keep level of independence, delay needing higher level of services). John was also approved for assistive technology and home modifications funding to support his RCP episode. This is funded through the Assistive Technology-Home Modifications (AT-HM) scheme.

Delivery

John's restorative care provides:

- Support and referrals to help manage his health issues including to a care manager at the local primary health network for his diabetes
- Support from a registered nurse who provides education and advice around how John can manage his health conditions.
- An occupational therapist (OT) visits several times to talk to John and his family about what assistive technology and home modifications can help him and, how John and his family can use the assistive technology safely and to check that home modifications meet John's needs.
- Administration and coordination costs of sourcing relevant AT-HM to support his restorative care goals.
- An Aboriginal and Torres Strait Islander Health Worker works with John to help provide cultural support, treatments and conduct relevant health assessments and provide connection to other relevant services, as required.

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John's ongoing Support at Home services continue. A restorative care partner helps ensure restorative care services complement his ongoing Support at Home services.

Outcomes

John's restorative care partner finalises the exit plan after reviewing the goals identified in John's goal plan. John feels that he can apply what he learnt about managing his conditions, deciding he was happy with his current level of ongoing support. His RCP episode ceases and his ongoing Support at Home services continue.

FOI 27-3598 - Document 3

6.2.2. Expectation setting

Expectation setting is an important part of ensuring restorative care is successful and helps ensure people receive the care they need. Assessors should ensure the roles, responsibilities and objectives of RCP are fully explained during the assessment (including in comparison to ongoing care). This should happen before the RCP is recommended to ensure the older person fully understands the support that will be available to them and their role. Older people who do not have the capacity or the willingness to engage with the RCP should not be recommended and approved for it.

For older people new to the aged care system and who are not receiving aged care services:

- an ongoing Support at Home or CHSP classification cannot be recommended at the same time as the RCP.
- the RCP is not a mechanism to access urgent services.

For older people who are receiving aged care services through an ongoing classification:

- The RCP can be recommended and approved where eligibility criteria **are** met.
  - Assessors must consider the potential for functional improvement that would delay the need for a higher-level classification when approving RCP (as a higher ongoing Support at Home classification cannot be recommended at the same time).
  - The RCP is not a mechanism to provide additional funding to supplement ongoing services.

- If, through a reassessment, the IAT Outcome is a higher ongoing classification, assessors will only be able to select the higher ongoing classification OR the RCP.
  - If the RCP is selected, the person will remain on their current ongoing classification (rather than the higher classification recommended).

- Assessors should consider if the older person's current provider delivers the RCP.
  - Under Support at Home, services must be delivered by a single provider (service delivery branch level). If the provider does not deliver the RCP, the participant will need to change providers to access both RCP and ongoing services. This should be considered before approving the RCP for people already accessing ongoing services through Support at Home.

For those already accessing ongoing care, assessors should carefully consider ongoing needs before recommending the RCP. Assessors cannot recommend a new higher classification and the RCP at assessment. This will impact a new ongoing Support at Home classification entry into the Priority System.

For new participants, eligibility for ongoing services will need to be determined at the end of the RCP episode (if RCP is recommended).

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6.2.3. Recommending Restorative Care Pathway in the assessor portal

Upon finalisation of the IAT, if the IAT Outcome recommends an ongoing Support at Home classification, this can be overridden to change the IAT Outcome to the RCP by clicking the

FOI 27-3598 - Document 3

override button. By overriding to the RCP, assessors will be navigated to the '*Add Home Support Services*' page to add services.

Assessors may also be prompted that the participant may be eligible for RCP based on the older person's goals, which appears upon finalising the IAT. The assessor will have the option to accept or reject this suggestion.

Upon overriding the IAT Outcome to RCP, or by accepting the prompt, the Assistive Technology Medium Tier and Home Modifications Medium tier will automatically be added to the recommendation. The assessor can choose to remove the recommendation of an AT or HM tier or edit the recommended AT or HM tier to align with the older person's needs.

> Note:
>
> The IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment. However, assessors must not undertake this action and delegates must not approve assessments where this occurs.
>
> Where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.)
>
> An ongoing SaH classification must be generated to override and recommend RCP for approval.

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Older people approved for the RCP can only access services they have been approved for.

Assessors should consider what services are being accessed under the person's ongoing Support at Home classification and ensure they are complementary (and be based on need connected to their restorative care approval). Assessors should note that delivery of multidisciplinary intensive allied health/nursing services is a key element of the RCP.

Restorative care management is also a mandatory service type when undertaking the RCP. To search for a RCP provider, people can search for the service type 'restorative care management' through the 'Find a Provider' website (when 'Support at Home program' is selected.

> Note:
>
> From 29 June 2026, Hoarding and Squalor services and Restorative Care Pathway can be recommended together (which was previously blocked), however, they remain separate programs with Hoarding and Squalor still being delivered via CHSP.
>
> Note: If the client is assessed in hospital, the Restorative Care Pathway should not be recommended. Assessors should consider appropriate alternative services.

6.2.4. Interactions with other programs

Table 25. Restorative Care Pathway interaction with other programs

Program	Interaction with Restorative Care Pathway (RCP)
Ongoing Support at Home	If an older person receives an ongoing Support at Home classification through the IAT, this can be overridden to recommend the RCP.
Assistive Technology and Home Modifications (AT-HM) scheme	Older people approved for the RCP may also require Assistive Technology or Home Modifications to support good restorative care outcomes. Assessors must always ensure these needs are considered when approving the RCP. Older people who are approved for the RCP are eligible to receive an Assistive Technology low, medium and high funding tier, and low and medium tier **home modifications.** Participants with an ongoing Support at Home classification who already have high tier home modifications funding can keep this approval, noting this approval is connected to their ongoing classification approval. Assistive Technology **Medium** Tier and Home Modifications **Medium** tier will also be added to the recommendation. The assessor can choose to remove the recommendation of AT or HM or edit the recommended AT or HM tier to align with the older person's needs.
CHSP	Though the IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment, an assessor must **not** recommend or approve the RCP for: • an older person new to the aged care system and not receiving aged care services, who is recommended CHSP by the IAT Outcome; or • an older person already accessing CHSP, who is recommended CHSP by the IAT Outcome. (Noting, where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.) If an older person accessing CHSP is recommended an ongoing Support at Home classification through a reassessment using the IAT, this can be overridden to recommend the RCP. Note: Older people can access allied health and therapy services through CHSP. Assessors can recommend reablement and/or allied health and therapy services on their support plan.

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FOI 27-3598 - Document 3

Program	Interaction with Restorative Care Pathway (RCP)
End-of-Life Pathway (or if they have recently accessed this pathway)	Cannot receive the Restorative Care Pathway at the same time (applicable for EoL, TCP and permanent Residential Care).
Transition Care Program	
Permanent Residential Care	

6.2.5. Lapse in Restorative Care Pathway access

Access to the Restorative Care Pathway (RCP) will lapse if:

- the older person's episode of RCP ends (maximum 16 weeks); or
- a person does not enter into an agreement with a provider to deliver the RCP before the access code expires (within 56 days of approval with a further 28 days if My Aged Care is contacted for an extension).

An older person will need to be reassessed if they wish to access the RCP after their access period ends lapses (with a 90 day break applied).

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6.2.6. Manual oversight of Restorative Care Pathway places

RCP places are capped at 20,000 units per year across Australia, managed as around 5,000 units per quarter. There are no in-system prompts or controls to prevent the approval of RCP funding units beyond the quarterly caps. Weekly reports of approvals made are generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

Those with an active Short-Term Restorative Care (STRC) approval (who did not start STRC before 1 November 2025), have had their approvals transferred into an approval for RCP.

Note for this cohort using their STRC approval to access the RCP:

- This cohort will also be accessing the RCP units of funding for the first six months from 1 November 2025.
- A second unit of funding to use within a single RCP episode can be requested via a support plan review (SPR) request. However, assessors will need to self-refer this for reassessment to grant access to a second unit of funding. This is because the ability to add a second unit via SPR will not be available on the assessor portal for those with an STRC approval.
    - The reassessment can be done over the phone and does not require queuing for a face-to-face assessment.

FOI 27-3598 - Document 3

    - The decision to approve a second unit will be informed by evidence submitted by the provider with the SPR request.
    -
- When a request for a second unit of RCP is received assessors should confirm if there is approval for STRC and RCP on the client's record. If there is approval for both, the assessor will need to confirm with the client if the client entered care under the RCP after 1 November 2025 using the STRC approval. If this is the case, then the assessor must not approve a third unit of RCP funding.
- If the participant is eligible to access an additional RCP unit they must wait at least 12 months before accessing another episode.

Assessors will need to remain acutely aware of any communication from the department regarding RCP caps to ensure you are making informed decisions. These communications will be the **primary tool** for identifying the number of RCP approvals made. Being responsive to these insights is essential for avoiding over-allocation.

Before recommending the RCP for approval, assessors should consider whether other service types or alternative supports - such as other Support at Home services or reablement options under the Commonwealth Home Support Program (CHSP) - could provide an equivalent level of support. This ensures that recommendations for approval are appropriate to an individual's needs.

6.2.7. Restorative care funding

The RCP provides around $6,000 of funding, for up to 16 weeks. The total amount of funding a participant uses and length of time to complete an episode can differ. Restorative care partners will consider this when developing the goal plan.

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode. If the participant requires additional funding within a single 16-week episode, the provider can submit a request for a support plan review. If certain circumstances are met, approval can be given for the additional $6,000 in funds to support the episode (see Chapter 10 on support plan reviews).

If approved, a participant can access an additional unit of funding (up to $6,000), to provide a combined total of up to $12,000, for a single RCP episode. If additional funding is approved, a participant will not be eligible for a further episode of RCP within a 12-month period as they have accessed the maximum 2 units of funding within the first episode.

The decision to approve additional funding to the RCP episode is made under *subsection 195-3 of the Rules*. It is a non-reviewable decision. The criteria in the Rules includes that required evidence must be given by the participant's provider and there must be units of funding available for approval.

Evidence to support the additional funding may include:

- Goal plan and individualised budget outlining how the required clinical interventions are not supported by the initial funding
- Information as to why ongoing funding cannot be used to complement restorative care clinical goals.

The assessment delegate must send a letter to the older person (and their registered supporter/s, if required under the Act) notifying them of the outcome of the application for the additional funding. Refer to Section 9.3.6 for more details.

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FOI 27-3598 - Document 3

Note: This is a different template to the Notice of Decision issued for other approval decisions.

6.2.8. Restorative Care Pathway and the Support at Home Priority System

The Restorative Care Pathway (RCP) is not subject to the Support at Home Priority System. People can access RCP once a Notice of Decision letter has been received after delegate approval. Please note that selecting the RCP will mean that any new ongoing or higher ongoing Support at Home classifications cannot be selected. As such, assessors should consider long term need when approving for the RCP. An assessor may only select an ongoing (or new ongoing) Support at Home classification which will put them in the Priority system OR select RCP.

RCP participants will have immediate access to any recommended assistive technology and home modifications under the AT-HM scheme based on their assessed needs.

6.2.9. Hospitalisation, residential respite and leave

People may need to enter hospital or residential respite while accessing the RCP. There are no leave provisions under Support at Home. If a person's RCP episode finishes while they are in hospital or residential respite, they will need to consider reassessment to determine what will meet their needs.

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FOI 27-3598 - Document 3

6.3. Support at Home – End-of-Life Pathway

The End-of-Life Pathway is one of the short-term home support classifications under the Support at Home program. A participant can access one episode of the End-of-Life Pathway. A total of $25,000 is available per eligible participant over a 12-week period. This is the highest funding classification category (per day) available in the Support at Home program.

An older person is eligible to access this pathway if they meet the following criteria:

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

Funding can be used to access the participant's approved services from the Home Support service list, including care management.

6.3.1. End-of-Life Pathway form

The End-of-Life Pathway form is used to document the required medical evidence for accessing the End-of-Life Pathway under the Support at Home program. An individual seeking access to the End-of-Life Pathway must complete all relevant sections and present this form to a medical practitioner or nurse practitioner for completion. The completed form should then be submitted as part of the assessment process—either before or during triage, or assessment—and reviewed to confirm eligibility for the End-of-Life Pathway.

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The End-of-Life Pathway Form is required to be completed and submitted before a participant can be assessed as eligible for the End-of-Life Pathway. Assessors are responsible for ensuring they receive the completed End-of-Life Pathway Form to proceed with the assessment. In cases where an aged care assessment or support plan review (SPR) is undertaken via telehealth (and where digital referral or GP e-referral is not used), assessors must assist older people to ensure the completed End-of-Life Pathway Form is submitted. Options for lodging the completed End-of-Life Pathway Form include:

- An older person or their support person may nominate to send the signed form directly to the assessment organisation via their preferred mechanism (for example, email). Assessors should contact the person to discuss their options and assist to obtain the form in cases where a person is unable to send the form themselves due to circumstances such as digital barriers or limited access to support; or
- Assessors contact the relevant medical or nurse practitioner to request they send the completed End-of-Life Pathway Form to the assessment organisation via their standard processes for information sharing (for example, fax)

Assessment delegates are responsible for verifying the completion of this form in the older person's record when the End-of-Life Pathway has been flagged in the My Aged Care assessor portal.

Reviewing the form will involve:

- Checking the individual's details to ensure they match the record in the portal.
- Verifying the completion of all areas of the Medical Assessment section to confirm:

FOI 27-3598 - Document 3

1. The individual has a prognosis of a life expectancy of three months or less, and
2. An Australian-modified Karnofsky Performance Status (AKPS) score of 40 or less.
3. Medical practitioner or nurse practitioner has completed and signed the form.

An individual will **not** be eligible for approval for the End-of-Life Pathway if the required criteria outlined in the medical assessment section are not met.

6.3.2. Accessing the End-of-Life Pathway

Existing Support at Home participants can access End-of-Life Pathway through a support plan review. This is usually requested through the My Aged Care Service and Support Portal by the older person's provider and should be made using the approved form.

Older people can seek a referral through their medical practitioner or other health professional (using the Make a Referral or GP e-referral channels) or by contacting the My Aged Care contact centre or using Apply Online. The End-of-Life Pathway form must be attached for referrals using Make a Referral or GP e-referral. For other entry pathways, Triage is still able to be undertaken without a completed End-of-Life Pathway Form. In these instances, participants should be advised at Triage to have the form completed by an appropriate medical practitioner (their GP, non-GP specialist or nurse practitioner.) The End-of-Life Pathway Form must be completed before the End-of-Life Pathway is approved.

Once approved, services are delivered under the End-of-Life Pathway classification and care partners work with any relevant state and territory palliative services to ensure care is appropriate and tailored to the individual's preferences and needs.

6.3.3. Interactions with other programs

Table 26. End-of-Life Pathway interactions with other programs

Program	Interaction with the End-of-Life Pathway
Assistive Technology and Home Modifications (AT-HM) scheme	Individuals receiving support through the End-of-Life Pathway can be approved to access assistive technology **low** or **medium** tier only at the same time. If approved for assistive technology, immediate AT-HM scheme funding can also be used to access products and equipment from the AT-HM list. If eligible, primary supplements will also apply to participants. The assessor will need to select assistive technology for this to be added to the support plan. Access to home modifications is not permitted. If home modifications are already underway through the AT-HM scheme at the time the End-of-Life Pathway is approved, these modifications can continue while accessing the End-of-Life Pathway.

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FOI 27-3598 - Document 3

Program	Interaction with the End-of-Life Pathway
Residential Respite	Participants accessing the End-of-Life Pathway may continue to access these services during a period of Residential Respite, as long as services are not duplicative.
Transition Care Program	Participants accessing the End-of-Life Pathway are not eligible to receive transition care.
CHSP	Participants accessing the End-of-Life Pathway can access CHSP services, including urgent services, in limited circumstances. See Table 29 for more information.
Support at Home ongoing	An individual cannot access these services under the End-of-Life Pathway
Restorative Care Pathway	
Permanent Residential Care	

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If an individual is eligible for the End-of-Life Pathway, they can be referred and transitioned out of any of the above programs to begin receiving services under the End-of-Life Pathway. Individuals who are accessing services through MPSP or NATSIFACP, can access their SAH End-of-Life approval through those programs as well. Participants accessing the End-of-Life Pathway may continue to access these services during a period of Residential Respite, as long as services are not duplicative.

6.3.4. Funding for the End-of-Life Pathway

Funding for the End-of-Life Pathway is discrete from other Support at Home classifications. If an existing Support at Home participant moves to the End-of-Life Pathway, this will replace their ongoing Support at Home classification.

Unlike an ongoing classification, participants cannot accrue funds under the End-of-Life Pathway. This means that any unspent budget from an End-of-Life Pathway classification will not follow a participant if they live beyond the End-of-Life funding period and move to an ongoing classification.

FOI 27-3598 - Document 3

Transitioned HCP clients can access the End-of-Life Pathway via an SPR, like all existing Support at Home participants. If they require services beyond the End-of-Life Pathway funding period, they can return to their previous transitional classification via an SPR.

6.3.5. Allocation of ongoing Support at Home to the client after End-of-Life Pathway

If the participant requires ongoing Support at Home services following the completion of the End-of-Life Pathway, the following will apply:

Participants who were accessing ongoing Support at Home services prior to accessing the End-of-Life Pathway can be transferred to their previous Support at Home classification via an urgent support plan review.

Participants who were new to Support at Home when they commenced the End-of-Life Pathway can be transferred to the inactive classification that was assigned at their aged care assessment, via an urgent support plan review.

6.3.6. Assessing for End-of-Life Pathway

When assessing for the End-of-Life Pathway, only mandatory questions that are required to run the IAT Outcome and generate an ongoing Support at Home classification are required to be completed. This is to ensure the older person has a valid classification to return to if they need services beyond the End-of-Life Pathway funding period. Other questions are optional based on the individual's needs and context.

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6.3.7. Recommending the End-of-Life Pathway in the assessor portal

Assessors can select the End-of-Life Pathway for older people under the '*Goals & recommendations'* tab within the Support Plan and services section of the My Aged Care Assessor Portal. It is best practice for End-of-Life to be flagged and verified prior to the commencement of the assessment, however there are allowances to be able to complete these two tasks after an assessment has started.

Upon finalising the IAT, the system will recommend either a CHSP classification or an ongoing Support at Home classification (in nearly all instances, it will be a Support at Home classification for this cohort). If a Support at Home classification is generated, assessors will need to override the recommendation and choose 'End-of-Life.' Assessors will be navigated to the 'Add Home Support Services' page where services are pre-selected. Assessors should only unselect service sub types if they think the client may not have a need for this service. Assessors should carefully consider any services they deselect (for example, nursing care).

Note: the 'Allied health and other therapeutic' service type and all the services within, as well as the 'Therapeutic services for independent living' and all the services within, will not be pre-selected. An assessor must manually select these services for them to be approved in the support plan.

This will then enable assessors to allocate this pathway for assessment delegate approval.

By recommending the End-of-Life Pathway, Assistive Technology Medium Tier will automatically be added to the recommendation. The assessor can choose to remove the

FOI 27-3598 - Document 3

recommendation of AT or edit the recommended AT tier to align with the older person's needs.

6.4. Support at Home – Assistive Technology and Home Modifications (AT-HM) scheme

The Assistive Technology and Home Modification (AT-HM) scheme is a short-term pathway that supports older people to live at home and within their community with increased independence, safety, accessibility and wellbeing. The AT-HM scheme provides separate supports under Support at Home, with separate funding tiers (called *classification levels* under the Act) and program settings. Participants can access both assistive technology and home modifications funding tiers at the same time if needed. This will provide a separate funding budget to access products, equipment and home modifications. The AT-HM scheme is delivered in parallel to a participant accessing ongoing services through Support at Home. This means that participants can access these supports without needing to save up funds from their Support at Home quarterly budgets.

Older people new to the aged care system who are approved for the Support at Home AT-HM scheme cannot be issued referrals to Commonwealth Home Support Program (CHSP) AT and/or HM services while they wait for AT-HM scheme funding.

If an older person receiving CHSP services is reassessed for Support at Home and the AT-HM scheme, they may keep accessing CHSP AT and HM, if they have referrals for these services, until their AT-HM scheme budget becomes available. After that, CHSP-funded AT and HM services will no longer be available for them to access.

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6.4.1. AT-HM scheme participants

AT-HM scheme participants are empowered to actively participate in informed decision-making regarding the care, products, equipment and home modifications they receive. Providers are expected to consult participants to determine their support needs to ensure services are individualised and relevant.

Through the AT-HM scheme, participants will:

- have access to the AT-HM list to understand what equipment, products and home modifications are available to meet their assessed need,
- actively participate in the care planning process and have the AT-HM scheme explained in a way that they understand,
- identify their needs, life goals, strengths, and service delivery preferences including choice of health professionals,

6.4.2. Assistive technology

Assistive technology (AT) is any item, piece of equipment or product that is used to help an older person do things more easily or complete activities they can no longer do independently at home or in the community.

Examples of assistive technology include:

- mobility equipment such as walking sticks, walking frames and wheelchairs
- toileting supports including bedpans and commodes

FOI 27-3598 - Document 3

- bathing devices including shower chairs and bath boards
- alternative and augmentative communication (AAC) products
- products for food preparation and eating including adaptive cutting boards and knives, as well as modified cutlery
- a contribution toward costs associated with assistance dog maintenance.

The AT-HM scheme does not include items such as:

- everyday household appliances e.g., a dishwasher
- assessment or therapy tools used by a therapist
- products or technologies funded through an alternative national or state-based program (e.g., the Medical Aids Subsidy Scheme).



Assistive Technology and Home Modifications list (AT-HM list)

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6.4.3. Home modifications

Home modifications (HM) provide changes to an older person's home to create an environment that is safer and more accessible.

Examples of home modifications include:

- lever tap sets or lever door handles
- grab rails in the shower or bathroom
- internal and external handrails
- modified door locks
- non-slip materials and surfaces for floors and stairs.

In some circumstances, participants may be approved for more significant home modifications including:

- bathroom modification (e.g., level access shower and modifications to improve accessibility)
- ramps and stairlifts.

The AT-HM scheme does not include:

- general renovations to a home or dwelling
- restorations or repairs which are considered normal maintenance of home or dwelling
  changes to a home layout that do not relate to a participant's assessed clinical need(s) in their support plan.

6.4.4. Funding tiers for AT-HM

The table below outlines the 3 funding tiers for assistive technology and home modifications. Indexation will be applied to the below amounts; indexation will occur on 1 July and 1 August 2026. For the latest budget information, please go to: Schedules of Subsidies and Supplements for Aged Care | Australian Government Department of Health, Disability and Ageing

Table 27. AT-HM funding tiers

Funding tier	Funding allocation cap	Funding period
Assistive technology		
Low	$500	12 months (in most instances)
Medium	$2,000	12 months (in most instances)
High	$15,000[1] (nominal)	12 months (in most instances)
[1] Products and equipment with costs greater than $15,000 are available to participants with a prescribed need.		
Home modifications		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000	12 months[2]
[2] Funding may be extended for an additional 12 months to complete complex home modifications (24 months in total) if evidence is provided to Services Australia		
Other funding		
Assistance dog maintenance	$2,000 per year	Ongoing[3]
[3] Funding for assistance dog maintenance will be automatically allocated every 12 months; however, the funding cannot accrue or rollover.		

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This funding may cover the following:

- Assistive technology equipment and products
- Home modifications and associated services
- Repairs or maintenance of assistive technology items available on the AT-HM list
- Prescription of items, where appropriate, by a suitably qualified health professional working within their professional scope of practice
- Recurring AT costs including ongoing monitoring, software, subscription fees or rental costs.

FOI 27-3598 - Document 3

- Associated administration activities (cap will apply – see the AT-HM scheme guidelines for further details).

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

The cost of wrap-around services—such as delivery, setup, training, and follow-up—are also drawn from the AT-HM funding tier. Providers can add a 10% charge on administration costs for AT claims and a 15% charge for coordination costs for HM claims. Assessors must consider these costs when allocating a funding tier.

Participants may be required to contribute towards their assistive technology or home modifications.

AT-HM funds will not accrue over time, and funding will be available for 12 months (in most instances) once a participant is assessed (or reassessed) and approved. If major home modifications take longer than 12 months, funding may be available for a further 12 months if the participant can provide evidence the work has commenced. This will ensure enough time to complete the work to the required standards.

Recurring AT costs, e.g. subscription fees, rental costs, continued monitoring costs or software costs associated with an item on the AT-HM list must be paid out of the AT-HM scheme funds. For example, personal emergency alarm systems are included on the AT-HM list. The cost of the alarm and the ongoing monitoring (including by a third party) are both covered by AT-HM funding. Ongoing monitoring costs are part of the AT-HM item. The amount paid by the participant is the same as the independence category rate.

AT-HM funding normally lasts for 12 months. If the participant still needs to pay for recurring costs, subscription fees or continued monitoring after that, the participant will need to be reassessed by an aged care assessor, who can assess the participant for a new level of AT-HM funding if needed.

Older people identified at assessment with specific progressive conditions may be eligible to access assistive technology funding for 24 months to meet their rapidly changing needs. The 13 conditions listed below are all eligible AT-HM progressive conditions under Support at Home.

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These conditions are:

- Cerebral Palsy
- Epilepsy
- Huntington’s Disease
- Motor Neurone Disease (MND) noting different phenotypes require different management
- Multiple Sclerosis (MS)
- Parkinson’s Disease
- Late effects of Polio
- Spinal Cord Injury
- Spinal Muscular Atrophy
- Stroke
- Acquired Brain Injury noting different types of brain injury require different management
- Muscular Dystrophies and Muscular Atrophies.

FOI 27-3598 - Document 3

In some cases, this funding can be extended for another 24 months, providing a total of 48 months of support. If available, Home Care Package unspent funds must be used to access assistive technology and home modifications before AT-HM scheme funding is used.

6.4.5. AT-HM list

The AT-HM list sets out the assistive technology and home modifications that can be accessed and funded through the AT-HM scheme.

The AT-HM list is sorted into the following categories:

- **managing body functions –** including pressure cushions, anti-oedema stockings and memory support products
- **self-care products –** including adaptive clothing or shoes and assistive products for toileting, bathing and showering
- **mobility products –** including walking frames, wheelchairs and lifting devices
- **domestic life products –** including assistive products for food preparation, eating, drinking and house cleaning
- **communication and information management products –** products and equipment that assist with reading and writing, as well as alternative and augmentative communication (AAC) devices
- **home modifications** - including accessible showers, grabrails, fixed ramps and safety barriers.

The AT-HM list also includes a **guide** on the recommended prescription category for each item. The prescription category is the suggested level of skill or qualification required to effectively provide recommendations for the safe and effective use of assistive products or equipment or installation of home modifications.



Assistive Technology and Home Modifications list (AT-HM list)

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6.4.6. Assessing the need for AT-HM scheme funding

Existing questions in the IAT will help to identify and determine an older person's need for assistive technology and home modifications. The AT-HM tier guide will assist the assessor to make a funding tier recommendation. For example, the function section will provide a more detailed understanding of a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

Assessors are **not required** to determine the exact item or product to be provided. Rather, an assessor's role is to identify whether the person is likely to benefit from AT or HM supports based on observed and reported difficulties, risks, or goals. Assessors are asked to assign a funding tier for AT and HM based on the assessed need with the support of the AT-HM tier guide. It is recommended that assessors also familiarise themselves with the AT-HM list and how it is utilised in the AT-HM scheme. The specific types of AT-HM best suited to the client, and any required prescriptions, is the responsibility of the registered provider at the point of service delivery.

FOI 27-3598 - Document 3

During the assessment, consider whether the older person:

- has needs and goals that could be met through using assistive technology and home modifications
- can have those needs met through the products, equipment and home modifications included on the AT-HM list.
- may require prescription or wraparound services for the assessed needs of the assistive technology and home modifications. This will need to be considered and captured under the recommended funding tier allocation.

Older Aboriginal and Torres Strait Islander people may not reveal the full care needs to service providers who they may not know or with whom they have a trusted relationship. If trust and rapport has already been built with the FNAO assessor through the assessment process or with the ECS worker, the assessor/ECS worker may (if appropriate) choose to facilitate service providers and the client with the process of identifying specific types of AT-HM which are best suited and advise on any cultural matters that may need to be considered.

6.4.7. AT-HM funding tier guide

If assessors identify that the older person requires AT-HM they are required to recommend a funding tier. AT-HM funding tier guidance has been developed to assist assessors to make a funding tier recommendation for AT and HM based on the older person's assessed need in the IAT. This includes considering their current functional ability and home environment.

The guidance has been designed to consolidate the main elements of the IAT relevant to AT-HM and support assessors in choosing a funding tier. The guide will suggest an assessment tier which should sit where the majority of tier indicators have been selected. The guide groups indicators into three tiers: **low, medium, and high**—and uses a checkbox format for ease of completion. The AT-HM tier guide provides a non-scored pattern of recommendation—the more indicators selected within a particular tier, the stronger the alignment with that level of support.

Where the guide does not produce a clear outcome, or in more complex cases, clinical reasoning based on the person's functional ability, safety, independence, and home environment should guide the tier allocation. Progressive conditions—particularly if multiple are present—may also justify a higher tier allocation, even if fewer indicators are ticked.

Assessors should ensure their recommendations align with the participant's goals, safety, independence, and overall ability to remain living at home. Assessors should also consider the need for a prescription and/or wraparound services when assigning a funding tier. They may choose to select an alternate tier if funding does not align with assessed need. Assessors can upload the document as an attachment to allow the assessment delegate to review as supporting evidence for any funding tier recommendations made.

> Note:
>
> Assessment operation managers will have access to the AT-HM tier guide document on the assessor SharePoint site. Operation managers can download and provide the template to assessors.

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FOI 27-3598 - Document 3

6.4.8. Instructions for assessors completing the AT-HM Tier Guide



The AT-HM Tier Guide is used by assessors and assessment delegates to determine the appropriate funding tier for an older person who has been assessed as having a need for AT and/or HM.

Assessors are asked to complete the following:

- use the relevant information from the older person's assessment when completing the AT and HM tier guide
- select the relevant indicators on the tier guide for either AT and HM based on the older person's assessed need
- review the guide to support tier allocation recommendation. The AT-HM tier guide will suggest a tier where the highest number of tier indicators have been selected.
- upload the completed AT-HM tier guide (mandatory) to the assessor portal under 'other' and title the document 'AT-HM Tier Guide.' The Assessment Delegate should consider the guide when approving or declining the AT-HM funding tier.
- manually add the recommended AT and HM tier in the support plan once a funding tier is determined.

Assessment decisions for AT-HM funding tier allocation can be reviewed through a support plan review if the funding tier does not cover the assessed need.

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FOI 27-3598 - Document 3

CASE STUDY: AT low tier

Carol is 65 and has just been assessed and during her comprehensive assessment it was found that she is managing daily activities independently but would benefit from some help with housework and getting to and from the shops. She mentioned that she has some difficulty washing her legs, feet and back in the shower and finds it hard to bend down to put her shoes on.

The assessor thinks Carol may benefit from some basic items such as a long-handled sponge, a non-slip bathmat and a long-handled shoehorn. After looking at the AT-HM list the assessor believes that all these items are low-cost and low risk and Carol should be allocated Assistive Technology low tier (AT Tier 1) funding to cover the cost of these items.

Using the assessment findings the assessor completes the assistive technology section of the AT-HM tier guide. All selected indicators sit within Tier 1. The assessor allocates Carol with an Assistive Technology low tier (AT Tier 1) on the support plan. This decision is supported by the information gained during the assessment and the AT-HM tier guide recommendation.

The assessor uploads the AT-HM tier guide to the assessor portal under 'other' naming the document 'AT-HM tier guide.' This is considered by the delegate as supporting evidence of AT-HM tier recommendation.

Carol's AT recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate, Carol will receive a Notice of Decision letter informing her that she has been approved for a SaH on-going classification and AT low tier funding for assistive technology. Once funding is assigned and the Funding Assignment Notice is sent to the participant, she can then find a provider to help source the low-cost and low risk AT items she needs.

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CASE STUDY: HM high tier

David is 55 and lives in a small rural community in Western Queensland. He attends an Elders' social group at his local Aboriginal Community Controlled Organisation (ACCO). The ACCO's Elder Care Support worker supported David during an aged care needs assessment conducted by an Aboriginal and Torres Strait Islander assessment organisation. David has just been assessed. During David's assessment he explained that he would like to be able to come and go from his home more easily so he can do things for himself like shopping. During the subsequent discussion, the assessor noted that David has significant issues managing at home safely due to his home environment. He lives alone and is not able to easily enter or exit his house because of the steep front stairs and difficulties carrying his walking frame on the stairs.

After spending time with David to build his trust and understanding of the assessment process, David explained he feared falling when entering and exiting his shower due to a large step into his shower recess. David's son helps him when he can, but he lives in another town and can only visit a couple of times a week.

The assessor and Elder Care Support worker identify in the AT-HM list that David could benefit from some modifications to his home which could include a ramp or railings at the front and modifications to his bathroom. David agrees with this assessment. The assessor completes the tier guide, and the indicators show mostly in the high tier, with some also in the medium tier. As it is likely he will need major modifications to his front access or bathroom, the assessor recommends a HM high tier (HM Tier 3).

The assessor uploads the AT-HM tier guide to the assessor portal under 'other' naming the document 'AT-HM tier guide.' This is considered by the delegate as supporting evidence of AT-HM tier recommendation.

David's HM tier recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate, David will receive a Notice of Decision letter informing him that he has approval for a SaH on-going classification and approval for a home modifications high tier. Once funding is assigned and the Funding Assignment Notice has been sent, he can then find a provider to help source the prescriber and home modifications he needs. The Elder Care Support worker can assist David with this process. When this is explained to David, he says he is excited to think about being able to do shopping and other tasks for himself whenever he needs to. He is also glad this will take some of the pressure off his son.

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CASE STUDY: Progressive Condition

Margaret is 68 and was assessed at home to increase Support at Home services as she is not managing with her current allocation. The assessor reviews her medical history and finds that she suffered a stroke 5 years ago which left her with left sided weakness. Recently she has found it much harder to manage at home, she cannot get up and down the stairs by herself and her family report she is unsteady when walking around her home. She lives with her son and daughter-in-law but does not like being reliant on them for daily tasks. As Stroke is one of the identified AT-HM progressive conditions, the assessor selects it in the health condition section of the assessment. The assessor thinks that Margaret may benefit from a range of assistive technology and home modifications to support her current needs and as her condition declines. She will require assessment and prescription from a suitably qualified health professional to determine her AT and HM needs.

The assessor fills out the AT-HM tier guide which indicates a AT high tier (AT Tier 3) and a HM medium tier (HM Tier 2), this aligns with the complex needs identified at assessment. The assessor recommends a SaH on-going classification and allocates AT high tier and HM medium tier in the support plan. Margaret will have access to her AT funding allocation for 24 months and this can be further extended to 48 months if needed, as she has an identified progressive condition.

The assessor uploads the AT-HM tier guide to the assessor portal under 'other' naming the document 'AT-HM tier guide.' This is considered by the delegate as supporting evidence of AT-HM tier recommendation.

Margaret's AT-HM tier recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate Margaret will receive a Notice of Decision letter informing her of her new SaH ongoing classification and AT-HM funding. She has been recommended AT high tier and HM medium tier funding approval and once funding has been assigned and the Funding Assignment Notice sent, she can then find a provider to help source the prescriber, assistive technology and home modifications she needs.

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FOI 27-3598 - Document 3

6.4.9. Recommending AT-HM tiers in the assessor portal

The option to recommend an AT and HM funding tier will be available for those who have recommended ongoing Support at Home classification. The Restorative Care pathway and End-of-Life Pathway will display the AT and HM funding tier options that apply to that pathway.

From 29 June 2026, a new feature in the integrated assessment tool (IAT) will allow assessors to flag a consideration for either AT or HM throughout these categories of the assessment:

- Function (AT and HM)
- Physical personal health and frailty (AT and HM)
- Medications (AT only)
- Cognition (AT and HM)
- Social (AT and HM)
- Psychological (AT and HM)
- Home and safety (AT and HM)

If tick boxes are selected for either AT or HM in the assessment this will then be displayed in the Identified needs under other considerations on the support plan to assist the assessor in making a final decision on the assistive technology or home modifications funding tier required for the participant.

For more information, please see the IAT User Guide.

Assistive technology

- **Short-term classification** should be selected if AT is recommended for all AT needs other than assistance dogs.
- **Ongoing classification** should be selected if AT is recommended for assistance dogs.

If the recommended classification is Support at Home Restorative Care Pathway, then an **automated medium tier** will be assigned with the assessor being able to change to a low or high tier based on assessed need.

If the recommended classification is Support at Home End of Life pathway, then an **automated medium tier** will be assigned with the assessor being able to change to a low tier based on assessed need.

Assistance dogs

If a participant is not eligible or is unable to access the Physical Assistance Dogs Program, costs associated with essential assistance dog maintenance may be included under the AT-HM scheme where the services directly relate to the upkeep of the dog.

A dog must meet the definition of an assistance dog used by Health Direct and be required to enable participation in activities of domestic life.

Funding for assistance dogs is capped at $2,000 per annum for ongoing maintenance of the assistance dogs e.g., paying veterinary bills, animal vaccinations, deworming and flea treatments, essential grooming and dog food.

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Participants requiring assistance dogs will be identified and approved for funding through their aged care assessment. Funding for assistance dogs is a specific need, with separate funding for this purpose. If the participant no longer requires this specific funding, the provider must notify Services Australia through the Services Australia Aged Care Provider Portal.

The IAT now captures if a participant has an assistance dog through three new questions, including if the participant is able to access the Federal Government funded Physical Assistance Dogs Program and whether the participant's assistance dog meets the definition used by Health Direct.

Home modifications

By clicking the 'Recommend a Home Modification' button you will navigate to the Add Home Modification recommendation' page. On this page you must select an HM tier.

If the recommended classification is Support at Home Restorative Care Pathway, then an automated medium tier will be assigned with the assessor being able to change to a low tier based on assessed need.

If there are concerns and goals on the older person's support plan, the option to link goals will be available.

Service type and services will be pre-selected and read-only.

6.4.10. AT-HM Scheme Priority System

The AT-HM scheme has a separate priority system to the Support at Home Priority System. The AT-HM scheme has an Assistive Technology Priority System and a Home Modifications Priority System that allocate AT-HM scheme funding. An older person assessed as eligible for AT and HM will enter the AT-HM Priority Systems in one of its four priority categories (immediate, high, medium or standard). The older person will not be able to access AT-HM under Support at Home until funding has been allocated. The amount of time they wait for services will depend on the priority category they are in.

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The AT-HM Priority Systems ensure the equitable allocation of funding based on standardised criteria determined using information collected by an assessor through the IAT. This is used to calculate the priority category which is generated by the system. The assessor is not required to choose the priority category.

The following criteria are used. If the individual/'s:

1. lives alone
2. has an assessed severe mobility impairment
3. is an Aboriginal or Torres Strait Islander person
4. current place of residence poses a severe risk to their health or safety
5. has waited more than 6 months from initial referral and resides in a rural or remote area categorised under MM5-7

Older people actively seeking AT-HM at the time of their approval will be automatically placed in the AT and HM Priority System and set as 'seeking services.'

FOI 27-3598 - Document 3

Note: Participants assigned to the Restorative Care Pathway or the End-of-Life Pathway who have an assessed need for AT and HM will be allocated AT-HM funding immediately once approved by the assessment delegate. Note that the system will display an AT-HM priority of 'High' in this scenario, however the funds are allocated immediately. Further information will be available in the AT-HM scheme guidelines.

6.4.11. Interactions with other programs

Table 28. AT-HM scheme interactions with other programs

Program	Interaction with the AT-HM scheme
Support at Home ongoing	Can access funding through the AT-HM scheme at the same time.
Restorative Care Pathway	Older people accessing the Restorative Care Pathway can access: • Assistive technology: low, medium and high tiers • Home modifications: low and medium tiers An automated medium tier will be selected for both unless the assessor indicates otherwise.
End-of-Life Pathway	Older people accessing the End-of-Life Pathway can access: • Assistive technology (short-term): low and medium tiers An automated medium tier will be selected for AT. The assessor can change the AT recommendation to AT low or remove the auto-recommendation. They cannot select AT high tier.
Residential Respite	Can receive AT-HM in their home while in respite
Transition Care Program	TCP clients who have an on-going Support at Home classification will be eligible for the AT-HM scheme under Support at Home. TCP clients who are *not* currently on a Support at Home package will be able to access AT through TCP.
CHSP	Cannot access AT-HM. Older people with a CHSP classification will access Equipment and products and/or Home adjustment services under CHSP.

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FOI 27-3598 - Document 3

Program	Interaction with the AT-HM scheme
Permanent Residential Care	Cannot access AT-HM

6.5. Commonwealth Home Support Program (CHSP)

The CHSP is a grant funded program suitable for people who can live independently at home but need small amounts of entry-level support to do so. CHSP is not designed for people with intensive or complex care needs. People with higher needs are supported through other aged care programs such as the Support at Home program or residential aged care.

The CHSP operates under the *Aged Care Act 2024* (the Act). Individuals seeking CHSP services, even if they are time-limited such as urgent services, must meet the eligibility criteria under section 58 of the Act to be assessed for aged care services and then meet the eligibility requirements for CHSP as specified in the Act and *Aged Care Rules 2025.*

CHSP will transition to Support at Home no earlier than 1 July 2027.

The service catalogue for CHSP is closely aligned with the Support at Home list. See the CHSP service catalogue for further information.

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CHSP service catalogue 2025-2027

Commonwealth Home Support Program (CHSP) 2025–27 Manual (from 1 November 2025) | Australian Government Department of Health, Disability and Ageing

6.5.1. Care Finder program and Elder Care Support program participants

Clients in the Care Finder program and Elder Care Support program may be eligible for CHSP services that help to avoid homelessness or reduce the impact of homelessness. To access these CHSP services, clients must meet the eligibility requirements under section 58 of the *Aged Care Act 2024* and then meet the eligibility requirements for CHSP specified in the Act and *Aged Care Rules 2025*.

Elder Care Support program

Care Finders program

FOI 27-3598 - Document 3

6.5.2. Access to CHSP services

- An older person seeking CHSP services must be approved through an aged care needs assessment.
- Once the assessment has been finalised, based on the information entered into the IAT, the My Aged Care assessor portal or Aged Care Assessor App will indicate whether the client requires CHSP or Support at Home (SAH) services.
- If the IAT Outcome is CHSP, the assessor will proceed to recommend services.
- When assessors also recommend urgent services or periods of time-limited reablement under CHSP, they are requested to record any additional information about the client's situation in the assessment summary, as comments entered in the My Aged Care assessor portal will not appear on the Support Plan.
    - For example, "client needs urgent transport services until 28 February 2026 to purchase groceries/attend medical appointments, as they are unable to drive while recovering from acute episode/surgery".
- Urgent service referrals should cease if the CHSP episode is ongoing. The recommendation should explain why ongoing services are needed for the client (e.g., 'due to an ongoing health condition'). Ensure the explanation is justified, well-evidenced and consistent with the 2025 – 2027 CHSP Manual.
- If there is a significant change in the client's needs, they should be reassessed to determine if they should continue accessing services through CHSP or are better suited to Support at Home.
- There are some existing CHSP clients who have never been assessed for services. This includes clients who have been 'grandfathered' into the CHSP from previous programs. It is a requirement for all clients to be referred for an assessment, even if they are already accessing CHSP services. These CHSP clients need to be directed to contact My Aged Care or their provider and be referred for an assessment to continue receiving services if eligible.
- Unassessed clients, including those who choose not to be assessed, need to move to full fee-for-service arrangements if they wish to continue accessing aged care services.
- <u>If the client has pre-existing CHSP referrals in My Aged Care, and those services are approved in an assessment, the **referrals must be reissued by the assessor.**</u>

Note: Assessors cannot issue CHSP referral codes until *after* the assessment delegate has approved the recommendation. This is because all CHSP services require assessment delegate approval.

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6.5.3. Hoarding & squalor assistance

Hoarding and squalor assistance aims to support clients who are experiencing symptoms of hoarding disorder or are living in severe domestic squalor. Under the CHSP it is intended these services are accessed by individuals on a low income, who are living with hoarding behaviour or in squalid conditions, and are at risk of homelessness.

Note that people under 65 intending to access this service must first meet eligibility requirements under section 58 of the Act and then be assessed for ongoing home support.

FOI 27-3598 - Document 3

Note:

New clients that are Aboriginal and Torres Strait Islander people who are 45-49 years old are no longer eligible to access Hoarding and Squalor assistance.

Older people eligible for hoarding and squalor assistance keep their eligibility indefinitely and do not need reassessment, even after pausing services for years. They can also access other CHSP services aimed at reducing or preventing hoarding and squalor such as domestic assistance.

Assessment organisations should work collaboratively with hoarding and squalor assistance service providers to ensure services match the person's particular circumstances. Services may include:

- one-off clean-ups
- developing a client plan and reviewing care plans
- linking to specialist support services.

Aged care assessors may also refer suitable clients identified during the assessment process to care finders for further support.

Where there are significant changes in need or additional services needed, CHSP providers can request a support plan review, which may lead to a reassessment.

Hoarding and squalor assistance does not include:

- Assessment (referrals) and advocacy services (financial, legal), unless targeted at avoiding or reducing the impact of hoarding and squalor situations.
- Funding to purchase accommodation for clients.

Clients do not pay a client contribution towards their Hoarding and squalor services.

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6.5.4. Understanding AT and HM under CHSP

Equipment and products and Home adjustment services are available to eligible people under the CHSP. An annual subsidy cap applies:

- Equipment and products: low-cost assistive technology and products up to $1,000 per year.

- Home adjustments: home modifications up to $15,000 per year.

To access these services through the CHSP, eligible people will be approved for:

- the Home Support Service group with a classification level CHSP class, and
- the Assistive technology service group with a classification level of AT CHSP or
- the Home adjustment service group with a classification level of HM CHSP.

FOI 27-3598 - Document 3

Note: Unlike the Support at Home AT-HM scheme, AT and HM services under CHSP are not assigned a funding tier.

Equipment and products

- Self-care products
- Mobility products
- Domestic life products
- Communication and information management products
- Managing body functions

Home adjustments

- Home modifications

6.5.5. Interactions between CHSP and other programs

There are limited circumstances where a person can access CHSP services in addition to other government funded services, detailed in tables 29 and 30 below.

Services should not be duplicative. For example, if a client has access to domestic assistance from the Veterans' Home Care Program, they cannot access domestic assistance through the CHSP at the same time.

Current CHSP participants can continue to access CHSP services they are already approved for, including Equipment and products and Home adjustments, while waiting for funding to be approved under the Support at Home AT-HM scheme. Once services are accessed through the AT-HM Scheme, Support at Home participants will no longer be able to access these services under CHSP.

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Table 29. Guide to approving concurrent CHSP services with other government funded programs

Program	Can participant access CHSP services?
Support at Home participants (including participants who have accepted a Minimum Service Offer)	There are five circumstances where a Support at Home participant can access additional services through the CHSP. These are: 1. Pre-existing CHSP social support group 2. Hoarding and Squalor 3. Cottage respite, Community and centre-based respite and Flexible respite 4. Emergency access (this does not include equipment and product services or home adjustments services) 5. Specialised support (Vision advisory services)

Program	Can participant access CHSP services?
Waiting for a Support at Home place allocation	A **current CHSP client** can continue using approved CHSP services, including equipment and products and home adjustments, while they wait for ongoing Support at Home funding (including Minimum Service Offers) or AT-HM scheme funding. Once services begin through the **AT-HM scheme,** the individual will no longer be able to access these services through the CHSP. However, they may continue using their other CHSP services until Support at Home ongoing funding is accepted. **New aged care clients** waiting for AT-HM scheme funding, **and** are **not** approved for CHSP services, cannot access equipment and products or home adjustment services through the CHSP. They will need to access services through the AT-HM scheme. Urgent equipment and product services, or urgent home adjustments are not available through the CHSP for people approved for Support at Home AT-HM and waiting for funding.
Residential Aged Care	Approved residents of residential aged care facilities cannot access subsidised CHSP services
Disability Support for Older Australians, National Disability Insurance Scheme (NDIS), NATSIFAC Program, Transitional Care Program (TCP) and Veterans' Home Care Program	CHSP services are available with a referral for each service, provided that there is **no duplication of services.**

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Table 30. Circumstances when a Support at Home participant can access CHSP services

1. Pre-existing CHSP social support group	Support at Home participants who have transitioned from the CHSP may continue to access their pre-existing CHSP social support group through the social support and community engagement service on an ongoing basis to allow the continuity of social relationships. This only applies to participants attending a **pre-existing** CHSP social support group service.
2. Hoarding and Squalor	Support at Home participants who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need, can access time-limited Hoarding and Squalor services through the CHSP (in addition to their Support at Home funding) via reassessment.
3. Community and centre-based respite, Flexible respite and Cottage respite	Support at Home participants may access additional planned respite services through the Home or community general respite service or Community cottage respite.
4. Urgent services	In situations where a Support at Home participant has an urgent and immediate health or safety need, and their individualised budget has been fully allocated or they are waiting for their budget allocation, some additional time-limited CHSP services can be accessed on a short-term basis. This does not include equipment and product services or home adjustments services.
5. Specialised support services (Vision advisory services)	Support at Home participants may access Vision advisory services under Specialised support services on an ongoing basis to receive the aged care supports they need.

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6.5.6. Recording CHSP classification and Support at Home classification 1 to 8 approvals in the Notice of Decision

For CHSP Ongoing – there is one classification in the system. However, when an individual is approved for CHSP services alongside Support at Home (1 to 8 classification), the older person will ***only*** be approved for the Support at Home classification.

If an older person is approved for one of the Support at Home classification levels **and has not previously** been approved for funded aged care services in the home support service group, they can be referred to a CHSP provider to access approved services while they wait