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for the Support at Home place to be allocated, **without** having an assigned CHSP classification level (CHSP class).

See 6.5.5 section for further details about when an individual with a SaH classification can be approved to access CHSP services.

6.5.7. Time-limited definition

Short-term or time-limited services are defined according to the unique circumstances and requirements of each client. Generally, services provided for up to two months are regarded as short-term.

6.5.8. Wellness and reablement under CHSP

Reablement approaches under CHSP involve recommending time-limited services for a period of up to 12 weeks. Time-limited support aims to address a specific barrier to independence and to support the older person getting back to doing things for themselves. This involves a targeted timeframe, developed with the older person, to achieve their goals.

All providers are able to deliver this service under every CHSP service type. (i.e. assessors can refer for short-term reablement to any CHSP provider).

For further guidance taking a wellness and reablement approach through CHSP, see 'Delivering Time Limited Reablement' section in Chapter 5: Assessment activities.

Department of Health, Disability and Ageing website:

- Commonwealth Home Support Program (CHSP) 2025-27 Manual | Australian Government Department of Health, Disability and Ageing
- Wellness and reablement resources
- Living Well at Home – CHSP Good Practice Guide

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6.6. National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)

The NATSIFACP funds service providers to provide flexible, culturally safe aged care to older Aboriginal and Torres Strait Islander people close to their family, country, island home and community.

Service providers deliver a mix of residential, home and community care services in accordance with the needs of the community which are located mainly in rural and remote areas.

The NATSIFACP is administered under the *Aged Care Act 2024* as a specialist aged care program.

The services provided through NATSIFACP must reflect the service list prescribed by the *Aged Care Rules 2025*.

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6.6.1. Assessing for NATSIFACP

Anyone seeking NATSIFACP aged care services requires an aged care needs assessment under the *Aged Care Act 2024*. NATSIFACP providers can also make this application on the older person's behalf, either by phone or online. This may include supporting the older person by self-referring the assessment to known assessment organisations in the area, including Aboriginal and Torres Strait Islander assessment organisations where one is available.

Under the NATSIFACP, providers deliver a mix of residential, home and community care services in accordance with the individual's assessed care needs, and the needs of the community. Services may be provided on a permanent (ongoing) or short term (non-ongoing) basis, as well as to support emergency needs. To support this flexible service delivery model, the NATSIFACP is block funded. This means individuals accessing care under the program do not have allocated budgets. Arrangements for care recipient contributions are also variable and take into account the capacity of individuals to contribute toward the cost of the services delivered to them.

Older people already receiving NATSIFACP services in the 12-months before 1 November 2025 will be deemed across to the *Aged Care Act 2024 (the Act)* and will not have to have an aged care needs assessment if they wish to continue receiving NATSIFACP services after the Act starts.

In all cases, assessors should work with NATSIFACP organisations already providing care to inform their aged care assessments. By working together, assessors and providers can avoid older Aboriginal and Torres Strait Islander people having to tell their story multiple times and ensure culturally safe assessments are conducted. This includes using information the NATSIFACP provider has gathered to help inform the assessment.

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More information is available on the department's website at National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

6.6.2. Recommending NATSIFACP pathway

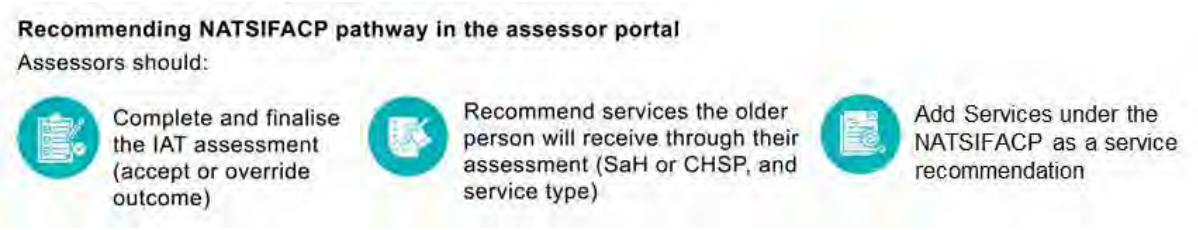


Figure 5 – recommending NATSIFACP pathway in the assessor portal

The option to add Services under the NATSIFACP as a service recommendation in an older person's Support Plan are available via the 'Add a service recommendation button' on the 'Support plan and services page.'

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When adding a service recommendation of Services under the NATSIFACP, a drop-down box will require the assessor to select a priority. From 1 November 2025, there is no priority system in place to receive services through NATSIFACP and the priority value in the service recommendation tab will not impact the timeliness of receiving these services. For consistency, assessors are required to set the priority value for the NATSIFACP service recommendation to low.

It is best practice for a service recommendation of Services under the NATISFACP to be fully recorded in the assessment notes to ensure that information in the support plan is accurate and complete.

In the Notes section, assessors should include the following information:

- If the older person would benefit from accessing services through a NATISFACP provider in their local area
- If the person would like to access services through a NATISFACP provider in their local area

6.6.3. Interactions with other programs

All service groups and types can be delivered under NATSIFACP.

In general, home care services must not be provided to individuals who are receiving other government-subsidised services that are similar. However, individuals may access both the NATSIFACP and Support at Home at the same time, provided the services accessed under the programs are different. For example, a participant could access gardening through Support at Home and personal care via the NATSIFACP. They may require a reassessment to change providers, this will depend on whether they only have a NATSIFACP default classification level, the service types they require and the range of programs available at their new location.

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For further information, please refer to the NATSIFACP Manual.

6.7. Multi-Purpose Service Program (MPSP)

The MPSP provides integrated health and aged care services for older people living in small rural towns and remote areas that cannot support stand-alone aged care and health services.

The MPSP is managed under the *Aged Care Act 2024* as a type of specialist aged care program.

The following aged care services can be delivered under the MPSP:

- Permanent residential care services
- Residential respite
- Home or community services

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6.7.1. Assessing for MPSP

Any person seeking to access services under the MPSP must make an application for funded aged care services. This must be in the approved form.

6.7.2. Recommending MPSP pathway in the assessor portal

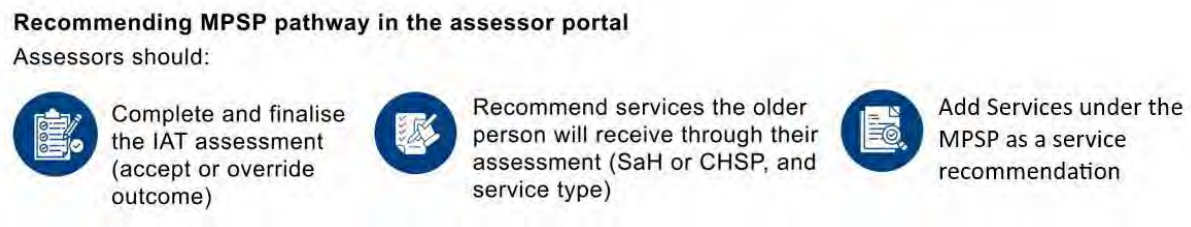


Figure 6 – Recommending MPSP pathway in the assessor portal

When adding a service recommendation of Services under the MPSP, a drop-down box will require the assessor to select a priority. There is no priority system in place to receive services through the MPSP and the priority value in the service recommendation tab will not impact the timeliness of receiving these services. For consistency, assessors are required to set the priority value for the MPSP service recommendation to low.

It is best practice for all service recommendations of Services under the MPSP to be fully recorded in the assessment notes to ensure that information in the support plan is accurate and complete.

In the Notes section, assessors should include the following information:

- If the older person would benefit from accessing services through a MPSP provider in their local area
- If the person would like to access services through a MPSP provider in their local area

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6.7.3. Interactions with other programs

An older person cannot usually access services in the home and community and in a residential care home at the same time.

A person approved for home support, assistive technology and home modification service groups may concurrently access some services through an MPSP, and other services through a mainstream registered provider (e.g. a provider who delivers services under the Support at Home program). For example, the person could access gardening and meal delivery services through Support at Home, while accessing nursing care through the MPSP. However, they cannot access the same type of service on the same day from a specialist aged care program provider and another service provider.

Where the needs assessor discussed the person seeking access to services through their local MPSP, the decision and plan should also include a specific referral code for Services under the MPSP that a provider delivering services under the MPSP can use.

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About the Multi-Purpose Service Program | Australian Government Department of Health, Disability and Ageing

6.7.4. Referrals to NATSIFACP and MPSP providers

If a person is recommended for one or more services groups (e.g. Home Support, Assistive Technology, Home Modifications or Residential Care) and they intend to access the services under MPSP or NATSIFACP, the assessor should provide a Services under the MPSP or Services under the NATSIFACP service recommendation for the person as appropriate.

This is in addition to providing service recommendations for one or more service groups which the assessor considers they meet the criteria for (e.g. Home Support, Assistive Technology, Home Modifications or Residential Care).

This will ensure the person will have a lawful access approval under the *Aged Care Act 2024*, but also that they can be referred to a specialist provider in their local area where they are approved to access services. It will also ensure that additional information about the relevant specialist aged care program is included in their decision letter.

Assessment delegates are responsible for approving service recommendations.

Important

It is not sufficient to only make a service recommendation of Services under the MPSP or Services under the NATSIFACP, as an individual cannot access services under these programs without an access approval from a delegate for one or more service groups.

If the client has been approved for home support with an ongoing Support at Home (SaH) classification or for the AT-HM scheme but intends to initially access services through their local MPSP or NATSIFACP provider, the assessor should set the 'Seeking Services' field to 'No' for one or all of these recommendations as needed. This must be confirmed with the individual before selecting the field. This will prevent the individual from being added to the prioritisation queue(s) for these services and being offered a place which they do not intend to accept at that time. You should not do this if you expect the older person will need to concurrently access services from both the MPSP/NATSIFACP and SaH program and/or the AT-HM scheme.

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If the client has only been approved for Home Support with a CHSP class, then an assessment delegate will need to ensure that:

- the Services under the MPSP or Services under the NATSIFACP service recommendation is recorded in the Notes section (as well as being a service recommendation in the support plan)
- the support plan

6.8. Transition Care Program (TCP)

Transition care is available to older people following admission to hospital. The program is delivered under the service groups home support, assistive technology, and residential

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care. Transition Care is designed to support individuals in the period immediately after discharge from hospital. It aims to facilitate recovery, improve functional capacity, and provide time and support in a non-hospital environment while long-term care arrangements are being considered.

Services include:

- social work
- nursing support
- personal care
- allied health care
- equipment and products to assist with mobility.

Transition care can take place in a person's home, a community setting or a residential aged care setting. Older people accessing Support at Home can also access TCP services if they are assessed as eligible to receive transition care and there is no duplication in service provision.

6.8.1. Access to transition care

Transition care is time-limited, with individuals allocated a funded period of 12 weeks to access services under the program. However, if the individual's recovery requires additional time, the service provider can apply for an extension.

The Transition Care Program is defined under the *Aged Care Act 2024* as a specialist aged care program. The number of places available for this care type is determined by the Federal Minister for Health, Disability and Ageing, based on state and territory needs.
Only registered providers are permitted to deliver hospital transition care using these allocated places.

Importantly, to be eligible for the program, the individual must be:

- medically stable at the time of assessment; and
- is in the concluding stage of a hospital episode; and
- has the potential to benefit from accessing services delivered through the relevant service group under the TCP; and
- at the time the assessment was carried out, an admitted hospital patient. This includes people receiving hospital-in-the-home.

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Once an individual is approved for hospital transition care, it is usual practice for hospital discharge staff to refer them directly to their local Transition Care provider, following delegated approval.

6.8.2. Recommending transition care

When recommending Transition Care in the support plan, assessors will add the care type Transition Care – After Hospital Care. When approved by the assessment delegate, the client will be approved for the following Service Groups:

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