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The client will then have access to all of the required Transition Care service types under each service group, to allow them to receive transition care across different care settings including their home/in the community and Residential Care or a mixture of both. The Assessor and Assessment Delegate are not required to action any additional tasks such as selecting service types within the system in order for the client to be approved for all of the service groups above. These service group approvals will appear in the Notice of Decision Letter.

Approving all three service groups will allow TCP to provide all of the following Service Types to TCP clients when needed:

- Section 8-15 – Allied health and therapy
- Section 8-20 – Assistance with transition care
- Section 8-35 – Domestic assistance
- Section 8-45 – Home maintenance and repairs
- Section 8-55 – Meals
- Section 8-60 – Nursing care
- Section 8-65 – Nutrition
- Section 8-70 – Personal care
- Section 8-110 – Equipment and products
- Section 8-140 - Residential accommodation
- Section 8-145 - Residential everyday living
- Section 8-150 - Residential non-clinical care
- Section 8-155 - Residential clinical care.

These service types are all funded through the Transition Care daily subsidy rate (paid to providers). There is no need to apply for separate funding through Support at Home or Residential Care.

Under Assistive Technology, the provision of loaned equipment and products to assist clients with mobility will continue to be offered by providers, funding for this will continue to be covered through the transition care daily subsidy rate (paid to providers). There is no need to apply for separate funding under the Assistive Technology Service Group.

However, the provision and management of equipment under TCP is determined at the discretion of each state and territory. Jurisdictions may choose to provide equipment on either a permanent or loaned basis, depending on their local policies and operational arrangements.

When the older person is approved as eligible for transition care at the time of the initial assessment, they may need a support plan review or reassessment before the completion of their transition care episode, to establish their long-term care requirements. Where this is necessary, the assessor should review any changes to the person's care needs and ensure that the long-term care recommendations reflect the revised level of need and the person's preferences. For older Aboriginal and Torres Strait Islander people, where applicable, an ECS worker may work with the client, the client's family and assessor to assist with identifying the best care arrangements.

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6.8.3. Accessing Transition Care Program with Support at Home or CHSP

An older person can be recommended and approved for CHSP or Support at Home services at the same time as TCP, provided the IAT Outcome generates an ongoing home support

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outcome. For example, Support at Home services can only be recommended if the IAT Outcome generates a SaH 1-8 classification level. The assessor must accept the IAT Outcome in line with 81-10 of the Rules.

Assessors should consider whether a hospital setting is the most appropriate setting to assess a patient for ongoing home support. They may determine the older person would be better assessed in their home. Alternatively, they may seek information about the older person's home environment from the older person's care and support team to make as accurate an assessment as possible of their ongoing aged care needs. See Chapter 5 for further information on undertaking assessments in a hospital setting.

The client may need a support plan review or reassessment at the end of their transition care period to establish their long-term care requirements.

For transitioned HCP, SaH clients and CHSP clients who are assessed for TCP, the IAT Outcome will need to be accepted, and TCP added as a care type.

Transitioned HCP, SaH and CHSP clients, can continue to access Support at Home and CHSP services while accessing TCP, as long as the services are not duplicative. For example, an older person may elect to continue receiving gardening services under Support at Home in order to maintain a safe home environment, while they receive other services under TCP. It is the responsibility of the participant to notify their Support at Home or CHSP provider of their intention to enter transition care. It is expected that the participant's Support at Home or CHSP provider and the relevant transition care provider will discuss and coordinate care provision to ensure the participant's needs are met.

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6.8.4. Accessing residential care/residential respite and transition care

A person in permanent residential care who is receiving Transition Care must take Hospital Transition Leave for the duration of their TCP episode. In addition, they are not eligible to receive services under the Restorative Care Pathway under Support at Home.

An individual receiving Transition Care is unable to access residential respite care while Transition Care is in effect.

6.8.5. Duration of transition care

The standard period for a transition care episode is 12 weeks (84 days).

This period may be extended by 6 weeks so the total transition care episode is 18 weeks (126 days) if the provider makes an application on behalf of the individual in accordance with the requirements of the Rules and is determined to require access to the services for the additional period.

Lapsing of transition care approval

A transition care approval will lapse under the following circumstances:

1. **Delayed Entry into Care:** If the individual does not commence transition care within four weeks (28 days) following the approval date, the approval will lapse.

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2. **Re-entry After Hospitalisation:** If an individual completes a transition care episode and, after a subsequent hospital stay, seeks to begin a new transition care episode beyond the initial four-week entry period, a new approval is required.

Breaks in care

Individuals in the Transition Care Program (TCP) may take breaks in their care, known as break days, for up to seven days in total during a single episode of transition care. These leave days do not need to be consecutive and may be used for a range of reasons, such as brief hospital readmission or personal/social circumstances.

If the individual exceeds the seven-day leave limit, their TCP approval will automatically expire. In such cases, the individual must be reassessed, and the older person must receive a new approval before they can recommence transition care.

6.8.6. Transition care extensions

If an individual is still making functional gains and would benefit from additional time in Transition Care, the Transition Care provider can request an extension of up to 42 days, with the potential for a further 42-day extension if clinically appropriate.

To initiate the process, the Transition Care provider must submit an extension request via the My Aged Care Service and Support Portal to the assessment organisation. This request must be submitted before and approved by the 84th day of the care episode. The request should include the reason for the extension, the duration requested, and any supporting information relevant to the individual's ongoing care needs. Note there is no right of review if an extension request is declined.

The assessment organisation will receive and action the request through the My Aged Care Assessor Portal. The Assessment Delegate will be responsible for reviewing and making a decision on the request.

When recording a decision to approve an individual for Transition Care, a drop-down box will require the assessor to select a priority. There is no priority system in place to receive services through Transition Care, and the priority value will not impact the timeliness of receiving these services. For consistency, assessors are required to set the priority to 'high' for all assessments.

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Transition Care Program Guidelines – November 2025 | Australian Government Department of Health, Disability and Ageing

6.9. Residential care

Residential aged care is a care type that can be recommended to an older person. There are two types of residential care: ongoing (permanent) and short-term (respite).

An ongoing residential care approval does not compel an older person to enter residential care, it simply enables a person to commence residential care services if and when they choose to do so, without the need for further assessment.

Matters relating to residential care must be decided with the consent of the older person, and if they do not have capacity, their appointed decision maker recognised under the Act

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(whether or not that person is a registered supporter). Appointed decision makers must have authority to make any decisions relative to residential care, and that authority must be active.

Where possible, older people should be supported to live in their community for as long as possible. An assessment may, however, identify residential care as a suitable option for an older person who is no longer able to be adequately cared for by carers or family, and is incapable of living in their community without support.

Application and approval for residential care means the person meets the eligibility criteria and the care type is appropriate for their care needs. To be approved for residential care a delegate must be satisfied that section 68 of the Act applies to an older person (except for older Aboriginal and Torres Strait Islander people who access services on a different constitution basis). The older non-Aboriginal and Torres Strait Islander person must require aged care services due to their sickness as defined under the Act. For further information on the Act's definition of sickness and approvals under sections 67 and 68, refer to section 7.6.4 of Chapter 7.

On 1 October 2022, the Australian National Aged Care Classification (AN-ACC) residential care funding model replaced the Aged Care Funding Instrument.

Following an older person's admission to residential care, a residential aged care funding assessor (RAC funding assessor) will conduct an assessment using the AN-ACC assessment tool. The assessment information is uploaded and is used to determine the resident's classification.

A person who is eligible for residential care may require daily assistance with:

1. meals (including special diets)
2. bathing, showering, dressing and personal hygiene
3. toileting and continence management
4. general nursing care (e.g. wound management)
5. organising and taking medication
6. communication (including fitting sensory or communication aids)
7. transfers and mobility
8. assessment and referral for appropriate health services; and/or
9. emotional support

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If an older person's concerns and goals identify the need for residential care, ongoing and short-term residential care can be added to a person's support plan through the 'add care type' button on the *Goals & recommendations* tab.

An assessor will need to consider the person's:

- physical needs – how much support does the person need for daily living activities (i.e. preparing meals, eating, showering, dressing etc.) their level of mobility and whether they need assistance to walk, sit and stand
- health needs - does the person have chronic health issues that require nursing intervention or regular clinical/medical procedures
- cognitive needs – does the person have issues with memory, orientation, or thinking abilities? is there a diagnosis of dementia?
- psychological and wellbeing needs – do they have any symptoms of depression, anxiety or other mental health challenges, or isolation. Is there a strong social support network for the person
- current living arrangements – what is their living situation and is their living environment safe, do they have family and friends for informal support

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- carer impacts – does the carer need a break and would respite support the person's wishes to stay in their own home longer

There may be a combination of any of the above needs or factors, or a single need that results in the assessor determining that an individual is incapable of living in a home or community setting without support (*Aged Care Rules 2025* Section 65-20 eligibility requirement – service group residential care) and has a continuing need for funded aged care services, including nursing services (*Aged Care Act 2024*, Division 3, Section 68).

6.9.1. Recommending residential care

If an assessor recommends that a client only receive ongoing residential care and/or short-term residential care, there are two pathways to consider when recommending these services:

- An assessor can choose to override the IAT Outcome to 'ineligible for CHSP/SAH' and then choose Residential Permanent and/or Residential Respite options under the 'Add a Care type for Delegate Decision' button
- An assessor can accept a 'SaH Classification' or 'CHSP' IAT Outcome, then choose Residential Permanent and/or Residential Respite from the 'Add a care type for delegate decision' button. The assessor must then ensure that the Support at Home classification is switched to 'not seeking services' and kept as a latent class. This provides the client with flexibility in case they want to return home in the future and access home support services.

6.9.2. Priority for ongoing residential care

To meet the requirements of the *Aged Care Act 2024*, an older person being approved for permanent residential care will be assigned a priority category (1, 2 or 3). Although important, the priority category will not impact when a person can access residential care services or services under a specialist aged care program.

Table 31. Description of priority categories

Category	Description
1	The person: • has a high urgency rating; or • resides in a rural or remote area classified as MM 5, MM 6 or MMM 7; or • is Aboriginal or Torres Strait Islander, homeless, or is entering residential care due to emergency circumstances.
2	The person does not meet the criteria for Priority Category 1 and has a medium urgency rating.
3	The person does not meet the criteria for Priority Category 1 and has a low urgency rating.

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The priority category is automatically generated by the assessor portal based on the individual's circumstances, urgency rating and in accordance with the criteria specified by the *Aged Care Rules 2025*.

Assessment Delegates will need to verify that the urgency rating assigned to the individual accurately reflects their needs and are supported by the evidence provided.

6.9.3. Urgency rating for residential care

A person's urgency rating is different to their need for residential care. While it is expected that all people with a recommendation for residential care have been assessed as having high-level care needs, their level of urgency indicates the extent to which a person may be at immediate risk, including to personal health and safety, if they are not admitted to residential care within a timely manner.

This rating will not undermine the older person's ability to choose to remain in their home but will provide a guide for providers of residential care homes and others (such as Care Finders) to prioritise people who may be most at risk.

When selecting 'Residential Permanent' under the 'Add a care type for Delegate decision' in the My Aged Care assessor portal, assessors will be required to give a response to 'What is the urgency of this care type.' This question is a mandatory question with a rating to be selected from high, medium or low.

The Rules specify when an urgency rating of low, medium or high will apply to an individual in relation the classification type ongoing for residential care. The table below summarises the criteria for each urgency rating.

Provide a rating (low, medium or high) which balances objective consideration of needs with the subjective perspective of the older person. The older person's perspective may be conveyed by their registered supporter. Include a brief note in the *reason or comments* section explaining key reasons for the rating, which may include:

- Key individual, care related or contextual needs and how these relate to any safety/wellbeing risks
- Whether the older person/ has expressed an urgent need to enter care
- Perspective on estimated timeframe the older person needs to enter care

Relevant factors to consider in determining urgency may include:

- Current care settings (including if the person is transitioning into residential aged care from hospital or residential respite care)
- Significant and visible decline in the level of function, cognition and/or ability to perform activities of daily living in the home with available support
- Health conditions and ability to manage these in the home with available support
- Severe incontinence that cannot be managed within the current care settings
- High risk to personal safety (e.g. hazardous home environment, high risk of falls, wandering, or elder abuse)
- Complex factors, including but not limited to homelessness or risk of homelessness; drug and alcohol abuse; mental health issues; or severe social isolation
- Lack of available and sustainable formal, informal support (including any impacts on carers)

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The following can be used as a guide to what urgency may look like within each category. Examples are provided for demonstrative purposes only and each case will need to be judged independently based on diverse individual factors.

Table 32. Guide to urgency ratings for residential care

Level of urgency	Description
High urgency	**This rating applies if:** • The individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk. **Indicators**: Recent falls, hospital admission, unsafe to return home, severe decline. **Example**: A client in hospital post-fall who lives alone and whose needs exceed Home Care supports. Example: John has an ongoing Support at Home classification 8. He recently had a fall and is currently in hospital. John feels like he is unable to return home, and the hospital requests an urgent aged care assessment. The outcomes of John's assessment reveal several risk factors. His health and function are declining, and he has experienced several incidences of falls in recent months leading to hospital admissions. He lives alone, feels socially isolated and needs substantially more hours of care than is possible through the formal support he can receive through Support at Home. The Assessment Delegate approves John for ongoing residential aged care services, with a high urgency rating.
Medium urgency	**This rating applies if:** • The circumstances for a high urgency rating do not apply to the individual; and • When considering the individual's circumstances and preferences, the individual is expected to seek access to permanent residential care within the next 6 months. Example:

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Level of urgency	Description
	Mei has been receiving CHSP services for a few years and recently requested a support plan review to have her needs and services reviewed. As her needs have increased, and she has some complex factors, including declining cognition and moderate incontinence, a reassessment was arranged by the assessor. Mei's daughter, Tao, is her primary carer and is becoming overwhelmed. She's concerned about how much longer Mei will be able to remain living at home by herself, should her cognition and incontinence deteriorate. Mei speaks to her GP and requests a reassessment. The assessor has a conversation with Mei and Tao about the option of ongoing residential care, and they agree that Mei will likely move into an aged care home within the next three to six months. Mei is approved for ongoing Support at Home as well as ongoing residential aged care services, with a medium urgency rating.
Low urgency	**This rating applies if**: • The circumstances for a high or medium urgency rating do not apply to the individual. Example: Maria has been receiving CHSP services in her home. She can still complete many basic and daily living tasks without help but has had a few minor falls recently and is becoming less mobile around the house. Through a reassessment, an ongoing Support at Home classification is approved to meet her current needs. She's feeling very lonely as many of her friends in the community have already moved into aged care facilities, and her children live interstate. She is worried that she might have another fall and need to move into an aged care home. Maria's son agrees to move in with her to provide informal care for 6 months, but she knows that she'll probably need to move into residential aged care once he leaves. Maria is approved for ongoing residential aged care, with a low urgency rating.

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Clients residing in rural and remote areas

IT System enhancements have been built to map a client's residential address to their relevant Modified Monash Model (MMM) 2023 region which is needed to determine their priority. This will be completed automatically for every client approved for residential aged care.

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If the client is being assessed in a temporary location, the address where the client is generally located should be used. If the older person is being assessed in a city whilst staying with family, this will greatly skew the urgency rating.

When an older person registers with My Aged Care, they will be prompted to enter in relevant contact details including their home address. If a home address has not been inputted or is incorrect, an assessor may input or update a clients address at the time of assessment. This is a mandatory field as part of My Aged Care registration/assessment. If you update the individual's address, you will need to click on the 'validate this address' button to populate the MM classification.

A yellow text box may appear when residential care is added or edited as a care type in the *'goals and recommendations'* section of the support plan and the MM classification has not been mapped to the individual's record. The yellow box will seek to update the clients address in their record or manually select the appropriate Modified Monash (MM) area.

Modified Monash Model | Australian Government Department of Health, Disability and Ageing

6.9.4. Place allocation

The residential care system allocates residential care places (permanent or respite) directly to older people. This is the 'Places to People' reform.

Places will be assigned directly to older people who can then access government-funded residential care services. This will give them more choice and control over what provider delivers their services.

Mainstream residential care providers will no longer need an allocation of places to deliver government-funded aged care services.

Providers that deliver residential aged care through a specialist program (such as MPSP or TCP) will still get allocated places, for further information see resource below.

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Places to people – Embedding choice in residential aged care | Australian Government Department of Health, Disability and Ageing

If a person has been approved for residential care, (permanent or respite), they will be allocated a place immediately. They will be advised on this in the Notice of Decision letter.

There will be no delays to allocate the place. Once the person has their place it stays on their My Aged Care account and will not be withdrawn. There are no time limits for when people need to enter into care.

6.9.5. Exiting residential care

If an individual has an existing transitioned Home Care Package or Support at Home approval and chooses to exit residential care, they can rejoin the Support at Home Priority System queue by:

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- being formally exited by their residential care provider in the Services Australia system
- calling My Aged Care and requesting to opt back in, once formally exited.

When an older person with an existing transitioned Home Care Package or Support at Home approval contacts My Aged Care and requests to opt back in to the Priority System, their queue status will be re-activated and place determined by their previous approval date and priority.

Depending on the date of their previous approval under HCP/SaH, they will be assigned funding when it is available. While waiting for assignment of Support at Home funding, individuals may have other care options available.

They could consider accessing aged care services through the Commonwealth Home Support Program (CHSP), state or privately funded services.

If an individual has approvals for residential respite care, this service may also be accessed, noting it is a temporary arrangement.

If an individual is interested in understanding if CHSP or residential respite is an option in the interim, they can call My Aged Care for support with accessing approvals and arranging services.

Additionally, all Australians are eligible to access the primary care health system through hospitals, GPs and allied health practitioners. All Australians, regardless of age can and should access these services as needed.

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6.10. Residential respite care

Short-term (respite) care is provided as an alternative care arrangement with the primary purpose of giving a carer or an individual in need of care a short-term break from their usual care arrangement. Residential respite is not intended as an alternative to restorative care.

Older people will continue to be able to access emergency respite care through the alternative entry pathway, even if they have not been assessed and approved for short-term residential care.

6.10.1. Recommending residential respite care

When recommending an individual for residential respite care, assessors should complete the De Morton Mobility Index – modified (DEMMI-modified) assessment. This tool assesses the individual's mobility and determines their eligibility for one of three respite funding classes: Respite class 1, Respite class 2, Respite class 3, based on the level of mobility observed.

The DEMMI-modified assessment is available within the IAT and can only be used as part of a comprehensive assessment, as it must be completed by a clinically trained assessor. A non-clinical assessor cannot complete the DEMMI-modified even with clinical attendance.

The question, '*Are you likely to recommend residential respite care*' in the IAT is only available in comprehensive assessments. Assessors who are completing a home support assessment and likely to recommend residential respite must convert the assessment to a comprehensive assessment.

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If the DEMMI-modified assessment cannot be completed at the time of assessment, the individual will be temporarily assigned a default funding class (Class 0). This classification remains in place until a formal RAC funding assessment is carried out within the residential aged care home, by a RAC funding assessor, at which point the appropriate funding class can be determined based on the individual's assessed mobility.

> Note:
>
> Approvals for short-term residential care will not be prioritised. When you view the care type recommendation for Residential Respite Care, you will see the 'Urgency' field has been automatically set to 'High' and cannot be edited.

6.10.2. Extensions for residential respite

Assessment delegates may receive requests for a 21-day extension to residential respite care —for example, when a carer is unwell or temporarily unable to resume their care responsibilities. There is no limit to the number of extensions that may be granted beyond the standard 63 days of respite care per financial year.

Typically, the residential aged care provider submits the extension request via the My Aged Care Service and Support Portal, and the assessment organisation receives it through the Assessor Portal for the assessment delegate's action.

An assessment delegate's responsibility is to review the request and either approve or decline it. Once a decision is made, they must communicate the outcome to the provider.

The assessment delegate will need to be satisfied that an increase in the number of respite days was necessary due to any of the following:

(a) carer stress

(b) severity of the individual's condition

(c) absence of the individual's carer

(d) any other relevant matter (for example, where a provider delivers an episode of respite care in good faith but subsequently finds out the care recipient's allocation of respite days had already been exhausted).

> Note:
>
> There is no right of review if an extension request is declined.

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Once decided, the assessment delegate must give written notice to the registered provider of your decision whether to extend within 28 days after the application was made. This written notice must include the day the decision takes effect, which may be before the day the decision is made.

Extensions are granted only at the previously approved level of care. If a higher level is needed, a reassessment and new approval by a Clinical Assessment Delegate is required before the extension can be granted

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Where multiple extensions are being requested in one financial year, the assessor should review the Support Plan in consultation with the client, family and provider, to confirm the appropriateness of the residential respite care with the possibility of considering other care options. This will include whether there is an appropriate Support Plan in place to safely support the person to return home following the residential respite care episode (see section: Residential Care).

For more information on managing residential respite extensions, refer to Managing residential respite care | Australian Government Department of Health, Disability and Ageing

6.11. Other programs and supports

6.11.1. Dementia specific programs and supports

Counselling, education, information, and other support for people living with dementia or experiencing cognitive decline, and their care partners, families, and representatives is available through the National Dementia Support Program (NDSP), delivered by Dementia Australia. They can be contacted 24 hours a day, 7 days a week via the National Dementia Helpline on **1800 100 500** or by visiting the Dementia Australia website.

Chapter 12: Supporting diverse experiences and needs, outlines a system to refer carers of older people living with dementia or experiencing cognitive decline to the National Dementia Helpline, with their consent. A trained professional from Dementia Australia will call the older person and speak to them about dementia-specific services and supports that might assist to help improve or maintain their quality of life.

Note:
A person does not need to have a formal dementia diagnosis to be referred to Dementia Australia for support.

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6.11.2. Dementia Carer Respite and Wellbeing Program

The Dementia Carer Respite and Wellbeing Program (also known as the Staying at Home program) delivers models of respite care through a shared respite experience, attended by both the person living with dementia and their care partner.

The program expands on existing supports to:

- maintain or improve quality of life for care partners and people living with dementia
- increase care partner knowledge, skills and capability to care for a person living with dementia at home improve the experience and quality of respite care for care partners and people living with dementia
- support people living with dementia to stay at home for longer
- provide peer support connections for care partners and people living with dementia

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Care providers (supported by Dementia Support Australia) deliver the Staying at Home program. Family carers can find more information about the program on the Dementia Support Australia website.

There are also a small number of dementia specific innovative respite care programs being trialled across Australia.

6.11.3. Dementia behaviour support

The Australian Government funds national dementia behaviour support programs through Dementia Support Australia (DSA) to support carers and service providers, which can be accessed by contacting the 24-hour DSA helpline on **1800 699 799**.

Dementia Behaviour Management Advisory Service (DBMAS), delivered by DSA, provides free personalised support and advice to service providers and individuals caring for people with dementia in any location or setting in Australia. It provides support when the behavioural and psychological symptoms of dementia (BPSD) start to impact a person's quality of care. DBMAS assists carers and service providers to understand the underlying causes of behaviour, promotes person-centred and trauma-informed approaches, and assists with practical strategies to reduce distress, use of restraints, and inappropriate responses to behaviour.

Severe Behaviour Response Teams (SBRT), also delivered by DSA, provide urgent, specialist outreach support where behaviours are severe, persistent or place the person or others at significant risk. It offers free support and advice to approved aged care providers where there is heightened severity of BPSD or risk to the person living with dementia, or their care network. SBRT may provide onsite assessment (or virtual support where appropriate), multidisciplinary clinical input, and short-term intensive interventions. SBRT will partner with the person living with dementia and their care network to identify unmet needs, contributing factors, and appropriate strategies to stabilise behaviour and support continuity of care.

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The **Specialist Dementia Care Program (SDCP)** supports people with very severe BPSD whose support needs cannot be met in a residential aged care home. Care is provided in a small unit in a cottage-like dementia friendly environment. The program enables specialised care in circumstances where the person has very severe BPSD complicated by physical aggression or other behaviours that the person's residential aged care home or carer partners cannot manage, even with help from other services.

The program provides transitional care aimed at stabilising behaviours over approximately a 12-month period to enable the resident to transition to a less intensive care setting when they no longer need SDCP care.

Referral and eligibility for the program is undertaken by Dementia Support Australia (DSA) through the Needs Based Assessment service.

The **Hospital to Aged Care Dementia Support Program** helps older people living with dementia transition from hospital into residential aged care or home with aged care support. The program supports hospital and aged care staff, the older person and their family or carers:

- during their hospital stay
- when transitioning out of hospital

- following hospital discharge into an aged care supported environment for up to 3 months

DSA are delivering the program in select locations across all states and territories and referrals are accepted from hospital staff in participating hospital sites.

A HACDSP program framework has been developed and provides high level program overview, scope, and administrative arrangements and is available by emailing HACDSP@health.gov.au

A list of current locations and participating hospital sites, along with information on program eligibility and referral processes, is available on DSA's website Hospital to Aged Care Dementia Support Program (HACDSP)

Dementia Support Australia

Staying at Home

Assessing for Eligibility for the Specialist Dementia Care Program (SDCP)

Specialist Dementia Care Program information booklet

6.11.4. Department of Veterans' Affairs (DVA)

Veterans have the same right of access to community and aged care programs as any other member of the community. The *Aged Care Act 2024* lists veterans under the Statement of Principles (section 25). Veterans should not be discriminated against or refused care when accessing services from other community and aged care programs on an assumption that DVA will provide for all their care needs. DVA provides some entry-level care services but does not provide higher-level care services.

Veterans' Home Care (VHC) Program

Veterans' Home Care (VHC) is a DVA program designed to assist veterans and war widows/widowers who need a small amount of practical help to continue living independently in their own home. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance. VHC is not designed to meet complex or high-level care needs.

Community nursing (CN)

CN provides clinical nursing and/or personal care services to eligible members of the veteran community in their own home. CN services can assist with medication, wound care, hygiene and dressing. CN services can help to restore or maintain health and independence at home and assist to avoid early admittance to hospital or residential care. Veterans requiring high-level care require prior approval by DVA.

CN services are provided by a mix of personnel including registered and enrolled nurses and nursing support staff, who work within the framework of their relevant national standards.

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Duplication of services

As long as there is no duplication of services between the programs, Veterans may access DVA's VHC and CN services at the same time as accessing **different services** from:

- Ongoing Support at Home
- CHSP
- TCP

For ongoing Support at Home, this access can occur regardless of the level of the package.

CHSP offers services that are not available through the VHC Program or other DVA arrangements, such as a wide range of social support, food services, community transport and centre-based day respite.

Assistance with fees

DVA may assist with the cost of fees for government funded aged care services for veterans, depending on the type of aged care and the eligibility of the veteran. We recommend the older person contact DVA on 1800 838 372 to check if they are eligible for assistance. If the person is a Prisoner of War or Victoria Cross recipient that served with the Australian Defence Force, DVA may provide additional fee assistance.



- Department of Veterans' Affairs
- Care at home and aged care services
- Community nursing
- Community Nursing Services and Providers

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6.11.5. NDIS participants

For NDIS participants who have turned 65 requesting access to CHSP, assessors must ensure a person is not referred for services they are already receiving through the NDIS and/or other Commonwealth, state, territory or local government programs.

An assessment delegate should be aware of and advise NDIS participants that under the *NDIS Act 2013* (NDIS Act) an under 65 NDIS participant can remain in the NDIS if they are an aged care recipient who subsequently turns 65. However, a NDIS participant whose first permanent entry to residential care or home care (but not residential respite care) is after the age of 65, ceases to be a NDIS participant. (NDIS Act section 29 (1)(b)).



6.11.6. Disability Support for Older Australians (DSOA) and aged care

The Disability Support for Older Australians (DSOA) Program commenced on 1 July 2021. It is a closed program with no new participants and provides funding for a range of services including Assistance in Supported Independent Living, Assistance with Self-Care Activities, Specialist/Behavioural Intervention Support, Therapy, and Case Management.

DSOA supports older Australians with a disability who cannot be supported by the in-home aged care system and were not eligible for the NDIS when it was rolled out in their region.

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Under changes to the *Aged Care Rules 2025* from 29 June 2026, assessors can approve Disability Support for Older Australians (DSOA) clients for CHSP only, even if the IAT Outcome is a Support at Home classification. Selecting a CHSP outcome means the DSOA client can continue to receive their DSOA services alongside the CHSP services listed below.

Should a DSOA client want a Support at Home classification, the assessor should ensure the DSOA client is informed of the considerations relating to their DSOA funding and supports when they consent to proceed with the aged care assessment. DSOA clients must confirm they understand that if they want to be deemed eligible for aged care services under Support at Home rather than CHSP, their DSOA funding will be capped, or they may be required to exit the existing DSOA program.

The following services under CHSP can be accessed by DSOA clients at the same time as DSOA:

- Hoarding and squalor assistance
- Social support and community engagement (Social Supports Group and Individual)
- Equipment and products
- Home adjustments
- Domestic assistance (General house cleaning and other approved household activities)
- Home maintenance and repairs (Home and Garden Maintenance)
- Meals
- Transport
- Specialised support services (Vision advisory services)

Specialist aged care services also do not affect DSOA funding (i.e. TCP).

All other assessment outcomes will affect DSOA funding, and will do so in the following ways:

- An assessment for permanent Residential Aged Care will result in DSOA funding being capped at current levels. This also applies to CHSP service referrals not listed above. If a DSOA client is assessed as eligible for Support at Home and commences services, they will be required to exit the DSOA Program from the date aged care services commenced. These dates will be verified through My Aged Care.
- If a client commenced their Home Care Package prior to 1 July 2021 and are a transitioned HCP care recipient under SaH, they can continue in the DSOA Program. However, their DSOA funding will remain capped.
- If a client commenced CHSP services that are available through the DSOA program, they will be required to exit the DSOA Program from the date the aged care services commenced. These dates will be verified through My Aged Care. However, if a client commenced CHSP services, which are not available via the DSOA program, **prior to 30 June 2021**, the client can continue to access these services as a grandfathered support without any impact to their DSOA funding.

If an assessor receives a referral for a DSOA older person, they should:

- establish if the older person has advised their DSOA service coordinator (provider) that they are seeking a referral for an aged care assessment;
- establish if the older person discussed with their DSOA service coordinator their options to increase supports under the DSOA Program prior to an aged care assessment;

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- establish if the DSOA service coordinator has initiated a Change of Needs application and reviewed the DSOA older person's Individual Support Package prior to consideration of an aged care assessment; and
- establish that the DSOA older people understands the impacts on their DSOA funding should they proceed to assessment.

Aged care assessors should keep these policy settings in mind when making recommendations for aged care supports for a DSOA older person. That is, in making a recommendation, the aged care assessor needs to consider whether aged care services can appropriately support the older person were they to exit the DSOA Program.

Department of Health, Disability and Ageing website:

Disability Support for Older Australians Program (DSOA) manual

About the Disability Support for Older Australians Program

6.11.7. Carer support

Assessors should inform carers there is support and services specifically for them to access. This support is available through **Carer Gateway** and the National Dementia Helpline (for care partners of people with dementia or experiencing cognitive decline), both funded by the department.

Carer Gateway provides early-intervention and preventative supports and services to carers to help improve their well-being and long-term outcomes.

Carer Gateway is for all carers, no matter their age or the condition of the person they are caring for.

Carer Gateway consists of a website (www.carergateway.gov.au) and a national network of Carer Gateway service providers (CGSPs) (located in each state and territory).

CGSPs support carers with access to in person and digitally based supports and services including support planning, counselling, peer support, coaching, tailored support packages (including access to planned respite), emergency respite, and information and practical advice:

- Support Planning – assess the carer's needs and work with the carer to develop an agreed individual support plan.
- Counselling - professional counsellors for carers who are experiencing difficulties with anxiety, stress, depression and low mood as a result of their caring role.
- Peer Support – a service for carers to connect with people in similar caring circumstances and learning from their peers through the sharing of lived experiences.
- Coaching – carers work one to one with a coach, taking time to think about their own wellbeing and steps towards personal life goals.
- Tailored Support Packages – offers a range of practical supports to support carers access education and/or employment or assist carers in their caring role (e.g., access to planned respite, assistance with transport).
- Emergency Respite - help with accessing emergency respite support when a carer can no longer maintain the caring role due to illness for example.

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CGSPs also assist with navigating relevant, local services available to carers, including My Aged Care, National Disability Insurance Scheme, Dementia Australia and referrals to other state/territory government funded carer support services.

CGSP staff talk with carers about the registration and support planning process and then work with them to provide access to supports and services based on their individual needs and caring circumstances. The intent of the support planning is for carers to have the most appropriate supports in place to help maintain their wellbeing, which in turn helps maintain their capacity to continue their caring role and also to participate in their communities.

Assessors should collect carer information in the My Aged Care Assessor Portal or Aged Care Assessor App and register the older person and their carer's consent to request a call back from Carer Gateway and/or the National Dementia Helpline. The carer's local CGSP and/or the National Dementia Helpline will then contact them to assist with accessing supports to help them in their caring role.

Alternatively, assessors may inform carers they can contact their local CGSP by calling 1800 422 737 (selecting Option 1), Monday to Friday, between 8am and 5pm, or by visiting the Carer Gateway website (www.carergateway.gov.au) and completing the online 'Request for Call Back' form.

The Carer Gateway website also provides carers with practical advice, information and resources to help them in their caring role, as well as access to:

- a national carer phone counselling service to help them manage daily challenges, reduce stress and strain, and plan for the future;
- an online peer support forum, connecting carers with other carers for knowledge and experience sharing, emotional support and mentoring;
- online self-guided coaching resources with simple techniques and strategies for goal-setting and future planning; and sources to increase skills and knowledge of carers relating to specific caring situations, to build confidence and improve wellbeing.

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Assessors should also **note**, that CGSPs currently **do not** have the capability to receive referrals to book flexible, centre-based, cottage or residential respite for carers of My Aged Care older people.

Assessors should also be aware that under the Carer Gateway model, assistance for young carers to continue with or commence study through the Young Carer Bursary Program is available. Further information on the Young Carer Bursary Program and the application process is available at www.youngcarersnetwork.com.au/young-carer-bursary.

Dementia Australia's support for carers, family members, and representatives of people with dementia or experiencing cognitive decline includes providing in person, phone-based, or online dementia-specific counselling, peer support, and education.

Dementia Australia's carer supports can help people better understand the nature and impact of dementia, develop strategies to manage stress and mixed emotions, plan for the future, and manage grief.



Carer Gateway website

Carer Gateway service provider free call:1800 422 737

Department of Health, Disability and Ageing website:

My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships

Young Carers Network website

For family, friends and carers | Dementia Australia

National Dementia Helpline: 1800 100 500 - 24 hours a day, 7 days a week

6.11.8. Aged Care Volunteers Visitors Scheme (ACVVS)

The Aged Care Volunteer Visitors Scheme (ACVVS) provides friendship and companionship to older people who are feeling lonely or socially isolated by matching them with a volunteer visitor. The ACVVS is a free program for eligible aged care recipients. Visits are available to anyone receiving Australian government-subsidised residential aged care or the Support at Home services. This includes care recipients approved or on the Support at Home Priority System and excludes those with a Commonwealth Home Support Program (CHSP).

The program requires the volunteer to make 20 ACVVS visits per year. These occur for approximately an hour a fortnight.

Anyone can refer an eligible older person to the ACVVS, including Aged Care Assessors, aged care service providers, health professionals, family members and friends. Older people can also refer themselves.

You can request a volunteer for an older person via the ACVVS website.

Aged Care Volunteer Visitors Scheme (ACVVS) | Australian Government Department of Health, Disability and Aged Care

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6.11.9. Interpreting and translation services for people from culturally and linguistically diverse backgrounds

Every older person has a right to communicate in their preferred language or method of communication, with access to interpreters and communication aids as required.

If an older person requires an interpreter or translation services, it is the responsibility of the assessment organisation to access these services as needed to support the older person through the assessment process.

Sign language interpreting services

Older Australians who are deaf, deafblind or hard of hearing, who are seeking to access or are in receipt of Commonwealth funded aged care services can access **free** sign language interpreting and captioning services. Sign language services can be provided face-to-face or by Video Remote, and live captioning services are available to support older people to better engage and fully participate in their aged care journey and activities of daily living.

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Information on how service providers can access interpreting services is available online at My Aged Care (or by calling 1800 200 422) or Deaf Connect (or by calling 1300 773 803).

If an older person enquires about sign language interpreting for daily activities, not aged care related, please refer them to Deaf Connect where they can also receive free services.

Sign language services are available in Auslan, American Sign Language, International Sign Language, and Signed English for Deaf or people who are hard of hearing, and tactile signing and hand over hand for people who are deafblind.

6.11.10. Interpreting services for Aboriginal and Torres Strait Islander people

It is important for older Aboriginal and Torres Strait Islander people accessing or thinking of accessing Australian Government-funded aged care services to be able to communicate in an Aboriginal and Torres Strait Islander language if that is their preference.

To access Interpreter Connect, an Aboriginal and Torres Strait Islander person should call My Aged Care on 1800 200 422 and ask for an interpreter from the following list of languages. Through the interpreter, My Aged Care will answer the person's aged care questions and then, if asked to, will assist them with accessing services. Languages available include:

- Alyawarre
- Anmatyerre
- Arrernte (Eastern and Central)
- Arrernte (Western)
- Djambarrpuyngu
- Gumatj
- Kriol (Top End)
- Murrinh Patha
- Ngaanyatjarra
- Ngaatjatjarra
- Pintupi-Luritja
- Pitjantjatjara
- Torres Strait Creole/Yumpla Tok
- Warlpiri
- Yankunytjatjara
- Yolngu Matha

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If an interpreter from the above list is not available at the time of the call, an appropriate time that suits the Aboriginal and Torres Strait Islander person will be arranged. This service aims to make it easier for older Aboriginal and Torres Strait Islander people, their families and carers to access information on ageing and aged care, to have their needs assessed and to be supported to find the most appropriate services.

6.11.11. Elder Care Support

The Elder Care Support Program was established to recruit and train a trusted workforce to support older Aboriginal and Torres Strait Islander people and their families throughout their aged care journey. This support contributes to older people achieving a better, safer experience when accessing aged care services and having the information to make decisions on the care they need and receive.

The Elder Care Support program provides services that include:

- supporting older Aboriginal and Torres Strait Islander people to understand aged care services, navigate the assessment process and help with choosing a provider

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- supporting families, friends and carers to understand how to access aged care services
- advocating for older Aboriginal and Torres Strait Islander people by working with assessors and providers to meet their needs
- supporting older Aboriginal and Torres Strait Islander people while they receive aged care services
- assisting with other types of health needs, such as disability supports.

The National Aboriginal Community Controlled Health Organisation (NACCHO) Aged Care Programs team can provide further information about the program at agedcare@naccho.org.au.

Elder Care Support

6.11.12. Care Finder Program

The care finder program offers tailored, intensive support to people who have one or more reasons for requiring assistance to interact with My Aged Care and access aged care services and other relevant community supports.

Care finders help vulnerable older people understand and access aged care and connect with other relevant supports in their community. This includes people who are, or are not yet, receiving aged care services or other relevant supports.

Care finders support people who don't have family, friends, a carer or any other person they are comfortable receiving help from and who is willing and able to help them access aged care services and supports. Care finders conduct outreach and then register the older person through the My Aged Care contact centre.

Primary Health Networks (PHNs) are responsible for commissioning and managing care finder services, leveraging their commissioning expertise and in-depth understanding of local community needs.

Contact information for care finder services in each region is on the My Aged Care website at Help from a care finder.

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Care finder program

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7. Chapter 7: Delegations and approvals under the Act

What you'll find in this chapter

This chapter includes information about:

- the powers under the *Aged Care Act 2024* that are delegated to triage delegates and clinical and non-Clinical assessment delegates.
- how approvals work under the *Aged Care Act* 2024, and the decisions that delegates make.

7.1. Delegation of powers and functions under the *Aged Care Act 2024*

Under section 339 of the *Aged Care Act 2024* (the Act), the System Governor plays a key role in the governance of the aged care system responsible for facilitating equitable access to funded aged care services. Section 7 of the Act specifies the position of the System Governor is occupied by the Secretary of the Department of Health, Disability and Ageing.

The System Governor has the power under section 567 of the Act to delegate their functions and powers to others who may exercise them on their behalf. The Instrument of Delegation outlines the specific functions, powers and responsibilities of the System Governor which are delegated to certain positions within assessment organisations. Staff who occupy these positions are considered delegates and will continue to be nominated through the on/off delegate form.

Delegations are tied to the position, not to the individual. This means that the powers and functions stay with the role, and any qualified person who has been approved to hold the position can exercise these powers. The Instrument of Delegation outlines which positions within each assessment organisation can hold these responsibilities.

These delegations operate within the Single Assessment System, and delegates must comply with Commonwealth guidelines, and any directions issued by the Secretary. This ensures that the delegation framework remains in line with current policies and standards.

7.2. Delegate responsibility

The role of the delegate is that of a primary decision-maker within a structured legal system. This means delegate decisions must be based on the legal requirements, facts, evidence, and clear reasoning. Understanding the legal framework and decision-making requirements is essential to making sound, defensible judgments.

The Single Assessment System relies on delegates to fulfil their role efficiently and effectively. Delegate decisions ensure that due process is followed and that eligible clients receive the care and support they need.

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Decisions made by assessment delegates may be subject to review in various contexts. This could include reconsideration requests or formal reviews by bodies such as the Administrative Review Tribunal (ART).

As a result, it is important that delegates maintain accurate, complete records and clear justifications for every decision they make.

There are three delegate positions which sit within assessment organisations:

- Triage delegates
- Clinical assessment delegates
- Non-clinical assessment delegates

Under the *Aged Care Act 2024*, these delegate positions will be involved in certain assessment related activities outlined in the table below.

Table 33. Assessment related activities of delegate positions

Delegate position	Delegate activity
Triage Delegates	• Consider and determine an older person's eligibility for an aged care needs assessment or reassessment • Determine whether an older person requires a reassessment • Notify an older person of decisions and their right to review • Consider whether the older person requires access to urgent services
Non-clinical Assessment Delegate	• Approve an older person's eligibility to access aged care services under the Commonwealth Home Support Program • Limit or vary an older person's approval for funded aged care services • Notify an older person of decisions and their right to review • Consider and approve any appropriate changes to an older person's access approval for services under the CHSP as a result of a support plan review
Clinical Assessment Delegate	• Approve an older person's eligibility to access funded aged care services, including Urgent services through the CHSP • Limit or varying an older person's approval for funded aged care services • Approve extensions for transition care and residential respite care services • Notify an older person of decisions and their right to review • Consider and approve any appropriate changes to an older person's access approval for services as a result of a support plan review • Consider and determine the outcome of a classification reassessment

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For information about how to assign individuals to delegate positions, see Chapter 13: Operating procedures.

7.3. Triage delegates

Triage delegates are delegated under the *Aged Care Act 2024* (the Act) to decide:

- under Section 58 of the Act, whether an older person is eligible for a needs assessment for government funded aged care services.
- under section 64 of the Act, whether an older person has undergone a significant change of circumstances or other change in their circumstances and requires a reassessment of their needs.

To find someone eligible for a needs assessment, a triage delegate must be satisfied the older person meets the age eligibility requirement and has declared they have an aged care need.

See Chapter 5: Assessment activities for information about the function of the triage delegate and conducting triage.

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7.4. Assessment delegates

7.4.1. Non-clinical assessment delegates

Non-clinical Assessment Delegates are delegated the authority under the Act to approve entry-level services arising from a home support assessment.

- This means they can only approve access to the Commonwealth Home Support Program (CHSP).
- assistive technology (AT) and/or home modifications (HM) under CHSP (*not* under the AT-HM scheme).

If any approvals other than those listed above are required, the assessor must convert the assessment to a comprehensive assessment. Once an assessment is converted to a comprehensive assessment, the approval will flow to a Clinical Assessment Delegate. Clinical Assessment Delegate approval is required for all other approvals as outlined in detail in the next section.

All needs assessors will have the ability to apply for non-clinical assessment delegation under the *Aged Care Act 2024* (the Act) to approve entry-level services. Assessment organisations can determine whether to permit all needs assessors to perform this function.



A learner assessor must not be appointed a non-clinical delegate until they have completed all mandatory training requirements set out in the My Aged Care Workforce Learning Strategy and been issued with a completion certificate on MAClearning.

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When approving the recommendations from an assessment they have undertaken, needs assessors, acting in their capacity as a non-clinical assessment delegate should exercise due care to ensure the assessment is complete, evidence based, free from errors, contradictions, or omissions.

7.4.2. Clinical assessment delegates

Clinical assessment delegates are delegated the authority under the Act to approve an older person for all service groups, classification types and classification levels.

> Note: Clinical Assessment Delegates can approve entry-level home support services (as non-clinical assessment delegates do) if assessment organisations have chosen to allocate home support assessments to clinical assessment delegates.

7.5. Overview of approvals under the *Aged Care Act 2024*

The *Aged Care Act 2024* (the Act) standardises the approval approach for funded aged care services, with all approvals given under the Act, using one service list which is divided into four Service Groups. This makes it more straightforward to give an older person a tailored package of care that meets their needs.

To be eligible for any funded aged care service an individual must first meet the criteria for an aged care needs assessment (as specified in Section 58 of the Act). Eligibility is now determined by a triage delegate, who holds relevant decision-making powers delegated by the System Governor.

Once determined as eligible, an aged care needs assessment is conducted to determine whether the older person requires funded aged care services. Based on this assessment, the assessor recommends funded aged care services they consider the individual needs to meet their care needs as well as any services, service types and service groups they consider the individual should be approved for under section 65 of the Act. It should be noted that under the same provision, older Aboriginal and Torres Strait Islander persons only need an approval at the service group level to receive aged care services. These recommendations are documented in a support plan, which is issued to an assessment delegate for consideration shortly after the assessment has been completed.

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For an older person to start using funded aged care services, they need to be approved for the following under the Act:

1. **Service groups,** which specify the setting and nature of care an individual can access
2. **Classification types,** which specify the different time periods that services are delivered for under the service group.
3. **Service types** and **services** (for some older people, in some circumstances) – Service types are groups of different services. The services under these types are set out under the Aged Care Service list. Different service types sit under each service group. Older Aboriginal and Torres Strait Islander people only need an approval at the service group level – they are automatically approved for all service types and services in that group.

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4. **Classification levels,** which determine the amount of funding available to deliver funded aged care services to the individual. The individual receives a classification level for the classification type for the service group they have been approved to access. The classification levels are specified in the Rules (see Division 3 Part 3 of Chapter 2 of the Rules).
5. **Priority categories** – determines priority for a classification type for a service group.

> Note: individuals must be approved under the *Aged Care Act 2024* to access any funded aged care services, including if delivered through CHSP, MPSP and NATISFACP. This is a significant change as individuals could previously access services through these programs without approval under the *Aged Care Act 1997*.

7.6. Delegate decisions under the *Aged Care Act 2024*

Although assessors provide recommendations and supporting evidence via the assessment report (support plan), the final approval decision rests with the assessment delegate, except an ongoing home support classification level and assigning a priority level for Support at Home which are automated decisions.

While assessment delegates exercise the powers of the aged care System Governor, they remain personally accountable for the decisions they make under the *Aged Care Act 2024* (the Act). This underscores the significant responsibility of the Assessment Delegate role.

Once an aged care needs assessment is finalised, the assessment delegate must ensure that all eligibility requirements are met before approving any service group, service type, or specific funded aged care service. This means that the older person's situation must comply with the conditions outlined in sections 65-68 of the Act and any additional eligibility criteria set by the relevant rules must be satisfied. If these requirements are not met, the assessment delegate cannot approve the provision of aged care services.

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7.6.1. Deciding if the older person requires aged care services

Assessment delegates must first determine whether the individual requires access to funded aged care services, and which service groups, and in some cases service types and services they require. This requirement is set out in section 65(2) of the Act.

This decision is made based on:

- An assessment report (referred to in practice as the support plan),
- In the case of reassessments in accordance with 64(1)(c)(ii) of the Act, any relevant information relating to the individual provided.

The table below summarises the sections of the Act that relate to eligibility for access to services. These sections of the Act, and how they apply to an assessment delegate's decision-making, are explained in detail in the following sections.

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Table 34: Approval to access funded aged care services under section 65

Section criteria of the Act		Available service group/s	Available classification type/s	Relevant program/s
66	Individual must be an Aboriginal or Torres Strait Islander person The individual must meet any eligibility requirements prescribed by the rules for the relevant service group.	• Residential Care • Home Support • Assistive Technology • Home Modifications	All classification types	All programs.
67	Individual must have an impairment; **and** There must be a specific reason why the individual requires access to the service type/s or services. The individual must meet any eligibility requirements prescribed by the rules for the relevant service group.	• Home Support • Assistive Technology • Home modifications	All classification types	• Support at Home • CHSP • TCP • MPSP • NATSIFACP
68	Individual must have a continuing need for residential care because they are 'sick' The individual must meet the eligibility requirements prescribed by the rules for the service group residential care.	• Residential Care	All classification types	• Residential care (ongoing or short-term) • TCP • MPSP • NATSIFACP

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Figure 7 below provides a visual summary of the three pathways to access approval (sections 66, 67 and 68).

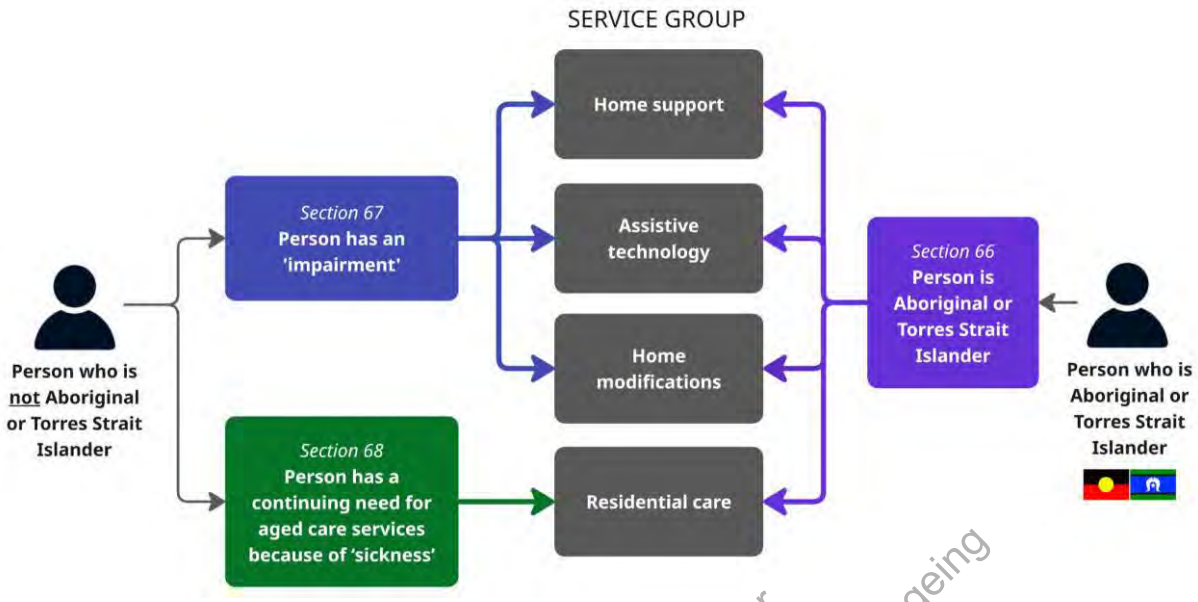


Figure 7 – Overview of pathways to approval for service access under the Act

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7.6.2. Section 66 – Aboriginal or Torres Strait Islander persons

Section 66 provides a special pathway for Aboriginal or Torres Strait Islander people to be approved under section 65(1) to access funded aged care services. This pathway is unique for Aboriginal and Torres Strait Islander people because it relies on a different power in the Constitution to the other eligibility for approval provisions.

Under section 66, an older Aboriginal or Torres Strait Islander person can be approved under section 65(1) for any service group, which includes all of the service types and services in the group.

Figure 8 below gives an overview of the section 66 pathway to access approval for older people who are Aboriginal or Torres Strait Islander.

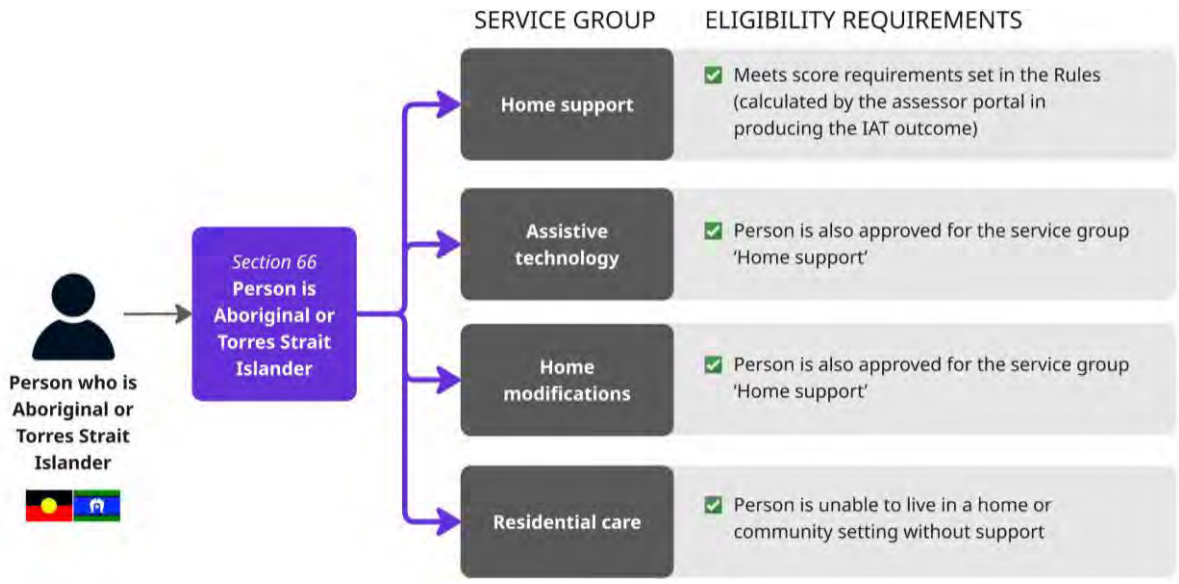


Figure 8 – Overview of section 66 pathway to approval for service access

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Additional eligibility requirements

While an older Aboriginal or Torres Strait Islander person can be approved at the service group level for any service group, delegates will still need to take into account the additional eligibility requirements in the *Aged Care Rules 2025* (the Rules) for the service group (or groups) the person is actually approved for (section 65-10 to section 65-20 of the Rules). This is required because of section 65(3) of the *Aged Care Act 2024*.

The additional requirements for each service group are set out below.

Additional eligibility requirements for home support

The system will calculate the score necessary to determine whether an older person has met the additional eligibility requirements for the home support service group listed below. This calculation is made by drawing on the responses from within the Integrated Assessment Tool (IAT). The role of an assessment delegate is to ensure information is accurately recorded in the IAT and to have consideration for the legislative eligibility criteria even though the score is calculated by the system.

The additional requirements for the home support service group are that the person meets any of the 'score' requirements for the particular questions in the IAT. These are outlined in the table below.

Table 35. Additional eligibility requirements for the home support service group under section 66

A person has a total score of less than 20 for the questions in the IAT with the following headings:	• Climb stairs • Eating • Dressing • Take a bath or shower • Grooming • Transfers • Toilet use • Toileting – bladder • Toileting – bowels • Walk
OR	
The person has a total score of less than 14 for the questions in the IAT with the following headings:	• Get to places out of walking distance • Undertake housework (heavy/moderate) • Go shopping (assuming transportation) • Prepare meals • Take medicine • Handle money • Use the telephone
OR	
The person has a score greater than zero for the questions in the sections of the IAT headed:	• Cognition • Medical and Medications
OR	
The individual has a score greater than zero for questions in the section of the IAT headed:	• Psychological
OR	
The individual has a score greater than zero for the questions in the section of the IAT headed:	• Physical, Personal Health or Frailty

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Additional eligibility requirements for assistive technology and home modifications

- the individual is also approved for the home support service group.

Additional eligibility requirements for residential care

- the individual is incapable of living in home or community setting without support.

7.6.3. Section 67 – a person who has an impairment or sickness

Section 67 is the pathway for non- Aboriginal or Torres Strait Islander people to be approved under section 65(1) for the following service groups:

- home support
- assistive technology
- home modifications.

There are special requirements for approving a person where section 67 applies to them, because of the legal basis in the Constitution that supports the approvals.

When approving a person for service types or particular government-funded aged care services because section 67 applies to them, it is not possible to approve them at the service group level. Assessment Delegates will need to select and decide the particular service type/s the older person requires, or for particular service types the individual service/s (further information below). This is a necessary legal requirement because of the constitutional powers that support the provision of these types of services under the *Aged Care Act 2024 (the Act)*.

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Figure 9 below gives an overview of the section 67 pathway to access approval.

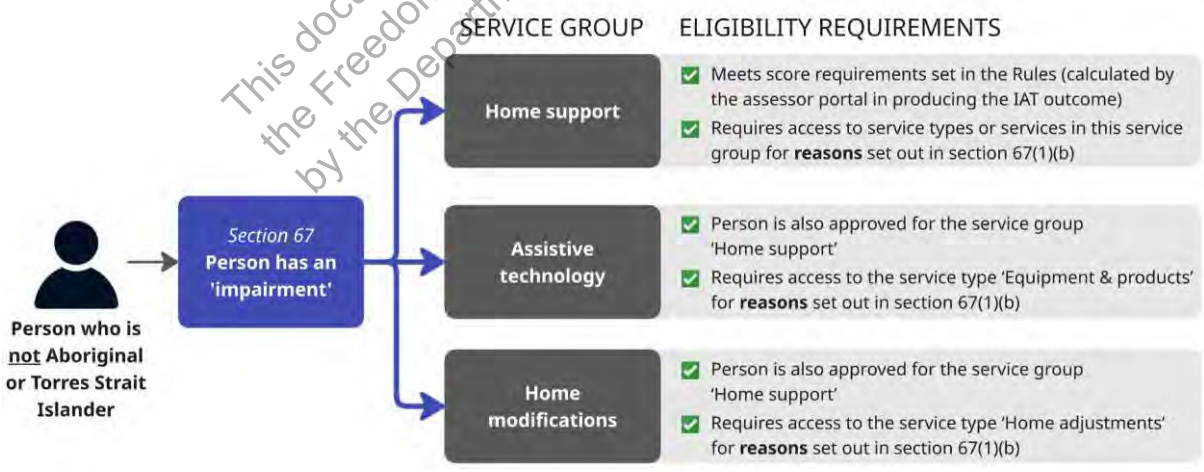


Figure 9 – Overview of section 67 pathway to approval for service access

Deciding if the person should be approved

When deciding if an older person should be approved for the Home Support, Assistive Technology or Home Modifications service group/s under section 65 of the Act where section 67 applies to them, assessment delegates will need to take the following steps:

1. Assessment delegates must be satisfied that the older person has a disability or an "impairment"

    a. the impairment must be long-term and be a physical, mental, sensory or intellectual impairment, and

    b. because of its interaction with various barriers, the impairment may hinder the person's participation in society on an equal basis with others.

2. Decide which service types the older person requires access to.

    a. For the service types 'Allied health and therapy' and 'Therapeutic services for independent living' an assessment delegate must also decide which individual services in those service types they require access to.

3. Assessment delegates must then be satisfied that there is a specific reason why the person requires access to the service types (or the particular funded aged care services – see step 2a.). These reasons are set out in section 67(1)(b) of the Act and explained further below.

4. Assessment delegates must also be satisfied that the person meets the additional eligibility criteria in the Rules. These criteria are outlined below.

Impairment

Information about the person's "impairment" will already be reflected in the information collected using the Integrated Assessment Tool (IAT) and any other relevant information gathered during the assessment, such as information from the person's GP or other health records. For the purposes of recording the approval decision, an assessment delegate will need to be satisfied the information provided identifies the long-term impairment (or impairments) that the older person has. This should be evident from the assessment information.

It should also be evident from the assessment/IAT/Support Plan information the barriers the person faces to their independence because of their impairment and how this impacts their ability to participate and be included in the community.

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EXAMPLE 1

The older person may be physically impaired because of a musculoskeletal disorder or be vision impaired, which was identified through their assessment and recorded in the IAT, or evidenced in a record or report for the person provided by a GP or other health professional. This may impact, among other things, their functional ability and be recorded under the Function section of the IAT.

EXAMPLE 2

The older person may have a diagnosis of a pre-existing condition, such as arthritis or another physical or neurological condition, such as dementia or Motor neurone disease, as identified through their assessment in the IAT. This may be recorded as a health condition under the Medical and medications section.

For both above examples, the older person's condition may impact their ability to participate in the community, as they would require support to enable them to continue living at home and maintain their independence.

Special requirements for 'Allied health and therapy' and 'Therapeutic services for independent living'

When approving an older person for the service types 'Allied health and therapy' and 'Therapeutic services for independent living,' assessment delegates will need to consider which individual service (or services) in the service type the person requires access to because of their needs.

This is because each funded aged care service that is considered an allied health, therapy or other therapeutic service is directed at a different physical, functional or cognitive issue – it's not possible to determine that a person with disabilities requires access to allied health or therapeutic services *generally* without considering if each particular service is required. This is an essential requirement because of the changes to the legal basis supporting the *Aged Care Act 2024* (the Act).

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Specific reason/s why access is needed under Section 67

The Act requires Assessment Delegates to consider reasons why an older person needs access to the service types or particular services. Assessment Delegates must turn their minds to these reasons when deciding on the service types/services.

The reasons are that the service type (or service(s) within the service types of *Allied health and therapy* and *Therapeutic services for independent living*):

i. is an in-home, residential or community support service that is necessary to support the person to live and be included in the community and prevent them from being isolated or segregated from their community

ii. will facilitate personal mobility of the person in a way that the individual chooses

iii. involves a mobility device or equipment, or assistive technology, that will facilitate personal mobility

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iv. is a health service that the person needs because of their impairment or because of the impairment and the interaction with various barriers

v. is a habilitation or rehabilitation service

vi. is a service that will assist the person to access any of the services they need because of any of the reasons above

vii. will minimise the prospects of the person, or prevent the person from, acquiring a further impairment

viii. is a medical service required by the person because of sickness.

For ease of understanding, these have been re-framed as needs of the older person in the table below (this is how they appear in the Notice of Decision).

Table 36. Reframed reasons for access under section 67

It has also been determined that you require access to the stated service types and/or services because you …
need support to live and be included in your community
need support with your mobility
need support to reduce the chances of you becoming more impaired
need health services because of your impairment
need support to regain skills and abilities or learn new ones
need help to access services for which you've been approved

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When making a decision, assessment delegates must consider the older person's circumstances overall and what service types and services they need, and for what reason. This should already be evident from the information recorded in the Integrated Assessment Tool (IAT) or the support plan, which detail what the person's needs are, and why the person needs support and what help they need.

Potential applicable reasons for service types/services are set out in the table below.

Table 37. Service types/services and potential applicable reasons under section 67

Reason	Reason may apply when approving the older person for…
1. Need support to live and be included in your community	• any service type **except** 'Nursing care' from the service group 'home support' (including services accessed through TCP) • 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme, CHSP or TCP
2. Need support with your mobility	• the service type 'Transport' from the service group 'home support' (included in any approval for TCP) • 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme or CHSP
3. Need support to reduce the chances of you becoming more impaired	• the service type 'Assistance with transition care' (part of any approval for TCP) • 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme or CHSP
4. Need health services because of your impairment	• The service type 'Allied health and therapy'[4] • The service type 'Nursing care' • The service type 'Therapeutic services for independent living'[5] • *Note that all of the above may be accessed through TCP*
5. Need support to regain skills and abilities or learn new ones	• the service type 'Assistance with transition care' (part of any approval for TCP)

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[4] Remembering that for this service type you will need to decide the individual service (or services) the older person needs and turn your mind to the reason why they need that particular service (or services).
[5] Remembering that for this service type you will need to decide the individual service (or services) the older person needs and turn your mind to the reason why they need that particular service (or services).

Reason	Reason may apply when approving the older person for…
6. Need help to access services for which you've been approved	• 'Equipment and products' under the AT-HM Scheme or CHSP • The service type 'Restorative care management' under the service group 'home support' (e.g. Restorative Care Pathway) • the service type 'Assistance with transition care' (part of any approval for TCP)

Once an Assessment Delegate has considered which service types are needed and why, they need to record the reasons for their decision in the Notice of Decision. Assessment Delegates will be required to delete the reasons which they consider do not apply from the list of reasons above.

Health services - examples

An example of a health service is physiotherapy or other services delivered by a registered health professional.

An example of approving access to a service because it is a 'health service' required 'because of the individual's impairment' could be approving them for the service 'Physiotherapy' in the 'Allied health and therapy service type.' This is because the physiotherapy is required to support them with managing their diagnosis of Motor Neuron disease.

Habilitation and rehabilitation services - examples

Allied health services such as occupational therapy or physiotherapy are examples of habilitation or rehabilitation services.

An example of approving access to a service because it is a 'habilitation or rehabilitation service' could be approving them for 'Acupuncture' in the 'Therapeutic services for independent living' service type, to support them in rehabilitation following a stroke.

Additional eligibility requirements

When approving a person under section 65(1) because section 67 applies to them, Assessment Delegates will also need to turn their mind to the additional eligibility requirements in the *Aged Care Rules 2025* for the service groups the person is actually approved for. This is required because of section 65(3) of the *Aged Care Act 2024*.

The additional requirements for each service group are set out below.

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Additional requirements for home support

The system will do the work in calculating the score necessary to determine whether an older person has met the additional eligibility requirements for the home support service group listed below. This calculation is made by drawing on the responses from within the Integrated Assessment Tool (IAT). The Assessment Delegate is to ensure information is accurately recorded in the IAT and that you have consideration for legislative eligibility criteria even though the score is calculated by the system.

The additional requirements for the home support service group are that the person meets any of the 'score' requirements for the particular questions in the IAT, outlined in the table below.

Table 38. Additional eligibility requirements for the home support service group under the Rules

A person has a total score of less than 20 for the questions in the IAT with the following headings:	• Climb stairs • Eating • Dressing • Take a bath or shower • Grooming • Transfers • Toilet use • Toileting – bladder • Toileting – bowels • Walk
OR	
The person has a total score of less than 14 for the questions in the IAT with the following headings:	• Get to places out of walking distance • Undertake housework (heavy/moderate) • Go shopping (assuming transportation) • Prepare meals • Take medicine • Handle money • Use the telephone
OR	
The person has a score greater than zero for the questions in the sections of the IAT headed:	• Cognition • Medical and Medications
OR	

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The individual has a score greater than zero for questions in the section of the IAT headed:	• Psychological
OR	
The individual has a score greater than zero for the questions in the section of the IAT headed:	• Physical, Personal Health or Frailty

Additional requirements for assistive technology and home modifications:

- the individual is also approved for the home support service group.

7.6.4. Section 68 – 'individuals with a sickness'

Section 68 is the pathway for non Aboriginal or Torres Strait Islander people to be approved under section 65(1) for funded aged care services in residential care.

This covers the residential care service group which includes both permanent (ongoing) and respite (short-term) residential care. It also covers older people who will access funded aged care services through the residential care service group under the Transition Care Program (TCP).

Approving a person for the residential care service group because section 68 applies to them will automatically approve them for all residential care service types, including the services under those types.

Figure 10 below gives an overview of the section 68 pathway to approval to access the residential care service group.

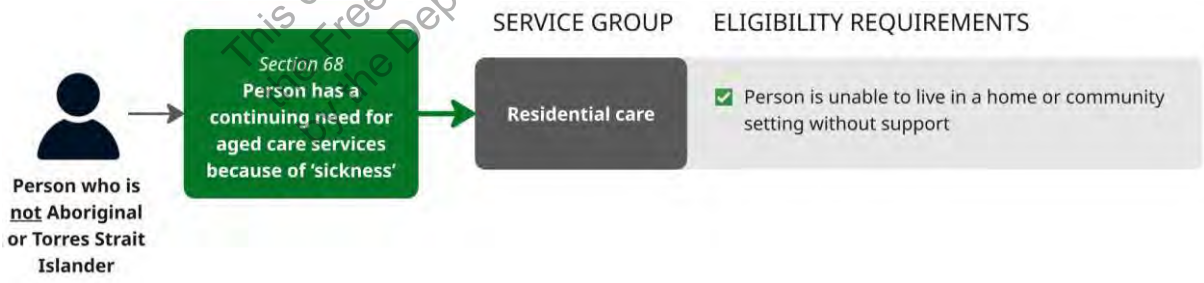


Figure 10– Overview of section 68 pathway to access approval for residential care

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Deciding if the person should be approved

When approving an older person for the residential care service group, Assessment Delegates will need to be satisfied that:

1. the person is "sick," and
2. Because of their "sickness," they have a continuing need for residential care services, including nursing services.
3. The person meets the additional eligibility criteria in the Rules. These criteria are outlined below.

Sickness

"Sickness" for the purposes of the *Aged Care Act 2024* (the Act) means an infirmity, illness, disease, incapacity or impairment. Sickness can be a strictly physical illness, such as a heart condition but will also encompass mental health conditions like depression or anxiety, or neurological disorders, such as dementia.

Information about the person and their "sickness" will already be reflected in the information collected using the Integrated Assessment Tool and any other relevant information gathered during the assessment, such as information from the person's GP or other health records. For the purposes of recording the approval decision Assessment Delegates will need to be satisfied the information provided identifies that the older person is "sick" and because of that they have a continuing need for residential care, including nursing services. This is a necessary legal requirement because of the constitutional powers that support the provision of residential care under the Act.

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The requirement that the person is sick and has a "continuing need" for residential care "including nursing services" applies in the same way to respite care (short-term) and Transition Care (hospital transition) as it does to permanent (ongoing) residential care. While the person will only be approved to access care for a limited period of time if they are approved for respite or Transition Care, Assessment Delegates will still need to be satisfied they at the time of the assessment that they have a continuing need for residential care including nursing services due to their sickness.

Additional eligibility requirements

When approving a person for the residential care service group because section 68 applies to them, Assessment Delegates will also need to turn their mind to the additional eligibility requirement in the Rules. This is required because of section 65(3) of the Act.

The additional requirement is:

- the person is incapable of living in a home or community setting without support.

7.7. Approvals for service groups, classification types and classification levels

The foundational building blocks of approvals under the *Aged Care Act 2024 (*the Act) are service groups, classification types and classification levels.

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- Service groups specify the setting and nature of care an individual can access. There are four service groups: home support, assistive technology, home modifications and residential care.
- Classification types differentiate the time period that services are delivered for under the service group. There are three classification types: ongoing, short-term and hospital transition. Each classification type has a different purpose in meeting the needs of an individual and so are funded and timed accordingly.
- Classification levels determine the amount of funding available to deliver the aged care services that an individual has been approved to access under a service group.

Under the Act, approvals for a service group, a classification type and a classification level combine to create something that is comparable to an approval for a program under the *Aged Care Act 1997*.

The table below compares some examples before and after the introduction of the Act.

Table 39. Comparison of approvals under the Aged Care Act 1997 and Act Care Act 2024

Before the introduction of the *Aged Care Act 2024*	**After the introduction of the *Aged Care Act 2024*, the older person is approved for⋯**
Home Care Package Level (1-4)	**Service group:** Home support **Classification type:** Ongoing **Classification level:** SAH (Support at Home) Class (1-8)
Commonwealth Home Support Program (CHSP)	**Service group:** Home support **Classification type:** Ongoing **Classification level:** CHSP Class
Residential respite care	**Service group:** Residential care **Classification type:** Short-term **Classification level:** Respite Class (1-3)
Short-term Restorative Care Programme	**Service group:** Home support **Classification type:** Short-term **Classification level:** SAH Restorative Care Pathway

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The following sections show the possible combinations of classification type and classification level a person can be approved for under each service group.

Decisions for service group and classification type are made under section 65(2) of the Act. Decisions for classification level are made under section 78 of the Act.

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7.7.1. Service group: Home support

Table 40. Possible combinations of classification type and classification level under the service group of home support

Service group	Classification type	Classification level
Home Support	**Ongoing**	CHSP class Support at Home (SAH) class 1 to 8
	Short-term	SAH restorative care pathway SAH end-of-life pathway
	Hospital transition	Home Support Hospital Transition class (HS HT class)

7.7.2. Service group: Assistive technology

Table 41. Possible combinations of classification type and classification level under the service group of assistive technology

Service group	Classification type	Classification level
Assistive technology	**Ongoing**	assistance dogs
	Short-term	AT CHSP AT low AT medium AT high
	Hospital transition	AT HT class

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Note that classification levels are also referred to as 'funding tiers' in the Support at Home program.

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7.7.3. Service group: Home modifications

Table 42. Possible combinations of classification type and classification level under the service group of home modifications

Service group	Classification type	Classification level
Home modifications	**Short-term**	HM CHSP HM low HM medium HM high

Note that classification levels are also referred to as 'funding tiers' in the Support at Home program.

7.7.4. Service group: Residential care

Table 43. Possible combinations of classification type and classification level under the service group of residential care

Service group	Classification type	Classification level
Residential Care	**Ongoing**	Class 0 Class 1 to Class 13
	Short-term	Class 0 Respite class 1 to Respite class 3
	Hospital transition	RC HT class

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Note that 'Class 0' is a default classification applied before the client has been assessed for their classification level.

7.8. Approvals for service types and services

The Aged Care Service List is defined in the *Aged Care Rules 2025*. It lists the four service groups, and the service types and services within them.

> Important:
>
> For an Aboriginal or Torres Strait Islander person, an Assessment Delegate only needs to approve them for one or more service groups. They are automatically approved for all the service types and services in any service group they are approved for.

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If the older person is not an Aboriginal or Torres Strait Islander person, and an Assessment Delegate is approving the Home Support, Assistive Technology or Home Modifications service groups, they must decide:

- which **service types** to approve within each service group
- which **services** to approve, but **only if they are being approved for the following 'prescribed' service types**: *Allied health and Therapy* and *Therapeutic Services for Independent Living.*

> Note:
>
> If an Assessment Delegate is approving an older person for any service type other than the 'prescribed' service types (Allied health and Therapy and Therapeutic Services for Independent Living), they are also approved for all services in that service type.

Any older person approved for the residential care service group is automatically approved for **all service types and services in that service group.** Section 65(2) of the Act has more information about these requirements.

7.9. Approvals for priority categories

Priority categories are assigned to individuals (under section 86 of the *Aged Care Act 2024* (the Act)) to determine when certain services are allocated under section 92 of the Act. These categories are based on the assessed urgency of need, complexity of care requirements and potential risks associated with delayed support.

The Assessment Delegate does not make decisions on priority category under the Act. Priority categories are assigned by the system (assessor portal). However, Assessment Delegates are responsible for ensuring the correct information is used to calculate any priority category and communicating any priority category decision to the older person.

Priority categories are required to be assigned for an individual for the following service groups and classification types:

- Home support – ongoing (excluding CHSP class)
- Assistive technology – ongoing and short-term
- Home modifications – short-term
- Residential care – ongoing

In practice, this looks like the following:

1. The aged care needs assessment is carried out.
2. A priority category is calculated and assigned by the system (**not** the assessor) at the end of an assessment. In some cases, there is only one applicable priority category.
3. The assessment delegate confirms the information that has been used to calculate the priority category.
4. The priority category is pre-populated into the Notice of Decision (the assessment outcome letter).

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Approvals for Transition Care, End-of-Life Pathway, Restorative Care Pathway, short-term residential care (respite care), and CHSP class do not require a priority category. The Notice of Decision template marks the priority category for these as 'N/A,' you should leave these fields unchanged.

The below table summarises the service groups, classification types, classification levels, and priority categories covered in this section.

Table 44. Priority categories for service groups, classification types and classification levels

Service group	Classification type	Classification level *Referred to as 'funding tiers' for AT and HM*	Priority category
Home support	Ongoing	SAH class 1 SAH class 8	Urgent, High, Medium, Standard
	Ongoing	CHSP class	N/A
	Short-term	SAH restorative care pathway SAH end-of-life pathway	N/A
	Hospital transition	HS HT class	N/A
Assistive technology	Ongoing	assistance dogs	High, Medium, Standard
	Short-term	AT low AT medium AT high	High, Medium, Standard
		AT CHSP	Immediate
	Hospital transition	AT HT class	N/A
Home modifications	Short-term	HM low HM medium HM high	High, Medium, Standard
		HM CHSP	Immediate
Residential care	Ongoing	Class 0 (pre AN-ACC assessment) Class 1 to Class 13	Priority One, Priority Two, Priority Three

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Service group	Classification type	Classification level *Referred to as 'funding tiers' for AT and HM*	Priority category
	Short-term	Class 0 (pre AN-ACC assessment) Respite class 1 to Respite class 3	N/A
	Hospital transition	RC HT class	N/A

7.9.1. Home support – ongoing

The priority category for ongoing Support at Home is assigned by the prioritisation algorithm using seven criteria captured in the Integrated Assessment Tool (IAT) or on the client's record. These are whether the older person:

1. lives alone
2. identifies as Aboriginal or Torres Strait Islander
3. has an assessed cognitive impairment
4. is experiencing homelessness or is at risk of homelessness
5. requires urgent service provision
6. has waited more than six months from the initial assessment referral and lives in a regional or remote area categorised under MMM 5-7
7. has Motor Neurone Disease (MND).

7.9.2. AT-HM scheme

The priority categories for AT-HM are calculated based on 5 different criteria captured in the Integrated Assessment Tool (IAT) or on the client record. These are whether the person:

1. lives alone
2. has an assessed severe mobility impairment
3. identifies as 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 six months from the initial assessment referral and lives in a regional or remote area categorised under MMM 5-7.

Further information is available in the AT-HM scheme guidelines.

The priority category for all ongoing CHSP services will be 'Not applicable.'

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7.9.3. Residential care

The priority category for Residential Care is calculated based on 5 different criteria captured in the IAT or on the client's record. The criteria is the older person/'s:

1. identifies as Aboriginal or Torres Strait Islander
2. is experiencing homelessness
3. resides in a rural or remote area (MMM 5 - 7)
4. has entered residential care through emergency circumstances
5. Urgency rating for residential care

7.10. Period of effect of approvals

Each access approval, classification level, and priority category has a period of effect that is prescribed under the *Aged Care Act 2024* (the Act). This means that access approvals remain in effect for the period of time specified by the Act unless the approval is revoked or a reassessment occurs resulting in a new approval.

In addition to the other legislative requirements, for an older person to receive funded aged care services they need both:

- An access approval that is in effect (or 'active') and
- A classification level that is in effect

Periods of effect for an approval decision made by Assessment Delegates are detailed in sections 71, 80 and 89 of the Act.

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7.10.1. Period of effect of access approvals

When an individual is approved for access to funded aged care services 65(2) of the *Aged Care Act 2024* (the Act), the approval takes effect from the access approval date of effect specified in the Notice of Decision (as outlined in Section 70). The approval stays in effect unless it is revoked under the Act or replaced by a new decision.

7.10.2. Period of effect of classification levels

Classification levels are in effect for the period specified in the *Aged Care Rules 2025* (the Rules). Once the specified period has elapsed, the classification level will cease to be in effect. A classification may also cease to be in effect once another classification level comes in effect.

Written notice must be provided to an individual in accordance with section 79 of the Act which specifies the day when each classification level comes into effect. For individuals approved for the service groups home support, assistive technology or home modifications this notice is usually included in the Notice of Decision provided under section 70 of the Act.

Some classification levels, such as *CHSP class*, come into effect on the access approval date of effect. Others, such as the residential care classification levels, do not come into effect until the service provider notifies Services Australia that service has commenced.

The Rules also prescribe that, for some classification levels, the maximum period of effect may be extended. The criteria and requirements for granting such extensions are prescribed within the rules under the Act.