Trilogy Care

Your simplified guide to

Support at Home

Hybrid Clients

December 2025 update – version 1.9

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Version 1.9
December 2025

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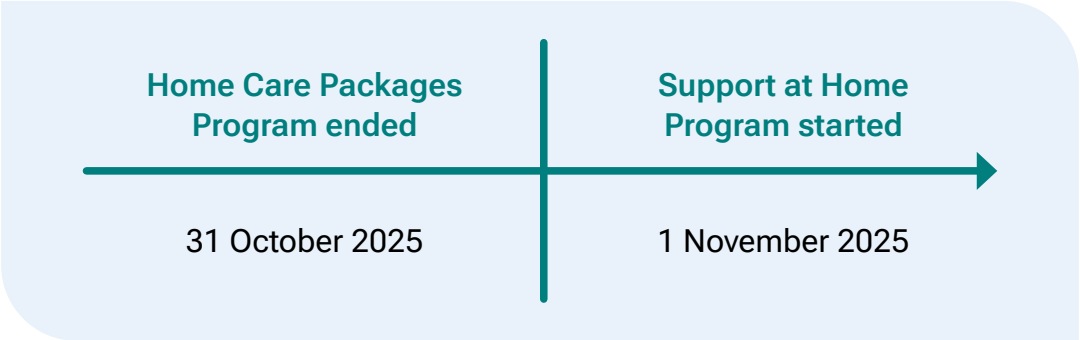
What has changed in home care in Australia?

With the introduction of the Aged Care Act (2024), Government-subsidised Home Care programs have been overhauled, and changes have been made to the way home care is funded and delivered.

On 1 November 2025, the Department of Health, Disability & Ageing (the department) introduced the new Support at Home program to replace the previous Home Care Packages program.

Two of their primary objectives are:

1. To implement key recommendations from the Royal Commission into the Aged Care Quality and Safety Final Report, and
2. To create a new program that is more accessible to older people and financially sustainable from a government funding perspective.



What is this resource?

This resource is specifically written for people who are known as Hybrid clients. It explains some of the most important aspects of these changes, what to expect, and what they mean for people who have entered the Home Care Packages program within the transitional 'Hybrid' period.

Transitional "Hybrid" Clients

- **Assessed as eligible and assigned** a home care package after 12 Sept 2024 but before 31 October 2025, or
- **Assessed as eligible** for a Home Care Package before 31 October 2025 and **awaiting their package assignment** after 1 November 2025

WHY AM I KNOWN AS A 'HYBRID' CLIENT?

Clients who fall into this group will experience a blend of some elements of Home Care Packages *and* some elements of Support at Home programs.

They are a Hybrid of the two programs because until they require a formal reassessment for a higher support classification, they will have a HCP funding level, HCP Care Plan, HCP unspent funds (potentially), automatic approval for all three service categories, and their quarterly budgets can pay for AT-HM if they have sufficient available funding to do so.

Until they require a formal reassessment, the key part of the Support at Home program that applies to the Hybrid client is the contributions. Hence, these Hybrid clients will have a foot in both camps until their care needs increase.

In this resource for Hybrid clients, we will explore the key information that you need to know and cover some questions you may have, such as:

- What are the changes?
- What do I need to know?
- In what way will I be affected?

We have included information and details that are the most relevant and will have the biggest impact on the care and services being delivered to Hybrid clients.

Definition of terms

Throughout this resource, we use some slightly different terms depending on whether we are referring to the previous Home Care Packages program or the new Support at Home program.

CURRENT PROGRAM ENDED 31 OCTOBER 2025	NEW PROGRAM COMMENCED 1 NOVEMBER 2025
• Home Care Package (HCP)	• Support at Home (SaH)
• Consumer	• Client
• Care Manager	• Care Partner
• Daily Subsidy	• Quarterly Budget

From: Home Care Packages → To: Support at Home

The new program name change reinforces the preferences of older people to age in their homes with appropriate and timely support. Every client has a registered provider to coordinate their care and manage the package financials on their behalf.

From: Consumer → To: Client

Older people have given feedback to the government that they want strengthened rights and to be more involved in decisions relating to their care at home. Some clients want to rely less on their Care Partner by taking on some aspects of organising their care and services, but everyone will continue to have the safeguards of having a Care Partner to assist them when they need it.

From: Care Manager → To: Care Partner

This represents a significant shift in the relationship between the provider and the person receiving care. Care Management is a core component of the Support at Home program, and requires a collaborative relationship between you and your provider. Your care partner will involve you in decision-making to give you autonomy, independence and control.

Significant dates from the previous Home Care Packages (HCP) program

SIGNIFICANT DATE: 12TH OF SEPTEMBER 2024:

This date separates Support at Home clients concerning the contributions they are required to pay from 1 November 2025, based on their date of assessment and approval for a package.

People who were formally assessed as eligible for a Home Care Package before 12 September 2024 are considered by the government to be Legacy HCP clients. These clients have their conditions grandfathered into the new Support at Home program and are protected by the 'no worse off' principle regarding the fees they have to pay for their care.

WILL I BE AFFECTED BY THIS CHANGE?

Yes. Hybrid clients experience a combination of the outgoing Home Care Packages program and the new Support at Home program. Most things will stay much the same, except for the amount you are required to contribute for ongoing services you receive under the Independence and Everyday Living categories, and additional short-term support categories, if applicable.

WHAT WILL STAY THE SAME?

In every other sense, you will be treated like a 'Grandfathered' client, and apart from the new out-of-pocket contributions, you will not notice many other significant changes until you require a higher level classification if your needs increase.

OUT-OF-POCKET COSTS FOR CLIENTS

Support at Home is a user-pays system. Hybrid clients are required to have their income and assets assessed by Services Australia and are required to contribute to the cost of their care.

DOES THIS APPLY TO ME?

Yes. The total amount of your Support at Home funding to pay for your care is made up of two parts: the government portion and your out-of-pocket contribution portion.

CAN I OPT-OUT OR AVOID PAYING CONTRIBUTIONS?

No. The government said the new contribution rules will apply to people assessed and approved for either a Home Care Package (between 12 Sept 2024 and 31 Oct 2025) or, for a Support at Home classification from 1 November 2025 onwards.

Providers cannot waive or reduce the fee and are required to collect your portion from you, to cover the overall cost of your care and services. Hybrid clients can apply for a Fee Reduction Supplement via Services Australia if they are significantly impacted financially. Providers can support and assist you to apply, but they have no say in this process or the outcome of a hardship application.

Hybrid clients definition

WHAT DEFINES THE DIFFERENT CLIENT GROUPS?

There are three distinct groups of people in the Support at Home program, and they are known as CLIENTS. The groups are determined by the date that they were first assessed as eligible for either the old Home Care Packages program or the new Support at Home program.

For many years to come, each of these groups will be treated slightly differently by the Support at Home program. It is important to know which of the groups you belong to, so you know what to expect.

You are a **HYBRID** client so all the information in this booklet relates to you.

EXISTING CLIENTS "GRANDFATHERED"	• **Receiving** a Home Care Package as of 12 September 2024, or • On the **National Priority System** (waiting list) or **assessed as eligible** for a Home Care Package before 12 Sept 2024
You **TRANSITIONAL CLIENTS "HYBRIDS"**	• **Assessed as eligible and assigned** a home care package after 12 Sept 2024 but before 31 October 2025, or • **Assessed as eligible** for a Home Care Package before 31 October 2025 and **awaiting their package assignment** after 1 November 2025.
NEW CLIENTS "NEWBIES"	• **Assessed and approved** for a Support at Home funding classification from 1 November 2025 onwards

Support at Home for Hybrid clients

The Department of Health, Disability & Ageing commenced a new program to support older people to age in their homes. From 1 November 2025, it replaced the Home Care Packages (HCP) program with the Support at Home program.

IN A NUTSHELL, HERE IS WHAT YOU NEED TO KNOW:

- Hybrid HCP clients will be automatically transitioned on 1 November 2025 to the Support at Home program;
- You will continue to have a single registered home care provider who coordinates your care and manages your quarterly budget;
- Your funding moved from a daily subsidy to four equal quarterly budgets at the same total annual funding level as your current Home Care Package;
- Care Management charges are set at 10% of a person's quarterly budget, quarantined by Services Australia and pooled for use by your provider;
- Your quarterly budget will only be charged for services you receive;
- Package Management charges have been removed as a separate charge. Your provider's business costs will be incorporated into the overall price for services you receive;
- You will retain all of your unspent HCP funds, but new limits apply to rolling over any of your unspent Support at Home quarterly budget;
- Until 31 October 2025, most Hybrid clients did not pay any personal contributions to their care (unless you were required to pay an income-tested care fee);
- New out-of-pocket contributions apply for all Hybrid clients from 1 November 2025;
- A new personal contributions (fees) framework will be introduced for people assessed as eligible for a home care package after 12 September 2024. This means all Hybrid clients will automatically be moved on to the new personal contributions (fees) framework under the Support at Home program on 1 November 2025;
- The Department's 'no worse off' principle does NOT apply to Hybrid clients in terms of personal contributions (out-of-pocket fees);
- If you currently pay a HCP income-tested care fee, Services Australia will advise you of the new Support at Home contribution rate you will need to pay;
- A new services list means some changes in how funding is categorised and spent.

Culturally safe care for older First Nations people

The Support at Home program recognises the unique cultural needs of older Aboriginal and Torres Strait Islander people by providing assistance that honours their identity, culture, and history, and creates an environment where they feel secure, respected, and accepted without judgement or discrimination.

The Support at Home program promises to be responsive to the diverse and changing needs of older Aboriginal and Torres Strait Islander people through:

- Including culturally safe care services on the service list–such as assistance to participate in cultural activities and access to Aboriginal and Torres Strait Islander health practitioners and health workers, and end-of-life care
- Providing a supplement for extra hours of care management to providers who support older Aboriginal and Torres Strait Islander clients
- Future option for screening to be conducted by an Aboriginal and Torres Strait Islander assessment organisation
- Elder Care Support Program which includes increasing workforce capacity, and improving access, support and advocacy for older First Nations people

Support at Home aims to address and remove barriers experienced by older Aboriginal and Torres Strait Islander people to accessing aged care services, to ensure they receive the care they need.

Interim funding packages (60%)

Hybrid clients who have been waiting a long time for a Home Care Package may be allocated a special Interim Funding package, to help them receive some much-needed additional support while they wait for their full funding package to be available.

Interim funding bridges the gap between your assessment and receiving full support, making sure you're not left waiting too long. It gives you access to 60% of your approved Home Care Package budget while you wait for the rest of your package funding to be released.

If you were approved and have been waiting for a Home Care Package, you will be allocated that equivalent HCP package level funding, even if the new funding is allocated to you after 1 November 2025. You will only move up to a specific Support at Home Classification level if you are formally assessed by the Single Assessment Service after 1 November 2025.

It is important to know that 10% of this interim amount is set aside for care management to help organise and monitor your care, including developing an interim care plan and providing ongoing care management activities.

Once your full funding is available, you'll receive a letter from Services Australia confirming the rest of your budget (the remaining 40%) has been released. At that time, your care plan and budget will be reviewed and updated to make sure you're getting the right services. The extra funding applies from the day it's allocated, not backdated to when you started on the interim package.

Defined service list

The Support at Home service list separates all services into three distinct service categories and contains a comprehensive list of approved services that can be provided to clients - see below:

1	**CLINICAL SUPPORTS:** Specialised services to maintain or regain functional and/or cognitive capabilities	Nursing, most allied health, nutrition, care management and restorative care management
2	**INDEPENDENCE:** Support to manage activities of daily living and loss of skills or function to live independently	Personal care, social support and community engagement, therapeutic services, respite, transport, assistive technology, home modifications
3	**EVERYDAY LIVING:** Support to keep your home in a liveable state and support your independence at home	Domestic assistance, shopping assistance, home maintenance (including light gardening) & home repairs, meals (preparation and/or delivery)

This means that spending will be more defined regarding what services and supports are 'in-scope' and 'out-of-scope' under Support at Home.

Hybrid clients will continue to receive the services and supports already included in their care plan as long as they align with the new service list. Whilst there will be some room for adjustments as your care needs change, your care plan may need to follow a more structured format to align with these service categories because Hybrid client fees are tied to these service categories.

There will also be an expectation that you will use your quarterly budget each quarter, as there are new limits on the amount you can save or accumulate if any budget is unspent at the end of each quarter.

You will not need a new care plan to transition to Support at Home, but your services will need to align with the new service categories.

Allied Health and Therapeutic Services

There is a strong focus on the benefits of Allied Health and Therapeutic Services in the context of improving the health and well-being of older people using the Support at Home program. Approved services are separated into two categories.

1. CLINICAL SUPPORT SERVICES CATEGORY:

These are specialised services to maintain or regain functional and/or cognitive capabilities. Services must be delivered directly, or be supervised, by universityqualified or accredited health professionals trained in the use of evidence-based prevention, diagnosis, treatment and management practices to deliver safe and quality care to older people.

Services in this category do not require a contribution from any Support at Home clients.

ALLIED HEALTH AND OTHER THERAPEUTIC SERVICES	
Aboriginal and Torres Strait Islander Health Practitioner	Aboriginal and Torres Strait Islander Health Worker
Music Therapy	Occupational Therapy
Allied Health Assistance	Physiotherapy
Counselling or Psychotherapy	Podiatry
Dietitian or Nutritionist	Psychology
Exercise Physiology	Social Work
Speech Pathology	

2. INDEPENDENCE SERVICES CATEGORY:

This category includes supports that are delivered to older people to help them manage activities of daily living and the loss of skills required to live independently.

Services in this category do require a contribution from Hybrid clients.

THERAPEUTIC SERVICES FOR INDEPENDENT LIVING	
Acupuncture	Remedial massage
Chiropractic	Art therapy
Diversional therapy	Osteopathy

Classifications and budgets for Support at Home

The Support at Home program consists of eight funding classification levels in addition to the four previous Home Care Package levels.

The table below lists all 12 funding levels from lowest to highest, showing the annual and quarterly budget amounts. You will transition with your previous HCP funding level.

A	B	C	D	E
Classification Level	Annual budget	Quarterly budget	Deduct 10% Quarterly care management	Quarterly spending amount (actual)
	$	$	$	$
1	10,731	2,682	268	2,414
Level 1 HCP	10,986	2,746	274	2,472
2	16,034	4,008	400	3,608
Level 2 HCP	19, 319	4,829	482	4,347
3	21,965	5,491	549	4,942
4	29,696	7,424	742	6,682
5	39,697	9,924	992	8,932
Level 3 HCP	42,055	10,513	1,051	9,462
6	48,114	12,028	1,202	10,826
7	58,147	14,537	1,453	13,084
Level 4 HCP	63,758	15,939	1,593	14,346
8	78,106	19,526	1,952	17,574

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Column D shows the amount that will be automatically deducted from each client's funding level and held by Services Australia for Care Management activities (10%). Providers claim against this pooled amount for care management activities they perform with clients.

Column E shows the amount remaining at each funding level for clients to spend on care and services each quarter.

Hybrid clients will remain on the same Home Care Package funding level (green lines) once they have moved to the Support at Home program on 1 November 2025 and retain access to all their unspent HCP funds.

Quarterly budgets replace daily subsidies

WHAT ARE THE CHANGES?

Hybrid clients will be automatically moved to the new Support at Home program on 1 November 2025 at the **same funding level** as their current Home Care Package (refer to the blue rows in the table above).

However, instead of the government subsidy being calculated on a daily basis, the new Support at Home budget is calculated on a quarterly basis. You will not be reassigned to a new Support at Home classification level.

DO THE CHANGES APPLY TO ME?

Yes. As a Hybrid client, your budget will be split into four quarterly budgets equal to the same total annual funding amount you currently receive on your Home Care Package.

ARE YOU WAITING FOR A HOME CARE PACKAGE LEVEL UPGRADE?

At the time of the commencement of Support at Home on 1 November 2025, if you are receiving an interim Home Care Package level while waiting for a higher-level package, you will be assigned your approved HCP funding level when you reach the top of the National Priority System (waiting list), even if this occurs after 1 November 2025.

You will not be re-assigned to one of the eight Support at Home classification levels if you are already waiting for a higher-level Home Care Package as of 31 October 2025.

NEW HIGHER LEVEL ASSESSMENTS:

If your care needs increase or your circumstances change, you will need a formal reassessment for additional funding for care and services. The Single Assessment Service (SAS), previously known as the Aged Care Assessment Team (ACAT), will conduct a new assessment of your care needs and may approve you for a new Support at Home classification level.

Remember, you are a Hybrid client in terms of the fees you pay, so your contributions will apply regardless of what HCP or Support at Home level you are receiving.

IN SUMMARY, WHAT DO I NEED TO KNOW?

- Your quarterly budget is meant to last for the entire quarter, so careful planning and budgeting will be required by clients and providers
- You cannot spend more than is allocated in your quarterly budget. This means you cannot go into a budget deficit and make it up in the next quarter, and your provider cannot withhold an overspend claim to the next quarter
- If you do not have access to unspent HCP funds, you can pay privately for services over and above your quarterly budget, if required
- You will continue receiving a monthly statement with details of the care and services provided to you
- You can only roll over up to the maximum amounts detailed in the Unspent Support at Home quarterly budget section

It is important that you communicate regularly with your Care Partner so that your quarterly budget funding level keeps up with your changing needs.

Unspent Quarterly Support at Home budgets

From 1 November 2025, if there are unspent funds from your quarterly budget at the end of each quarter, a limited amount of funds will automatically carry over (in your home support account) to the next quarterly budget period to address unplanned or emerging needs.

However, unlike the previous Home Care Packages program, where all unspent funds are rolled over every month, in Support at Home, there is a limit on the amount that carries over to the next quarter.

It's important to understand that you can only accumulate a maximum of $1,000 or 10% of your quarterly budget at any one time. You are not allowed to exceed this limit across or between quarters.

This means that the maximum amount available for a client per quarter is their quarterly budget plus $1,000 or 10% of their previous quarterly budget.

The Table below shows the maximum allowable rollover amount for each Home Care Package level and Support at Home classification level from 1 November 2025.

CLASSIFICATION FOR HCP LEVEL	QUARTERLY BUDGET	MAXIMUM ROLLOVER PER QUARTER	MAXIMUM QUARTERLY BUDGET AFTER ROLLOVER
	$	$	$
1	2,682	1,000	3,682
Level 1 HCP	2,746	1,000	3,746
2	4,008	1,000	5,008
Level 2 HCP	4,829	1,000	5,829
3	5,491	1,000	6,491
4	7,424	1,000	8,424
5	9,924	1,000	10,924
Level 3 HCP	10,513	1,051	11,564
6	12,028	1,202	13,230
7	14,537	1,453	15,990
Level 4 HCP	15,939	1,593	17,532
8	19,526	1,953	21,479

What is the ‘no worse off’ principle?

The term ‘no worse off’ is something the Department of Health, Disability & Ageing uses to define a client’s individual contribution (fees) towards the cost of their care.

This principle applies only to Grandfathered clients who were either receiving a Home Care Package, or, on the National Priority System (waiting list), or assessed as eligible for a Home Care Package, as of 12 September 2024.

The department is saying that these clients will have their fee arrangements grandfathered into the new system on 1 November 2025, and they will not pay more for their care than they currently do.

WHAT DOES THIS MEAN FOR HYBRID CLIENTS?

You were assessed as eligible for a Home Care Package after 12 September 2024, so unfortunately, the ‘no worse off’ principle does not apply to you, even if you had previously not paid a fee since commencing your Home Care Package.

This means your fee arrangements up to 31 October 2025 will not be grandfathered, and the government will automatically transition you into the new contributions (fees) framework on 1 November 2025.

From 1 November 2025, you will be required to pay a contribution for services received in line with the defined service list and the services in your care plan.

We will support you with this fee transition, so you know what to expect and to prepare you for the change.

WILL MY CARE AND SERVICES HAVE TO CHANGE?

It is important to note that the ‘no worse off’ principle does not extend to the way care and services are used and does not mean clients can access services that are outside the new service category lists or deemed to be excluded items.

Providers will review all services and support items in place for clients to ensure they fit into the new program boundaries.

Do I have to pay the client contributions?

A new framework to determine client contributions (out-of-pocket fees) is one of the major changes in the Support at Home program. The changes being introduced concerning client contributions are of great interest to people already using the Home Care Packages program.

WILL I BE AFFECTED BY THE CHANGES TO CLIENT CONTRIBUTIONS?

Yes. The government's 'no worse off' principle does not apply to Hybrid clients so the new Support at Home client contributions framework will apply to you from 1 November 2025.

PREVIOUS HOME CARE PACKAGE FEES ARRANGEMENTS:

The Home Care Packages (HCP) program had two types of fees. Both of these fees will no longer exist in Support at Home:

1. **Basic Daily Care Fee:** This was an optional fee, and the majority of HCP providers do not charge this fee to their consumers.
2. **Income Tested Care Fee (ITCF):** This fee was determined by Services Australia based on a person's income and was not optional. Only people with an income above the full Age Pension paid income-tested care fees.

The Support at Home program is a 'user pays' model where a person only pays for the services they receive, except for clinical supports. No one will be required to pay for clinical supports, regardless of their income or pension status.

However, as a Hybrid client, if you have any unspent HCP funds carried over to the new program, you will **not be required** to pay the contribution on services and items purchased with the unspent HCP funds.

The amount a Support at Home client is required to contribute is based on a percentage of the price for each service type (e.g. domestic assistance, personal care, shopping assistance, etc), or a percentage of the cost of the item (e.g. aids & equipment, delivered meals, etc).

The government sets the percentage you are required to pay. Your provider, or the supplier of the goods or services, sets the price for each service type.

Even though you did not have to pay fees while receiving a Home Care Package, you are a Hybrid client, and you will have to pay the new fees from 1 November 2025.

THE ‘HONEYMOON PERIOD’ FOR HYBRID CLIENTS

Hybrid clients have generally not been required to pay the Basic Daily Care Fee while receiving their Home Care Package, but as a Hybrid client, this arrangement ended on 31 October 2025. Even if you are a full Age Pensioner, as a Hybrid client, you will start paying the new Support at Home contribution rates from 1 November 2025.

If you previously paid an Income Tested Care Fee for your Home Care Package, you will switch over to the new Support at Home contribution rates on 1 November 2025. The government’s ‘no worse off’ principle does not apply to Hybrid clients so your new fees may or may not be more than you have been paying. It will depend on the types and quantities of the services you receive.

How to determine contributions for Hybrid clients

All Hybrid clients must have their income and assets assessed by Services Australia to determine the contributions they are required to pay for each service they use.

FULL AGE PENSIONER AND PART AGE PENSIONER:

Services Australia will use the information on a person's income and assets that has been provided for their pension assessment to determine their Support at Home contributions.

NON-PENSIONER/SELF-FUNDED RETIREE:

Non-pensioners, once approved for Support at Home, will need to complete an income and assets assessment if Services Australia does not already have their current financial details.

Every Hybrid client will receive a letter from Services Australia to notify them of their contribution rates, even if they have not disclosed their income or assets. The rate will default to the highest contribution rate if you have not completed the assessment, so it is recommended that Hybrid client undertake the income and assets assessment as soon as possible to avoid additional costs.

Once the correct contribution rate has been determined, Services Australia will backdate this to 1 November 2025 to align with the commencement of Support at Home.

Hybrid clients should take care to fully understand their obligations and responsibilities relating to their income and assets assessments and subsequent payments.

Providers will continue to provide care and services while you wait for your income assessment, and it's important to know that your contributions will be payable on all eligible services already provided to you since 1 November 2025.

It is the client's responsibility to notify Services Australia within 14 days of any changes in their financial status that may impact their contribution.

You can use the department's Fee Estimator Tool to get an estimate of your likely contribution rate, and you can start paying this estimated amount right away while you wait for the formal financial assessment process to occur.

Once Services Australia completes their assessment, if you have overpaid, your provider will issue you a refund. However, if you have underpaid, you will need to pay the difference to your provider to make up the shortfall.

Support at Home Hybrid client contributions

Under Support at Home, Hybrid clients will only pay contributions for the actual services they have received.

The contribution rate will be based on two factors:

1. The type of service received. See the table below.
2. The client's Age Pension status, Commonwealth Seniors Health Card status, and financial means

1	**CLINICAL SUPPORTS:** Specialised services to maintain or regain functional and/or cognitive capabilities	**No contributions required:** Clinical supports will be 100% fully funded by the government for all clients
2	**INDEPENDENCE:** Support to manage activities of daily living and loss of skills or function to live independently	**Moderate contributions required:** These services promote and maintain independence and address ageing-related care needs
3	**EVERYDAY LIVING:** Support to keep your home in a liveable state and support your independence at home	**Highest contributions required:** This recognises that the government does not typically fund these services for any individual at other stages of life.

HOW MUCH WILL HYBRID CLIENTS HAVE TO CONTRIBUTE?

The tables on the next page show the tiered contributions that Hybrid Support at Home clients will be asked to make from 1 November 2025. The amount they pay is dependent on their income and assets (Pension / Commonwealth Seniors Card status), and the type and frequency of services they receive.

Specific contributions are based on services received across the three service categories:

1. Clinical Supports
2. Independence Supports
3. Everyday Living Supports

Tiered contributions: Full pensioners and Part pensioners

FULL PENSIONER		
Full pensioner	**The government pays:**	**You pay:**
Clinical Supports (per service)	100%	0%
Independence Supports (per service)	95%	5%
Everyday Living Supports (per service)	82.5%	17.5%

PART-PENSIONER		
Part pensioner and Commonwealth Seniors Health Card holders	**The government pays:**	**You pay:**
Clinical Supports (per service)	100%	0%
Independence Supports (per service)	Between 50% and 95% (depending on your income and assets)	Between 5% and 50%
Everyday Living Supports (per service)	Between 20% and 82.5% (depending on your income and assets)	Between 17.5% and 80%

Tiered contributions: Self-funded Retiree

SELF-FUNDED RETIREE		
Self-funded Retiree	**The government pays:**	**You pay:**
Clinical Supports (per service)	100%	0%
Independence Supports (per service)	50%	50%
Everyday Living Supports (per service)	20%	80%

Fees versus contributions: What's the difference?

Under Support at Home, clients do not pay a 'fee' in the traditional sense of the word. Fees are often added **on top** of the total cost for something, such as bank fees added to the cost of a purchase, or transaction fees for international currency exchanges, and so forth.

Under the Support at Home program, contributions are a percentage of the cost of each individual service, with the client paying their required percentage and the government covering the rest. Together, the two amounts match the total cost of each service or item you have received.

This is an important distinction for Hybrid clients who may be accustomed to paying fees for services used in other programs, such as in the Commonwealth Home Support Program (CHSP).

The Support at Home program introduced a framework to determine client contributions. This works by the government contributing a portion of the total cost for each service and the Hybrid client contributes the remaining portion. For each dollar payable by the client, the government reduces their subsidy; therefore, your provider is out of pocket until you pay your portion.

Your contributions, whilst collected by your provider, are not fee income for your provider. Your contribution is used to offset the amount that the government withheld and goes directly to payment of the service that you used or received.

As a client, you will make no extra fee payments to your provider above your contribution, so all of their business revenue must be generated via the delivery of services and the 10% pooled care management amount that is automatically deducted from your quarterly budget.

Making payments for contributions

All Hybrid clients will be asked to pay contributions towards the cost of their care. Once you sign a service agreement with a home care provider, they will talk to you about three key things relating to your out-of-pocket payments:

1. HAS SERVICES AUSTRALIA ADVISED YOU ABOUT YOUR CONTRIBUTIONS RATES?

All Hybrid clients, including pensioners, need to be advised about the percentage they are required to contribute for each service or item they receive.

2. INFORMATION ABOUT THEIR PREFERRED PAYMENT METHODS FOR YOU TO PAY YOUR CONTRIBUTIONS.

Whilst the government sets the percentage rates that you must pay, it is providers who are responsible for setting up and managing the direct debit payment process, i.e. weekly, fortnightly or monthly.

3. WHAT HAPPENS IF YOU DON'T PAY YOUR CONTRIBUTIONS?

Your provider will talk with you if you do not pay and don't have hardship provisions in place. They'll explain:

- Your responsibilities
- Why contributions are collected
- What could happen if you don't pay

Providers are required to make every effort to resolve payment issues and must also comply with government rules about making sure your care continues.

Home Care Package – Unspent funds

WHAT HAPPENS TO PREVIOUSLY ACCRUED UNSPENT HOME CARE PACKAGE FUNDS?

Hybrid clients will retain their unspent funds amount (as of 31 October 2025) to purchase approved care, services, equipment and home modifications if needed. You will not lose your unspent HCP funds in the transition to Support at Home.

Even though Hybrid clients must contribute to care and services purchased from their ongoing Support at Home quarterly budget, the government have confirmed that there are no contributions payable for services paid for using Commonwealth-held unspent HCP funds.

The Support at Home service list contains a comprehensive list of approved services that can be provided to clients. Hybrid clients can continue to negotiate with their provider to access their unspent funds for care and services that address their ageing-related care needs, in addition to their ongoing Support at Home quarterly budget.

Once your unspent Home Care Package funds have been exhausted, your care and services spending must align with your ongoing Support at Home quarterly budget.

As a Hybrid HCP client, if you use your unspent HCP funds to purchase Home Modifications, you are not limited to the lifetime Home Modifications cap of $15,000. This means you can use unspent HCP funds to spend above the $15,000 limit as long as you have a justified need, professional recommendation and keep all relevant evidence and documentation relating to the expense.

What's included in my provider's hourly rate for services?

Registered Support at Home providers are not separately funded by the government for running their organisation or business, so they must recoup these costs by delivering care and services to their clients.

These essential "back-office" services may not be immediately visible to clients, but they are crucial for ensuring that services are coordinated and compliant, invoices are paid, monthly statements are generated, and provider obligations are met.

Under the previous Home Care Packages program, registered providers deducted a Package Management fee from the HCP subsidy. This fee was intended to cover the administrative costs associated with managing a person's package, however, this will change with the Support at Home program.

Separate Package Management charges ended on 31 October 2025.

Starting on 1 November 2025, registered providers cannot charge a separate fee to recover their package management costs. Instead, they are expected to include these costs in the prices they set for each service delivered to clients.

This means that each hourly rate or product cost will include not only the service itself but also a portion that covers travel expenses, administrative costs, backoffice expenses, scheduling costs, and more. All these costs will be bundled into the hourly rates of services provided, which makes the costs seem higher than might usually be expected.

If a client chooses and coordinates their own workers or third-party suppliers, providers will be able to apply a capped 10% loading to manage administrative and third-party compliance costs associated with that arrangement. This is explained more in the Self-Management section of this document.

Updating your care plan

All Hybrid clients have a care plan, developed in consultation with their provider. Your care plan should include: your identified goals and strategies to achieve these goals; types and frequency of services; care worker, cultural and other preferences; Assistive Technology & Home Modifications (AT-HM) summary; review dates; and additional information related to the delivery of culturally safe, trauma-aware and/or healing-informed care, as required.

Importantly, your care plan should be person-centred, reflect your assessed needs, document your choices, and describe the level of control you wish to exercise in the delivery of your care and services.

DO I NEED TO HAVE A NEW CARE PLAN TO MOVE INTO THE SUPPORT AT HOME PROGRAM?

No, you do not need a new care plan to transition to Support at Home. Your existing HCP care plan will remain in place until your needs, goals, or preferences change, or until your scheduled care plan annual review date arrives.

Your Care Partner will partner with you and others involved in your care to review your care plan if any of the following circumstances occur:

- If your needs, goals or preferences change
- If your ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes
- If you receive a higher Support at Home classification
- If you receive approval for Assistive Technology or Home Modifications (AT-HM)
- If you commence on a Restorative Care Pathway or End-of-Life Pathway
- If you want to change your services or the frequency of services
- If risks emerge or an incident occurs that impacts you
- If care or support responsibility changes between family, carers, or supporters
- Or at any time, when requested by you.

Care plans under Support at Home have a renewed focus on wellness and reablement, which aim to support improved function and capability for clients.

Ongoing care management support

Under Support at Home, there are some changes to the way providers charge for care management services.

From 1 November 2025, all Support at Home clients will automatically contribute 10% of their quarterly budget to their provider's pooled Care Management fund, held by Services Australia. The funds are pooled by the provider and used with discretion to meet the needs of all their clients concerning their care management needs.

From 1 November 2025, providers cannot separately charge for care management, and clients cannot opt out of contributing the 10% care management amount.

While the type and frequency of care management activities will vary between clients, care partners must deliver a care management activity to each client at least monthly. This activity should be delivered directly (i.e., speaking, communicating, or meeting with the client and/or their registered supporter) and for a minimum of 15 minutes.

Clients should not expect to have a precise allocation of care partner time each month or each quarter, and they should continue to communicate with their care partner when they require support or assistance.

Care Partners are responsible for:

- Identifying and assessing client needs, goals and risks, developing and reviewing care plans and agreements
- Supporting cultural preferences, planning, managing and reviewing services, including managing budgets and evaluating client goals
- Checking in with clients to ensure they are being well-supported, and communicating with registered supporters and others involved in their care
- Advice and practical support to address any changes in need or issues that arise, facilitating decision making and supporting rights
- Connecting and referring to other services, providing support and education where needed.

Providers are expected to be flexible in the way they support each client, understanding that there may be times when more, or less, care management will be needed.

Short-term additional support available

The Support at Home program consists of three short-term funding classifications in addition to the eight ongoing classification levels. These additional programs are designed to assist and support clients who may only require help for a short time and for a specific purpose.

The short-term programs are available to people who meet the relevant eligibility criteria when assessed by the Single Assessment Service (SAS) and Hybrid clients can access these short-term pathways in addition to their ongoing quarterly budget.

The short-term funding pathways consist of:

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

Restorative Care Pathway

Eligible clients can access the Restorative Care Pathway which provides intensive nursing and allied health services to help clients regain and improve their strengths and capabilities.

A budget of up to $6,000 will be available for up to 16 weeks to purchase specifically targeted supports and services, which also include restorative care management, a tailored goal plan, support & education, and exit planning activities. The Restorative Care budget amount is in addition to a person's ongoing quarterly budget.

As a Hybrid client, you may be able to access Restorative Care Pathway funding to access targeted, intensive clinical and/or allied health services, subject to meeting the relevant criteria. Contributions will apply for Hybrid clients as per the contribution rates for Independence Supports.

Eligible clients can also access additional funds from the Assistive Technology & Home Modifications (AT-HM) program to support the overall outcomes of the Restorative Care episode.

End-of-Life Pathway

The End-of-Life Pathway funding stream will support clients diagnosed with three months or less to live who wish to stay at home, surrounded by their loved ones and allow them to end their lives with dignity and support. Hybrid clients can be referred for an assessment to access the End-of-Life pathway via a Support Plan Review conducted by an aged care assessor.

The End-of-Life pathway can provide funding of up to $25,000 and must be used within 12 weeks, with a possible 4-week extension if required. Older people assessed as requiring the End-of-Life Pathway may also be able to access assistive technology under the AT-HM Scheme at the same time.

This funding replaces a client's quarterly Support at Home budget for the 12-week duration and can be used to purchase the same types of care and services set out in the Support at Home service list, including care management. It cannot be used to pay for services that are already available from specialist palliative care services, and any unspent budget cannot be accrued or rolled over.

If a person outlives their End-of-Life pathway funding, they will revert to their previous Support at Home quarterly budget, and if required, a Support Plan Review may be requested to review and potentially increase their funding level.

The table below shows the indicative difference in funding per week for the 12-week End-of-Life budget compared to a client's ongoing Support at Home quarterly budget.

Classification level	Quarterly budget	Ongoing budget per week	End of Life $25,000 (12 weeks)	Difference in Funding
	$	$ per week –Suspended	$ per week	$ per week
1	2,682	~~223~~	2,083	+ 1,860
Level 1 HCP	2,746	~~228~~	2,083	+ 1,855
2	4,008	~~334~~	2,083	+ 1,749
Level 2 HCP	4,829	~~402~~	2,083	+ 1,681
3	5,491	~~457~~	2,083	+ 1,626
4	7,424	~~618~~	2,083	+ 1,465
5	9,924	~~827~~	2,083	+ 1,256
Level 3 HCP	10,513	~~876~~	2,083	+ 1,207
6	12,028	~~1,002~~	2,083	+ 1,081
7	14,537	~~1,211~~	2,083	+ 872
Level 4 HCP	15,939	~~1,328~~	2,083	+ 755
8	19,526	~~1,627~~	2,083	+ 456

Assistive Technology and Home Modifications (AT-HM)

The government introduced additional Support at Home funding classifications for Assistive Technology and Home Modifications from 1 November 2025. All Support at Home clients, including Hybrid clients, will have access to the new AT-HM funding pool, which can cover:

- **Products and equipment**
- **Coordination costs**
- **Home modifications**
- **Prescription (i.e. assessments by Occupational Therapists, Physiotherapists, etc)**
- **Wrap-around Services (i.e. set-up and training to safely use equipment)**

Clients can access these classifications in addition to their quarterly budget, so they do not need to save from their quarterly budget to meet their AT-HM needs. However, as a Hybrid client, you must use any unspent HCP funds you have carried over from your home care package before you can apply for an assessment to access the AT-HM funding scheme.

WHAT ARE 'WRAP-AROUND' SERVICES?

Clients may need special additional services to ensure that their assistive technology or home modifications are suitable for their purpose and can be used safely. This is known as 'wraparound services' and must be funded from the AT-HM funding allocation.

Wrap-around services can include:

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

Importantly, wrap-around services are classified as a Clinical Support and require no out-of-pocket contribution.

WHAT DO I NEED TO KNOW ABOUT THE AT-HM SCHEME OVERALL?

- Access to AT-HM funding comes from a separate pool of government funding, so from 1 November 2025, you do not need to use your ongoing quarterly budget to access these supports, however, you need to exhaust any unspent HCP funds before you can apply for AT-HM funds
- Formal Allied Health assessments from a professional operating within their scope of practice will be required in most instances
- Hybrid clients can access AT-HM via one of two methods: complete the AT-HM scheme data collection process to seek an appropriate Assistive Technology or Home Modifications tier, or, be referred for a Support Plan Review by an aged care needs assessor
- Each of the new AT-HM funding classifications has a lifetime cap of $15,000 per client. Additional amounts may be available for Assistive Technology with the appropriate professional recommendation in certain circumstances
- Hybrid clients who receive AT-HM scheme funding will contribute to the cost of the equipment at the same contribution rate for Independence Supports (except when purchased using unspent HCP funds, where no fees apply).

WHAT DO I NEED TO KNOW, SPECIFIC TO ASSISTIVE TECHNOLOGY?

Many older people already use their Home Care Package funds to purchase or lease helpful aids and equipment (known as Assistive Technology) to meet their age-related care needs. The Support at Home program introduces a separate funding pool instead of using your quarterly budget to pay for Assistive Technology (AT).

The Assistive Technology list is sorted into the following categories:

Managing body functions

Self care

Mobility

Domestic Life

Communication and information management

IN SUMMARY:

- HCP unspent funds can be used to purchase equipment and products from the AT-HM list, but you must exhaust any unspent funds before applying to the new AT-HM funding scheme
- Low-risk/low-cost items may not require a formal assessment or prescription
- A new Assistive Technology Loans Scheme will enable some items to be loaned rather than purchased outright
- There are three funding tiers and a lifetime cap of $15,000 for Assistive Technology per client, and funding must be used within 12 months
- Hybrid clients must contribute to a portion of the Assistive Technology costs at the Independence Support category rates, noting that prescription and wrap-around services do not require a contribution.

WHAT DO I NEED TO KNOW, SPECIFIC TO HOME MODIFICATIONS?

The Support at Home program enables clients, including Hybrid clients, to access a separate pool of funds for approved home modifications.

- Your HCP unspent funds can be used to pay for home modifications
- You can spend above the Home Modifications lifetime cap of $15,000 using your unspent HCP funds, however you must exhaust any unspent funds before you can apply to the new AT-HM funding scheme
- There will be a rigorous process, and professional recommendations required to secure the funding from the AT-HM Scheme. This process also applies if you use your unspent HCP funds for Home Modifications
- There is a lifetime cap of $15,000 for Home Modifications per client (unless you're using unspent HCP funds, in which case, the limit does not apply)
- Once approved, funding must be utilised within 12 months, though an extension may be granted in certain circumstances
- Hybrid clients need to contribute to some Home Modification costs at the Independence Support rates (prescription & wrap-around services excepted).

Care Management for short-term funding streams

Care partners are expected to support clients to get the most from their short-term scheme funding through targeted care management and coordination activities.

Each of the short-term pathways include an allocation of funding for additional care management or coordination activities, and there are strict guidelines in place regarding how the activities are claimed by providers. Importantly, these activities are not part of the 10% pooled Care Management activities and are expected to be funded from a client's short-term total funding amount.

Unlike ongoing Support at Home package classifications, for short-term funding programs, there are variable allowable deductions from the short-term budget for care management. See below:

CARE MANAGEMENT SHORT-TERM FUNDING SUMMARY	
Short-term funding stream	**Allowable funding for care management-type activities**
Restorative Care Management	No specified limit; must be proportionate
End-of-Life Care Management	No specified limit; must be proportionate
Assistive Technology Administration	10% of the total cost, or up to $500 (whichever is lower)
Home Modifications Coordination	15% of the quoted costs, or up to $1,500 (whichever is lower)

CARE MANAGEMENT FOR RESTORATIVE CARE PATHWAY FUNDING:

Care management under this pathway is a specialised role requiring specialised skills and qualifications. Not all registered providers will be able to deliver the Restorative Care pathway care management activities, so your provider will discuss how this funding will be implemented with you if you are eligible for the scheme.

Restorative Care Partners will develop a care plan, liaise with relevant professionals, make referrals and implement the necessary interventions to help the client meet their short-term restorative care goals.

There is no specific limit or amount deducted from the budget for restorative care management activities and it will be determined between the provider and client. However, it should be proportionate and in the best interests of the client.

CARE MANAGEMENT FOR END-OF-LIFE PATHWAY FUNDING:

It is anticipated that for clients receiving end-of-life care, there may be significant planning and coordination required between your Support at Home Care Partner, medical teams and palliative care services.

Care Partners are responsible for ensuring that necessary services are in place to ensure the client is receiving holistic and sufficient care at this challenging time. A special end-of-life care plan should be developed specific to the needs of the client with a focus on delivering supports that complement any medical and/or palliative care services already in place.

There is no specific limit or amount deducted from the budget for end-of-life care management activities, and it will be determined between the provider and client. However, it should be proportionate and in the best interests of the client.

CARE MANAGEMENT FOR ASSISTIVE TECHNOLOGY & HOME MODIFICATIONS SCHEME (AT-HM)

Providers may deliver administration (for Assistive Technology) or coordination (for Home Modifications) activities as part of delivering the AT-HM scheme to a client. Administration and coordination activities must be claimed from a client's AT-HM funding and cannot be claimed as care management activities from the 10% pooled Care Management fund.

ASSISTIVE TECHNOLOGY ADMINISTRATION FUNDING:

A provider's **administration** (Assistive Technology) activities may include:

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

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

HOME MODIFICATIONS COORDINATION FUNDING:

A provider's coordination (Home Modifications) activities may include:

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

Note: A provider's coordination costs in delivering Home Modifications must not exceed 15% of the quoted costs or up to $1,500 (whichever is lower). Providers can provide coordination services for home modifications or subcontract this service to a third-party.

What happens if I need a new assessment for more care and support?

There are different approaches to reassessment, depending on when a person entered the Support at Home program. You are a Hybrid client.

Before you can apply for reassessment to receive a higher-level classification under Support at Home, you may need to use any unspent Home Care Package funds available to you. Additionally, you should be able to show that your quarterly budget can no longer cover the care hours and other supports you require.

If you are reassessed by the Single Assessment Service (SAS), you may be offered a higher Support at Home funding classification as determined by the assessor in collaboration with you, however you are not obliged to accept the new classification.

If you accept your new funding level, you can only access the specific service categories and service types listed in your Notice of Decision and Support Plan, which may seem less flexible than you were used to under the Home Care Packages program. If a service is not listed, you are not permitted to access it, and must apply for another Support Plan Review if any of your needs change.

Because you are a Hybrid client, from 1 November 2025, you will have to contribute to the cost of your care regardless of which budget classification you receive under Support at Home in the future.

Self-management in Support at Home

A key feature of the Support at Home program is enabling clients and their carers/representatives to maximise their choice and independence, and to be more involved in arranging and managing their care and services, should they wish to do so.

In Support at Home, self-management involves the client leading and making key decisions about the mix of services they need (in accordance with the services they are approved to receive), management of their budget and, in some instances, which suppliers, organisations and/or workers will provide the services required.

All providers, including those offering self-management, must continue to offer care management services and monitor the relationship between clients and their contracted or third-party workers. In doing so, providers must deliver at least one direct care management activity, to each client, every month.

While not all providers have a formal self-management model, all are expected to enable clients to have a say in who provides their care and services as well as when those services are delivered. However, this may or may not extend to a formal self- management arrangement.

If their provider can support these arrangements, self-management may enable the client to:

- Choose, coordinate and communicate with their own workers and/or suppliers
- Coordinate and schedule their own services, in line with their assessed needs, care plan and budget
- Pay invoices for services delivered and seek reimbursement from their provider

All self-management arrangements need to be detailed in a formal agreement between clients and their provider, including (but not limited to) agreements regarding mutual obligations, approved spending, invoicing and payments, receipts, reimbursements, and expectations for managing overspending or conflict resolution.

Self-managing clients cannot opt out of contributing 10% of their quarterly budget to the provider's pooled care management account. Like all other Support at Home clients, they will have the remaining 90% of their quarterly budget available to pay for care and services according to their assessed needs and care plan.

Providers will provide oversight for quality, safety, governance, compliance, and Care Partners will regularly check in with self-managing clients to ensure their services meet their needs. Providers will still need to perform some administrative functions, such as claiming and worker screening checks.

Providers will be permitted to apply a proportionate capped loading to the agreed service price to cover administrative costs when clients have chosen and coordinated their own workers or suppliers. This capped loading cannot exceed 10% of the cost of the third-party service price. If the final price exceeds the provider's advertised in-house rate for the same service, this agreement must be documented in the client's care plan and notes.

This capped loading may also apply to fully provider-managed clients who choose and coordinate their own worker/s to ensure their provider can comply with contractor management obligations.

The capped loading cannot be added to the price if the decision to broker the service to a third party is made by the provider themselves and the client is not contributing to coordinating the third party.

OBLIGATIONS FOR SELF-MANAGEMENT

For self-management to be successful for clients and compliant for providers, there are a range of responsibilities and obligations that underpin self-management in Support at Home.

First and foremost, all self-management arrangements need to be agreed upon and documented, so both parties know what to expect from each other. Until, or unless, there is mutual and ongoing agreement between the client and their provider about these obligations, the provider must assume full responsibility.

This table outlines the minimum obligations for providers and clients for a self management arrangement.

Provider (Us)	Shared Responsibility	Client (You)
• Deliver care management services at least monthly • Guide and inform on working with third-party providers and legal requirements • Share current Support at Home program information • Monitor your budget and build your knowledge • Arrange third-party workers and ensure compliance with the Aged Care Act 2024 • Assist with subsidy claims by checking invoices and submitting them quickly • Monitor service delivery for quality, safety, and compliance with laws and guidelines	• Develop formal agreement for services and prices • Regularly review your care plan to ensure needs and goals are being met • Regularly review your budget and spending • Proactive and open communication between those involved in your care, including risks, issues and changing needs	• Only arrange and use services from your preapproved service list, and stay within your budget • Seek pre-approval from Care Partner before changing services • Acknowledge that only approved services will be subsidised • Agree to and comply with our requirements and processes

Couples with different Support at Home funding classifications

Couples with different care needs receive separate assessments, classifications, and funding under the Support at Home program, allowing each individual to receive tailored care and services.

This may require some careful planning and management if one person in the couple is grandfathered from the old Home Care Packages program and the other person is not.

In this situation, the newer client will be required to make out-of-pocket contributions, but their grandfathered client partner does not need to contribute. Similarly, one person may have access to previously accumulated unspent HCP funds and the newer client may not.

It may be prudent that shared services such as domestic assistance, and home & garden maintenance are assigned to the package held by the grandfathered client in the couple, as these are the services that would otherwise attract the highest co-contributions from newer Support at Home clients.

There will be some obvious limitations to where this type of pooling of services can apply, so care partners will work closely with the couple to plan the most suitable and acceptable arrangements, taking each person's individual needs, approvals and access to funding into account.

Changing providers

Under Support at Home, all clients can choose which Registered Provider will manage their funding package. Their Registered Provider receives government subsidies on their behalf and offers care management services to ensure they receive the support they need based on their assessed care requirements.

Clients are also entitled to change Registered Providers if they believe that a different provider can better meet their care needs.

WHAT DO I NEED TO KNOW ABOUT CHANGING PROVIDERS?

You can change providers at any time, and your budget approval will move with you. You will not be switched to a different funding classification if you move.

Importantly, you must advise your existing provider of your changeover date, who your new provider will be and cooperate with the changeover process to ensure your services and supports are seamlessly transferred. Effective and transparent communication between clients, providers, and the new provider is essential to ensuring a smooth transition.

Clients should be aware that the provider you leave is not required to transfer remaining unspent HCP funds for up to 70 days after a client has switched to their new provider.

Taking leave or temporarily stopping services

The Support at Home program brings some changes to the way temporary leave is managed. From 1 November 2025, you will no longer need to put your funding on hold, but you still need to advise your provider so your services can be suspended. This is important so you are not charged for services unnecessarily, noting that provider cancellation policies will apply in some circumstances.

The reasons a client may temporarily stop receiving some or all services include, but are not limited to:

- Hospital admission
- Transition care following a hospital stay
- Residential respite care - either planned or unplanned
- Other reasons such as social leave, holidays or other personal circumstances.

Your provider will continue to provide care management activities to you while you have temporarily stopped services. However, if you'd rather decline, this will be recorded in your care notes until you ask your provider to recommence services.

Even though your funding continues to accrue if you temporarily stop services, the carryover unspent budget limits will apply, i.e. $1000 or 10%, whichever is greater.

RETURNING HOME

If you need more help once you return home, you can use your quarterly budget and any unspent HCP funds to increase your services in accordance with your assessment and care plan. It's important to maintain regular communication with your provider so they can plan to restart your services in a timely manner, and to give them time to arrange any necessary referrals if your care needs have changed.

The department has some limits on how long a client can keep their Support at Home program 'active' if they are not receiving any services. It is important to note that a client's funding will be reduced to zero and reallocated when a total of four consecutive quarters (one year) and 60 days have passed since the end of the quarter from when the last service was delivered to you.

Primary Supplements

Hybrid clients may be eligible for additional financial supplements to assist with the cost of meeting their complex care needs. Specific eligibility criteria must be met, and, in most cases, an assessment is also required.

There are five Primary Supplements and two Additional Supplements available under Support at Home:

1. ENTERAL FEEDING SUPPLEMENT - FOR PEOPLE WITH SPECIAL FEEDING NEEDS:

This supplement is for clients with a specified medical need for enteral feeding to help pay for specialised products and equipment.

Your provider must apply to Services Australia for this supplement on your behalf, and this supplement will automatically move with you if you change providers.

2. OXYGEN SUPPLEMENT - FOR PEOPLE WHO NEED OXYGEN

This supplement is for clients with a specified medical need for the continual administration of oxygen and to help pay for specialised products and equipment.

Your provider must apply to Services Australia for this supplement on your behalf, and this supplement will automatically move with you if you change providers.

3. VETERANS SUPPLEMENT - FOR VETERANS WITH MENTAL HEALTH CONDITIONS

This supplement provides additional funding for veterans with a mental health condition accepted by the Department of Veterans Affairs (DVA) as related to their service.

DVA determines a person's eligibility and advises Services Australia on your behalf. This supplement will automatically move with you if you change providers. Eligible clients will have the Veterans Supplement added to their quarterly budget.

Additionally, providers will receive three hours per quarter of additional care management funding for eligible clients as part of the Care Management Additional Supplement.

4. REMOTE SUPPLEMENT

Clients living in very rural and remote areas may be eligible for an additional supplement to support their access to Assistive Technology and Home Modifications (AT-HM). The amount of the supplement is 50% of the assigned AT-HM funding tier and will be applied automatically by Services Australia if they meet the criteria based on the residential location of the client.

5. ** DEMENTIA AND COGNITION SUPPLEMENT (CARRIED OVER FROM HOME CARE PACKAGES PROGRAM)

This supplement was previously available under the Home Care Packages program to provide additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other eligible cognitive conditions.

This separate Dementia and Cognition Supplement has been discontinued as a standalone payment, however, Hybrid clients receiving this supplement as of 31 October 2025 will have the supplement amount transferred and added automatically to their new Support at Home quarterly budget.

Moving forward, the Single Assessment Service will consider a person's care needs relating to dementia and recommend an appropriate funding classification level to address those specialised needs. If a Hybrid client is reassessed and subsequently accepts a new Support at Home classification, their Dementia and Cognition Supplement will cease.

Additional Supplements

6. ADDITIONAL CARE MANAGEMENT SUPPLEMENT

This Supplement for the Support at Home program acknowledges the special and complex needs of many older people as they age. Clients eligible for the supplement will be identified by Services Australia based on their aged care assessment.

This supplement provides an additional 3 hours per quarter of care management activities and will be added to a provider's pooled care management fund in respect of:

- Veterans who are approved for the Veteran's Supplement for aged care
- Older Aboriginal and Torres Strait Islander people
- People who are homeless or at risk of homelessness
- People referred from the Care Finder program
- People who are care leavers (i.e., a person who has spent time in institutional or out-of-home care, including Forgotten Australians and former child migrants).

If a person meets more than one of the above eligibility criteria, the supplement will only be applied once.

7. FEE REDUCTION SUPPLEMENT – FOR PEOPLE IN FINANCIAL HARDSHIP

This time-limited supplement is available to Support at Home clients experiencing financial hardship who cannot pay their Support at Home contributions due to their financial circumstances. If approved, the government will pay the client's portion of their contributions.

The Fee Reduction Supplement will move with you if you change providers.

Applying for Fee Reduction Supplement due to financial hardship

To apply for the Fee Reduction Supplement, clients are required to submit an 'Aged Care Claim for Financial Hardship Assistance' form (SA462) to Services Australia. The Fee Reduction Supplement has strict eligibility criteria and requires the clients to disclose details of all assets and income and to provide proof of costs and expenses.

Providers have no say in the process or outcome of an application, however they can give assistance to complete this form as part of their care management responsibilities. Alternatively, clients may seek assistance from Services Australia, a financial counsellor, or the Aged Care Advocacy Line on 1800 700 600.

Providers are not required to collect client contributions while Services Australia is assessing their hardship application, however, fees will accumulate for services used during this assessment and processing period.

If the application is approved, the government will pay their home care fees, including any amount accumulated up to that time. Conversely, if the application is not approved by Services Australia, the client will be required to pay their contributions, including the backdated amount accumulated up to that time.

Disclaimer

This resource contains information that is correct as of the publication date.

Information in the resource has been gathered from government sources, including:

- Support at Home Handbook v1.4 (June 2025)
- Support at Home Operational Manual v4.1 (October 2025)
- Support at Home Frequently Asked Questions (2025)
- Support at Home Frequently Asked Questions for Providers (2025)
- Department of Health, Disability & Ageing fact sheets and webinars for providers and clients (various)

It has been created especially for people using the home care system as a HYBRID client.

It is tailored and includes information that is directly relevant to you.

Version 1.9

December 2025

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