



Choosing the right home care provider

What to know before you pick a provider





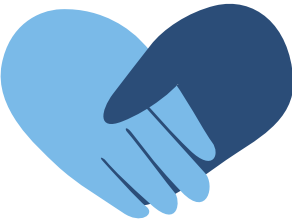
Once you've been approved for the Support at Home program and are in the queue of the priority system, it's time to start researching providers.

Under Support at Home, you have choice and control of the providers delivering your care, so long as the services you receive:

- Are directly linked to your identified care needs and goals
- Will improve your health and wellbeing
- And are necessary for you to remain living safely and independently in your own home

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The information contained in this booklet was correct at the time of publication and is subject to change.

What is the Support at Home program?

From 1 Nov 2025, the new Support at Home (SAH) program replaced the Home Care Package (HCP) program and the Short-term Restorative Care program. SAH is designed to provide flexible, tailored support according to a person’s health care needs. It is a government-subsidised program, with client contributions applying to some people dependent on individual circumstances.

WELL AND INDEPENDENT

With personal care, nursing, and allied health support

COMFORTABLE AT HOME

With cleaning, gardening, home maintenance and nutritional support

CONNECTED TO YOUR COMMUNITY

With transport and social support services

You need an assessment through the Single Assessment System (SAS). If approved, you receive funding based on your care needs. This funding helps you stay living at home.

Older people who were on the National Priority System awaiting allocation of a Home Care Package under the former aged care system were automatically transitioned to the Support at Home priority system. So, clients don’t need a new assessment unless their needs change.

The SAH and HCP classifications in the table following table outline what core care funding is available to support your needs, depending on whether your funding transitioned from the HCP Program or has been assigned since the introduction of Support at Home.

HCP FUNDING AMOUNTS*

Classification Level	Annual budget	Quarterly budget
Level 1 HCP	\$10,931	\$2,732
Level 2 HCP	\$19,224	\$4,806
Level 3 HCP	\$41,847	\$10,461
Level 4 HCP	\$63,440	\$15,860

*The above home care subsidy amounts are correct as of 10 October 2025.

SAH FUNDING AMOUNTS*

Classification Level	Annual budget	Quarterly budget
1	\$10,696	\$2,674
2	\$15,981	\$3,995
3	\$21,919	\$5,479
4	\$29,545	\$7,386
5	\$39,535	\$9,883
6	\$47,957	\$11,989
7	\$58,122	\$14,530
8	\$77,709	\$19,427

SHORT-TERM CLASSIFICATION

Support at Home offers three distinct short-term classifications designed to meet specific time-limited care needs. These classifications provide targeted funding outside of a client's ongoing quarterly budget and are intended to support recovery, urgent care needs, or one-off assistive and environmental interventions. You need a clinical assessment and formal approval for each short-term funding type.

Assistive Technology and Home Modifications (AT-HM)

The AT-HM classification supports clients who need specific equipment or changes to their living environment to maintain safety, function, and independence. Eligible clients can access:

- Up to \$15,000 lifetime for Assistive Technology – this includes mobility aids (e.g. walkers, wheelchairs), communication devices, and adaptive technologies to support daily living.
- Up to \$15,000 lifetime for Home Modifications – this includes structural changes like ramps, grab rails, widened doorways, or bathroom alterations. Funding is only accessible for items included in the AT-HM list, clinically justified, included in the care plan, and approved by an aged care assessor. Caps are for life. Home Modifications cannot go over \$15,000. Assistive Technology may go over \$15,000 only in rare cases, after reassessment.

Restorative Care Pathway

The Restorative Care Pathway is designed for older people experiencing a functional decline that may be reversible. This short-term support aims to improve or restore physical,

cognitive, or psychosocial functioning through a coordinated intervention:

- Funding: Up to \$12,000 over a maximum of 16 weeks.
- Services may include allied health therapy, reablement coaching, assistive supports, and care coordination.

You need a goal-based plan and a clinical assessment for restorative care. This pathway helps you regain independence and avoid long-term care.

End-of-Life Pathway

The End-of-Life Pathway provides time-limited, intensive support to clients with a terminal prognosis of three months or less who wish to remain at home:

- Funding: Up to \$25,000 over a 16-week episode.
- Supports may include nursing, personal care, respite, equipment hire, and other services. These are to keep you comfortable and support your carers at the end of life.

Eligibility must be confirmed by a medical practitioner or nurse practitioner using the End-of-Life Pathway Form. Funding is separate from ongoing care budgets and is intended to enable a dignified death at home, respecting the individual's preferences and needs.

For more information about the Short-Term Restorative Care program, view the department's guidelines: health.gov.au/our-work/short-term-restorative-care-strc-programme/about-the-short-term-restorative-care-strc-programme or visit the Trilogy Care Support at Home page: trilogycare.com.au/support-at-home/

How do I apply for the Support at Home program?

Step-by-Step Guide

STEP 1: CHECK YOUR ELIGIBILITY



- Apply for an assessment with My Aged Care
- You can do this on their website or over the phone. You may also seek a referral from a GP, health professional, or hospital
 - myagedcare.com.au
 - 1800 200 422
- If eligible, you will be booked in to have an assessment using the Integrated assessment tool

STEP 2: HAVE YOUR AGED CARE ASSESSMENT



- The Single Assessment System (SAS) is a new, nationwide process that makes it easier for older Australians to access aged care services. It replaces the old assessment pathways and ensures your care needs are assessed fairly and consistently under the Aged Care Act 2024.
- An aged care assessor will assess you at home or over the phone, determining the level of care you need and your priority level.

STEP 3: DISCOVER YOUR ASSESSMENT OUTCOME



- My Aged Care will mail you a notice of decision and support plan
- When you receive your letter, log into your My Aged Care online account to:
 - see which services you've been approved to access under Support at Home
 - obtain referral codes so we can waitlist you
 - review the individual support plan the aged care assessor developed
- You will be placed in the Support at Home Priority System until funding is assigned
- The Support at Home Priority System is the way the Australian Government prioritises the allocation of Support at Home funding. It is a waitlist based on the needs and circumstances of individuals, regardless of where you live.

STEP 4 BEING ASSIGNED FUNDING AND YOUR REFERRAL CODE



- Call your chosen provider with the referral code to activate your Support at Home funding. You can reach Trilogy Care on 1300 459 190

Finding a Support at Home provider

As soon as you've been assigned your Support at Home funding, you'll need to look for a registered provider that can deliver the services you want, in the way you want.

Every provider is a little different in how they do things and what they charge, so it pays to be thorough.

What should I look for in a Support at Home provider?

The most important thing is that you receive high-quality care. At a bare minimum, My Aged Care's 'Find a Provider' tool will allow you to find service providers in your area that are regulated by the Aged Care Quality and Safety Commission and meet a defined set of standards.

The Statement of Rights lays out what your expectations should be of services supplied by providers. If at any stage you have concerns that your provider is not addressing – or not addressing to your satisfaction – the Older Persons Advocacy Network can help.

For most people, the starting point for selecting a registered provider is to establish a few key facts:

- Do they provide services in my area?
- Do they provide the type of services I want?
- Do they have availability?
- Are they in alignment with anything that is particularly important to me e.g. culture or faith?
- They should help reduce your missed care rate

What is the missed care rate?

Missed care rate is the share of your approved quarterly budget that isn't activated as services within the quarter (e.g. if you use

70% of budget, you will have a 30% missed care rate). Because budgets reset with limited carryover, a good provider should help you plan and book services on time.

Practical questions to ask about missed care rate

- How will you track my usage and let me know if I'm underspending?
- Will I get reminders before the quarter ends?
- Can I book or change services easily (phone, portal or app)?
- How quickly can you find a worker if I add services at short notice?
- Will my care partner check in to align services with my goals?
- Can a family member receive usage updates with my consent?
- Do your statements or portal show activated services versus remaining budget?
- What happens to any unspent funds and how will you help me prioritise services before reset?

From there, we suggest finding the answers to a range of practical questions to make an informed decision.

How do I choose a Support at Home provider?

Choosing a Home Care Package provider is a very important and entirely personal decision. While recommendations are always great, it's about finding the right fit for your individual circumstances.

For all provider types, we recommend one key, overarching question – 'how will you meet my

care needs?' Your provider's answer should indicate their whole process, from planning to budget to how they guarantee the quality of their services.

Other important questions include:

- Can you break down my quarterly budget and tell me what that will look like in practice?
- How much will each service cost?
- How much will I have to personally contribute?
- If I decide to change provider, is there a notice period?

If you've decided to take the fully-managed route, there are some additional questions to ask:

- Who chooses the people that deliver my services, and can I have a say in that decision?
- Can you guarantee the same care worker each shift?

- What is the process if I want to change my care worker? And are there any wait times?
- Do you employ your own staff or use subcontractors?
- Are services delivered within set hours, or can I choose my own hours?
- What do I do if I have a complaint?

My Aged Care (MAC) also recommends asking how the organisation receives and actions feedback from clients and if they've had any recent sanctions or notices of non-compliance. If so, what were they for, and what did they do (or what are they doing) to address them?

Can I change my Support at Home provider?

You can change your Support at Home provider at any time. Whether you need to change because of your circumstances or because you feel there's a better option for you, your current provider is obliged to support you in your move, and facilitate a handover to your new provider, at no additional cost.



Support at Home providers – your questions answered

What do Support at Home providers do?

Support at Home providers work with you to develop your care plan and manage your funding as part of your overall service agreement.

They will draw on the information contained in your aged care assessment and notice of decision, and the information you share with them during meetings, to create a plan for the services you need with the funding available.

Why do I need a Support at Home provider?

To access your Support at Home funding, you have to first sign on with a registered provider who will then become responsible for all reporting requirements related to your funding. Registered providers are responsible for ensuring that the funding is used for delivering safe and quality services that support each person to meet their ageing related goals.

Their role is to ensure you receive quality care and that your funds are managed properly, in compliance with national standards and legislation.

Choosing a service option

One of the first things you'll need to think about before choosing your Support at Home provider is how 'hands-on' you want to be with your care and services.

Providers can offer a fully-managed or self-managed service, and various degrees in between. The amount of provider involvement in the day-to-day management of your services may have implications for your funding as well as the flexibility and control you have over your care.

Not all providers offer both fully-managed and self-managed services, so it's important to understand the level of involvement you want before you start the process of selecting a provider.

Support at Home providers – Fully-managed vs self-managed

FULLY-MANAGED HOME CARE PACKAGE PROVIDERS

When we think about home care, the model we're traditionally used to is what's known as 'fully-managed'. Your provider takes care of all the financial and administrative elements of your funding, they choose and book your care services and carers are rostered from within their own workforce.

You might choose this option if you feel you do not have the capacity to take on any level of self-management and are happy to hand over the reins to a care manager.

THE BENEFITS OF SELF-MANAGING YOUR SUPPORT AT HOME

Self-management is a highly individual approach to managing your support plan. It allows you to manage specific aspects of your care – such as choosing the care workers who deliver it – while still receiving support from your provider. This can allow you to engage suppliers at a rate that suits you, rather than a rate set by your provider. as well as having absolute control over who is in your home, when, and at what cost.

There's also an intermediate level of self-management, whereby a care-coordinator can help you to find the right workforce for your needs without being restricted to the pool of employees within a fully-managed provider. Trilogy Care's Fully Coordinated option uses this model.

This is typically still much more cost-effective than working under a fully-managed arrangement.

Importantly, 'self-management' doesn't mean that you and you alone must manage your care plan – you can nominate a friend or family member to help.

Self-managing your Support at Home funding doesn't mean you won't be supported, but it does open up a world of opportunity, including:

1. Being able to maximise control over the services you receive and the people who deliver them. No need to work within the confines of an organisation's service offering or use only their staff. You can employ anyone who is appropriately qualified and who you feel comfortable with, including people already support you.
2. Flexibility to move around your schedule. As your needs evolve, or when something changes, you're able to quickly adapt. Self-managing your care means no renegotiating plans or waiting for a gap to open up on a roster.
3. Self-management can also be a more cost-effective option. With fewer provider fees involved, more of your package funding is available for direct services and supports. This means better value from your care budget and greater control over how it's used.
4. By choosing a self-managed model with Trilogy Care, you can put more of your funding into the care and services that matter most to you, helping you maintain your independence and meet your goals more effectively.

5. Your team. Your schedule.

Your standards.

Choose who delivers your support and when it happens. Set the rate, timing and frequency, and your package provider will handle screening and onboarding so you stay in control without the admin burden. No strangers. No surprises.

More care hours from the same funding

With self-management, more of your package goes to real support rather than overheads. Trilogy Care clients typically receive 30–40%

more care hours than those with fully managed providers because they can agree local rates with trusted workers instead of being locked into fixed, higher prices.

Your funding, your care — no waste.

Self-management is also a great way to retain independence in every sense – you know your needs and how you want to live your life. By self-managing, your funding becomes a ‘tool’ to fill the gaps and make everyday living safer and more comfortable.



Understanding provider costs and contributions

Under the Support at Home program, every provider sets their own service prices and must publish a complete price list online. Because costs vary widely, it's important to compare providers to ensure you're getting the best value from your quarterly budget.

Client contributions apply to most services except clinical care, which is fully funded by the government. Independence services (such as personal care and assistive technology) attract moderate contributions, while Everyday Living services (such as cleaning or gardening) attract higher contributions. Meal services are split, with 70% subsidised and 30% (ingredient cost) paid by the client in full.

Contribution levels are based on your income and assets assessment, using the same method as the age pension means test.

If you were receiving a Home Care Package, had been approved for one, or were on the National Priority System as of 12 September 2024, the "no worse off" principle applies. This means you will not pay more under Support at Home than you would have under the previous arrangements.

Client contributions

Support at Home focuses government funding on care needs that help clients to stay at home and avoid hospitalisations. In line with Aged Care Taskforce recommendations, most clients will make a greater contribution towards items they have paid or provided for themselves their entire lives.

Client contributions are set at a percentage for each service type. This means:

- a client will pay the dollar amount set by the percentage
- the government will pay the remainder of the price, as a subsidy to you.

The rate is based on the type of service received. Clients will make:

- no contribution for clinical support services (such as nursing and physiotherapy) – the government fully funds all aged care services classed as clinical care
- moderate contributions for independence services (such as personal care) and products and equipment under the AT-HM Scheme – many of these supports help keep participants out of hospital and residential aged care
- the highest contributions for everyday living services (such as domestic assistance and gardening).

Your age pension status will determine individual contribution rates, with the:

- lowest contributions for full pensioners
- moderate contributions for part pensioners
- highest contributions for self-funded retirees.

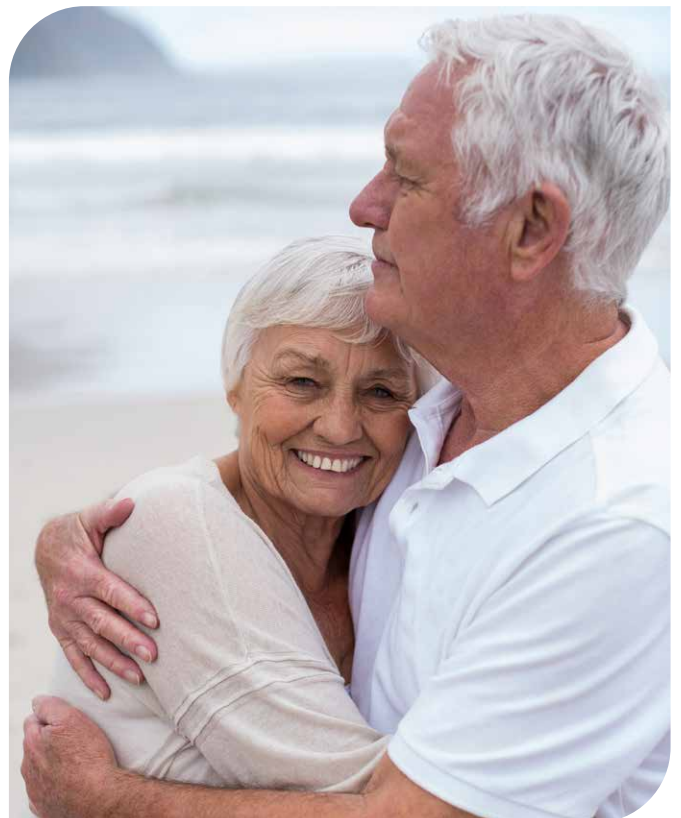
Trilogy Care does not charge set-up fees, daily fees or exit fees.

SUMMARY OF SERVICE TYPES

Category	Service examples	Who pays	Purpose
Clinical support	<ul style="list-style-type: none"> • Nursing care • Allied health • Prescribed nutrition 	Fully funded (no client contribution)	Health care needs requiring clinical qualifications
Independence	<ul style="list-style-type: none"> • Community engagement • Personal care • Medication administration 	Partial contribution based on means test	Helps with daily physical safety
Everyday living	<ul style="list-style-type: none"> • Domestic assistance • Home maintenance • Gardening • Meal delivery 	Higher contribution based on means test	General household help and social access

To protect self-funded retirees with lower incomes, clients eligible for a Commonwealth Seniors Health Card (CSHC) holders have lower contributions. This lower rate applies regardless of whether the individual has applied for a CHSC.

There is a \$130,000 lifetime cap on contributions to protect those who receive aged care for a long time. This is a combined cap with the non-clinical care contribution in residential aged care.



Your Support at Home funding

Your Support at Home funding is the total amount of funds available to cover the cost of your care and associated services, plus ongoing allocated supplements.

Once you've selected your provider, and formally entered into your Services Agreement, your funding will be allocated across your care plan to ensure you receive the services and support you need.

SUPPLEMENTS

The Australian Government pays several supplements under the Support at Home program to help providers meet the cost of delivering care for specific needs. Under Support at Home, supplements are split into person-centred and provider-based supplements.

Thin market supplementary grants

Two-year grants via the Community Grants Hub to support providers in under-serviced areas, such as rural or remote locations. This is a provider-based supplement that does not increase client funding.

Enteral feeding supplement

For people who receive nutrients through a tube in their nose, stomach or small intestine.

Oxygen supplement

For people who have a medical need for continual oxygen therapy.

Veterans' supplement

For veterans with a mental health condition related to their service.

There are currently two Veterans' supplements. The person-centred one provides clients with additional funding for services. The provider-

based one ensures your provider receives extra funding to provide extra care management services to you in the quarter, if needed.

Diverse Needs – Care Management Additional Supplement

For people with complex or specific needs, including:

- Veterans eligible for the Veterans' supplement
- Aboriginal or Torres Strait Islander people
- People who are homeless or at risk of homelessness
- People referred by the Care Finder program
- Care leavers (e.g. survivors of forced adoption)

These supplements are paid to the provider so they can provide extra care management services within a quarter, if required.

Fee Reduction Supplement

For people who are in genuine financial hardship and unable to pay aged care contributions due to circumstances beyond their control.

Dementia and cognition supplement

No longer available under the Support at Home program. Existing recipients of discontinued supplements are protected by grandfathering arrangements that ensure they are not worse off under SAH. If re-assessed into a Support at Home classification through a Support Plan Review, this supplement will no longer apply but instead be considered when determining the increased level of funding.

If you've managed a household budget, you can manage your Support at Home funding with ease. Trilogy Care will pay your care suppliers

directly – which can be easily done via the user-friendly Trilogy Care Portal.

Your Support at Home provider will work with you to establish what services you'll receive and when, within your funding. If things change, reach out to them immediately so that your care plan and funding can be revisited and adjusted accordingly.

Get the most from your care funding with Trilogy Care

At Trilogy Care, we help you make every dollar of your government-funded aged care count. Once your funding is in place, you'll get access to our secure client portal to track your budget, view your services and receive clear monthly statements. Our funding calculator shows you how to plan ahead, while your care partner will work with you to create a care plan that fits your needs and spending goals. We regularly review your service mix and provide tailored suggestions to minimise your missed care rate and make smart use of your available funds. This might include recommendations for eligible equipment, home modifications or short-term supports. With Trilogy Care, you stay informed, in control and confident you're getting the most from your care package.

Monthly Statements

Your provider will supply monthly statements that show what has been spent from your quarterly budget. You can choose to access that via hard copy, by email or online. Trilogy Care has an industry leading client portal that provides access to statements, up to date funding use, and much more.

The monthly statement from your provider should be itemised as follows:

1. Government subsidy

- Amount of Support at Home subsidy applied for the month
 - Display the monthly allocation derived from the quarterly budget

2. Client contributions (Fees)

- Fees paid or payable by the client for the month, including:
 - Income-tested fees (if assessed)
 - Other agreed client contributions (e.g. ingredient costs for meals)
- Unpaid fees from previous months, clearly carried forward

3. Itemised services

Each service must be listed individually, showing:

- Service type (e.g. cleaning, transport)
- Service date
- Provider or contractor name
- Units delivered (e.g. hours, quantity)
- Unit price
- Total cost

4. Additional funding allocations (if used)

- Assistive Technology (AT) and Home Modifications (HM)
 - Include separate tables with:
 - Service or item description
 - Quote value and coordination/admin fees
 - Cap balances and expiry dates

5. Funding summary

- Quarterly budget
- Amount spent this month
- Carry-over funds (up to \$1,000 or 10%)
- Remaining balance

Planning care and support plans

Understanding the support plan

The support plan is developed by the government following an aged care assessment. It outlines a client's assessed needs, preferences and goals, and lists the services they're eligible to receive under the Support at Home program.

Key parts of a government-issued support plan include:

- The client's classification level, which determines their quarterly budget
- Approval for short-term pathways such as:
 - Assistive Technology and Home Modifications (AT-HM)
 - Restorative Care
 - End-of-Life Care
- A list of services the client is eligible to access, based on the Support at Home service list

Care plan – your provider's responsibility

The care plan is developed in partnership between you and your care partner (previously known as your care manager). It explains how the services approved in your support plan will be delivered day-to-day.

Your care plan must:

- Reflect your personal goals and preferences
- Align with the three Support at Home service categories:
 - Clinical care – such as nursing and allied health services
 - Independence support – including personal care, transport and social support

- Everyday living support – such as cleaning, gardening and meals

- Be consistent with your classification level and funding
- Be reviewed regularly, or whenever your needs change

How the process works

1. Assessment and Notice of Decision

You'll be assessed through the Single Assessment System and receive a Notice of Decision that includes your classification level and support plan.

2. Care plan development

Your provider will work with you to create a personalised care plan, detailing which services will be delivered, when they'll occur and who will deliver them.

3. Service delivery

Only services listed in the Support at Home service list and within your funding and classification level can be delivered and claimed.

4. Support plan review

If your needs change significantly or you ask for a reassessment, your support plan may be reviewed.

What is a care coordinator?

Care coordination is a helpful add-on for self-managed clients who would like support with the process of sourcing carers.

Fees for a coordinated service are higher than the self-managed hourly rate due to coordination fees, but still significantly lower than what you can expect to pay in a fully managed arrangement.

Care coordinators work with you to facilitate sourcing and recruiting care workers for services detailed in your care plan.

An independent relationship between the care coordinator and care provider means that service rates can be negotiated to fair market value, helping you maximise your quarterly budget while maintaining compliance and quality standards.

How often should my care plan be reviewed?

Your care plan should, at a minimum, be reviewed every year, and more frequently if your needs or circumstances are changing significantly.

Support at Home inclusions and exclusions

Before commissioning services or purchasing any items, you need to consult with your care partner to ensure that they meet Support at Home criteria, including:

- Does it meet an assessed need as outlined in your care plan?
- Do you have sufficient funds?
- Is it value for money?

Support at Home offers a wide range of subsidised services.

All services must meet the government-defined criteria for what is 'in scope' (inclusions) and avoid anything listed as 'out of scope' (exclusions). This ensures services are safe, effective, and aligned with the Support at Home Service List and AT-HM guidelines.

Services are only subsidised if:

- They are listed as an in-scope item under SAH

- They relate to age-related or functional decline
- They are not already covered by the health system, other government programs, or private payments

Some services or items (such as general gym memberships, groceries, or non-prescribed supplements) are explicitly excluded and must be paid for in full by the client.

Assistive Technology and Home Modifications (AT-HM)

Support at Home includes access to separate funding for approved equipment and home modifications. Eligible clients can access up to \$15,000 in lifetime funding for assistive technology (e.g. mobility aids, communication devices), though this can be exceeded on prescription. There is also a separate \$15,000 available for home modifications (e.g. ramps, rails, structural changes).

If applicable, client contributions also apply.

Switching providers

The joy of self-management is that you can change providers without losing the people who make a difference in your day-to-day life. Moving to a new provider doesn't mean having to change care workers – those people and services can continue to work with you so long as they meet the requirements of your new provider. Under the Support at Home program, the best time to change providers is near the start or end of a quarter. This allows for minimal disruption in your services.

FOLLOW THESE FOUR STEPS FOR SWITCHING TO A NEW PROVIDER:



STEP 1 CHECK YOUR PROVIDER TERMS AND CONDITIONS

Establish any notice periods, so you know what you need to do and when for a smooth transition. Providers are not allowed to charge exit fees.



STEP 2 FIND A NEW PROVIDER

Consider what you like and don't like about your current provider and ask the right questions (see page 7) to find the perfect fit moving forward.



STEP 3 RE-ACTIVATE YOUR HOME CARE PACKAGE REFERRAL CODE

Your new provider will need your referral code, which will need to be reactivated through My Aged Care before you can start receiving services.



STEP 4 GIVE YOUR PROVIDER NOTICE

Set an official end date and give it to your current provider in writing. To retain your Support at Home funding, you must enter into a new Service Agreement within 56 days (there can be no overlap between providers)

Your rights

The purpose of the aged care system is to help you stay safe and well through services that are delivered respectfully and with dignity. The Australian Government has established standards to ensure the care you receive is of the quality you deserve.

CONSUMER DIRECTED CARE

Consumer Directed Care is a way of delivering care that 'gives individuals choice and flexibility'. These principles are enshrined in Aged Care law to ensure your rights are protected.

When it comes to Support at Home, this includes ensuring full financial transparency. You will be involved decisions relating to use of your funding with your provider. A monthly statement of available funds and expenditure must also be provided, in a format that is easy to read and understand.

THE STATEMENT OF RIGHTS

Your aged care provider is required to help you understand your rights under the Statement of Rights before you begin receiving services.

If you're unhappy with your care, or the care being received by someone else, an aged care advocate can help you explore options and raise your concerns.

CODE OF CONDUCT FOR AGED CARE

The Code of Conduct for Aged Care defines what good care looks like, within a clear framework:

The Code outlines 8 elements of expected behaviour:

1. Act with respect for people's rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions.
2. Act in a way that treats people with dignity and respect and values their diversity.
3. Act with respect for the privacy of people.
4. Provide care, supports and services safely and competently, with care and skill.
5. Act with integrity, honesty and transparency.
6. Promptly take steps to raise and act on concerns about matters that may impact the quality and safety of care, support and services.
7. Provide care, supports and services free from:
all forms of violence, discrimination, exploitation, neglect and abuse, sexual misconduct.
8. Take all reasonable steps to prevent and respond to:
all forms of violence, discrimination, exploitation, neglect and abuse, sexual misconduct

Glossary of terms

Assistive Technology and Home Modifications (AT-HM) Scheme

Support at Home funding stream for prescribed equipment and home modifications that help clients stay safe and independent at home.

AT-HM List

A definitive list of eligible items and modifications under the AT-HM Scheme. Includes categories for low-risk, under advice, and prescribed items.

Care Partner

Trilogy Care's term for the professional who supports the client to coordinate their services, manage their funding, and review their care plan. Equivalent to "Care Manager" in national program documents.

Care Plan

A plan developed between the client and their Care Partner that sets out the services to be delivered, how they will be provided, and the client's goals.

Client

An older person receiving aged care services through the Support at Home program. (Replaces the term "participant" used in government documents.)

Client Contribution

The amount a client is required to pay for services under Support at Home. Contributions are based on means testing and vary by service category.

Classification (Support at Home)

A level from 1 to 8 assigned to each client following a needs assessment. Determines the client's quarterly budget for ongoing services.

End-of-Life Pathway

A short-term support option under Support at Home for clients with a prognosis of three months or less who wish to remain at home. Provides up to \$25,000 in funding over 12–16 weeks.

Everyday Living Support

Category of Support at Home services that includes domestic assistance, meals, transport, and other non-clinical daily tasks. Requires the highest client contribution.

Fully Coordinated

A service model where Trilogy Care provides dedicated care coordination, clinical oversight, and full administrative support to help you manage your Support at Home funding while retaining choice over your care workers and services.

Independence Support

Category of services that support personal care, assistive equipment, and home modifications. Client contributions are lower than for everyday living services.

Means Testing

The government process of assessing income and assets to determine a client's eligibility for reduced contributions under Support at Home.

Missed care rate

The proportion of your quarterly budget not used on services (100% minus the percentage spent)

My Aged Care

The national entry point for aged care services. Manages assessments, referrals, and registration for government-subsidised aged care.

National Priority System (NPS)

The government's waitlist used prior to 1 July 2025 to assign clients to home care packages. Now used to manage wait times for Support at Home funding.

Quarterly Budget

Funding allocation received every three months under Support at Home. Includes a capped amount based on classification and supplements. Up to \$1,000 or 10% can carry over to the next quarter.

Restorative Care Pathway

A short-term pathway under Support at Home providing up to 16 weeks of clinical care for clients experiencing functional decline.

SAS – Single Assessment System

New aged care assessment method for the Support at Home program

Self-Management

An option under Support at Home where clients engage and coordinate their own support workers and services, within the rules of the program and with support from their Care Partner.

Short-Term Classification

Funding categories that apply for time-limited support: Restorative Care, End-of-Life, or AT-HM.

Support at Home

Support at Home is a new aged care program providing tailored services to help older Australians live safely and independently at home. It commenced on 1 July 2025, replacing Home Care Packages and Short-Term Restorative Cares.

Support at Home Priority System

The new waitlist for Support at Home funding, transitioning from the National Priority System.

Support Plan

A plan developed between the client and the government.

Support Plan Review

A scheduled or as-needed review of the client's needs, classification, and care plan, conducted by an aged care assessor. May lead to a reclassification or funding adjustment.



Helpful contacts

AGED CARE QUALITY AND SAFETY COMMISSION

Website: agedcarequality.gov.au

Phone: 1800 951 822

DEPARTMENT OF HEALTH AND AGED CARE

Website: health.gov.au

Phone: 1800 020 103

DEPARTMENT OF HEALTH AND AGED CARE – ELDER ABUSE PHONE LINE

Phone: 1800 353 374

MY AGED CARE

Website: myagedcare.com.au

Phone: 1800 200 422

OPAN – OLDER PERSONS ADVOCACY NETWORK

Website: opan.org.au

Phone: 1800 700 600

SERVICES AUSTRALIA

Website: servicesaustralia.gov.au

Phone: 132 300

TRILOGY CARE

Website: trilogycare.com.au

Phone: 1300 459 190





Our services

SUPPORT AT HOME MANAGEMENT

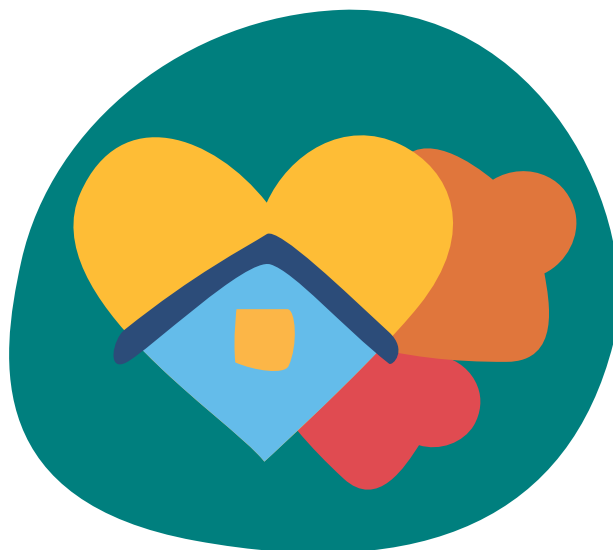
Trilogy Care is a registered Support at Home provider that empowers older Australians to live independently in the home they love for longer.

With two options for Support at Home management – Self Managed and Fully Coordinated – you to choose how involved you want or need to be.

Empowering independence through more active, personalised, and easy-to-manage care

For more help understanding your care options, contact us today:

trilogycare.com.au | 1300 459 190





Contact Us

Start your Self Managed or Fully Coordinated home care journey to receive better value from your Support at Home funding today!

1300 459 190

trilogycare.com.au

info@trilogycare.com.au

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