Support at Home

Webinar 2 – Your Questions Answered

What are Trilogy Cares expectations for Coordinators?

Coordinators are expected to continue their current responsibilities, including supporting clients, reviewing care needs, and liaising with service providers. Under Support at Home, there is an added expectation to manage the utilisation of each client's quarterly budget. This includes monitoring how funds are used, identifying when spending is too low or too high, and adjusting services to ensure clients receive appropriate support within their available funding.

Are we able to get individual implementation reports for each client to see what each client percentage is at?

Yes. Your Partnerships Manager is now equipped to provide detailed client-level utilisation information. In addition, our team is preparing a tailored report for each coordination partner that highlights clients requiring attention. This will factor in coordination and platform loadings applied to current budgets to ensure upcoming changes do not lead to overspending.

Will there be a Trilogy SAH Handbook for newbies also?

Yes. This will be sent to coordinators prior to 1 July 2025.

When will I get a copy of the new agreement?

We aim to have the new brokerage agreement to all partners by close of business **Friday 30 May.** We are also working with our legal team to finalise the new client agreement, however, some terms cannot be confirmed until the Government finalises the supporting Aged Care Rules. We will keep our partners updated as this progresses.

Coordinators still need a separate budget tool over and above the portal budget, we need to be able to do workings with clients on services to make decisions.

We are currently in the final stages of developing a working budget tool that our partners can use to support planning discussions and decision-making with their clients. This tool will allow partners to analyse different budget allocation scenarios and clearly describe the flow-on effect to an individual's contributions, where applicable.

What documentation is needed to get approved EOL funding?

An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:

- A medical practitioner or nurse practitioner provides an estimated life expectancy of 3 months or less to live, and

- A score of 40 or less on the Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator).

The individual's practitioner must sign the End-of-Life Pathway Form, which captures specific medical information related to the client's medical condition and evidence of end-of-life.

The client, their supporter, or care partner will then request an urgent support plan review through My Aged Care and upload a copy of the completed End-of-Life Pathway Form as part of that request.

An aged care assessor will complete the Support Plan Review and issue a Notice of Decision and new support plan (if approved).

What is the process for clients to apply for fee relief if financial hardship is significant?

If a client is unable to pay their client contribution, the first step is to support them in applying for the Fee Reduction Supplement through Services Australia. This supplement is designed for clients experiencing significant and genuine financial hardship and can reduce or waive the required contributions. The application process uses the Aged Care Claim for financial hardship assistance form (SA462) and considers the client's income, assets, and essential living expenses.

While the application is being assessed, providers must continue delivering approved services but are not permitted to collect contributions from the client. If the application is approved, the government will cover some or all of the contribution costs. If it is not approved, the client is expected to resume paying their assessed contribution. If a client declines to apply for financial hardship and cannot or will not pay, providers should initiate a structured discussion with the client to explore options and document all actions taken.

The government will not cover unpaid contributions, so providers must manage service levels within the available budget or consider a support plan review to realign services with what the client can access

Many clients need ramps that can cost more than $15,000. What do we do in these situations? What if bathroom remodelling costs upward of $30,000?

Funding for high-tier home modifications will be capped at **$15,000 per lifetime** (this does not include any additional supplement a participant may be eligible for). Lifetime caps will be monitored by Services Australia. Any amount outside this cap must be funded privately.

The "additional supplements" that a client may be eligible for are the fee reduction supplement, which will reduce or remove the client contributions required, and the Rural and Remote Supplement, which is additional funding for clients that receive AT-HM funding and reside in MMM6 or MMM7, totalling 50% of the assigned AT or HM funding tier, paid into their AT-HM budget.

How often can a client access the AT-HM funding?

It is expected that the full AT-HM Scheme guidelines, which are slated for release on 1 July 2025, will provide detailed information on how often clients can access or increase their AT-HM funding.

For now, we know that AT-HM funding approvals are time-limited and must be spent, not just committed, within 12 months of signing an AT-HM agreement. Following the 12-month period, AT-HM funding will no longer be accessible for use.

Exceptions:

- If there is a delay to home modifications which prevent the funding from being used in the 12-month period, it may be extended for an additional 12 months to complete complex home modifications.
- If a client has a progressive condition as outlined in the Aged Care Act 2024 (e.g. cerebral palsy, Parkinson's disease) their access to funding will be for 24 months, and able to be extended to 48 months.
- Funding for assistance dogs, if approved, is separate funding capped at $2,000 per year. This is allocated every 12 months and cannot accrue or rollover.

Are grandfathered clients exempt from the contribution fee for AT and HM?

Grandfathered clients are exempt from client contributions for Assistive Technology and Home Modifications (AT-HM) if they were not previously paying an Income-Tested Fee (ITF) under the Home Care Package program. If a grandfathered client was paying an ITF, they will continue to pay a contribution under Support at Home, including for AT-HM services.

The level of contribution will not increase, in line with the "no worse off" principle.

Clients must also use any Grandfathered Unspent Home Care Package funds (which do not require a client contribution) before accessing AT-HM funding and remain responsible for any costs that exceed their approved funding tier and applicable supplements

What happens if the person who is expected to pass does not? Do they then have to go into Palliative care?

The End-of-Life Pathway is intended to provide additional in-home aged care services (such as personal care, domestic assistance, general nursing care) to complement services available under state and territory-based palliative care schemes.

This pathway provides funding over a 12-week period, which can be extended to a maximum of 16 weeks. In the event a client requires ongoing services following completion of the End-of-Life Pathway funding period, they will return to a Support at Home classification via a Support Plan Review. For clients previously accessing Support at Home, this will be their previous classification level. For clients who entered Support at Home on the End-of-Life Pathway, this

will be the inactive classification assigned at their assessment.

Whether the client remains eligible to access state or territory-funded palliative care is subject to the rules of those schemes.

Can a classification status be dropped if a client does not fully utilise their budget?

Under the **Support at Home program,** a client's classification—and the associated funding level—is determined by their assessed care needs, not by how much of their budget they spend. Therefore, a client's classification will not be downgraded solely due to underutilisation of their budget.

If no claim is made for services for four consecutive quarters, a client's funding will be reduced to zero and reallocated.

Can you clarify if a self-funded retiree who does not earn greater than the threshold but has no ITF – will they still need to contribute 25%? Or is that for self-funded retirees who have ITF?

If they are a Grandfathered Client (approved before 12 September 2024) do not pay an income-tested fee currently, they are protected under the "no worse off" principle. If they pay an ITF currently, they will be assigned an individual contribution rate that means they do not pay any more than they do under their current fee arrangements.

If they are a Hybrid or New client and a self-funded retiree, the amount of their contribution depends on whether they hold a Commonwealth Seniors Health Card (CSHC).

CSHC holders will pay between 5-50% for independence services, and 17.5-80% for everyday living services. These rates are tapered based on the client's income and assets assessment completed by Services Australia. Non-CSHC holders will pay 50% for independence services, and 80% or everyday living services.

Hybrid or New clients who choose not to provide their income and assets information to Services Australia pay the maximum contribution amounts

If a client upgrades, will they contribute to all services?

Grandfathered clients (approved before 12 September 2024) are protected by the **'no worse off'** principle. This means their client contribution rates will not increase as a result of Support Plan Review.

Grandfathered Clients: What level will they be moved to in Support at Home since there will be four new levels?

Grandfathered clients will stay on their current HCP funding. Their quarterly budget will be their annual HCP Level funding amount divided by four.

If a client is approved for a higher level through a Support Plan review, they will be assigned one of the eight Support at Home classifications.

Can grandfathered clients use unspent funds for AT-HM post 1 July even if they have accessed their SAH allocation?

All transitional clients that have Grandfathered Unspent Funds must exhaust those funds before being eligible to apply for the AT-HM funding stream.

Does the coordinator loading include services under Allied Health services e.g. physiotherapy, podiatry, remedial massage etc.?

(information updated since webinar)

As allied health services fall within the Clinical Category, they do not attract any client contribution. They do, however, have special limits on the loading that can be charged:

- The coordination loading for AT is limited to the lower amount of 5% of the AT item's supplier price or $250.
- The coordination loading for HM is limited to the lower amount of 5% of the HM item's supplier price or $500.

If we organise OT appointments how does our fee incorporate this?

You apply your coordination loading to the supplier cost of all third-party services. The only exception to this is where the service forms part of the AT-HM funding scheme, which attracts the loading limits noted above.

Will both care management loading and platform loading mean less funds available for the client?

No. Care management and platform loading under Support at Home will not reduce the client's total budget. The client's quarterly budget is fixed based on their assessed classification, with 10% of this amount allocated to care management through a separate care management account. Coordination loading and platform loading are built into service prices, but they do not reduce the overall quarterly funding available to the client. The remaining 90% of the budget is available for direct service delivery.

Can we add coordination loading for a purchase?

(information updated since webinar)

Yes, however the amount you can apply depends on whether the purchase is being funded from a Grandfathered client's unspent funds or through the AT-HM Scheme:

- The coordination loading for AT is limited to the lower amount of 5% of the AT item's supplier price or $250.
- The coordination loading for HM is limited to the lower amount of 5% of the HM item's supplier price or $500.

How do we manage reduced support services due to clients being unable to make the client contributions?

If a client declines to apply for financial hardship and cannot or will not pay, providers should initiate a structured discussion with the client to explore options and document all actions taken.

The government will not cover unpaid contributions, so providers must manage service levels within the available budget or consider a support plan review to realign services with what the client can access.

Does platform loading apply on everything, including: allied health, personal care, cleaning etc.?

Yes, the platform loading applies to all supports funded through the client's quarterly budget, including allied health, personal care, cleaning, and similar services. This loading is applied in addition to the coordination loading, where coordination support has been provided.

Where the item or service is being funded through the AT-HM Scheme, there are limits on the platform loading that can be charged.

In all instances, both the Trilogy Care loading and coordination loading are added to the supplier cost and are managed by Trilogy as part of the invoicing process.

If a client chooses not to use services because they do not wish to contribute, is there a timeframe for them to use their funds? What should I do if they continually refuse to use their funds?

If a client chooses not to use services because they do not wish to contribute, there is no formal timeframe in which they must begin using their funds. However, if they continually refuse services and are not using their budget, coordinators should document the discussions and confirm the client's decision in writing. In these cases, it is important to:

- Ensure the client understands the implications of not accessing support
- Offer a review of the care plan to explore alternative supports, including clinical-only services which do not attract a contribution
- Encourage application for a fee reduction supplement if affordability is the barrier. If the client remains inactive, Trilogy Care will monitor their utilisation and may contact the client directly to discuss ongoing suitability and care needs.

Do we invoice when doing check-ins? Or is Trilogy Care doing this?

Coordinators do not need to invoice for check-ins, as this activity forms part of the overheads recovered through coordination loading.

If you have a worker doing multiple service tasks during a block service time, how does that get split?

If a worker delivers multiple service types during a single block of time, the time must be proportionally allocated to each service type based on the tasks completed. For example, if a worker provides both personal care and domestic assistance in a one-hour visit, and roughly half the time was spent on each, then 30 minutes would be claimed under personal care and 30 minutes under domestic assistance.

It is essential that the time split reflects actual service delivery, aligns with the service list, and is documented clearly for compliance and claiming purposes.

Given the complexity of the new information, will the statements be simplified for consumers? Currently, many are perplexed and can often require a home visit to explain, multiple times.

Yes. Trilogy Care is committed to making statements clearer and more accessible for clients under Support at Home. While the statements must include all required financial and service details, we are working to present this information in a simpler, more structured format. This includes clearer headings, plain language summaries, and visual cues where appropriate. Additionally, care partners and support teams will continue to assist clients in understanding their statements, and further resources are being developed to help explain key elements. Feedback from coordinators on what confuses clients most is welcomed and will inform ongoing improvements.

With streamlined invoicing, will there be a list of service line items sent out that correspond with the claimable services?

Yes. Trilogy Care will provide a standard list of service line items aligned with the national Support at Home Service List from the Department of Health and Aged Care. This will simplify invoicing and ensure each item matches an approved claimable service. Once finalised, the list will be shared with all partners.

Will the client be aware that their services are charged at an hourly rate plus the coordinator charge?

Clients won't see a separate coordination charge on their statements, as it must be shown as a single "all inclusive" price for the item or service. However, it's important to inform clients that a coordination loading now applies to each hour where coordination is provided, even though it won't appear as a separate line.

Does the coordination loading apply to pre-prepared meals and kilometres travelled as well as hourly services?

Yes. The coordination loading applies to all supports, including pre-prepared meals as well as hourly services. If coordination time is required to arrange or manage these supports, the coordination loading is applied and added to the total cost submitted to Trilogy Care.

However. It is important to remember that you can only charge for travel as a stand-alone service (e.g. transporting a client). Any costs related to travel required to deliver another service must be included in the price for that service and cannot be charged in addition.

In the past, the client had a fee % in total of 26% broken up as 15% from Trilogy Care and 11 % from Coordinators. Under the new system, if we choose the 20% option - client will be incurring 30% fee being broken up as 10% from Trilogy Care and 20% from Coordinators. I can see clients seeing Coordinators are too costly moving forward.

Under the new system, the structure has changed significantly and is no longer based on percentage deductions from a client's available budget. Previously, the client may have experienced a total fee impact of around 26%—15% Trilogy Care and 11% for coordination—deducted from their package funds, regardless of how much they actually spent. Now, under Support at Home:

- Trilogy Care's 10% loading is added to the cost of each support, not deducted from the client's budget.
- The coordination loading (e.g. 20%) is also added to the cost of supports where coordination is provided.

Utilisation levels are an important factor. At an average utilisation of 80%, the new pricing model does not result in a materially lower level of funds available to the client compared to the previous system.

If a person requires two hours cleaning totaling $120 plus 20% coordination loading = $144 then the customer pays 17.5% will this cost come from the clients' pension?

In your example, if a client receives two hours of domestic assistance totalling $120, and a 20% coordination loading is applied, the cost of the service becomes $144, plus the Trilogy Care loading of 10% – $14.40. This makes the total cost $158.40. Under Support at Home, clients who receive the full age pension pay a 17.5% contribution for Everyday Living services. This means the client would contribute $27.70, with the remaining $130.68 covered by the government subsidy.

If your client is experiencing financial hardship, support them to make an application for the Fee Reduction Supplement as soon as possible.

The budget and statement information is complicated and too complex – not sure if this is because of the new requirements or because of the level of information Trilogy Care feel obliged to deliver.

The complexity in the new budget and statement information is largely due to the expanded requirements under the Support at Home program. The government mandates detailed reporting on spending, funding streams, and contributions across multiple categories and supplements.

That said, Trilogy Care is committed to meeting these requirements while also delivering clear and transparent information to clients. We recognise that this level of detail can feel overwhelming, and we are actively working on simplifying the presentation without removing key compliance elements. Additional support materials and one-on-one guidance will continue to be offered to help clients and coordinators interpret their statements with confidence.

How is Trilogy Care allowed to add an additional percentage to the 10% Package loading? Yet we are limited to 30%, which is about $16 per hour.

Under Support at Home, providers must include all fees within the total service price—separate admin or package fees are not permitted. Trilogy's 10% platform loading is applied in line with program guidance to support self-managed arrangements, not automatically deducted from the client's budget. The 30% coordination loading cap is an internal control, not a program rule, and reflects the value of coordination services delivered.

We're available to walk you through our calculator to show how this structure works in practice in close comparison to previous fee model.

If workers are using the QR code, do they still have to fill out support notes on digital platforms used?

The QR code is a Trilogy Care requirement to meet mandatory service verification and is separate from the worker platform. It does not require an app—just a phone with a camera—and only needs to be scanned once per visit, with no check-in or check-out process. Clients will be provided with QR codes for display both inside and outside the home, using weather-resistant materials where needed. This approach is still being finalised but reflects current planning.

Will Trilogy Care be offering any internal coordination option to clients for cheaper if they call asking questions? Will we have the option to adjust fees and charges before or if they go internal with Trilogy Care?

Trilogy Care will always refer clients back to their coordinator if they contact us to discuss their management options, including any questions about the coordination loading. If a client expresses concerns about pricing, we encourage coordinators to review and adjust their loading where appropriate to retain the relationship. Trilogy Care is committed to supporting continuity of care and transparent communication between clients and their chosen coordinators.

The new pricing model has potential to create competition amongst coordinators. Those with HCP packages may be inclined to call around to both providers and coordinators to find their 'best deal'.

Trilogy welcomes healthy competition that promotes value. However, if a client contacts us to discuss switching or pricing, we will always refer them back to their existing coordinator first. This ensures continuity, respects the existing relationship, and allows you the opportunity to discuss and adjust your service offering if needed.

It just seems the 10% loading fee is reintroducing the 'clip on fee' that was removed a few years ago – the handling fee that providers were putting onto outside invoices. It seems like it's back in. That is how it will be perceived. Why does the loading have to be percentage?

The 10% Trilogy Care loading is not a return to the old 'clip-on' model but a consistent charge that covers the full cost of supporting self-managed care. It scales with service value to reflect administrative effort, compliance, and the added responsibility of co-payment collection. This also includes holding the debt facility and absorbing the interest cost to ensure suppliers are paid promptly, even while awaiting Services Australia to process and release claim payments.

We are happy to walk through pricing impacts using our calculator to show how this model works in practice.

Would you consider the notes/invoice from Mable as service confirmation, or will providers have to do both? Workers using platforms like Mable still submit their support notes through their Mable profile, so they are covered by insurance, etc. correct?

Support notes or invoices submitted through platforms like Mable may be accepted as service confirmation if they include sufficient detail about the service delivered, timing, and tasks completed. However, this does not replace the requirement to scan the Trilogy-issued QR code at the time of the visit. While still being finalised, the intent is for the QR code to become a mandatory, standalone verification step. It will need to be scanned once per visit, regardless of the platform used, to meet Support at Home compliance and Trilogy Care's verification standards.

Workers using Mable who submit support notes through the platform remain covered by Mable's insurance, provided they operate within Mable's terms of use. However, providers or coordinators do not need to duplicate these notes, but they must ensure that the services align with the client's care plan and are reflected accurately in reports to Trilogy.

Is service confirmation mandatory for every single shift? Please explain the coordination loading calculations in more details.

Yes, service confirmation is mandatory and required by law for every single shift under Support at Home. This is a core compliance requirement to verify that a service was delivered, who delivered it, when, and what was provided. This applies to all types of services—hourly supports, meals, and even one-off purchases. Trilogy Care accepts service confirmation in various formats, including platform- generated notes (like from Mable), direct invoices with detail, or written notes submitted through our forms or templates.

The coordination loading is the agreed percentage that you receive for coordinating services for a client. This includes tasks such as arranging services, liaising with suppliers, or supporting a

purchase. For example, if you procure a service for a client that costs $100 and submit the bill to Trilogy Care, we will complete the following steps:

1. Add your coordination loading to the invoice. If your rate is 20%, this would be $20
2. Add our 10% platform loading
3. Claim the total from Services Australia

On receipt of the invoice, we will have made payment to the original supplier of $100. The $20 coordination loading will be accrued to your coordinator account for payment when the claimed amount is received from Services Australia.

The amount claimed from Services Australia is shown on the client's monthly statement.

Your coordination loading applies to all support types where coordination has occurred, however it is important to remember that there are limits that apply when the support is paid for using the AT-HM funding scheme.

Who decides how much of the budget is allocated to each of the 3 categories. Is it simply 33% in each category? Will it be different between grandfathered and new clients?

Transitioned Clients are free to allocate their quarterly funding across the three categories as required to meet their assessed aged care needs.

Clients assessed after 1 July 2025 will be provided a support plan that details the approved services they can access from the Support at Home service list. Additionally, they will be supplied a Notice of Decision including the approved service groups (service types and services), and an ongoing quarterly budget based on the assessed classification.

Will we receive face-to-face training on the new software we are expected to implement?

Trilogy Care will continue to support our Partners with additional training as we move into SAH.

If current clients are reviewed and their package is updated, will they then be required to pay the fee?

If a grandfathered client undergoes a reassessment and is allocated a new Support at Home classification, they will still retain their grandfathered status. This means they will continue to pay no more than what they were required to pay under their previous Home Care Package, even if their classification changes.

Their contribution will only change if they were previously paying an Income-Tested Fee—this would carry over, but not increase. The "no worse off" principle ensures that reassessment does not trigger new or higher fees for grandfathered clients.

Will AT-HM request a proof of ownership or landlords' approval for home modifications?

Yes, providers must ensure that home modifications under the AT-HM Scheme are supported by appropriate documentation, which includes evidence of property ownership or landlord approval where applicable. The Support at Home program manual states that all prescribed home modifications must align with the client's assessed needs and that providers must retain evidence justifying the modification. While it does not explicitly mandate landlord approval in every case, such evidence is considered part of the verification process, especially for rented properties, to ensure modifications are lawful and feasible.

Will a customer who has services after September 12, 2024 have to contribute in July?

If a client was assessed and placed on the National Priority System (NPS) on or before 12 September 2024, they are considered grandfathered under Support at Home. This applies even if their services commence after that date. What matters is their approval date, not when services began. Being grandfathered means their contribution obligations will not increase under the new program. They will continue to pay the same contribution—or less—than they would have under the Home Care Packages program. If they were assessed as not required to pay an Income-Tested Fee, they will not be required to contribute under Support at Home from 1 July 2025. This protection is part of the government's "no worse off" principle.

Will the rural and remote, dementia and oxygen supplements still be in play?

Yes, several supplements will continue under Support at Home, though some are changing in how they are applied:

- The Viability Supplement is replaced by two different amounts under Support at Home:
  - The Rural and Remote Supplement under the AT-HM Scheme. Clients living in Modified Monash Model (MMM) areas 6 or 7 who are approved for AT-HM funding will receive an additional 50% of their assigned AT or HM funding tier as a supplement. This is added to their AT-HM budget.
  - The Thin Market Grant supplies providers with supplementary funding to use toward the cost of delivering services in rural, regional and remote areas.
- Grandfathered HCP clients who currently receive the Dementia & Cognition Supplement will continue to do so under Support at Home. Future dementia-related needs for these clients, as well as for new entrants to the aged care system, will be considered by aged care assessor when setting the ongoing classification level.
- Oxygen, Enteral Feeding, and Veterans' Supplements remain unchanged.
- The Hardship/Top-up Supplement is now known as the Fee Reduction Supplement.
- New care management supplements supply providers with an additional three hours per quarter of care management funding for clients with complex needs, suich as Veterans, older Aboriginal and Torres Strait Islander people, people who are homeless or at risk of homelessness, people referred by the Care Finder program, and care leavers.

Have clients onboarded since 12th September been notified of fees or is this to flow out in the next 6 weeks?

Trilogy Care is ensuring that all client correspondence regarding Support at Home is targeted to their individual circumstances, particularly whether they are Grandfathered or Hybrid clients.

In addition to this, the Department of Health and Aged Care have started to issue correspondence to clients regarding the upcoming changes and how they affect them. It is expected that Hybrid and Grandfathered clients will be notified of their individual client contribution rate after the commencement of Support at Home in July 2025.

The responses provided in this document are correct, as at 26 May 2025, information is subject to change.