Australian Government
Department of Health and Aged Care

Commonwealth Home Support Programme

Program Manual 2023-2024

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The Department reserves the right to review and amend this Manual as deemed necessary and will provide reasonable notice of any amendments.

The Commonwealth Home Support Programme – Program Manual 2023-24 is the nineth version of the Manual since its inception in July 2015 and supersedes all previous versions.

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Chapter 1 – Overview of the CHSP

1.1 What is the purpose of the program manual?

The Department of Health and Aged Care (the Department) has designed this manual for use by CHSP service providers. The manual forms part of the CHSP Grant Agreement and outlines the operation of the program.

Part A – The program provides an overview of the CHSP, including funded service types and their requirements.

Part B – Administration of the CHSP outlines the responsibilities of the service provider and the Department, including funding and reporting requirements.

The CHSP program manual 2023-24 replaces the previous versions of this manual. The Department will review the ongoing operations of the CHSP. The Department may update this manual in the future.

The manual includes a range of scenarios showing how the CHSP may be delivered and how it interacts with other programs.

You will find a glossary of terms at the back of this document.

More information

This manual is available on the Department of Health and Aged Care website.

CHSP Service Providers should refer all program inquiries to their Funding Arrangement Manager.

Clients can access information about the program through the My Aged Care contact centre (1800 200 422) or website.

1.2 The Commonwealth Home Support Programme

1.2.1 What is the CHSP?

The CHSP provides small amounts of entry-level support to assist older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) to remain living at home and in their community. The CHSP funds domestic assistance, transport, meals, personal care, home maintenance, social support, nursing, and allied health. The CHSP also supports care relationships through planned respite services for older people. These respite services allow carers to take a break from their usual caring responsibilities.

CHSP services may be short-term, intermittent or ongoing. The program places a strong focus on activities that support independence and social connectedness and take into account each person's individual goals and choices.

For a full list of CHSP services see section 1.2.12.

1.2.2 Entry-level support

The CHSP provides a small amount of services to help frail older people maintain their independence and continue living safely at home and in their communities.

The CHSP is not designed for older people with more intensive or complex care needs. Clients who need ongoing high intensity care are outside the scope of this program. People with higher needs can receive appropriate support through other aged care programs, such as the Home

Care Package (HCP) program or residential aged care. The CHSP does not replace or fund support systems provided under the health care system.

CHSP services delivered to a client should be lower than the subsidised cost of a Level 1 HCP (less than $9,000 per annum). CHSP providers may deliver higher intensity services on a short-term basis where clear improvements in function or capacity can be made, or further decline avoided. These services should aim to get the client "back on their feet" and able to resume previous activities without the need for ongoing support.

Client scenario – Entry-level support (social engagement)

Joyce

Joyce's son comes to visit her and notices that she is not eating well and seems low in spirits. When they talk about it, Joyce reveals that her closest friend has moved interstate to live with family. Joyce misses her friend's company and is feeling lonely. Since she no longer drives, she has not been able to see her other friends at the local seniors' centre.

Joyce and her son call My Aged Care and she consents to register as a client and for a client record to be created. My Aged Care explains the process and arranges a Regional Assessment Services (RAS) assessment for Joyce.

The RAS assessor talks to Joyce about her needs and goals and establishes a support plan that includes:

Referral to see a CHSP funded accredited practising dietitian on a short-term basis (to address nutrition issues)

community transport to the local seniors' centre where Joyce will see her friends again.

This minimal but practical support enables Joyce to re-connect with her community, improve her physical and emotional health and continue living in her own home.

1.2.3 History of the CHSP

The Australian Government developed the CHSP as part of a broader suite of changes to the aged care system aimed at streamlining access to support services.

Since 1 July 2015, the CHSP has delivered a single home support program which consolidated the following Commonwealth-funded aged care programs:

- The Commonwealth Home and Community Care (HACC) Program
- Planned respite services under the National Respite for Carers Program (NRCP)
- The Day Therapy Centres (DTC) Program
- The Assistance with Care and Housing for the Aged (ACHA) Program.

On 1 July 2016, HACC services for older people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) in Victoria transitioned to the CHSP.

On 1 July 2018, HACC services for older people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) in Western Australia transitioned to the CHSP creating a nationally accessible program.

The design of the CHSP has been informed by a comprehensive consultation process. This has included advice from the National Aged Care Alliance (NACA), its CHSP Advisory Group and feedback received from peak groups, organisations and individuals in early 2015. The Australian Government has continued to refine the CHSP through ongoing consultations with peak representative bodies, service providers and individuals through targeted consultation and review processes.

Following the May 2023 Federal Budget, the CHSP has funding allocated for a further 12 months from 1 July 2024 to 30 June 2025. This aligns with the postponement of the new Support at Home program to 1 July 2025.

1.2.4 Position in the Australian Government's end-to-end aged care system

My Aged Care is the entry point to the aged care system for older people, their families and carers and is responsible for conducting assessments for the CHSP. This streamlined entry to aged care makes it easier for older people to access information, have their needs assessed and be supported to locate and access aged care services available to them, including entry level support as delivered under the CHSP. My Aged Care was launched in 2013 and consists of the My Aged Care website and the contact centre (1800 200 422) and referral to assessment services. See Chapter 4 for more detail.

The CHSP represents the entry-level tier of the Commonwealth aged care system. In conjunction with the Home Care Package (HCP) program, residential aged care and other specialised aged care programs, it forms part of an end-to-end aged care system offering frail older people a continuum of care options as their care needs change over time.

As people age, they can develop conditions or experience increased frailties which impede their ability to continue living in their own home. The CHSP plays an important role in supporting frail older people helping them maintain their independence at own home.

Investment in entry-level support that focuses on keeping people independent and safe in their own homes can delay the need to move to more intensive forms of care. This benefits frail older people through increasing their independence and quality of life as well as reducing government outlays for other forms of care, such as residential aged care. The CHSP ensures that whole-of-system aged care costs can be kept at a sustainable level as the population ages and the number of people requiring aged care increases.

The CHSP is complemented by the HCP program which provides the second tier of support in the aged care system. The HCP program is designed to support older people living in the community whose care needs exceed the level of support provided through the CHSP. It provides consumers with higher intensity, ongoing services and case management as well as an individualised budget developed by the consumer and their provider and sets out how available package funds will be used to deliver the care and services the consumer needs. Frail older people who need higher levels of ongoing support are also able to access Australian Government subsidised residential aged care places.

The Australian Government subsidises information services, assessment services, aged care services and related support services.

Aged care is provided in home and community settings and in residential aged care settings. Three levels of subsidised aged care services have been available since 1 July 2015:

- entry level support at home
- more complex support for older people who are able to continue living in their own homes with assistance
- a range of care options and accommodation for older people who are unable to continue living in their own home.

Seven aged care programs operate across the three levels of service:

- The CHSP provides entry level support for frail older people who are able to continue living independently in their own homes with some small amounts of assistance.
- The HCP program provides four levels of consumer directed coordinated packages of services for more complex support for older people who are able to continue living independently in their own homes with assistance.
- Residential aged care provides a range of care options and accommodation for older people who are unable to continue living independently in their own home. Residential Respite Care also provides short-term planned or emergency residential aged care.
- The Short-Term Restorative Care (STRC) Programme is an early intervention program that aims to reverse and/or slow 'functional decline' in older people and improve wellbeing through the delivery of a time-limited (up to 56 paid days), goal-oriented, multi-disciplinary and coordinated range of services designed for, and approved by, the client.

STRC services may be delivered in a home care setting, a residential care setting, or a combination of both.

- Transition Care provides short-term, goal oriented and therapy-focused care for older people after hospital stays either in a home or community setting or in a residential aged care setting.
- The Multi-Purpose Services (MPS) program is a joint initiative of the Australian Government and state governments and provides integrated health and aged care services for small rural and remote communities either in a residential, home or community setting.
- National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) provides culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home and community and are mainly located in rural and remote areas. Service providers deliver a range of services to meet the needs of the client, which can include residential, home care or community services.

Aged care services are underpinned by the Aged Care Quality Standards (Quality Standards), which sets and monitors care standards and provider responsibilities to ensure older people receive safe, quality aged care services.

Delivery of aged care services is supported by My Aged Care including independent assessment services that assess care needs and client care:

- Home Support Assessments for the CHSP are conducted by the My Aged Care Regional Assessment Services (RAS).
- Comprehensive assessments for the Home Care Packages (HCP) Program, Transition Care, STRC and residential aged care are conducted by Aged Care Assessment Teams (ACAT). ACAT assessors may refer clients to CHSP services where the client is not eligible for more intensive support or for interim support at entry-level until more intensive services commence.
- Service providers may directly assess potential clients for the NATSIFAC and MPS programs. NATSIFAC care recipients are not required to be assessed by the ACAT to receive care services under the NATSIFAC Program. However, it is recommended that an assessment be undertaken by a qualified health professional e.g. GP, Registered Nurse or allied health professional

The CHSP Client Contribution Framework outlines the principles for service providers to adopt in setting and implementing their own client contribution policy, with a view to ensuring that those clients who can afford to contribute to the cost of their care do so, whilst protecting those most vulnerable. Service providers must be transparent about their fees and advise CHSP clients of any client contributions payable. More detail on the CHSP Client Contribution Framework is provided under Chapter 5.

HCP clients require an income assessment by Services Australia and/or the Department of Veterans' Affairs.

Residential aged care clients require a combined assets and income assessment by the Services Australia and/or the Department of Veterans' Affairs.

Additional support for clients and their carers while care is being received is provided through:

- Carer support, which operates across all three levels of aged care services, Carer Gateway and through carer specific programs funded through the Department of Social Services (refer section 1.2.10 Carers).
- Dementia support, which operates across all three levels of aged care services, through various dementia support services.
- Consumer support and advocacy, which operates across all three levels of aged care services, through the Community Visitors Scheme, the National Aged Care Advocacy Program (NACAP), and the Aged Care Quality and Safety Commission.

1.2.5 Objectives

The objectives of the CHSP are to:

1. Provide high-quality support, at a low intensity on a short-term or ongoing basis, or higher intensity services delivered on a short-term basis, to frail older people to maximise their independence at home and in the community, enhancing their wellbeing and quality of life.
2. Provide entry-level support services for frail older people aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islander people) who are assessed by the RAS as needing assistance, to continue to live independently at home and in their community.
3. Support frail older clients aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) through the direct service delivery of planned respite services to CHSP clients, which will allow carers to take a break from their usual caring duties.
4. Support frail older people or prematurely aged people 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) on a low income who are homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation through access to Assistance with Care and Housing and other CHSP services targeted at avoiding homelessness or reducing the impact of homelessness.
5. Support frail older people or prematurely aged people 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) on a low income who are living with hoarding behaviour or in a squalid environment and at risk of homelessness or unable to receive the aged care services they need through access to CHSP services targeted at reducing the impact of homelessness or hoarding and squalor situations.
6. Support clients to delay, or avoid altogether, the need to move into more complex aged care by being kept socially active and connected with their community, so that whole-of-system aged care costs can be kept at a sustainable level as the population ages and the number of people requiring care increases.
7. Ensure that all clients have equal access to services that are socially and culturally appropriate and free from discrimination.
8. Ensure compliance with all relevant codes of ethics, industry quality standards and guidelines, to ensure that clients receive high quality services.
9. Facilitate client choice to enhance the independence and wellbeing of older people and ensure that services are responsive to the needs of clients.
10. Provide a standardised assessment process which encompasses a holistic view of client needs.
11. Provide flexible, timely services that are responsive to local needs.

1.2.6 Outcomes

The intended outcomes of the CHSP are to ensure:

- frail older people with functional limitations are supported to live in their own homes.
- frail older people have increased social participation and access to the community, including through the use of technology.
- frail older people's psychological, emotional and physical wellbeing and functional status is maintained and/or improved.
- frail older people are supported to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing or delaying their admission to long-term residential care.
- frail older people are supported in a safe, stable and enabling environment.

- carers and care relationships are supported.
- sustainability and service innovation are improved.
- equitable and affordable access to services is provided.

1.2.7 Key features

The CHSP will:

- provide streamlined entry-level support services.
- be supported by My Aged Care in providing access to information and services through:
    - a central client record to allow client information to be appropriately shared with assessors and service providers
    - a consistent, needs-based assessment process
    - better access to relevant and accurate information (for clients, carers and family members, service providers and assessors), and
    - appropriate referrals for assessments and services.
- deliver services and support with a strong focus on wellness and reablement and restorative care on a short-term basis, or of an ongoing nature, or across a small number of time limited interventions, to maximise a client's independence.
- provide sector support and development activities.
- promote equity and sustainability through a nationally consistent client contribution framework.
- streamlined contractual obligations such as consistent record keeping processes and reporting requirements.

1.2.8 Service delivery principles

CHSP service providers must implement the service delivery principles below when developing, delivering or evaluating services directed to clients:

- Establish client consent to receive services as a prerequisite for all service delivery.
- Promote each client's opportunity to maximise their independence, autonomy and capacity and quality of life through:
    - being client-centred and providing opportunities for each client to be actively involved in addressing their goals
    - focusing on retaining or regaining each client's functional and psychosocial independence, and
    - building on the strengths, capacity and goals of individuals.
- Provide services tailored to the unique circumstances and cultural preference of each client, their family and carers.
- Ensure choice and flexibility is optimised for each client, their carers and families.
- Invite clients to identify their preferences in service delivery and where possible honour that request.
- Ensure services are delivered in line with a client's agreed support plan to ensure their needs are being met as identified by the RAS.
- Emphasise responsive service provision for an agreed time period and with agreed review points.
- Support community and social participation opportunities that provide valued roles, a sense of purpose and personal confidence.

- Develop and promote strong partnerships and collaborative working relationships between the person, their carers and family, support workers and RAS.
- Develop and promote local collaborative partnerships and alliances to facilitate clients' access to responsive service provision.
- Have a client contribution policy in place which must be publicly available.
- Establish the client contribution for services delivered with the client prior delivering any services.

Consumer choice

The CHSP aims to provide choice for consumers through the implementation of a service delivery model that focuses on a client's goals and abilities in determining their support service needs. It aims to empower individuals to take charge of, and participate in, informed decision-making about the care and services they receive. Through the CHSP, clients will:

- have access to detailed information on aged care options provided through My AgedCare.
- actively participate in assessment of their needs through a two-way conversation with My Aged Care assessors.
- identify any special needs, life goals, strengths and service delivery preferences.
- have their carers' needs recognised and supported by My Aged Care assessors.
- have access to free, independent and confidential advocacy services through the NACAP.
- have options on how to select their preferred service provider (if they choose to) from information available through My Aged Care.
- have access to complaint mechanisms, including the Aged Care Quality and Safety Commission.

In addition, CHSP service providers must:

- comply with the Aged Care Quality and Safety Standards.
- comply with the Charter of Aged Care Rights (the Charter), including providing clients with a copy of the Charter and assisting clients to understand their rights (refer to section 6.1.2 for further details).
- manage and update their service information regularly via the My Aged Care Service and Support Portal to ensure accurate information is presented publicly through the My Aged Care service finders and to support appropriate referrals to services by the contact centre and RAS or ACAT assessors.
- deliver services consistent with the goals and recommendations contained in the client's support plan as agreed with the My Aged Care assessor.
- manage client referrals via the My Aged Care Service and Support Portal by accepting or rejecting a client for service within three calendar days and commencing service delivery in line with the priority timeframes stipulated in the My Aged Care Service and Support Portal User Guide and the Portal User Guide Part 2 document available on the Department's website.
- update the client record (when a client is accepted for service) through the My Aged Care Service and Support Portal with service delivery information, including commencement date, frequency and volume of services.
- Have a client fee's contribution policy in place.

The CHSP does not provide individual budgets like the HCP program and the support services provided must be targeted towards a client's needs, not their 'wants'. However, the high-level principles of consumer choice underpinning the CHSP include providing choice and flexibility in service delivery preferences (where possible), consumer rights and participation.

1.2.9 Target groups

Target groups for the CHSP are:

- Frail older people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need assistance with daily living to remain living independently at home and in the community.
- Frail older clients aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need planned respite services, to provide their carers with a break from their usual caring duties.
- Frail older people or prematurely aged people 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) on a low income who are:
    - homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation; or
    - living with hoarding behaviour or in a squalid environment and at risk of homelessness or unable to receive the aged care services they need.
- CHSP service providers will benefit from a range of activities that are designed to support, develop and strengthen the service system and the sector.

Clients do not need to be an Australian citizen or permanent resident to access CHSP services.

In exceptional circumstances, CHSP services may be provided to people who do not meet the target group criteria and who need assistance with daily living to remain living independently at home and in the community.

These circumstances include where:

- The client is receiving a certain level of care under a program that was consolidated under the CHSP prior to 1 July 2015 and should therefore expect to retain this service level until other suitable care options become available.
- Specific arrangements have been agreed to by the respective state or territory governments and the Commonwealth.

People receiving assistance through the care finder program or Trusted Indigenous Facilitators program (rolling out in 2023) may be eligible to access CHSP services targeted at avoiding homelessness or reducing the impact of homelessness. Any entry level CHSP services made available to a care finder or Trusted Indigenous Facilitator client between the age of 50 and 65 (or between 45 and 50 for Aboriginal and Torres Strait Islander people) must be targeted at avoiding homelessness or reducing the impact of homelessness. All care finder and Trusted Indigenous Facilitator clients must be assessed by My Aged Care via the assessment services to determine eligibility and need to receive additional CHSP services.

Specific eligibility requirements apply for each sub-program. Chapter 3 of this program manual provides more detail on sub-programs and eligibility.

The Department recognises that a number of service providers deliver a range of culturally appropriate support services. While these specialist services are strongly encouraged as important components of the program, CHSP service providers cannot discriminate against clients from other cultural or ethnic backgrounds.

1.2.10 Carers

Carers are integral to ensuring the quality of life and independence of many frail older people. They make a significant contribution to the lives of the older people they care for and an important economic contribution to the community.

In recognition of the vital role that carers play in supporting frail older people to remain living at home and in the community, the CHSP supports the care relationship through planned respite services delivered to frail older people. These services are provided under the Care Relationships and Carer Support Sub-Program.

Services offered through Carer Gateway, which is funded through the Department of Social Services, focus on early-intervention and, preventative and skills building supports. Carer

Gateway aims to improve well-being and long-term outcomes of the care relationship, as well as crisis support when needed. Specific services include:

- a national phone counselling service to help carers manage daily challenges, reduce stress and strain, and plan for the future;
- an online peer support forum, connecting carers with other carers for knowledge and experience sharing, emotional support and mentoring;
- online self-guided coaching resources with simple techniques and strategies for goal-setting and future planning;
- educational resources to increase skills and knowledge of carers relating to specific caring situations, to build confidence and improve wellbeing;
- in-person and phone-based counselling and peer support;
- targeted support packages with a focus on employment, education, respite and transport; and
- access to emergency respite.

1.2.11 Older people with diverse needs

The CHSP recognises that older people display the same diversity of characteristics and life experiences as the broader population and need to receive services which reflect their diverse needs. Each person may have specific social, cultural, linguistic, religious, spiritual, psychological, and medical care needs and may also identify with more than one characteristic.

The CHSP recognises the following special needs groups, which align with those identified under the *Aged Care Act 1997*:

- people who identify as Aboriginal and Torres Strait Islander
- people from culturally and linguistically diverse backgrounds
- people who live in rural and remote areas
- people who are financially or socially disadvantaged
- people who are veterans of the Australian Defence Force or an allied defence force including the spouse, widow or widower of a veteran
- people who are homeless, or at risk of becoming homeless
- people who are lesbian, gay, bisexual, transgender, intersex, queer or questioning or asexual (LGBTIQA+)
- people who are Care Leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations)
- parents separated from children by forced adoption or removal.

The above is not an exhaustive list, and the CHSP acknowledges there are other special needs groups, such as people with a disability, people with mental health problems and mental illness and people living with cognitive impairment including dementia. CHSP services may also be provided to clients in correctional centres and detention facilities where these services are not already provided by these institutions.

The CHSP will:

- ensure that all clients have equity of access to information and services that are effective and appropriate to their needs and take into account individual circumstances and are free from discrimination.
- ensure that services are delivered in a way that is culturally safe, appropriate and inclusive of all older people with diverse characteristics and life experiences.
- ensure through compliance with the quality framework, that service providers consider the requirements of people from diverse backgrounds and special needs groups. Note: New aged care quality standards and changes to the current quality assessment

process are being developed and service providers will be required to the meet the new Aged Care Quality Standards and participate in the new quality assessment process, once introduced.

- support access by service providers to translation and interpreting services.
- consider equity of access for all older people in the allocation of new funding.

These principles support the Imperatives and Priorities identified in the Aged Care Diversity Framework.

Client scenario — accommodating client choice and cultural preference

INKA

Inka is a 76 year old woman who is originally from Finland and lives alone. Though generally capable, Inka has osteoarthritis and has found that some domestic tasks are becoming more difficult to undertake due to pain and joint stiffness.

After contacting and registering with My Aged Care, Inka was referred to the RAS for an assessment, which identified that Inka needed regular help to keep her house clean. A local CHSP service provider accepted the referral and arranged for a cleaner to go to Inka's home once a week. The cleaner usually spent about an hour vacuuming, mopping and cleaning the bathroom whilst Inka continued to undertake lighter tasks such as dusting and wiping over the basins.

In summer, Inka asked the cleaner if her hand-woven rag mats could be taken outdoors for cleaning. This was a Finnish tradition that Inka had done all her life and involved hanging the mats over the clothesline and whacking them repeatedly with a rug-beater to remove dust and dirt. The job required shifting furniture, rolling up the long mats and carrying them to the clothesline in the back garden, which was beyond the cleaner's ability.

After speaking with her service provider, an arrangement was made for another worker to visit Inka's home to clean the mats twice a year, replacing the regular cleaner for just those two visits.

Interpreting services

Information on how service providers and clients can access interpreting services is available at Translating and Interpreting Service (TIS National).

Sign language interpreting services

Older Australians who are Deaf, deafblind, or hard of hearing who are seeking to access or are in receipt of Commonwealth funded aged care services can access free sign language interpreting and captioning services. Sign language services can be provided face-to-face or by Video Remote, and live captioning services are available to support clients to engage with:

- Activities of daily living
- My Aged Care
- Regional Assessment Services
- Aged Care Assessment Teams
- In-home aged care service providers
- Residential aged care service providers, and
- Other organisations involved in the provision of Commonwealth funded aged care services.

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

The sign-language interpreting and captioning services support older Australians to better engage and fully participate in their aged care journey. Information on how service providers can access interpreting services is available at My Aged Care on 1800 200 422 or Deaf

Connect at their Website: //bookings.deafconnect.org.au/ or by calling 1300 773 803 or emailing interpreting@deafconnect.org.au.

People with dementia

The Australian Government considers the provision of appropriate care and support of people with dementia, their families and carers to be core business for all providers of aged care, given its prevalence amongst frail older people.

The Australian Government funds a range of advisory services, education and training, support programs and other services for people with dementia, their families and carers.

CHSP clients may access these supports if appropriate to their needs.

1.2.12 What services are funded under the CHSP?

The following service types, including the activities or sub-types under each, are available under the CHSP:

Sub-program	Service type	Service sub-type
Community and Home Support	Allied Health and Therapy Services	Aboriginal and Torres Strait Islander Health Worker
		Accredited Practising Dietitian or Nutritionist
		Diversional Therapy
		Exercise Physiology
		Hydrotherapy
		Occupational Therapy
		Ongoing Allied Health and Therapy Services
		Other Allied Health and Therapy Services
		Physiotherapy
		Podiatry
		Psychology
		Restorative Care Services
		Social Work
		Speech Pathology
	Domestic Assistance	General House Cleaning
		Linen services
		Unaccompanied Shopping (delivered to home)
	Goods, Equipment and Assistive Technology	Car Modifications
		Communication Aids
		Medical Care Aids
		Other Goods and Equipment

Sub-program	Service type	Service sub-type
		Personal Monitoring Technology
		Reading Aids
		Self-care Aids
		Support and Mobility aids
	Home Maintenance	Garden Maintenance
		Major Home Maintenance and Repairs
		Minor Home Maintenance and Repairs
	Home Modifications	N/A
	Meals	At Centre
		At Home
	Nursing	N/A
	Other Food Services	Food Advice, Lessons, Training, Food Safety
		Food Preparation in the Home
	Personal Care	Assistance with Client Self-administration of Medicine
		Assistance with Self Care
	Social Support Individual	Accompanied Activities, e.g. Shopping
		Telephone/Web Contact
		Visiting
	Social Support Group	N/A
	Specialised Support Services	Continence Advisory Services
		Client Advocacy
		Dementia Advisory Services
		Hearing Services
		Other Support Services
		Vision Services
	Transport	Direct (driver is volunteer or worker)
		Indirect (through vouchers or subsidies)
Assistance with Care and Housing	Assistance with Care and Housing	Hoarding and Squalor
	Flexible Respite	Community Access – Individual respite

Sub-program	Service type	Service sub-type
Care Relationships and Carer Support		Host Family Day Respite
		Host Family Overnight Respite
		In-home Day Respite
		In-home Overnight Respite
		Mobile Respite
		Other Planned Respite
	Cottage Respite	Overnight Community Respite
	Centre-based Respite	Centre-based Day Respite
		Community Access – Group
		Residential Day Respite
Sector Support and Development	Sector Support and Development	Sector Support and Development

These services are funded under specific sub-programs based on the CHSP target groups (Section 1.2.9). Details of each sub-program, including eligibility and available service types, are provided in Chapter 3 of this program manual.

1.2.13 What CHSP funding must not be used for

CHSP grant recipients must not use any of the funds for:

- purchase of land
- purchase of vehicles without departmental approval
- coverage of retrospective costs
- costs incurred in the preparation of a grant application or related documentation
- international travel or expenses related to international travel
- activities that are already funded under other Commonwealth, state, territory or local government programs
- activities that could bring the Australian Government into disrepute
- client accommodation expenses, as these are provided for within the social security system (note: Assistance with Care and Housing Sub-Program services deliver assistance with accessing appropriate support)
- direct treatment for acute illness, including convalescent or post-acute care
- medical aids, appliances and devices which are to be provided as a result of a medical diagnosis or surgical intervention and which would be covered under a Health Care system, such as oxygen tanks or continence pads
- household items which are not related to improvement of functional impairment (i.e. general household or furniture or appliances)
- items which are likely to cause harm to the participant or pose a risk to others
- major construction or capital works, unless specified and authorised by the Department (see paragraph below).

For the purpose of the CHSP, capital infrastructure is considered to be real property of a non-expendable nature, specifically major renovations, buildings and land. CHSP funding must not be used for the acquisition of capital infrastructure.

The Department may authorise the expenditure of grant funding on capital works through a grant funding round. CHSP funding can only be used for the purpose intended and as outlined in the grant funding round.

The following services are delivered under My Aged Care:

- Assessment – undertaken via initial phone-based screening by the contact centre and assessments conducted by the RAS or ACAT.
- Case Management and Coordination – short-term case management services are available for vulnerable CHSP clients and short-term coordination services for CHSP clients undertaking a reablement program through My Aged Care linking and reablement services delivered by the RAS.

Client Care Coordination is not funded as a separate service type under the CHSP as this function is considered to be part of ongoing service delivery.

1.2.14 Where will CHSP services not be provided?

CHSP services will not be provided:

- to permanent residents of residential care facilities (including an MPS), except under grandfathering arrangements or on a full-cost recovery basis and depending on the CHSP provider's availability and capacity.
- where a resident's accommodation contract provides for similar services to those under the CHSP.
- where needs can be met by other more appropriate Commonwealth funded programs such as HCP as outlined in 4.1.1.

A DSOA client cannot access CHSP services that are in-scope or already provided for under DSOA e.g., a DSOA client accessing nursing and personal care cannot access nursing and personal care under the CHSP. Accessing services that are in scope under DSOA may impact a client's DSOA funding package. Further information on DSOA and its interface with other aged care funded programs can be found at DSOA Program and aged care services - for clients.

Services can be offered to people in retirement villages and independent living units, where a resident's accommodation contract does not include CHSP-like services. Residents of retirement villages and independent living unit can access subsidised CHSP services where they are not already receiving them through their facility. As an example, a retirement village client can access domestic assistance and home maintenance through their village services and access Personal Care and Respite through the CHSP if they are eligible. The retirement village client cannot access CHSP Domestic Assistance and Home Maintenance services if the village offers these services. This is to ensure there is no duplication of services.

The My Aged Care screening process will help identify what existing services a client is receiving including accommodation services subsidised by the Australian Government.

Chapter 2 – Supporting independence

2.1 Introduction

CHSP service providers are required to work with frail older people to maximise their independence and enable them to remain living safely in their own homes and communities. Providers must structure services with a focus on client strengths and goals to support independence. This means that service providers should generally not undertake tasks that the client is capable of doing safely for themselves. The longer a client avoids reliance on ongoing services, the longer they are likely to maintain their functional independence, giving them more good days doing the things that matter to them most.

This approach known as wellness and reablement builds on people's strengths and goals to promote greater independence and autonomy. Offering care that focuses on individual client goals and recognises the importance of client participation is fundamental to the CHSP.

The CHSP Reablement Community of Practice is available as a tool for providers to learn, share and engage with other providers across the CHSP sector. It is an online forum to support the sharing of ideas, best practice and practical examples to embed wellness and reablement into everyday service delivery practices. Join the CHSP Reablement Community of Practice at: more-good-days.

2.2 Why Wellness and Reablement?

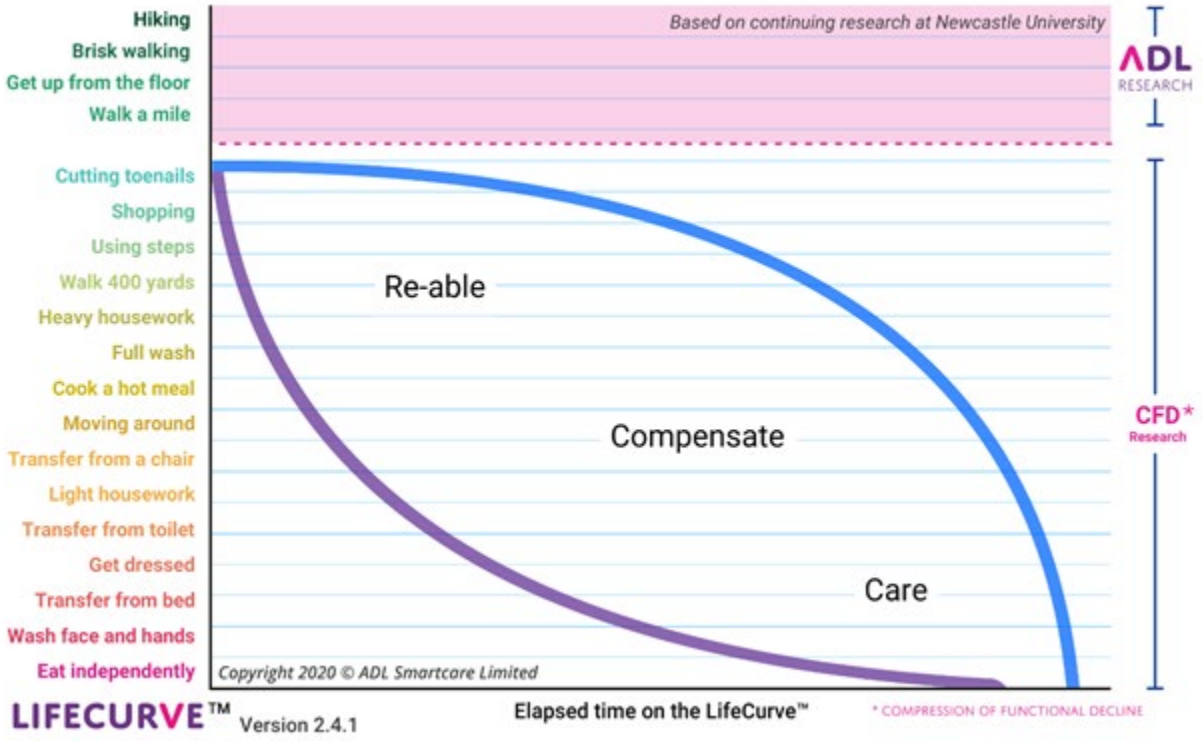
Over the past decade, emerging research has demonstrated the benefits of focussing on client independence. Traditional models of service delivery that focus on what a client can't do rather than what they can, tend to lead to an over-reliance on services by clients, which has been linked with accelerated functional decline.

2.2.1 Understanding the ageing journey

Research suggests that the largest influencer in age-related decline is not genetics, but rather lifestyle choices. People who continue to do things for themselves tend to remain independent and live better, longer.

Professor Peter Gore of the Institute of Aging at Newcastle University in the UK has developed a framework to understand the age-related decline. The framework, called the Life Curve, looks at the impact of maintaining independence on quality of life and the rate of age-related functional decline. It illustrates that the sooner someone stops performing certain tasks for themselves, the faster they tend to lose their functional ability. The aim is to assist people to perform these daily tasks independently for as long as possible, so they maintain the ability to maximise independence and autonomy. Retaining physical ability helps people to continue doing the things they enjoy for longer. The LifeCurve™ App can be downloaded for free from www.liveup.org.au.

The Life Curve is shown at Figure 1. The vertical axis lists activities of daily living that older people generally lose over time, in the order in which they tend to be lost, from top to bottom. The timeframe for this decline is variable and can be influenced by behaviour and interventions. Difficulty cutting toenails is typically seen as an early indicator that intervention may be needed. The graph shows two trajectories – a sub-optimal life curve with a fast early decline, and an optimal life curve in which the early decline is slowed down to give people more good days before losing the ability to undertake activities like walking, shopping and personal care.



2.3 Benefits of a wellness and reablement approach

Older Australians are not the only ones who benefit from wellness and reablement. Evidence suggests there are also significant benefits to service provider organisations, families and carers and the broader community.

2.3.1 Benefits for consumers

Implementing a wellness and reablement approach at the earliest opportunity, focussing on client goals to maintain or regain functional capacity and social connectedness can have significant long-term benefits for clients including:

- improved sense of purpose, autonomy and self-worth
- improved physical and emotional health and wellbeing
- reduction in service delivery needs
- increased ability to remain living independently and safely in their own homes for longer
- greater quality of life and retention of pride and dignity
- Improved connection with community
- reduced strain on family and carer relationships

2.3.2 Benefits for service provider organisations

Those organisations who have implemented wellness and reablement have identified significant benefits for their staff, business model, organisational processes and their clients including:

- greater job satisfaction from actively helping clients achieve their goals and become more independent
- better utilisation of resources as support workers are able to focus on more complicated tasks clients can't perform for them themselves, which means more meaningful and fulfilling work for staff
- opportunity to broaden the client base by offering more shorter-term support
- improved reputation and repeat business based on providing person-centred care, focussed on client goals

- better alignment to aged care reform initiatives, improving preparedness to respond to changes in aged care policy.

2.3.3. Benefits for families and carers

Wellness and reablement approaches can have significant benefits for family members and carers, including:

- an opportunity to be involved in supporting their loved one to reach their outcomes
- the benefit of knowing their loved one is retaining or regaining their independence
- reduced strain and pressure due to a decrease in caring requirements

Client scenarios — applying a wellness and reablement approach

HARRY

Harry is a 70 year old man who lives alone. After contacting My Aged Care, a RAS assessment was undertaken which identified that Harry needed some assistance with clothes-washing and meals. At first the CHSP service provider visited Harry's home three times a week to wash and hang out the clothes for him and cook basic meals for him.

The provider also worked with Harry to identify what he could do for himself and what he needed assistance with. The support worker encouraged Harry to continue to wash and hang out smaller items by using a trolley and an easy-to-reach drying rack inside, whilst they continued to come once a week to help hang out his bigger, heavier items.

Harry also indicated that he was open to doing the cooking, but lacked confidence since his wife, who had recently passed away, had always done most of the cooking. For a number of weeks the provider stayed and cooked with Harry to help him to prepare several meals to last over the week. With his confidence back, Harry has continued to do things for himself and has remained independent in his own home.

ELSA

Elsa is a 72 year old woman with osteoarthritis who has been receiving domestic assistance under the CHSP for a number of years. The support worker visited Elsa once a week for two hours to provide assistance with general housework and laundry. Elsa required no other assistance.

After applying a wellness and reablement approach to Elsa's support needs, the service provider identified that Elsa could still do some basic household chores such as light dusting, wiping over surfaces, doing her own dishes and using a light weight carpet sweeper.

Over a two month period instead of 'doing for' Elsa, the support worker encouraged and supported Elsa to undertake some of these tasks by herself, whilst the support worker continued to do more difficult tasks such as vacuuming or cleaning the floors.

Elsa still requires ongoing support however she is now more involved and has increased activity levels.

2.3.4 Empowering older Australians to remain independent for longer

The LiveUp website enables Australians over 65 years of age to check their health and find personalised suggestions for products and services that promote healthy ageing. LiveUp can suggest low-cost assistive products and equipment to help people with everyday living, as well as personalised exercises and services, to help them or a loved one with age-related wellbeing. At the LiveUp website anyone can download the free LifeCurve™ App that can track a person's health, giving them easy to understand long term advice tailored to their needs. To learn more about LiveUp, and the products and services that are available, visit www.liveup.org.au or call 1800 951 971.

2.4 Principles of wellness and reablement

Wellness and reablement describe an overall approach to service delivery. The following principles underpin a wellness and reablement approach.

- **Promote Independence** – people value their independence, loss of independence can have a devastating effect, particularly for older people who may find it more difficult to regain
- **Identify clients' goals** – a person's independence requires more than just services to help them remain in their home and maintain their current capacity. Service delivery should focus on supporting the client to actively work towards their goals and improved independence wherever possible
- **Consider physical and psychological needs** – independence is not limited to physical function; it also includes both social and psychological function
- **Encourage client participation** – being an active participant, rather than a passive recipient of services, is an important part of being physically and emotionally healthy. Service delivery should focus on assisting a person to complete tasks, not taking over tasks that a person can do for themselves
- **Regular assessment** – client assessment should be ongoing, not one-off. It should focus on progress towards client goals and consider the support and duration of services required to meet these goals
- **Focus on strengths** - the focus should be on what a person can do, rather than what they can't. Wherever possible, services should aim to retain, regain, or learn skills rather than creating dependencies
- **Support clients to reach their potential** – help clients to maintain and extend their activities in line with their capabilities
- **Individualised support** – service delivery should be individualised and suited to the goals, aspirations and needs of the individual.

Helen

Helen is a 78 year old woman with osteoarthritis. Lately, Helen has been experiencing difficulty performing household cleaning duties and doing her laundry. At assessment, the RAS assessor referred Helen for domestic assistance to help her manage around the house.

The CHSP service provider receiving Helen's referral for domestic assistance, contacts Helen to understand more about her circumstances and what she needs support with. Applying a wellness and reablement approach, the service provider speaks with Helen about what's happening and what she's having difficulty with. Throughout this conversation, the service provider identifies there are still tasks Helen can do but there are certain tasks that impact on her arthritis. The service provider also identifies that Helen used to enjoy doing the housework to keep her home nice and clean. Helen also alluded to feeling lonely because she hasn't had many visitors lately because she's worried about her house.

The service provider works with Helen to develop a care plan focused on Helen's strengths and the things she wants to regain/maintain. The service provider visits Helen once a week for a few hours to help her with cleaning and washing. Over a two-month period, the service provider supports Helen continue to do the things she wanted to, while the provider focuses on the tasks which provoke Helen's arthritis such as vacuuming and mopping.

While Helen still requires ongoing support with harder domestic duties, she has improved on her functional capacity and feels more like herself. By taking a strength-based approach to service delivery, focusing on 'doing with' not 'doing for', Helen has been able to maintain some physical activity and by regaining some independence she is feeling more fulfilled and capable. Helen has begun engaging with her friends again which has improved her social connectedness.

2.4.1 Time limited support

Wellness and reablement approaches often involve time-limited services. Time-limited care aims to address a client's specific barriers to independence and support them getting back to

doing things for themselves. This involves a targeted timeframe, developed with the client, for achieving their goals.

Understanding what a good day looks like for a client and how it relates to their individual goals and outcomes is important for determining short-term support needs. This could be maintaining a level of activity or independence or working towards regaining it. Time-limited reablement services tend to be delivered within a 12-week period with the aim to wrap up services when the client has met their goal or specific outcome.

Restorative care services may also be involved where the client has the potential to make a functional gain. Restorative care involves the delivery of evidence-based interventions led by an allied health worker or health professional that allows a person to make a functional gain or improvement after a setback, or in order to avoid a preventable injury. These interventions may be delivered as one-to-one or group services and may involve a multi-disciplinary approach that goes beyond CHSP services, for example, involving primary health care providers. These services are coordinated by providers of allied health and therapy services based on clinical assessments of the clients. Other time-limited support could include:

- training in a new skill or actively working to regain or maintain an existing skill
- modification to a person's home environment
- having access to equipment or assistive technology.

2.5 Wellness and reablement obligations and supports

As part of applying a wellness and reablement approach to service delivery, service providers are required to:

- ensure services are targeted towards assisting clients to achieve their agreed goals as outlined in the assessment support plan
- apply a 'doing with' approach across service delivery
- offer time limited interventions where appropriate
- monitor changes in client needs and regularly review support services
- comply with wellness and reablement reporting requirements.
- have an implementation plan outlining their service's approach to embedding wellness and reablement in service delivery.

The *Living well at home: CHSP Good Practice Guide*, provides guidance in how to adopt a wellness and reablement approach into service delivery. In addition, as part of the outcomes of the Promoting Independent Living evaluation, the Department has developed additional tools and information, including training for CHSP service providers and an online community of practice, to help service providers to continue to embed wellness and reablement in their service delivery.

2.5.1 CHSP Wellness and Reablement Training program

The Wellness and Reablement online training modules help CHSP support workers, allied health professionals and team leaders to embed wellness and reablement into everyday service delivery approaches. Training consists of three eLearning modules:

- Foundations in wellness and reablement
- Wellness and reablement in practice
- Reablement planning and strategy development

A podcast series in wellness and reablement supplements the eLearning modules.

The eLearning modules are available on the My Aged Care Learning Environment (MACLE), with free places available for CHSP providers. The training is self-paced and adult learning principles apply. This allows individuals to complete the training at their own pace, learning style and speed. To register please contact wellnessandreablement@health.gov.au.

Client scenarios – supporting greater independence[1]

ADELINA

Adelina is a 77 year old woman who had a stroke which affected her left side. Her speech was unaffected but her movement was restricted. She has little function in her left arm, and her left leg is slightly affected although she is able to walk with a stick.

Adelina felt that she was unable to do very much for herself. She really wanted to be able to make her own cup of tea, however because of the lack of function in her left arm she felt she was dependent on carers and unable to make a cup of tea between carer visits unless a friend or neighbour came by. Adelina had become reconciled that this was how her life would be. She was dispirited and resistant to her son's suggestion that she might do a bit more for herself.

However, at the request of her son, Adelina's support plan was reviewed by the RAS who recommended a referral to an occupational therapist. An occupational therapist was engaged under the CHSP who suggested that she could be assisted to learn to use the microwave oven and a kettle fitted onto a tipper so that she could make her own cup of tea.

For a number of weeks Adelina was supported to build up her confidence in her ability to use the microwave and the kettle. After a few months Adelina was able to make meals for herself, her own cup of tea and is living a more independent life. As a result, Adelina has said that she is feeling more hopeful and has started to invite friends over for a meal. Adelina's son has been delighted to see his mother's renewed sense of self and independence.

ROSE

Rose is an 87 year old woman who, as a day centre client, had become very dependent on support staff. Her confidence had declined to the point where she was not confident in tending to her own toileting without assistance to and from the toilet at the centre. After discussion between centre staff and Rose, it was agreed that she was well enough to do more for herself in the centre and over time was encouraged to do so. Staff were advised to enable her to toilet independently rather than attempt to assist as previously.

Over time Rose has become more confident and is more independent at the centre. This confidence has extended to transport arrangements to and from the day centre. Rose does not like to travel on the centre bus, so has arranged her own transport on the days she attends. She has commented on how proud she feels of herself and her achievements and is now more actively involved with the centre, rather than being a passive recipient.

2.5.1 Strategies to assist embedding wellness and reablement

Experience of organisations that have successfully embedded a wellness and reablement approach into service delivery practice suggests that there are a number of key drivers for success. These include:

- a whole-of-organisation approach, including commitment from both management and staff
- reflecting wellness and reablement in organisational policy and procedures, especially in recruitment, employment, orientation and induction practices
- providing and encouraging staff training and education program
- changing the mindset for management, staff, volunteers, clients and their families and carers
- establishing a staged approach to implementation and taking time to work with staff at the beginning of the process to ensure they understand the benefits and reasons for change.
- understanding your organisations maturity and readiness in terms of W&R is the first step to embedding the change

[1] Wellness Approach to Community Home Care Information Booklet July 2008 produced by the Western Australian Department of Health

- ensuring communication materials need to reflect the wellness and reablement approach to assist with setting client and staff expectations.

Client scenarios — short-term wellness and reablement, and restorative interventions

DAVID

David is an 81 year old man who was referred to My Aged Care following a fall he had had two weeks previously. Although he had sustained no specific injuries, David was pretty shaken up from the fall and was now lacking in confidence to shower himself independently.

Following his initial screening process through the My Aged Care contact centre, David was referred to the RAS for an assessment. The assessment identified that David was previously independent and was motivated to regain his independence. The assessor also identified that David was still independent in many daily activities but was struggling with his personal care.

Based on the RAS assessment, a support plan was developed with David, which identified his goal of being able to maintain his personal care independently. The support plan provided information on David's strengths and abilities as well as his areas of difficulty and recommendations to achieve his goals, including a referral to a CHSP service provider for an occupational therapy assessment and the delivery of time limited personal care services.

The occupational therapist then worked with David and his personal carer to devise a plan to achieve his goals. Initially personal care services were provided to David three times a week to assist him with showering. Over a four-week period, the CHSP service provider worked with David to develop specific strategies such as how to step in and out of the shower safely, to help him to build his capacity and regain confidence in showering. After four weeks of service David was confident to shower independently again and the services were withdrawn.

BILL

Bill is a 75 year old man who lives at home with his wife Irene. Bill had not previously received any aged care services since he and Irene had always enjoyed good health. Recently Bill had an accident which had resulted in him spending time in hospital. Although Bill recovered well from his accident, it had left him feeling anxious about leaving the house. Also, his hospital stay and inactivity had reduced his physical fitness, preventing Bill from doing as much around the house and garden as he had done before.

Bill's wife Irene contacted My Aged Care and Bill was referred for a RAS assessment. Bill's assessor worked with him to identify the things that he liked to do and what he no longer felt comfortable doing. A support plan was developed with Bill, which included some time limited interventions with a restorative care focus, including:

- referral to physiotherapy or exercise physiologist (to develop a suitable strength, balance and endurance program)
- referral to an occupational therapist (to identify energy conservation strategies and/or suitable equipment to promote functional independence)
- referral for some time-limited home maintenance and domestic assistance.

Following this time-limited support, Bill now feels more confident living at home and has regained much of his former capacity to undertake the home maintenance and domestic chores that he used to do. Applying this short-term restorative care intervention approach enabled Bill to regain his strength and confidence and prevented a possible longer-term dependence on ongoing support services.

2.5.2 Assessment and support planning

Assessment and support planning conducted by the RAS (or ACATs in some circumstances) must also adopt a wellness and reablement approach to assessment.

The role of the RAS is to work with the client to identify their needs and concerns, as well as their goals and aspirations.

A Home Support Assessment is conducted using the National Screening and Assessment Form (NSAF) on My Aged Care and includes an assessment of a client's:

- current level of support (formal and informal) and engagement
- carer availability and sustainability
- health concerns and priorities
- functional status
- psychosocial and psychological concerns, and
- home and personal safety considerations.

The assessor then works with the client to develop a support plan which focuses the support needed to assist them to achieve their goals. In developing a support plan with a client, the RAS will:

- focus on what a client can do and discuss what they need to complete more difficult tasks.
- discuss strategies to manage day-to-day tasks (e.g. transport planning to meet goals around the use of public transport to maintain usual activities).
- explore the client's opportunity for supporting independence through wellness and reablement approaches (e.g. can the client benefit from time-limited support and/or the use of specific aids and equipment or home modifications such as installing shower rails to build confidence and independence).

Developing a support plan with the client helps to ensure that it accurately reflects the client's needs and goals. This will increase the likelihood that the client will be motivated to work towards the goals they have identified, including supporting their independence through wellness and reablement approaches. The client's support plan is saved to the client record on My Aged Care and can be viewed by the client's service provider.

In some circumstances, where the assessment has identified that a short-term intervention is appropriate, the RAS assessor might take on a coordination role to ensure that all referrals in the support plan are linked to one or more service providers and that they will all be delivered within an agreed time frame.

For clients receiving wellness and reablement support, assessors should include review dates on the client's support plan to monitor the client's progress towards their goals and desired outcomes. The need for ongoing, or an adjustment in services will also be assessed. CHSP service providers are required to provide time limited services in line with the support plan.

Client scenario – wellness and reablement-focused assessment with support planning

CECELIA

Cecelia is an 81 year old woman who lives alone. Before experiencing a stroke earlier in the year, Cecelia had been actively involved in her church and local community. However, following the stroke, Cecelia stopped going out on her own, fearing that her poor balance could result in a fall. Within her house she had also cut down on the heavier housekeeping tasks like vacuuming, large cleaning jobs, laundry and gardening.

Cecelia was referred to My Aged Care by her doctor and following the initial registration process, a RAS assessment was organised. Cecelia's assessment helped to identify her strengths and capabilities as well as her needs. The resulting support plan was centred around Cecelia's own goals which included getting stronger, resuming her church activities, doing more about the house and getting back out in the garden. Cecelia's support plan included:

- referral to an allied health professional to assist with her goal of getting stronger,
- referral to a CHSP domestic assistance service provider to provide assistance with the more difficult household chores and to help Cecelia to identify which chores she could still manage to do on her own,
- assistance to identify and make contact with a pastoral care team member to discuss her continued interest in participating in church activities, and
- referral to a home maintenance service for discussion and planning to convert her garden to be safer and more accessible, and lower maintenance.

After mastering basic strength and balance exercises through a home exercise program designed by the allied health professional, Cecelia was eventually able to walk unaided inside her home. A more confident Cecelia then arranged a 'buddy' to drive her to and from church activities. At the same time, the CHSP domestic assistance service provider worked with Cecelia to assist her to take on some of the easier housekeeping chores enabling her to remain more active and independent.

2.5.3 Reporting requirements

CHSP providers are required to submit a wellness and reablement report to the Department annually outlining their progress in implementing a wellness and reablement approach within their organisation.

The latest wellness and reablement report, was undertaken in 2022 with the aim of building understanding and identifying areas that the Department and CHSP providers can focus on to further imbed wellness and reablement practices.

More information on service provider reporting requirements is provided under Section 6.3.4 of this manual.

Chapter 3 – Sub-Programs: Eligibility and Services

3.1 CHSP Program Framework

The CHSP program framework includes four distinct sub-programs based on the CHSP's target groups as outlined in Section 1.2.9 of this manual:

- Community and Home Support
- Care Relationships and Carer Support
- Assistance with Care and Housing – Hoarding and Squalor, and
- Sector Support and Development.

Each sub-program has its own objective, eligibility criteria and service types.

Under the CHSP Grant Agreement, service providers may receive funding to deliver specific activities under one or a combination of service types under each sub-program. Details on these funding arrangements are set out in Chapter 6 of this manual.

The Program Framework of the CHSP, including its sub-programs is provided in the table below. Details of each sub-program are provided under Section 3.2.

Client scenario – supporting frail older people across sub-programs

MABEL

Mabel is 82 years old and lives alone. Her daughter Claire is her primary carer and visits most days to help her mother with a range of activities, including shopping, cooking and cleaning. Mabel has been diagnosed with macular degeneration and is losing her vision. She no longer drives and is finding it increasingly difficult to access activities and services in her community without Claire's help. However, Claire has a young family of her own and has limited availability. Mabel wants to remain as independent as possible. She and Claire call My Aged Care together to see what support is available.

Screening undertaken by the contact centre identifies that Mabel would benefit from a RAS assessment. Mabel is also provided with information on how to arrange a specialist assessment and a mobility and orientation instructor to help her manage the functional impacts of her vision loss.

The RAS assessor discusses Mabel's care needs with Mabel and Claire and develops a support plan to assist in meeting her goals, which includes:

- referral to CHSP-funded specialised support services for advice on living independently with vision loss
- weekly community transport to services and activities in her community, and
- flexible respite services to support Mabel when Claire is unavailable, including a two-week period when Claire will be on holiday later in the year.

The community transport provider sends drivers who have experience with vision-loss clients.

Ultimately, the support provided to Mabel addresses the challenges facing her, helping her to retain as much independence as possible, while supporting the sustainability of her carer relationship with her daughter.

Program Framework – Commonwealth Home Support Programme

Sub-Program	Community and Home Support	Care Relationships and Carer Support	Assistance with Care and Housing	Sector Support and Development
Objective	To provide entry-level support services to assist frail older people to live independently at home and in the community	To support and maintain care relationships between carers and clients, through providing good quality respite care for frail older people so that carers can take a break	To support those who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need.	To increase CHSP provider capability and improve quality of service delivery through activities under a targeted range of primary focus areas.
Target Group	Frail older people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need assistance with daily living to remain living independently at home and in the community	Frail older clients aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) will be the recipients of planned respite services	Frail older people or prematurely aged[1] who meet each of the following three criteria: 1. On a low income[2]. 2. Living with hoarding behaviour and/or in a squalid living environment. 3. At risk of homelessness or unable to receive the aged care services they need.	CHSP service providers, excluding the provider delivering the SSD activity. Aged care clients and consumers for specified activities.
Service types / activities funded	○ Allied Health and Therapy Services ○ Domestic Assistance ○ Goods, Equipment and Assistive Technology ○ Home Maintenance ○ Home Modifications ○ Meals ○ Nursing ○ Other Food Services ○ Personal Care ○ Social Support-Individual ○ Social Support-Group ○ Specialised Support Services	**Centre-based respite:** ○ Centre based day respite ○ Residential day respite ○ Community access-group respite **Cottage respite:** ○ Overnight community **Flexible Respite:** ○ In-home day respite ○ In-home overnight respite ○ Community access – individual respite ○ Host family day respite ○ Host family overnight respite	ACH – Hoarding and Squalor	Sector Support and Development

[2] See Section 1.2.9, 3.3.3 and/or Glossary

Sub-Program	Community and Home Support	Care Relationships and Carer Support	Assistance with Care and Housing	Sector Support and Development
	○ Transport	○ Mobile respite ○ Other planned respite.		

CHSP providers can refer to the CHSP service catalogue on the Department of Health and Aged Care website.

3.2 CHSP national unit price ranges

The CHSP national unit prices will assist CHSP providers transition to payment in arrears and prepare for future in-home aged care reforms.

The unit price ranges are broadly in line with historical funding and in many cases consistent with unit costs of other government funded programs (for standard weekday delivery during business hours).

These ranges were developed after thorough assessment of unit price information, examining comparable pricing approaches for other programs, and considering market implications of funding design.

Unit prices include all providers costs in delivering CHSP services including wages, rent, insurances and other associated on costs. The subsidised funds, combined with the client contribution, make up the funding attributed to a service being delivered. Funds associated with the increase to wages from 30 June 2023 determined by the Fair Work Commission not included in the 2022-23 CHSP Unit Price range. A separate grant funding opportunity will be established for providers who have staff who deliver CHSP services to apply for additional funds to support this minimum wage increase and associated on costs. Assistance with Care and Housing (ACH), GEAT and Home Modifications do not have national unit price ranges:

- ACH advocacy and assessment services transitioned to the care finder program on 1 January 2023. Hoarding and Squalor continues to be funded through the CHSP.
- Home Modifications continues to deliver services based on the cost in dollars and remains capped at $10,000 (per client per financial year).
- GEAT continues with the output measure of cost in dollars and quantity of items (purchased or loaned), noting the cap of $1,000 applies per client per year. GEAT providers need to report the hours of Allied Health and Therapy services associated with complex GEAT in DEX.

It is important to note these ranges do not include a reasonable client contribution over and above funding from the Australian Government. CHSP service providers should implement their own client contribution policy, with a view that clients who can afford to contribute to the cost of their care should do so.

Client contribution arrangements

Charging clients a CHSP fee is determined by CHSP providers as part of their business operations, and all providers are required to have a Client Contribution arrangement.

There is no formal means testing for CHSP fee charging and CHSP providers need to consider a range of factors, such as what are the business cost drivers and socio-economic circumstances of their CHSP clients, when determining their fee schedule. This means that CHSP fee charging arrangements vary across the country and from client to client. Depending on where they live, two clients of a similar age with similar support needs may have to pay a different fee for the exact same service.

For some services in some areas, clients are not currently asked to contribute anything to the cost of their service, which places increased pressure on the service provider's ability to sustainably meet the needs of their local community.

A CHSP reasonable client contribution range for each service type is below. These ranges were developed along with the unit prices and have been provided as a guide to assist CHSP providers to implement or review their client contribution policy.

Please note that these reasonable client contribution ranges are provided as a guide and may not be suitable for all client contribution policies. CHSP providers will still need to follow the guidance under Chapter 5 – Client Contribution Framework.

Modified Monash Model (MMM) loadings

If a CHSP service provider delivers the majority of services (51% or more) in a MMM 6 or 7, they may be able to request a loading of up to 40% be applied to their unit price for a particular service type. Please note that changes to a service type unit price through an MMM loading will result in a reduction of outputs for that service type.

2022-23 and 2023-24 CHSP national unit prices ranges and client contributions

CHSP Service Type	Output Measure	2022-23 CHSP National Unit Price Ranges	2023-24 CHSP National Unit Price Ranges	CHSP reasonable client contribution
Allied Health and Therapy Services	Hour	$95-$125	$104.50-$131.25	$5-15
Centre-based Respite	Hour	$27-$51	$29.70-$53.55	$2-4
Cottage Respite	Hour	$28-$53	$30.80-$55.65	$2-6
Domestic Assistance	Hour	$48-$61	$52.80-$64.05	$6-12
Flexible Respite	Hour	$51-$67	$56.10-$70.35	$4-8
Home Maintenance	Hour	$53-$75	$58.30-$78.75	$8-20
Meals	Meal	$7.50-$13	$8.25-$13.65	$4-12
Nursing	Hour	$104-$129	$114.40-$135.45	$4-10
Other Food Services	Hour	$25-$41	$27.50-$43.05	$6-15
Personal Care	Hour	$51-$68	$56.10-$71.40	$6-12
Social Support Group	Hour	$17-$27	$18.70-$28.35	$2-4
Social Support Individual	Hour	$39-$60	$42.90-$63.00	$4-8
Specialised Support Services	Hour	$76-$118	$83.60-$123.90	$3-12
Transport	One-way trip	$18-$36	$19.98-$38.16	$2-12

Source: ACIL Allen Consulting

3.3 CHSP Sub-Programs – objectives, target populations, eligibility and services

3.3.1 Community and Home Support Sub-Program

Objective

To provide entry-level support services to frail older people to assist them to live independently at home and in the community.

Target population

Frail older people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need assistance with daily living to remain living independently at home and in the community.

Eligibility

Frail older person who:

- is aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people), and
- has difficulty performing activities of daily living without help due to functional limitations (including cognitive), for example communication, social interaction, mobility or self-care), and
- lives in the community.

Details about the service types provided under this sub-program are provided in the following tables, including service type definitions, service sub-types, service settings and out-of-scope activities.

Service type: Allied Health and Therapy Services

Objective	Allied Health and Therapy Services - To provide services that restore, improve or maintain frail older people's health, wellbeing and independence including time limited services to support wellness and reablement goals.
Service type description	Allied health and therapy services focus on restoring, improving, or maintaining older people's independent functioning and wellbeing. This is done through a range of clinical interventions, expertise, care and treatment, education including techniques for self-management, technologies including telehealth technology, advice and supervision to improve people's capacity. These services assist older people to regain or maintain physical, functional and cognitive abilities which support them to maintain or recover a level of independence, allowing them to remain living in the community. Non-clinical services, including some diversional and preventative therapies, may be provided to clients under this service type, however, these must be complementary supports for the client and not delivered in isolation from the focus of this service delivery. Allied Health and Therapy Services funded under the CHSP include (but are not limited to): • Aboriginal and Torres Strait Islander Health worker • diversional therapy • exercise physiology • formal counselling from a qualified social worker or psychologist • hydrotherapy • nutritional advice from an Accredited Practising Dietitian or a qualified nutritionist

Objective	Allied Health and Therapy Services - To provide services that restore, improve or maintain frail older people's health, wellbeing and independence including time limited services to support wellness and reablement goals.
	• occupational therapy • other allied health and therapy services* • physiotherapy • podiatry • social work • speech pathology This list of services is not exclusive and service providers are not expected to provide all the activities listed. There are two models of service provision for this service type available depending on intensity. These are additional service sub-types to those listed above. Service providers must indicate which (or both) of the models they are able to deliver, and which specific allied health or therapy they will provide under that model. It is anticipated that service providers will be able to deliver both models. 1) Ongoing Allied Health and Therapy services Service providers can deliver one or more of the services in the list above (exactly which services are delivered by the provider will need to be identified). These services are of an ongoing or intermittent nature, are delivered on an individual or group basis and provided at a low intensity or frequency, with a maintenance or preventative focus, for example regular podiatry for a client with diabetes and group exercise classes. 2) Restorative Care services Service providers can deliver a time-limited, allied-health led approach to service delivery that focuses on older clients who can make a functional gain after a setback. These may be one to one or group services that are delivered on a short-term basis which are delivered by, or under the guidance of an allied health professional. Their goal will to be to increase the independence of clients. They will target people who can make a functional gain after a setback, who are at risk of a preventable injury, or who need other allied health led services to maintain independence. In implementing restorative care services, service providers must: • Conduct an initial assessment of the client to establish a baseline from which progress or maintenance of function can be evaluated. This assessment must identify goals and must include the development of an individual plan for each client. • Use measurable, objective, quantitative and qualitative indicators and record results associated with therapeutic goals or desired outcomes which include the client's functional ability: on entry, at review and at discharge. • Complete an outcome assessment documenting achievement or progress made against identified client goals prior to discharge for each client. *Other allied health and therapy services should align to services recognised by the Australian Health Practitioner Regulation Agency (AHPRA). Further information on recognised practitioners is available on the AHPRA website at www.ahpra.gov.au.

Objective	Allied Health and Therapy Services - To provide services that restore, improve or maintain frail older people's health, wellbeing and independence including time limited services to support wellness and reablement goals.
Out-of-scope activities under this service type	Specialist post-acute care and rehabilitation services are out-of-scope and must not be purchased using CHSP funding.
Service delivery setting e.g. home/centre/clinic/community	Services may be delivered in a client's home, a clinic, at a day centre, a group environment or other community setting.
Legislation	Service providers must adhere to any relevant Commonwealth and/or state/territory legislation or regulations.
Output measure	Time (recorded in hours and minutes as appropriate). Type of care (identify which model/s will be delivered i.e. Ongoing Allied Health and Therapy Services and/or Restorative Care Services).
Staff qualifications	Allied health providers must meet their respective accreditation and registration requirements and operate within the scope of practice of their particular regulated or self-regulated body. For example, speech pathologists funded under the CHSP must hold the Speech Pathology Australia Certified Practising Speech Pathologist credential. Depending on the respective accreditation and registration requirements, this may permit activities being undertaken by assistant allied health professionals or less qualified staff.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Domestic Assistance

Objective	Domestic Assistance - To provide frail older people with assistance with domestic chores to maintain their capacity to manage everyday activities in a safe, secure and healthy home environment including time limited services to support wellness and reablement goals.
Service type description	Domestic Assistance is normally provided in the home and refers to: • general house cleaning • linen services • unaccompanied shopping (delivered to home) It can include: • bill paying (unaccompanied) • clothes washing and ironing • collection of firewood (in remote areas) • dishwashing • help with meal preparation (where this is not the primary focus of service delivery) • house cleaning • shopping (unaccompanied) • washing of household linen or provision and laundering of linen, usually by a separate laundry facility. Domestic Assistance services may also include demonstrating and encouraging the use of techniques or specific aids and equipment

Objective	Domestic Assistance - To provide frail older people with assistance with domestic chores to maintain their capacity to manage everyday activities in a safe, secure and healthy home environment including time limited services to support wellness and reablement goals.
	to improve the person's capacity for self-management, build confidence and support client participation where appropriate.
Out-of-scope activities under this service type	The level and frequency of Domestic Assistance services delivered to a client must directly relate to ensuring client safety in the home. CHSP service providers do not give financial advice or offer to assist with managing a person's finances. Accompanied shopping, bill paying and attendance at appointments are not included under Domestic Assistance but are included under Social Support Individual. Domestic assistance providers are not expected to move or re-arrange heavy furniture or items that may put them at risk of injury or harm.
Service delivery setting e.g. home/centre/clinic/community	Normally provided in the home, however in special situations domestic assistance may be delivered at a centre because it is not feasible to deliver the service in the client's home. For example, a day centre may provide washing facilities so that domestic assistance can be delivered to an individual client.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations, for example relating to safe food handling and laundering practices.
Output measure	Time (recorded in hours and minutes as appropriate).
Staff qualifications	Where additional services are performed, such as personal care, in conjunction with domestic assistance, requirements relating to that additional service apply.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Goods, Equipment and Assistive Technology

Objective	Goods, Equipment and Assistive Technology - To provide access to goods, equipment or assistive technology which enables the client to perform tasks they would otherwise be unable to do or promote the older person's safety and independence including time limited services to support wellness and reablement goals.
Service type description	Goods, equipment and assistive technology are provided to assist a client to cope with a functional limitation and maintain their independence. Items include those that provide short-term and ongoing support and assist with mobility, communication, reading and personal care. These can be provided through loan or purchase. Older people may need a range of items, from smaller inexpensive 'off the shelf' items to customised equipment and technology which requires assessment and prescription by professionals with specialised skills and knowledge.

Objective	Goods, Equipment and Assistive Technology - To provide access to goods, equipment or assistive technology which enables the client to perform tasks they would otherwise be unable to do or promote the older person's safety and independence including time limited services to support wellness and reablement goals.
	Goods, equipment and assistive technologies that can be purchased under the CHSP fall under the following service sub-types: • car modifications • communication aids • medical care aids • other goods and equipment • personal monitoring** • reading aids • self-care aids • support and mobility aids (including contributing towards the cost of mobility scooters and vehicle modifications) and include a wide range of items such as: • adapted utensils • assistive technologies such as robotic vacuum cleaners • dressing aids • low vision aids such as binoculars, electronic magnifiers and magnifying/reading software. • over-toilet frames • sensor mats • shower chairs • walking frames Generally, clients who are unable to purchase the item/s independently will be able to access up to $1,000 in total support per financial year under this service type. This cap applies in total per client, regardless of how many items are loaned or purchased, and includes any delivery/installation costs. It is not a cap applied per item. For example, a client may purchase or lease a walking frame and shower chair in the same financial year as long as the total cost for all items is not greater than the maximum annual cap. HCP recipients will be able to access up to $2,500 in total support per financial year for urgent GEAT (See Chapter 4). It is not a cap applied per item. The HCP recipient will be required to pay any additional cost above this cap using private funds. Where a provider determines it is necessary, a client may be referred to an allied health professional e.g., occupational therapist or physiotherapist for an assessment for items where professional advice is needed to ensure they are installed and used correctly e.g., body system monitors and personal alarms. CHSP GEAT providers may also use grant funds to purchase an allied health assessment for their clients. **Note:** that these funding caps also apply where funds are used to contribute to the purchase of higher cost items such as mobility scooters and vehicle modifications

Objective	Goods, Equipment and Assistive Technology - To provide access to goods, equipment or assistive technology which enables the client to perform tasks they would otherwise be unable to do or promote the older person's safety and independence including time limited services to support wellness and reablement goals.
	Note: Service providers must record the amount spent in the 'Notes' section of the My Aged Care client record. **Note**: while some CHSP service providers deliver occupational therapy and other allied health professional assessments, GEAT providers may also purchase assessment services privately from other organisations that do not receive funding through the CHSP. Any allied health professional assessments delivered or purchased must be reported in the Data Exchange.
Out-of-scope activities under this service type	• Items that are not related to the functional impairment (e.g., general household or furniture or appliances) • Items that are likely to cause harm to the participant or pose a risk to others. • Continuous Positive Airway Pressure (CPAP) machines are generally out of scope as they are supported through the health system. • Hearing aids are generally out of scope of the CHSP. Clients may be able to access support through the Hearing Services Program at www.health.gov.au/our-work/hearing-services-program.
Service delivery setting e.g. home/centre/clinic/community	Varied settings.
Use of funds including any target areas	When recording the total cost in dollars for GEAT, CHSP providers should ensure the total cost includes the item cost and any other charges (if applicable) ie service fee, delivery, and installation. Service providers can use goods, equipment and assistive technology funds to provide services that may be necessary to providing equipment for a client, such as specialised assessment for goods and equipment, providing training or support using the item, and maintaining or repairing the item. These hours must be reported as Allied Health and Therapy Services hours if they were delivered by an Allied Health professional. A client should only be referred for complex goods, equipment and assistive technology following an assessment by a qualified allied health professional. Service providers may purchase allied health professional assessments for clients requiring complex goods and equipment, for example where home installation is required. ****Personal alarms** are becoming increasingly popular to prescribe to older Australians. Whilst for many clients an alarm is an appropriate device, this is not always the case. **Personal alarms should only be ordered at the request of the client.** Research shows that personal alarms are most suitable for seniors who: • have had a recent fall or are at risk of a fall, or recent illness • have limited or no family/friends to check in on their wellbeing • have a medical condition that increases the risk of requiring immediate assistance

Objective	Goods, Equipment and Assistive Technology - To provide access to goods, equipment or assistive technology which enables the client to perform tasks they would otherwise be unable to do or promote the older person's safety and independence including time limited services to support wellness and reablement goals.
	Research has also highlighted the importance of follow-up with the client to set up the alarm, provide instruction and encouragement on use, and to identify any issues that arise following provision. This will help to reduce abandonment of the alarms. Clients with cognitive impairment or complex needs should be referred for an assessment by an allied health professional such as an occupational therapist for the most appropriate alarm options according to the clients specific needs and capabilities.
Specific funding advice	The CHSP is not designed to replace existing state managed schemes which provide medical aids and equipment (e.g., Medical Aids Subsidy Scheme). CHSP service providers are encouraged to access these state and territory aids and equipment and personal alarm programs, where appropriate. Where a local CHSP GEAT provider is unable to meet a client's need, referrals can be made to national GEAT provider GEAT2GO. **Note**: to ensure funding is accessible throughout the year, GEAT2GO will reduce access to their service when maximum number of orders is reached each month. GEAT2GO will re-open at the beginning of each month and prescribers will be able to submit their 'draft' saved orders. Service providers may seek advice from GEAT2GO, or their state or territory Independent Living Centre for independent information on the types of equipment available, and which equipment best meets the client's needs.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Quantity – number of items purchased or loaned Cost in dollars – of the amount service provider spent (noting the cap of $1,000 applies per client per year). Cost is total amount for **ALL** items per client. **Notes**: Both fields are mandatory and must be reported. Hours of Allied Health and Therapy Services delivered must be recorded separately in the Data Exchange if applicable.
Staff qualifications	Training for clients in the use of goods, equipment and assistive technology should be provided by qualified health professionals with appropriate knowledge and skills. For example, speech pathology assessment is required to assess clients for communication aids and equipment.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Home Maintenance

Objective	Home Maintenance - To provide home maintenance services that assist clients to maintain their home in a safe and habitable condition. Maintenance services provided must be linked to assisting clients to maintain their independence, safety, accessibility and health and wellbeing within the home environment. Maintenance services can also assist in creating a home environment that facilitates a client's wellness and reablement goals.
Service type description	Home maintenance services provided to clients must focus on repairs or maintenance of the home and garden to improve safety, accessibility and independence within the home environment for the client, by minimising environmental health and safety hazards. This includes home and yard maintenance and repairs that mitigate or remove identified risks to a client's health and safety and/or services targeted at maintaining a home environment which supports a client's wellness and reablement goals. Services refer to: • garden maintenance • major home maintenance and repairs • minor home maintenance and repairs A RAS assessment is important for developing initial home and yard maintenance plans. Activities funded can include a range of maintenance or repair tasks such as: • Accessible, low maintenance garden redesign to support wellness and reablement goals • Minor plumbing, electrical & carpentry repairs where client safety is an issue • Repair of internal flooring and external access pathways to address slip and trip hazards • Secure access issues for clients' personal safety • Working-at-height related repairs or cleaning for client health and safety i.e. gutters, roofs, windows, ceilings, smoke alarms • Yard maintenance – essential pruning, yard clearance or lawn mowing where there are issues for client safety and access.* * The provision and frequency of on-going home maintenance services (lawn mowing and garden pruning) must directly relate to assessed client need in terms of maintaining accessibility, safety, independence or health and wellbeing and be subject to regular review. Consideration may be given to adjustments in frequency with respect to seasonal changes (e.g., mowing less often in winter than summer) as long as the client's safety and accessibility is maintained. These are basic services primarily for function and safety rather than for aesthetic effect.
Out-of-scope activities under this service type	Yard maintenance and gardening services must directly relate to ensuring client safety, rather than maintaining a garden's visual appeal or aesthetic value. Extensive gardening services – planting and maintaining crops, natives and ornamental plants; the installation, maintenance and removal of garden beds, compost heaps, watering systems, water features and rock gardens; and landscaping are outside the scope of this service type.

Objective	Home Maintenance - To provide home maintenance services that assist clients to maintain their home in a safe and habitable condition. Maintenance services provided must be linked to assisting clients to maintain their independence, safety, accessibility and health and wellbeing within the home environment. Maintenance services can also assist in creating a home environment that facilitates a client's wellness and reablement goals.
	General renovations of the home must not be purchased using CHSP funding. The program does not provide services that are the responsibility of other parties e.g. private rental landlords, government housing, Local Government Authorities or where damage to a property is covered by insurance.
Service delivery setting e.g. home/centre/clinic/community	The client's home and/or yard where the client holds responsibility for the maintenance or repair of same. **Note:** Services will not be delivered where another entity holds responsibility for maintenance or repair to the home; similar Government support is already provided or where it is a state or territory government responsibility to provide this type of support e.g. clients living in social housing would receive home maintenance and repair support through their state or territory government but may still hold responsibility for the maintenance of their yard.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and local Council Authority regulations e.g. where the work is undertaken by licensed or registered tradespeople.
Output measure	Time – the total number of hours and minutes (as appropriate). Cost in dollars - the total amount based on time spent. **Notes:** Both fields are mandatory and must be reported.
Staff qualifications	Service providers must adhere to any legislative or regulatory requirements where the work is undertaken by licensed or registered tradespeople.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Home Modifications

Objective	Home Modifications - To provide home modifications that increase or maintain levels of independence, safety, accessibility and wellbeing. Modification services can also assist in creating a home environment that supports wellness and reablement and restorative practices.
Service type description	Services are provided to assist eligible clients with the organisation and cost of simple home modifications and where clinically justified, more complex modifications. Home modifications provide changes to a client's home that may include structural changes to increase or maintain the person's functional independence so that they can continue to live and move safely about the house. Examples of home modification activities could include: • access and egress pathways through a property • appropriate lever tap sets or lever door handles • grab rails in the shower • client engagement and support • installation and fitting of emergency alarms and other safety aids and assistive technology • internal and external handrails next • ramps (permanent and temporary) • lifts (noting CHSP providers can only contribute up to $10,000 per client per financial year, with the client covering the remaining costs) • step modifications In some clinically justified circumstances home modifications could also include: • bathroom redesign (e.g. lowering or removal of shower hobs, changes to design lay out to improve accessibility) • kitchen redesign (e.g. lowering kitchen bench tops, changes to design layout to improve accessibility) • widening doorways and passages (e.g. to allow wheelchair access). Home modifications are provided to improve safety and accessibility and independence within the home environment for the client. Simple modifications can be installed by the service provider, in line with the Building Code of Australia and in compliance with state and territory building regulations and include: • hand-held showers, sliding shower rails • removal of shower screens/doors – installation of weighted shower curtains • doorway wedges <35 mm rise • slip resistant flooring/step treatments including highlighter strips • lowering or removal of shower hobs • lever taps and door handles • repositioning of clotheslines, letterboxes • widening of pathways.

Objective	Home Modifications - To provide home modifications that increase or maintain levels of independence, safety, accessibility and wellbeing. Modification services can also assist in creating a home environment that supports wellness and reablement and restorative practices.
	More complex home modifications require a specialised functional assessment of the client to be undertaken by an Occupational Therapist who will assess the need for home modification, as well as consider alternative solutions that may be more suitable (for example assistive technology and equipment). Home Modification providers may use grant funds to purchase occupational therapy assessments for their clients to help determine their specific care needs and requirements. Clients can arrange and purchase a qualified private OT assessment and providers can accept this report if it is current and specific to the purpose. Clients can access information about OTs through the Occupational Therapy Australia website at www.otaus.com.au. Any occupational therapy assessments purchased or delivered must be reported on the Data Exchange. The intent of the CHSP is to primarily fund simple home modifications for wellness and safety purposes (i.e. modifications that would incur a cost of less than $1,000 to the Commonwealth). The Commonwealth contribution to the cost of a complex modification is capped at $10,000 and applies per client per financial year. Any cost over the cap must be borne by the client.
Out-of-scope activities under this service type	General renovations of the home and Capital Works are not in the scope of the CHSP
Service delivery setting e.g. home/centre/clinic/community	Client's home. **Note:** Services will not be delivered where another entity holds responsibility for structural changes to the home; similar Government support is already provided through other programs or where it is a state or territory government responsibility to provide this type of support (e.g. clients living in social housing would receive home modification support through their state or territory government). It is the responsibility of the client to investigate and gain any permission necessary before modifications are undertaken, for example permission to modify a private property the client is renting, strata scheme permission or local council authority where applicable. Support to the client to undertake this process may form part of the project management activities undertaken by a service provider.
Use of funds including any target areas	Funds must be targeted towards lower cost modifications that meet client needs. Any complex modification that would incur a cost over the Commonwealth's capped contribution of $10,000 must be borne by the client. Service providers can use their home modification funds flexibly to obtain appropriate services for clients where clinically justifiable to increase independence within the home. Service providers may purchase Occupational Therapy assessments for clients requiring complex home modifications that may be prescribed through the Occupational Therapy assessment.
Specific funding advice	Funding can be used to cover both the labour costs and the materials cost or only some part of this, for example the initial work

Objective	Home Modifications - To provide home modifications that increase or maintain levels of independence, safety, accessibility and wellbeing. Modification services can also assist in creating a home environment that supports wellness and reablement and restorative practices.
	including measurement of the home, planning processes and for project management of the modification.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and Local Government Authority regulations and Building Code of Australia. This includes holding appropriate licences and insurances, where required. For example, service providers are required to be aware of their obligations to comply with state and territory-based laws and regulations relevant to the safe handling and removal of asbestos when undertaking home modifications in the homes of clients.
Output measure	Cost in dollars. Types of modification - activity provided, including any Occupational Therapy assessments funded through this service type. **Notes**: Both fields are mandatory and must be reported. Service providers must also record the amount spent in the 'Notes' section of the My Aged Care central client record. Hours of Allied Health and Therapy Services delivered as part of the overall service to the client by an allied health professional must be reported in the Data Exchange under Home Modifications, and the activity included in the description of activities provided.
Staff qualifications	Providers must comply with Commonwealth and state and territory legislation regarding who can undertake home modifications.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Meals

Objective	Meals - To provide frail older people with access to meals.
Service type description	This service type refers to: • meals prepared and delivered to the client's home • meals prepared in distribution centres ('meal hubs') for other CHSP meals service providers • meals provided at a centre or other setting. Providing meals to frail older people at home, a centre or in another setting may deliver a range of benefits. These include informal health monitoring of clients and supporting social participation e.g. time spent with the older person when delivering the meal and social interactions enjoyed by the older person at a centre or other setting. The term 'Meals' recognises and includes all varieties of service models in operation, including the provision of main meals such as two and three course lunches and dinners and complementary meal options such as breakfast and snack packs. The carers of frail older people accessing CHSP meal services may receive a meal provided at a centre or other setting where they are accompanying those clients where required.

Objective	Meals - To provide frail older people with access to meals.
Out-of-scope activities under this service type (i.e. must not be purchased using CHSP funding)	This service type does not include meals prepared in the client's home. This service does not include meals to carers when meals are delivered to the client's home.
Service delivery setting e.g. home/centre/clinic/community	Delivered to the client's home or another CHSP service provider to distribute to CHSP clients or provided at a centre or other setting. Centres may include but are not limited to Senior Citizen Centres and other community-based venues.
Use of funds including any target areas	For meals delivered to the client at home, funds must assist in paying for the production and distribution of the meal. Funding for meals at a centre or other setting must assist in paying for the production of the meal. Funding may be used to access dietetic advice from an Accredited Practising Dietitian where required. Because social security payments provide for the cost of living of recipients it is expected that the cost of the ingredients of the meal will be covered by the client (through their personal income, pension etc.).
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations, for example relevant state and territory safe food handling practices.
Output measure	Number of meals provided. Meals provided to a carer accompanying the client at a centre should be counted separately. If meals are provided as part of the main service being delivered (e.g. meals provided as part of a Centre Based Respite or Social Support – Group social excursion) this should not be counted or reported separately within the Data Exchange. If the service provider receives separate funding to deliver both Meals and Social Support – Group and/or Centre Based Respite, any meals delivered as part of the group or respite activity must be reported under that service type within the Data Exchange and not separately as an output under the Meals service type. Where a provider delivers for example, a two-course meal (e.g. a main and dessert) this would be considered as one meal. Similarly, if a provider delivered a larger portion to a client, but it was still intended to be a part of the same meal, for reporting purposes, this would also be counted as one meal. By contrast, if a provider delivered dinners intended for two meals across the week, this would be considered two meals. Providers receiving meals via a meals distribution centre (meals hub) must report within the Data Exchange when the meal is delivered to the client. The meals hub provider must not report any meals within the Data Exchange, unless the meal is provided directly to the client.
Staff qualifications	All paid staff and volunteers involved in preparation and handling of food must adhere to safe food handling practices including personal hygiene and cleanliness and must be provided with information regarding safe food handling as it relates to their activities.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Nursing

Objective	Nursing - To provide short-term or intermittent treatment and monitoring of medically diagnosed clinical conditions to support frail older people to remain living at home.
Service type description	Nursing care is the clinical care provided by a registered or enrolled nurse. This care is directed to treatment and monitoring of medically diagnosed clinical conditions and can include use of telehealth technologies to support nursing care and recording client observations. Nursing services can include wound care. Nursing services also play a role in education of clients in maintenance of good health practices and the delivery of treatments and care that improve a client's capacity to self-manage. Nursing care includes and allows the delegation of nursing-related tasks to other workers, including personal care workers. Where nursing tasks are delegated to a personal care worker and the service provider does not have personal care workers on staff, the provider should contact My Aged Care to facilitate the client's access to that support. CHSP nursing services are not intended to replace or fund support services more appropriately provided under another system, such as the health system or palliative care services.
Out-of-scope activities under this service type	Palliative care and nursing services that would otherwise be undertaken by the health system are not funded under the CHSP. These (complementary) services are considered out-of-scope because government funding is already provided for them through other government programs. For example, where only post-acute care is required, this is considered out-of-scope for the CHSP. However, a client can receive non-health related CHSP services in conjunction with post-acute services, for example following a hospital stay, noting that clients should access appropriate community nursing services following a hospital stay in the first instance. After this, support services must be reviewed to determine whether the client's current needs are being met.
Service delivery setting e.g. home/centre/clinic/community	Nursing care can be delivered in the client's home, a centre, clinic or other location. It is expected they will be primarily delivered in the client's home.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Time (recorded in hours and minutes as appropriate). Where nursing is provided, including training of a personal care worker to undertake delegated tasks, this should be recorded as nursing hours. Where personal care tasks are provided this should be recorded as personal care hours.
Staff qualifications	Nursing care must be provided by a Registered Nurse or an Enrolled Nurse. Nursing-related tasks may be overseen by a Registered Nurse or Enrolled Nurse. Nursing care allows the delegation of nursing-related tasks to other workers, including personal care workers.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Other Food Services

Objective	Other Food Services - To educate, train and re-skill frail older people in preparing and cooking a meal in their own home to promote their independence supporting their wellness and reablement goals.
Service type description	Other Food Services refers to: • assistance with preparing and cooking a meal in a client's home to promote knowledge, skills, independence, confidence and safety • advice on food including food preparation and nutrition, lessons, training and food storage and safety.
Out-of-scope activities under this service type	This does not cover the delivery of a meal prepared elsewhere or providing shopping services for clients.
Service delivery setting e.g. home/centre/clinic/community	The client's home is the primary setting. Some group-based education activities, however, may occur at centres such as education classes about nutrition.
Use of funds including any target areas	Funding must be used for activities that directly involve the client and promote their independence through education and re-skilling activities.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations, for example safe food handling practices.
Output measure	Time (recorded in hours and minutes as appropriate).
Staff qualifications	All paid staff and volunteers involved in the preparation and handling of food must be provided with information regarding safe food handling as it relates to their activities. Service providers are required to comply with state and territory-based references and guidelines relevant to safe food handling practices. When advice on nutrition is required, it must be provided by an Accredited Practising Dietitian, a Certificate IV Nutrition and Dietetics Assistant under the guidance of an Accredited Practising Dietitian, or a qualified nutritionist.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Personal Care

Objective	Personal Care - To provide frail older people with support in activities of daily living that help them maintain appropriate standards of hygiene and grooming including time limited services to support wellness and reablement goals.
Service type description	Personal care provides assistance with activities of daily living self-care tasks in order to help a client maintain appropriate standards of hygiene and grooming, including: • assistance with self-care • assistance with client self-administration of medicine. Activities can include support with: • eating • bathing

Objective	Personal Care - To provide frail older people with support in activities of daily living that help them maintain appropriate standards of hygiene and grooming including time limited services to support wellness and reablement goals.
	• toileting • dressing • grooming • getting in and out of bed • moving about the house • assistance with client self-administration of medicine (including from dose-administration aids and reporting of failure to take medicines). Services may also include demonstrating and encouraging the use of techniques to improve the person's capacity for self-management and building confidence in the use of equipment or aids, such as a bath seat or handheld shower hose to support wellness and reablement goals.
Service delivery setting e.g. home/centre/clinic/community	Personal care is normally provided in the home. In special situations personal care assistance may be delivered at a centre or other community setting because it is not feasible to deliver the service in the client's home. This may be because the client is homeless, itinerant or living in a temporary shelter and the centre is able to provide the shower and washing facilities required for client care.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations. State and territory legislation governs medication management. Service providers must consider all relevant legislation and guidelines in developing policies and procedures around assistance with client self-administration of medicine (including from dose-administration aids and reporting of failure to take medicines) provided under the CHSP.
Output measure	Time (recorded in hours and minutes as appropriate).
Staff qualifications	For personal care, including assistance with client self-administration of medicine, a Certificate III in aged/community care or equivalent is desirable. This includes any circumstances where nursing-related tasks are delegated to personal care workers which is permitted under the CHSP (see the Nursing service type in this program manual for more information).
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Social Support – Group

Objective	Social Support Group - To assist frail older people to participate in community life and feel socially included through structured, group-based activities that develop, maintain or support independent living and social interaction whilst facilitating their wellness and reablement goals.
Service type description	Social support – Group (formerly known as Centre-Based Day Care) provides an opportunity for clients to attend and participate in

Objective	Social Support Group - To assist frail older people to participate in community life and feel socially included through structured, group-based activities that develop, maintain or support independent living and social interaction whilst facilitating their wellness and reablement goals.
	social interactions which are conducted away from the client's home and in, or from, a fixed base facility or community based settings. These structured activities are provided in a group-based environment and designed to develop, maintain and support social interaction and independent living. Activities may take the form of: • group-based activities held in or from a facility/centre (e.g. pre-set or individually tailored activities promoting physical activity, cognitive stimulation and emotional wellbeing) • group excursions conducted by centre staff but held away from the centre • Online group activities facilitated by the CHSP provider. This may include computers, laptops or devices owned by or leased to clients Services may include light refreshments and associated transport and personal assistance (e.g. help with toileting) involved in attendance at the centre. Social Support Group providers may use grant funding to purchase IT equipment, including tablets, laptops, and internet subscriptions to help connect older Australians to their family, carers and social groups. This support is capped at $500 per client per year (or up to $1,000 in exceptional circumstances). This does not include the purchase of smart phones or phone plans. .
Out-of-scope activities under this service type	Social gatherings that do not specifically aim to support older people's social inclusion and independence. Personal Alarms and Home Monitoring Equipment.
Service delivery setting e.g. home/centre/clinic/community	Usually centres or fixed-base facilities but can include community settings away from the centre (e.g. group excursions).
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Time (recorded in hours and minutes as appropriate). If a service provider provides transport to/from a centre and receives funding to deliver both CHSP Transport and Social Support – Group, they should record the transport to/from the centre separately to the Social Support – Group activity. Where transport is provided (separate to any excursion) to a carer accompanying the frail older client this should also be counted. CHSP providers that are not funded for Transport may incorporate the cost of transporting clients to their Social Support – Group unit price but should not report them as separate Transport outputs in the Data Exchange. Any transport provided as part of an excursion or activity within the centre's program will not be counted as a separate transport service. Any meals provided as part of an excursion or activity within the centre's program will not be counted as a separate meal service. IT equipment purchased under this service type should be separately reported under the GEAT service type.

Objective	Social Support Group - To assist frail older people to participate in community life and feel socially included through structured, group-based activities that develop, maintain or support independent living and social interaction whilst facilitating their wellness and reablement goals.
Staff qualifications	Appropriately qualified staff must be used to conduct activities of a specific nature, such as allied health activities or exercise programs. Where staff or volunteers are involved in other activities as part of Social Support – Group, they must have relevant qualifications, for example any food handling and meal preparation must adhere to safe food handling practices including personal hygiene and cleanliness.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Social Support – Individual

Objective	Social Support Individual - To assist frail older people to participate in community life and feel socially included through meeting their need for social contact and company whilst facilitating their wellness and reablement goals.
Service type description	Social support – individual is assistance provided by a companion (paid worker or volunteer) to an individual, either within the home environment or while accessing community services, which is primarily directed towards meeting the person's need for social contact and/or company in order to participate in community life. Services funded include: • visiting services • telephone and web-based monitoring services (including other technologies that help connect older people to their community e.g. to assist people with sensory impairments or those living in geographically isolated areas) • accompanied activities (such as assisting the person through accompanied shopping, bill-paying, attendance at appointments and other related activities). Social support is usually provided one-on-one but may also be provided to more than one person, for example, where social support is provided to an aged couple. Social Support Individual providers may use grant funding to purchase IT equipment, including tablets, smart devices and internet subscriptions to help connect older Australians to their family, carers and social groups. This support is capped at $500 per client per year (or up to $1,000 in exceptional circumstances). This does not include the purchase of smart phones or phone plans.
Out-of-scope activities under this service type	Unaccompanied activities such as bill-paying and shopping, which are considered Domestic Assistance. Social Support provided to the client in a group-based environment at, or from a fixed base facility away from their residence, which is considered Social Support – Group. Care workers may assist clients to schedule medical appointments and can wait for the client in the waiting room but are not required to attend the medical consultation.

Objective	Social Support Individual - To assist frail older people to participate in community life and feel socially included through meeting their need for social contact and company whilst facilitating their wellness and reablement goals.
	Personal Alarms and Home Monitoring Equipment.
Service delivery setting e.g. home/centre/clinic/community	Client's home or community setting.
Use of funds including any target areas	Funding must be targeted at supporting older people to participate in community life.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Time (recorded in hours and minutes as appropriate). IT equipment purchased under this service type should be separately reported under the GEAT service type.
Staff qualifications	Where staff or volunteers are involved in other activities as part of Social Support – Individual, they must have relevant qualifications, for example any food handling and meal preparation must adhere to safe food handling practices including personal hygiene and cleanliness.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Specialised Support Services

Objective	Specialised Support Services refers to specialised services for frail older people who are living at home with a clinical condition and/or specialised needs.
Service type description	The SSS service type refers to specialised services for frail older people who are living at home with a clinical condition and/or specialised needs. Services are entry-level and intended to complement other CHSP services. These services are targeted primarily at supporting individuals. Services must help clients, and their carers and families, to access episodic support and information to manage these conditions and maximise client independence to enable them to remain living in their own homes. Services provide a holistic and integrated approach for people with diverse and/or individualised needs, comprising a mix of advisory, targeted support and tailored advice. Services are not intended to substitute primary health services or allied health services available through the health care system or other CHSP services. These services may include: • developing plans and strategies to manage clients' conditions, incorporating elements of prevention and risk reduction • conducting timely evaluations and monitoring progress • establishing client-centred goals • providing advocacy, education and advice • supporting capacity building sessions for those with a clinical condition and/or specialised needs.

Objective	Specialised Support Services refers to specialised services for frail older people who are living at home with a clinical condition and/or specialised needs.
	Examples of specific specialised services include, but are not limited to: • continence advisory services • dementia advisory services • vision services • hearing services • other clinical conditions • client advocacy – advisory and support services for diverse groups in aged care *Advisory and support services* Client advocacy is now referred to as 'advisory and support services' and includes services to older people who have a clinical condition or identify with one or more of the diverse groups in aged care[3]. Advisory and support services target clients and their families who can proactively access aged care services without needing intensive one on one support. The services include: • **Capacity building supports** to help clients to maintain their independence and build skills to better manage their clinical condition and understand their individual needs when accessing aged care services. • **Linking support** to help clients access My Aged Care and other services. *Interaction with the care finder program* New clients should be referred to a care finder if they meet the eligibility criteria, particularly clients from vulnerable or diverse groups who require intensive one-on-one support. Existing SSS clients who are eligible for a care finder may wish to remain with their current SSS services provider. *Reporting* SSS providers are responsible for monthly reporting through the Data Exchange (DEX). Providers can report client-facing services under continence advisory services, dementia advisory services, vision services, hearing services, other support services and client advocacy. The following reporting requirements must be applied from 1 July 2023: • **Advisory and support services** (including for diverse groups in aged care) must be reported under **client advocacy**. • Services reported under **other support services** must only include services to clients with **other clinical conditions** not listed in the service sub-type levels. This may include other conditions such as motor neurone disease or other neurological conditions.

[3] Services provided should not duplicate services available through other Government funded programs such as the care finder program, Veterans' Home Care Services and Disability Support for Older Australians.

Objective	Specialised Support Services refers to specialised services for frail older people who are living at home with a clinical condition and/or specialised needs.
Out-of-scope activities under this service type	Specialised support services that would otherwise be undertaken by the health system are not within scope. Services that are already funded under other Commonwealth, state, territory or local government programs are not within scope.
Service delivery setting e.g. home/centre/clinic/community	Varied settings.
Use of funds including any target areas	Service providers can use funds to support clients with specific needs such as those with dementia, incontinence, vision impairment, hearing loss or other specialised needs for diverse groups in aged care.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Time (recorded in hours and minutes as appropriate). Outputs recorded should include delivery of all advice and support. Note: both fields are mandatory and must be reported.
Staff qualifications	Appropriately qualified staff must be used to conduct activities. Allied health providers must meet their respective accreditation and registration requirements and operate within the scope of practice of their particular regulated or self-regulated body. Depending on the respective accreditation and registration requirements, this may permit activities being undertaken by assistant allied health professionals or less qualified staff.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Client scenario – The following client scenarios help to demonstrate the revised SSS definition.

Harry – CALD background

Harry is 68 years old and comes from a non-English speaking background. Harry has low literacy and relies on his wife Maria (62 years old) to complete any household paperwork. They have been managing to remain at home, but Harry has been feeling increasingly unsteady on his feet and had a couple of falls at home recently. Maria feels like she can't leave Harry home alone or safely assist him to attend appointments. Harry can no longer drive, and neither of them use the internet. They do not receive aged care services and instead rely on members of their church community to help with shopping and transport. They have 2 adult children who are also worried about Harry's risk of more falls but they both live in other parts of Australia. Their daughter suggests Maria speaks to her church leader for guidance.

There can be a high level of stigma around aged care in many CALD communities. There may be an expectation that family look after other family members instead of seeking formal support. There can also be language barriers, lack of knowledge of the aged care system and services available, and cultural differences.

Maria confides in her church leader that she is scared about Harry's falls, doesn't feel confident to assist him and does not know what to do. The church leader (with consent) organises a call with a SSS provider attached to their community group. The provider speaks to Maria and determines that Harry does not qualify for the care finder program because Maria and their children are willing to assist.

The SSS provider begins speaking with Harry and Maria every week over the phone to explain the services available, the aged care system and build trust and rapport. The provider also organises calls with their children to keep them informed. The SSS provider discusses Harry's care goals and provides translated materials relating to services available. When Harry and Maria do agree to receive aged care services, the SSS provider supports them through the My Aged Care registration and assessment process.

Following the assessment process, Harry was recommended a range of support services, including SSS, assistive equipment, an allied health assessment for falls prevention and transport.

The SSS provider remained in contact with Harry and Maria to ensure the relevant services were meeting their needs and goals. With the right support in place, the risk of falls and hospitalisations, and carer burden were significantly reduced.

Betty – hearing decline and continence support

Betty is 75 years old and lives alone in a unit within an independent living community. The community has many social activities and Betty has enjoyed the move since her partner passed away. She lives independently, looks after herself and does her food shopping online.

Over the last 12 months Betty has noticed her hearing is declining. She keeps turning the TV up to hear the news and gets behind in bingo and card games in the facility's common room. She feels embarrassed and now does not want to attend the social activities.

In a regular check-up, Betty's doctor recommends phoning My Aged Care to register for hearing services. After being assessed by a RAS, Betty is referred to a SSS provider, where she is supported and guided with accessing hearing services. The SSS provider gives her information on hearing loss, recommends places to have a hearing test and supports her to get hearing aids and demonstrates how to change batteries and clean the aids. The SSS provider checks in a couple of months later to see if Betty's hearing aids are helping her and she explains she has re-joined the social activities and remains independent at home.

Later, Betty contacts the SSS provider to ask for additional help with getting continence aids. The provider gives Betty guidance and expert advice on being referred to an allied health professional and assists her to register for the Continence Aids Payment Scheme (CAPS). They also recommend she contacts the National Continence Foundation of Australia for additional clinical advice.

While in contact with the SSS provider, Betty confides it is getting hard for her to vacuum and mop these days. The SSS provider with consent, refers Betty to My Aged Care for a support plan review. Betty is re-assessment for DA services to support her to continue living independently at home.

Service type: Transport

Objective	Transport - To provide frail older people with access to transport services that supports their access to the community.
Service type description	Transport refers to the provision of a structure or network that delivers accessible transport to eligible clients and includes: • direct transport services which are those where the trip is provided by a worker or a volunteer • indirect transport services including trips provided through vouchers. The provision of community transport services under the CHSP assists frail older people to remain actively connected with their local community. Transport services aim to assist client to continue with their usual activities, such as attending community groups or medical appointments, enabling them to keep active and socially engaged.

Objective	Transport - To provide frail older people with access to transport services that supports their access to the community.
	Clients can access more than one transport referral where the need is not met by one provider e.g. one referral for a transport provider for week days and one referral for a one-off medical transport or weekend trip which is not provided by the week day provider. Clients should contact My Aged Care for assistance with accessing these referrals.
Service delivery setting e.g. home/centre/clinic/community	Includes, but is not limited to, transport services provided to or from facilities or the client's home.
Use of funds including any target areas	Funding must be used for non-assisted/assisted transport and planned (group) and on-demand (individual) services. The carers of frail older people accessing CHSP transport services may accompany those clients when using those services where required. Transport providers may only use CHSP funding to lease, rather than purchase vehicles.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations, for example holding appropriate licenses, meeting state accreditation standards and meeting any legislated access requirements. As per Section 4.2 of this program manual, all CHSP services must be able to offer accessible service options to people with physical or sensory disabilities.
Output measure	Number of one-way trips. Service providers are to count clients and carers separately when reporting outputs within the Data Exchange. If transport is funded under CHSP and provided as a related, but still separate service (e.g. transport of clients attending a Day Therapy Centre) this should be counted as a separate service for each trip, in addition to the attendance at the Day Therapy Centre, when recording in the Data Exchange. Where transport forms part of the main service being delivered (e.g. a bus trip as part of a Social Support – Group social excursion) this should not be counted or reported separately within the Data Exchange. Community transport services delivered under the CHSP are not intended to replace or fund transport services more appropriately provided under another system, such as state/territory administered patient transport services.
Staff qualifications	Drivers of transport services must hold an appropriate licence. Service providers must also take reasonable care to ensure the safety of all concerned where paid staff or volunteers are providing transport services. It is the responsibility of the service provider to ensure they are meeting their Work Health and Safety responsibilities for safe driving and client transport practices.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

CHSP Service Type Referrals

In general, where a couple in a household has the same assessed need, it may not be appropriate to receive a referral for the same service type. Examples may include Domestic Assistance, Home Maintenance and Home Modifications.

Clients may be able to access more than one referral for the same service type in certain circumstances. For example:

- Allied Health and Therapy services – a client may have a referral for Podiatry services and Physiotherapy services with these services provided by different CHSP Allied Health and Therapy providers.
- Transport – a client may access Transport services from one provider during the week and use another Transport referral with a second provider on weekends as that provider only provides weekend services.

3.3.2 Care Relationships and Carer Support Sub-Program

Objective

To support and maintain care relationships between carers and clients, through providing good quality respite care for frail older people so that carers can take a break.

Target population

Frail older CHSP clients will be the recipients of planned respite services, providing their carers with a break from their usual caring duties.

Eligibility

CHSP clients who require planned respite services to support and assist with maintaining the caring relationship.

Funded services

Service providers should give consideration to models of respite care that support CHSP clients with carers in employment, training or study. This may include for example, the availability of respite services outside of current standard operating hours, to assist carers to balance work and caring responsibilities.

Details on the planned respite service types funded under this sub-program are provided in the tables on the following pages, including a service type definition and service settings.

Client scenario — helping carers continue caring, nurturing the care relationship

KERRY

Kerry is 75 years old. She is the carer for her 83 year old husband, Ronald, who has incontinence and mobility problems due to muscle weakness. Kerry assists him with his personal care, drives him to appointments, and takes him on short outings. In the last six months Kerry has noticed her health beginning to suffer from concern about her husband and poor sleep. She is also finding it increasingly difficult to balance providing for his needs and continuing the activities she used to enjoy, such as croquet at the local club with her friends. Her sister suggests that Kerry calls My Aged Care to see what support she and Ronald may be eligible for. Kerry and Ronald both consent for My Aged Care to register them as clients and create client records. After screening by the contact centre, they are both referred for a RAS assessment.

During the assessment process, both of their care needs and goals are identified: including what help is needed to support Kerry (as carer) and the care relationship she has with her husband. As a result of the assessment, CHSP services are organised to meet their needs. For Ronald, this includes continence aids and fortnightly physiotherapy to address his muscle weakness. Two hours per fortnight of ongoing, flexible (in-home) respite care is also arranged. Over the coming weeks Ronald becomes comfortable with the respite worker and requests that the same staff member provides the respite services each time. The respite is scheduled at a time that allows Kerry to return to croquet. These CHSP services benefit Ronald and give Kerry more balance in her life.

Service type: Centre-based respite

Objective	Centre-based respite - To support and maintain care relationships between carers and clients, through providing good quality respite care for frail older people so that carers can take a break.
Service type description	Respite care is available to CHSP clients. This service benefits the client's carer through providing supervision and assistance to the frail older client. The carer may or may not be present during the delivery of the service. Centre-based respite care includes: • **centre based day respite –** provides structured group activities to clients to develop, maintain or support independent living and social interaction conducted in a community setting. • **residential day respite –** provides day respite in a residential facility to the client. • **community access group –** provides small group day outings to give clients a social experience and offer respite to their carer. Service providers are required to structure services in such a way that allows them to be as responsive as possible to requests from carers for short-term or non-ongoing respite. Residential day respite is defined as day respite in a residential facility (where the booking cannot be used for overnight stays)
Out-of-scope activities under this service type	Residential respite that is delivered under the *Aged Care Act 1997* (see Glossary).
Service delivery setting e.g. home/centre/clinic/community	Varied group-based settings including a centre and respite delivered as an outing etc.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Time (recorded in hours and minutes as appropriate). If a service provider provides transport to/from a centre and receives funding to deliver both CHSP Transport and Centre-Based Respite, they should record the transport to/from the centre separately to the respite activity. CHSP providers that are not funded for Transport may incorporate the cost of transporting clients into their Centre Based Respite unit price but should not report them as separate Transport outputs in the Data Exchange. Any transport provided as part of an excursion or activity within the centre's program will not be counted as a separate transport service. Any meals provided as part of centre-based respite within the centre's program should not be counted as a separate meal service.
Staff qualifications	Where additional services are performed e.g. personal care, in conjunction with respite – requirements relating to that additional service apply.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Cottage Respite

Objective	Cottage respite - To support and maintain care relationships between carers and clients, through providing good quality respite care for frail older people so that carers can take a break.
Service type description	Respite care benefits the carer through providing supervision and assistance to the frail older client. The carer may or may not be present during the delivery of the service. **Cottage respite** (overnight community respite) provides overnight care delivered in a cottage-style respite facility or community setting other than in the home of the carer, care recipient or host family. Service providers are required to structure services in such a way that allows them to be as responsive as possible to requests from carers for short-term or non-ongoing respite.
Out-of-scope activities under this service type	Residential respite that is delivered under the *Aged Care Act 1997.* (see Glossary).
Service delivery setting e.g. home/centre/clinic/community	Cottage settings.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Time (recorded in hours and minutes delivered in a night)
Staff qualifications	Overnight respite can have unique risks for service providers and clients. Service providers need to identify and manage risk through consistent use of the Home Care Standards or any Standards that replace them, the CHSP Grant Agreement and relevant state and territory legislation. Where additional services are performed e.g. personal care, in conjunction with respite – requirements relating to that additional service apply.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

Service type: Flexible Respite

Objective	Flexible respite - To support and maintain care relationships between carers and clients, through providing good quality respite care for frail older people so that carers can take a break.
Service type description	Respite care benefits the carer through providing supervision and assistance to the frail older client. The carer may or may not be present during the delivery of the service. Flexible respite care includes: • **In-home day respite** – provides a daytime support service for carers of clients needing assisted support in the carer's or the client's home. • **In-home overnight respite** – provides overnight support service for carers of clients needing assisted support in the carer's or client's home. • **Community access–individual** – provides one-on-one structured activities to give clients a social experience to develop, maintain or support independent living and social interaction and offer respite to their carer.

Objective	Flexible respite - To support and maintain care relationships between carers and clients, through providing good quality respite care for frail older people so that carers can take a break.
	• **Host family day respite** – day care received by a client in another person's home. • **Host family overnight respite** – overnight care received by a client while in the care of a host family. • **Mobile respite** – provides respite care from a mobile setting • **Other** – innovative types of service delivery to clients. Service providers are required to structure services in such a way that allows them to be as responsive as possible to requests from carers for short-term or non-ongoing respite.
Out-of-scope activities under this service type	Residential respite that is delivered under the *Aged Care Act 1997*. (see Glossary). Group based respite.
Service delivery setting e.g. home/centre/clinic/community	Varied settings including the client's home, a host family's home, other suitable accommodation in the community and respite delivered as an outing etc.
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Time (recorded in hours and minutes as appropriate).
Staff qualifications	Where additional services are performed e.g. personal care, in conjunction with respite – requirements relating to that additional service apply.
Fees	Client contribution amount recorded in the Data Exchange (in Fees field).

3.3.3 Assistance with Care and Housing (ACH) – Hoarding and Squalor Sub-Program

Objective

To support those who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need.

Target population and eligibility

Frail older or prematurely aged people who meet each of the following three criteria:

1. On a low income.
2. Living with hoarding behaviour and/or in a squalid living environment.
3. At risk of homelessness or unable to receive the aged care services they need.

Prematurely aged people are those aged 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) whose life course such as active military service, homelessness or substance abuse, has seen them age prematurely.

The person being assessed for assistance under the sub-program, and who must meet the above eligibility requirement is regarded as the Principal Client (see Glossary). The Principal Client may have dependants, and these are regarded as co-habiting clients.

Co-habiting clients do not need to meet the eligibility requirements and are entitled to receive the same range of Assistance with Care and Housing support as Principal Clients. This is because the stability of the client household is important to the long-term viability of future accommodation arrangements.

Once an individual has been assessed as eligible to access ACH – Hoarding and Squalor services, they remain eligible for this service type indefinitely and do not require a re-assessment for ACH – Hoarding and Squalor services, even if they suspend them for several

years. This applies to all ACH – Hoarding and Squalor clients, regardless of age of entry into the program.

Clients who are eligible to access ACH – Hoarding and Squalor services are also eligible to access other CHSP services. Any additional entry level CHSP services made available to an ACH – Hoarding and Squalor client between the age of 50 and 65 (or between 45 and 50 for Aboriginal and Torres Strait Islander people) must be targeted at avoiding or reducing the impact of hoarding and squalor situations. All clients must be assessed by My Aged Care via the assessment services to determine eligibility and need to receive additional CHSP services.

Service considerations

To ensure older people are supported to receive the care they need to continue living in the community, service providers funded to deliver ACH – Hoarding and Squalor must follow the principles below.

ACH – Hoarding and Squalor services:

- Will undertake outreach services where appropriate to identify potential clients in need of assistance and keep in contact with those clients.
- Will coordinate and link support for clients in a goal focussed client management relationship.
- Interact and work with multiple services across a range of sectors.
- Ensure a rapid response to older people who are at risk of homelessness through one-on-one contact.
- Ensure a flexible and individualised service delivery response within the requirements of the broader CHSP.
- Must have strong links with the community, housing services and all aspects of the aged care sector.
- Will have access to translation and interpreting services under the CHSP to support clients.
- Provide opportunities for all associated services and programs to work cooperatively to meet the essential decluttering, cleaning, social support and community care needs of extremely vulnerable and disadvantaged members of the community.
- Coordinate a service response that is directed at addressing hoarding and squalor situations for the older person and ensuring their care needs are met so they can continue to live in the community.

ACH – Hoarding and Squalor Sub-Program service providers

As of 1 January 2023, ACH navigation services (previously known as Assessment - Referrals and Advocacy – Financial Legal) are delivered and funded through the care finder program. Additional information is available on the My Aged Care website.

It is recognised that a specialised approach is required for ACH – Hoarding and Squalor clients due to their particular circumstances. For these clients, ACH – Hoarding and Squalor service providers or care finders may be a point of entry and assessment in addition to My Aged Care.

ACH – Hoarding and Squalor providers or care finders can help clients contact My Aged Care and work with My Aged Care assessors, particularly during the assessment process, to understand what services are available and to find and choose services. It is also appropriate for assessors to refer suitable clients identified during the assessment process to the ACH – Hoarding and Squalor Sub-Program or care finders for further support.

Service providers should also update the client's My Aged Care client record with service information (including commencement date and frequency/volume of services). Where there are significant changes in need or additional services needed service providers can request a support plan review, which may lead to a new assessment for the client.

Client scenario — ACH – Hoarding and Squalor and linking to community support

Francesco

Francesco is a 72-year-old man who lives in a social housing apartment complex. He has difficulty with hearing and has been in and out of hospital due to his multiple physical health conditions. Francesco has one sister who lives interstate and a close friend who lives in a retirement village on the other side of town. His friend has raised concerns on the bed bugs situation in his home as well as the clutter sitting around. Francesco was also recently hospitalised for scabies and the nurses were concerned by the bites left by the bed bugs.

A social worker was assigned to him in hospital, and she made contact with a local aged care organisation that provided the CHSP ACH – Hoarding and Squalor services. Francesco was registered and assessed for My Aged Care services during his stay in hospital where it was determined that he required additional support at home. He was approved for CHSP ACH – Hoarding and Squalor services. Other services included in his support plan were social support; domestic assistance; transport; goods, equipment and assistive technology; and Allied health (OT).

The social worker contacted a local ACH – Hoarding and Squalor provider and set up a meeting with the representative care manager to discuss Francesco's situation. Francesco explained to the care manager that his physical health and mobility had declined, it had become more difficult for him to stay on top of his cleaning and the house had become dirty and cluttered. He was experiencing urinary incontinence and due to the cluttered apartment, he had difficulty making it to the bathroom resulting in spills on the carpeted floors which were hard for him to clean up. After providing a clear explanation regarding the services and gaining Francesco's consent, pest control came in to sort out the bed bugs situation, and a deep clean occurred in his apartment including removing unwanted items (as decided by the client) and the soiled mattress and lounge. His soiled clothes were also discarded, and the washing machine was sanitised as there were bed bugs in it. A new lounge and a bed, mattress and bed linen was sourced through a local charity and a carpet clean was completed in his bedroom due to urine stains. Support workers were delegated to accompany Hogan to the mall for a day to assist with buying him clothes.

At the time of this service, Francesco was not engaged with any other services. He was assessed and assigned domestic assistance (DA) services under CHSP, but these services were not comfortable starting until a deep clean had occurred. Staff communicated with the DA provider to advise of the deep clean and requesting DA be ready to commence afterwards to assist with maintaining the apartment. With Francesco's consent, he was also referred to a local care finder who also worked with Francesco to set up the other services he had been approved for.

Following the ACH – Hoarding and Squalor service, Francesco reported to be feeling much happier living in his unit and felt more supported now that he had ongoing services in place. There was a noticeable improvement in his wellbeing as he was sleeping on a new mattress and in clean bedding, he had a clear thoroughfare to his bathroom and was living in a hygienic environment. Francesco is now set up with ongoing support to maintain his living environment to ensure his health and wellbeing.

Service type: Assistance with Care and Housing

Objective	**ACH – Hoarding and Squalor - To support those who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need.**
Service type description	Assistance with Care and Housing – Hoarding and Squalor services support clients to access the most appropriate range of services in order to meet their immediate and ongoing needs. Hoarding and squalor support may be required to conduct early intervention and prevent estrangement from support services and a resultant decline in the person's welfare.

Objective	**ACH – Hoarding and Squalor - To support those who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need.**
	In practice, it may take numerous interactions with the client for a provider to gradually develop trust, leading to a supportive professional relationship where de-cluttering and deep cleaning can occur and appropriate supports are in place. This requires persistence and a specialised capacity of the worker to manage challenging behaviour. When linking clients into services, clients may require a period of continued support to assist them to remain linked with those services. Service providers are required to develop links with other local care services. Examples of linkages to be made include but are not limited to: • CHSP service providers • the RAS as part of My Aged Care • Aged Care Assessment Program/Team • residential aged care where appropriate • Home Care Packages • state and territory programs and resources • veterans' home care services • health services • care finders • local government services • other services appropriate to the needs of the client, such as community care and other support services. **ACH - Hoarding and Squalor** Hoarding Disorder can be associated with health risks and can impact on an individual's friends and family. People experiencing Hoarding Disorder can be assisted by specialist intervention. ACH Hoarding and Squalor services can be offered to clients experiencing symptoms of Hoarding Disorder or who are living in severe domestic squalor. The range of ACH - Hoarding and Squalor services may include: • developing a client plan • one-off clean-ups • review care plans • linking clients to specialist support services.
Out-of-scope activities under this service type	Assessment (referrals) and advocacy services (financial, legal), unless targeted at avoiding or reducing the impact of hoarding and squalor situations. Permanent support and/or direct care provision are out-of-scope. Funding to purchase accommodation for clients. Assessment (referrals) and advocacy services (financial, legal).
Service delivery setting	Varied – including a client's home, at a centre or clinic, in the community.
Use of funds including any target areas	Service providers are funded to deliver hoarding and squalor services. They may provide clients with direct contact details for linked services, such as a care finder.

Objective	**ACH – Hoarding and Squalor - To support those who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need.**
Legislation	Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.
Output measure	Time (recorded in hours and minutes as appropriate).
Staff qualifications	Staff must possess an appropriate level of knowledge and skills in relation to socially isolated and/or disadvantaged people.

3.3.4 Sector Support and Development Sub-Program

Objective

To increase CHSP provider capability and improve quality of service delivery through activities under a targeted range of primary focus areas.

Target population

- CHSP service providers, excluding the provider delivering the SSD activity.
- Aged care clients and consumers for select activities as specified below.

Service considerations

Throughout 2023-24, as new details emerge regarding aged care reforms, SSD activities may be adjusted to reflect and incorporate any changes.

SSD providers can deliver their activities nationally and therefore activities should be made available to all CHSP providers across Australia, where possible. SSD activities must not be restricted to a preferred CHSP provider or a specific CHSP service type (e.g. Meals, Transport, Respite).

SSD providers are encouraged to collaborate on activities, form working groups and collaborate on their activities to reduce duplication and build national consistency and equal geographical distribution of support for CHSP providers.

During 2023-24, SSD providers may choose to deliver new activities, cease an activity or amend the details of existing activities. Reasons for this could include (but are not limited to): limited CHSP demand for activities; previously unknown duplication; or superseded content.

Please note, it is not anticipated additional funding will be available, and any additional or changed activities must fit within a provider's current funding envelope.

Service type: Sector Support and Development

Objective	**To increase CHSP provider capability and improve quality of service delivery through activities under a targeted range of primary focus areas.**
Service type description	SSD activities focus on supporting CHSP providers to uplift their capability ahead of reforms to the aged care system. SSD providers must allocate at least 75 per cent of their funding to activities that fall under a primary focus area, as listed below. These activities must only be delivered to CHSP providers. Clients and consumers cannot receive services funded through 75 per cent activities, unless the activity supports the volunteer workforce. SSD providers have the option to allocate up to 25 per cent of funding to activities that fall under a navigation primary focus area, as listed below. These activities can be delivered directly to consumers.

Objective	To increase CHSP provider capability and improve quality of service delivery through activities under a targeted range of primary focus areas.

	75 per cent activity primary focus areas:
	• Active participation in the SSD Community of Practice (mandatory)
	• Wellness and Reablement
	• Workforce enhancements (including attraction, retention and workforce planning)
	• Engagement on Aged care reforms
	• Developing and promoting collaborative partnerships
	  ○ Promoting and encouraging CHSP providers to establish partnerships within the CHSP and broader aged care service system
	  ○ Establishing partnerships and workgroups across the SSD network of providers
	• Compliance and CHSP business practices
	  ○ Compliance under the Aged Care Quality Standards
	  ○ Assistance with reporting, business transformation and operational procedures
	• Developing and disseminating information about the CHSP
	  ○ Developing and disseminating information packages and resources
	  ○ Information sharing only
	• Supporting the volunteer workforce
	  ○ Supporting CHSP Providers in building and maintaining a volunteer workforce
	  ○ Providing support and training to volunteers directly
	• Embedding diversity and inclusion into CHSP provider service delivery and practices
	  ○ General (all diversity types)
	  ○ Focused on one or more of the diverse groups as listed in the Aged Care Diversity Framework and below
	25 per cent navigation activity primary focuses
	• Mainstream navigation services (direct to clients/consumers)
	  ○ General, or
	  ○ Focused on one or more of the diverse groups as listed in the Aged Care Diversity Framework, including:
	  ▪ People who identify as First Nations
	  ▪ People who are Care Leavers
	  ▪ People who identify as culturally and linguistically diverse (CALD)
	  ▪ People who identify and lesbian, gay, transgender, queer, intersex, asexual and/or gender and sexuality diverse (LGBTQIA+)
	  ▪ People living with mental health issues or illness
	  ▪ People living with disability and/or cognitive impairment (including dementia)
	  ▪ People who live in rural or remote areas
	  ▪ People who are financially or socially disadvantaged

Objective	To increase CHSP provider capability and improve quality of service delivery through activities under a targeted range of primary focus areas.
	▪ Veterans (including their spouse, widow or widower) People at risk of or experiencing homelessness (only those who are not eligible for the Care Finder program).
Out-of-scope activities under this service type	Activities delivered under the SSD service type must not include: • Activities that do not relate to CHSP service delivery • Delivery of services directly to clients or consumers (except where noted above) • Activities that do not support building capability of CHSP service providers to improve quality of CHSP service delivery • Activities that exclusively build the capacity of the funded organisation, rather than the capacity of the CHSP sector in general, including: ○ the review and development of internal policies and procedures; ○ assessment and compliance with internal or external policies, procedures, guidelines and laws; ○ website maintenance, marketing and promoting other CHSP and/or non-CHSP services delivered by the funded organisation; ○ support for in-house training and induction for staff recruited for delivery of other CHSP service types of the funded organisation; ○ exclusively supporting the funded organisation's own volunteer workforce. • The provision of advocacy services • Capital works and building maintenance, repairs and refurbishments (e.g. renovations, refitting buildings, installing of gardens, solar panels and blinds etc.); • Developing training or information that duplicates existing resources; • Supporting researchers to recruit older people to participate in studies and research projects; • Facilitation of home share arrangements; • Operating and/or funding Senior Citizen Centres; • Supporting CHSP care recipients with re-assessment of their aged care services; • Services already provided under other Department of Health and Aged Care, Commonwealth or State/Territory programs.
Service delivery setting	Activities can be across a range of settings as appropriate for individual activities.
Use of funds including any target areas	Funding must be used to meet objectives and key deliverables as outlined in the organisation's approved Sector Support and Development Activity Work Plan.
Measure	Funds expended and reports provided in accordance with departmental reporting requirements and the activity described in the organisation's approved Sector Support and Development Activity Work Plan.

Chapter 4 – Access and interactions

4.1 Interaction between the CHSP and other programs

In general, CHSP services should not be provided to people who are already receiving other government-subsidised services that are similar to service types funded through the CHSP.

In certain circumstances it is permissible for clients of other programs to access services and support under the CHSP. However, where this occurs this must not unfairly disadvantage other members of the CHSP target population.

4.1.1 Interaction with specific programs and services

Health system

CHSP services must not replace, or fund supports provided for under other systems including the health care system. For example, the CHSP aims to maximise independence and autonomy for frail older people but is not a substitute for early intervention or rehabilitation, subacute or transition programs provided under the health system.

Post-acute care is also not funded under the CHSP. Where a client is already eligible for CHSP funded assistance or was receiving it prior to hospitalisation, additional support services can be provided following a hospital stay, for a short period of time. After this, support services must be reviewed.

Home Care Packages (HCP)

The care needs of a person receiving a Home Care Package should be addressed through their HCP. Any CHSP service types (e.g. meals, transport, nursing) delivered to them would generally be paid for on a full cost-recovery basis from the HCP client's individualised budget. Full cost recovery means that the CHSP provider would charge the HCP client the full cost of the service provision (e.g. in the case of meals, this would include the ingredients, preparation and distribution costs).

This is intended to ensure that the CHSP is able to provide entry-level support services to as broad a population as possible (given that in most cases this will be the only form of support that people receiving CHSP services access) and recognises that HCP clients already receive Government subsided HCP services. Clients can purchase additional services above the value of their package for an agreed fee with their provider.

Where a client needs additional services as a short-term or time limited arrangement, they can access certain CHSP subsidised services under the six conditions listed below. These are CHSP subsidised services in addition to the services they are receiving from their HCP. The additional CHSP services will not be charged to the client's individualised HCP budget, however, the client will still be expected to contribute to the cost of these services in line with the CHSP provider's client contribution policy. The client contribution must be paid for privately and not from the client's package funds.

The six defined circumstances include:

1. Clients on a Level 1 or 2 package: where a client's individualised budget has been fully allocated, HCP clients may access short-term Allied Health and Therapy Services or Nursing services through the CHSP, where these specific services may assist the client to get back on their feet after a setback (such as a fall).
2. Clients on Level 1 to 4 package: where a client's individualised budget has been fully allocated and a carer requires it, a HCP client may access additional planned short-term respite services through the CHSP.
3. Clients on Level 1 to 4 package: in an emergency situation where they have an urgent and immediate health or safety need and where a client's individualised budget has been fully allocated, some additional CHSP services can be accessed on a short term basis (for goods, equipment and assistive technology, see circumstance 6). These instances must be time limited, monitored and reviewed.

4. Clients on a Level 1 or Level 2 can access additional home modifications through the CHSP only when they are:
    - either waiting for an ACAT reassessment, or have been reassessed by an ACAT at Level 3 or 4 and are waiting for their package assignment, and
    - where the client's individualised budget has been fully allocated.
5. Clients on a Level 1 to 4 package who have transitioned from the CHSP may continue to access their existing CHSP social support group on an ongoing basis to allow the continuity of social relationships. This only applies to clients attending a pre-existing CHSP social support group service.
6. Clients on Level 1 to 4 package or awaiting their package: where there is urgent need, and the care recipient has insufficient funds in their package budget for goods, equipment and assistive technology (GEAT), they may access GEAT in the short term. See further details below.

The short-term or time limited CHSP services are not defined as this will vary on a case by case basis and will depend on the specific circumstances and needs of each individual client. However, it is anticipated that up to three months would be considered as short-term services. It is expected that some additional CHSP services might be delivered for a longer period where specific circumstances warrant it.

The ACAT is responsible for assessment of a client's eligibility for services under the Aged Care Act, including HCP. If an ACAT issues CHSP referrals for a HCP recipient, the ACAT is responsible for scheduling suitable Support Plan Reviews to review aged care needs.

CHSP service providers also have a responsibility to regularly review a client's progress against their individual goals and should refer the client to their most recent assessment service for a support plan review or re-assessment if their needs change.

Where CHSP services are provided to a HCP client, the CHSP service provider must accurately report the services delivered in DEX as they would with any other client.

All HCP clients must be assessed through My Aged Care to receive these additional CHSP services (with the exception of pre-existing CHSP social support group activities). The assessment should be undertaken by the assessment organisation that undertook the most recent assessment of the client, which in most instances will be an ACAT. The additional services must be provided in line with the first four circumstances described above and at an entry-level of support consistent with services provided under the CHSP.

In addition, CHSP service providers should only supply additional CHSP services to HCP clients in the first four categories above where they have capacity to do so without disadvantaging other current or potential CHSP clients - that is, CHSP services should prioritise people who need CHSP support but do not have access to other support services over people who are already in receipt of a HCP. Social support group services whose CHSP clients transition onto a HCP should continue to deliver services under normal CHSP arrangements to these clients.

Access to urgent GEAT for eligible HCP recipients

HCP care recipients, and approved recipients waiting for a package can access up to $2,500 per year for urgent equipment through the CHSP program.

It is important to note this funding is **not available for other CHSP services provided to HCP recipients**. Nor is this funding level available for CHSP clients accessing GEAT. CHSP clients will continue to access up to $1,000 per year for equipment.

An ACAT assessor will review a care recipient's situation and determine whether they are eligible to access urgent GEAT under CHSP.

Urgent circumstances are when the persons immediate health and safety may be at risk if they do not receive the necessary assistive equipment.

Some examples of urgent circumstances include:

- A care recipient is on the waiting list for a package but requires urgent GEAT.

- An existing care recipient sustains an injury and requires urgent GEAT but has insufficient funds in their package to cover the purchase.
- An existing care recipient uses most of their package each month. They were just reassessed and require urgent equipment, but with no increase to their package.
- An existing care recipient is receiving a lower-level package while waiting for assessment or allocation of a higher-level package, but they require urgent GEAT beyond what their current package allows.

These instances must be monitored and reviewed by the HCP care manager where applicable.

HCP providers should advise recipients what funding is available in their package budget, how much to allocate for GEAT and discuss options if urgent needs arise.

Depending on how much package funding is available, their options include:

- If a recipient has enough funds in their package to pay for new equipment, they will not have access to emergency GEAT under CHSP.
- If a recipient has limited unspent funds, they should consider renting or lease to buy options. All costs related to these arrangements must be agreed in a contract between a provider and care recipient and included in the home care agreement.
- If a recipient has spent their allocated funds or insufficient funds remain but they require urgent GEAT, their HCP provider can arrange a referral to the ACAT to have their circumstances assessed. **With this option**:
    - HCP providers should advise the care recipient that, if the total cost of the item/s is more than $2,500, the recipient is required to pay the full gap amount using private funds only.

All requests for urgent GEAT must be sent to the national CHSP provider GEAT2GO.

Please do not send referrals or requests to another CHSP GEAT provider. GEAT2GO is the only provider authorised to supply equipment under this initiative.

Interim CHSP services for clients on the HCP waitlist

Where a new client has been assessed and approved as eligible for a HCP but is waiting to receive that package, the Aged Care Assessment Team (ACAT) may approve the client for services under the CHSP as an interim arrangement. The services will be delivered as entry-level supports consistent with the CHSP not the level of support of the HCP they are eligible for. The number of CHSP services provided at an entry level will vary on a case by case basis and will depend on the specific needs and circumstances of each client. HCP clients will need to contribute to the cost of the CHSP as per the CHSP client contribution arrangements and pay for these fees privately (not from their package funds).

Clients with an approval for a HCP, or whom are on the National Priority System, should not be prioritised above clients without this on the basis of this alone. Priority timeframes are referenced in the My Aged Care Service and Support Portal User Guide document available on the Department's website. Service providers are to take this rating into account along with their own capacity to respond with existing resources within the timeframes before accepting a client.

Residential Care

Residential care recipients (including recipients of residential aged care though a MPS) will not be able to access subsidised CHSP services unless on a full cost recovery basis. This will also be dependent on CHSP provider availability.

National Disability Insurance Scheme (NDIS) and other disability supports

The NDIS is not intended to replace the health or aged care systems. The *National Disability Insurance Scheme Act 2013* specifies that a person is eligible for the NDIS if they meet its age, residential and disability requirements. The age eligibility requirements mean that a person needs to have acquired their disability and made their access request before the age of 65 to be an NDIS participant.

People who are not able to access the NDIS but have a disability and are aged 65 or over (or 50 years and over for Aboriginal and Torres Strait Islander people) will be able to access the CHSP if they are eligible, but within its scope as the entry tier of aged care.

A person's eligibility for the NDIS does not preclude that person from accessing services under the CHSP, so long as the client is eligible for services, the support required from the CHSP is entry-level, and there is no duplication in the specific services/assistance being provided. For example, a person may have NDIS support for domestic assistance and personal care, but also be receiving nursing or transport through the CHSP.

If a NDIS client meets the eligibility criteria for the CHSP, they may be able to access some CHSP services, providing they are not already accessing the same service through the NDIS.

Where a NDIS client prefers to access all services through the aged care system after turning 65, they can do so, noting their NDIS package will cease and they would only be eligible to receive support through the CHSP or Home Care Package program (depending on what they have been assessed as eligible for). A NDIS client will need to contact My Aged Care in the first instance and be assessed for their eligibility for aged care services. CHSP service providers will be required to make reasonable provisions to accommodate the specific needs of clients with disabilities to enable them to access services that are within scope, such as providing services that are responsive to the client's specific needs.

Disability Support for Older Australians

The Disability Support for Older Australians Program (DSOA) came into effect on 1 July 2021, replacing the Continuity of Support (CoS) Programme.

The DSOA Program provides support to older people aged 65 and over (and Aboriginal and Torres Strait Islander people aged 50 years and over) who received specialist disability services from states and territory governments, but were ineligible for the National Disability Insurance Scheme at the time of its rollout due to their age. As a result, DSOA is a closed program with no new client entrants.

The DSOA Program provides a client-centred program, with:

- funding for disability services that is broadly aligned with NDIS prices;
- clients receiving an Individual Support Package overseen by a single DSOA service coordinator;
- support for DSOA clients with complex needs to continue living at home or in supported accommodation as their needs change;
- the NDIS Quality and Safeguards Commission regulating DSOA service coordinators (including subcontracted providers).

DSOA clients are eligible to receive CHSP services that are not provided through DSOA. If a DSOA client wishes to access CHSP services, they should engage My Aged Care in order to undertake an assessment to determine whether they are eligible for support. In doing so, DSOA clients should clearly outline to My Aged Care they are a DSOA client, otherwise they may be found eligible for services that are provided through DSOA. In the event the DSOA client accepts supports under CHSP that are delivered through DSOA, it will be taken that the client has chosen to exit DSOA.

Further information on the DSOA Program is available in the Disability Support for Older Australians Program Manual.

Care Finder Program

Care finders assist clients by:

- supporting them to interact with My Aged Care so they can be screened for eligibility for aged care services and referred for assessment
- explain and guide them through the assessment process including, where appropriate, attending the assessment
- helping them to find the Commonwealth funded aged care supports and services they need and connect with other relevant supports in the community, including supporting them to:
    - understand the different types of aged care supports and services
    - find and make an informed choice about providers or services

- work through income or means testing, if relevant, and costs (with support from Services Australia as required)
- complete forms
- meet with providers to arrange services (such as by calling providers to check availability and attending meetings with providers)
- understand the agreement that needs to be signed with the provider
- connect with other relevant supports in the community, noting that, this may occur before they assist a person to access aged care (as well as any other time).

More information is available on the My Aged Care website.

Transition Care as a form of Flexible Care

In conjunction with State and Territory Governments, the Australian Government funds the Transition Care Programme which assists older people to return home after a hospital stay. A person can only enter transition care directly after being discharged from hospital.

Transition care provides time-limited (up to 126 paid days), goal-oriented and therapy-focused packages of services to older people after a hospital stay, allowing them time to complete their restorative journey and providing them with time to consider their longer-term care options.

Short-Term Restorative Care (STRC) as a form of Flexible Care

STRC is an early intervention program that aims to reverse and/or slow 'functional decline' in older people with the goal of improving individuals' wellbeing and delaying their need to enter residential care or receive a Home Care Package. Unlike transition care, short-term restorative care is available to people without the need for a hospital stay.

STRC provides a time-limited (up to 56 paid days), goal orientated, and coordinated package of services with a focus on multidisciplinary care. It is designed to be a high intensity period of care which may be delivered in a home setting, a residential aged care setting, or a combination of both.

Receiving Flexible Care and CHSP at the same time

People may receive CHSP and flexible care (transition care or STRC) services at the same time, providing they are assessed as being eligible for each program. There are, however, some instances where these programs can provide the same or similar services, such as home modifications or assistance with meals. The Department does not support someone receiving duplicate services through two programs.

When planning care, transition care and STRC providers are expected to liaise with their care recipient's existing supports including, where applicable, their CHSP provider.

Palliative care

State and Territory Governments are responsible for the provision and delivery of palliative care and hospice services as part of state health and community service provision responsibilities. As such, decisions on the funding and delivery of palliative care and hospice services in each jurisdiction, are the responsibility of individual State and Territory Governments.

CHSP clients are able to receive palliative care services from their local health system in addition to their home support services, but this needs to be arranged by the person's General Practitioner or treating hospital. As with any palliative care arrangement, the palliative care team would coordinate the skills and disciplines of many service providers to ensure appropriate care services. This would include working with the client's CHSP service provider(s).

Veterans

Veterans can access CHSP services in order to support them to remain independent in their own home in the same way as the general population. This access is determined by their eligibility, assessed need, and any service being provided by other government programs.

A person's eligibility for Department of Veterans' Affairs-funded services such as the Veterans' Home Care Program, community nursing, transport or respite does not preclude that person from accessing services under the CHSP, so long as the client is eligible for services, the

support required from the CHSP is entry-level, and there is no duplication in the specific services/assistance being provided.

For example, a person may access Veterans' Home Care for low-level domestic assistance and personal care, but also be receiving transport and delivered meals through the CHSP.

4.1.2 Transition Arrangements for Existing Clients

When the CHSP was implemented in July 2015, existing clients of the former programs that were consolidated into the CHSP (including the Commonwealth HACC program; planned respite services under the NRCP; DTC and ACHA) were transitioned directly into the CHSP to ensure that continuity of care was provided for these clients.

Existing clients of the Victorian HACC program were transitioned directly into the CHSP on 1 July 2016 and those in the Western Australian HACC program were transitioned directly into the CHSP on 1 July 2018.

Existing clients are defined as individuals who were accessing services or approved for services at 1 July 2015 in Queensland, New South Wales, the Australian Capital Territory, Tasmania, South Australia and the Northern Territory, at 1 July 2016 in Victoria and 1 July 2018 in Western Australia; have accessed services at least three times over the previous financial year; or who received care for a continuous period of six months or more in the previous financial year.

Existing clients that have not accessed a CHSP service in the past twelve months must be referred to My Aged Care for assessment before any services can be provided.

Existing clients that were transitioned into the CHSP also included some clients who would not otherwise be eligible for the program (due to their age and/or level of support required). These clients have been grandfathered into the CHSP and will be supported to transfer to more appropriate services (such as the NDIS or HCP Program) where appropriate. Service providers should work with My Aged Care and the client when their needs change to transition them to more appropriate services, where possible.

Residential Care

Prior to 1 July 2015, services funded under the DTC Program were available to residents with a previous Aged Care Funding Instrument (ACFI) 'low' score (now the Australian National Aged Care Classification AN-ACC funding model) in Australian Government funded residential care facilities. These DTC clients were grandfathered under the CHSP.

Clients needing services that exceed the level of 'entry-level support'

Existing clients receiving services prior to 1 July 2015 will continue to receive CHSP support from the current service providers at the current service level until they are transitioned to other forms of more appropriate care. Where the client's service needs have increased or changed, they must be referred to My Aged Care for an assessment.

Existing clients receiving services over 'entry-level support' as they wait for a home care package

Existing clients receiving services over 'entry-level' support prior to 1 July 2015 and waiting for a Home Care Package can continue to receive CHSP services at their current level until the Home Care Package becomes available.

Former NRCP or DTC Program clients aged under 65 years

Clients aged under 65 years who were accessing services under the NRCP or DTC Program prior to 1 July 2015, can continue to receive services under the CHSP until:

- a more appropriate service becomes available, such as the NDIS.
- they no longer require the service.

Carers of clients under the age of 65

Prior to 1 July 2015, there was a small group of carers of clients under the age of 65 receiving services under the former NRCP. Grandfathering arrangements will apply for existing respite arrangements to ensure continuity of care for these clients. These clients may retain access to equivalent services under the CHSP until other suitable services become available.

Registering CHSP clients with My Aged Care

All new and returning clients must enter into the CHSP through My Aged Care. In addition, where an existing client's needs change, including where there is a need for a new service type or a significant increase to their existing service level, the client must be referred to My Aged Care for an assessment before any additional services are provided.

Where an existing client does not have a My Aged Care record, but the client is receiving CHSP services and their needs have changed, they will need to contact My Aged Care for a re-assessment of their needs at which point a My Aged Care record will be created for the client.

4.2 Equity of access

Service providers must ensure that all their clients have equitable access to services. To achieve equitable access, service providers must consider the following key principles:

- Physical access: all CHSP services must be able to offer accessible service options to people with physical or sensory disabilities.
- All eligible people assessed as needing a service must have equal access to available CHSP services whether they are an Aboriginal and Torres Strait Islander person; from a diverse cultural and linguistic background; or on the grounds of location, marital status, religion and spirituality, gender identity, sexual orientation, disability or whether they have the ability to pay for services.
- The CHSP does not have any exclusion from services based on citizenship, residency status or eligibility for Medicare support.
- Eligibility does not translate to having an entitlement to services. Services may not be able to be provided due to other people being assessed as a higher priority or resources not being immediately available.

4.3 Prioritisation of referral

Priority of the referral will be determined by My Aged Care contact centre or assessor based on the information the contact centre has available at the time of screening, including carer availability, cognition and function. This will be provided with the referral through the My Aged Care Service and Support Portal. The priority timeframes - High, Medium and Low – are outlined in more detail in the Aged Care Assessment Manual on the Department's website. .

Service providers are to take this rating into account along with their own capacity to respond with existing resources within the timeframes before accepting a client.

4.4 Assessment for entry to the CHSP

4.4.1 Assessment functions undertaken by My Aged Care

Entry and assessment for the CHSP is through My Aged Care. Detailed information for service providers on interacting with My Aged Care and using the My Aged Care Service and Support Portal is available on the Department of Health and Aged Care website.

My Aged Care incorporates a website and contact centre. The contact centre registers clients via a phone-based screening process and determines the appropriate assessment pathway for referral.

Screening and assessment are supported by a standardised national assessment process (using the NSAF) and a central client record.

The My Aged Care assessment process

The contact centre registers the client (as appropriate), conducts a screening process over the phone and will then do one of the following:

- refer the client for a home support assessment to be conducted by a RAS, if the client can be supported by the CHSP.

- refer the client for a comprehensive assessment to be conducted by an Aged Care Assessment Team (ACAT), if the client's needs indicate a higher level of care could be required under the Aged Care Act 1997.
- refer the client directly to CHSP service(s), in exceptional circumstances only, as well as for a home support assessment to be conducted by a RAS or ACAT as circumstances require.
- provide information about non-Commonwealth funded services.

Where screening over the phone is not appropriate, the contact centre will refer the client for assessment using the information they were able to collect (and after obtaining the client's consent).

Assessments can also be applied for online at myagedcare.gov.au/assessment/apply-online. A client, family member or friend acting on the client's behalf, can register and complete a referral for assessment quickly and easily. Health professionals and GPs can also refer clients for an assessment. Further information about the range of ways to apply can be found at www.myagedcare.gov.au/health-professionals. Clients can also access the eligibility checker at myagedcare.gov.au/eligibility-checker.

Assessments can be conducted in the client's home, over the phone or by video conference.

In person supports are also available at dedicated Services Australia service centres. Appointments can be made with an Aged Care Specialist Officer (where one is available) at a Services Australia service centre. Bookings can be made by contacting 1800 227 475 weekdays from 8am to 5pm. Further information can be found on the Services Australia website.

CHSP clients can access information about the CHSP in the *Your Guide to CHSP Services* and the *Your Guide to CHSP Services Easy Read booklet*. These booklets are available on the My Aged Care website under Resources.

Core functions delivered by the Regional Assessment Service

Once clients have undertaken a preliminary assessment of their circumstances and eligibility for aged care services via a phone-based screening with the contact centre, they will then be further assessed by a RAS to determine their care needs and to provide access to CHSP services. The RAS is responsible for:

- independent assessment of new clients, with a holistic, goal oriented, wellness and reablement focus.
- face-to-face assessments as best practice and whenever possible, noting that assessments can also occur over the phone or by video conference where appropriate.
- involvement by family and their carers, representatives or other advocates as appropriate.
- valuing and supporting a client's identify, culture and diversity.
- assessing immediate needs of the client, and not recommending services that are not supported by the assessment.
- supporting client choice and incorporating goal-based support planning.
- matching and referral of assessed clients to appropriate CHSP services and other appropriate formal and informal support services to assist the client to live independently in their own home.
- review or reassessment of existing clients where there is a change in the client's circumstances or care needs.
- identifying and supporting clients with special needs and vulnerable clients who require short-term case management (i.e. linking support) to access a range of aged care and other services e.g. health, housing, disability and aged care services.
- short-term coordination services to assist and restore their independence using wellness and reablement approaches and reduce their need for ongoing CHSP services.

- during an assessment explain to a client that they are expected to contribute toward the cost of the CHSP services they receive, if they can afford to do so.
- building and maintaining effective and respectful working relationships with all My Aged Care assessors and service providers.

The RAS are required to have local knowledge of CHSP services.

Comprehensive assessments for aged care services (such as Home Care Packages) under the *Aged Care Act 1997* continue to be undertaken by ACATs. The RAS can refer clients to ACATs (when required). Note: ACATs can also refer clients to CHSP.

Access to Emergency CHSP services

People seeking access to aged care services for the first time must contact My Aged Care to have a client record created and arrange for an assessment of their care needs.

Clients seeking new or increased services should not approach CHSP service providers before registering with My Aged Care directly unless the client requires an urgent and immediate health or safety intervention.

A client can be referred by My Aged Care directly to a CHSP service provider only if the client has a need for an immediate health or safety intervention that is not available through other means. The services where this is likely to happen include nursing, personal care, meals, grocery shopping and transport.

The circumstances in which there is an urgent need for services to start immediately will vary. Providers and the contact centre will need to make judgments on a case-by-case basis. For example, a client may urgently need immediate services because a carer is no longer available or there has been a sudden and dramatic loss of a client's functional ability which, if not addressed immediately, will place the client at risk.

It is acknowledged that a number of other services including home maintenance, home modifications, goods, equipment and assistive technology and domestic assistance may be sought urgently. However, it is less likely that a client's safety would be at risk if these services are not provided immediately, in advance of a holistic assessment by the RAS and an Occupational Therapist (where appropriate).

If the client has a need for an immediate health or safety intervention that is not available through other means, the services should be:

- For a one-off or short-term intervention (e.g. such as nursing for wound care, transport to a specialist medical appointment or the delivery of meals, personal care and other support services due to the absence of a carer) usually up to a maximum period of eight weeks. An assessment may be required for ongoing services required beyond eight weeks and will depend on the client's needs.
- For a direct health or safety intervention that needs to occur before an aged care assessment can take place.
- Monitored by the provider and if the client requires long term or ongoing access to services, then the CHSP service provider must support the client to register with My Aged Care (if they have not already done so) and arrange for a RAS or ACAT assessment.

These circumstances recognise that there are limited situations where delivery of services is required while maintaining the commitment to a more thorough analysis of the client's needs by the RAS or ACAT when possible.

If clients require access to ongoing or long term (greater than eight weeks) services, then the CHSP service provider must support the client to register with My Aged Care (if they have not already done so) and arrange for a RAS or ACAT assessment. For clients referred for an assessment, who require services for more than eight weeks and are waiting for the assessment, the provider should maintain the urgent services until the assessment takes place.

GPs and hospitals should use their existing processes and networks to refer patients who need urgent CHSP services. My Aged Care should not be used for referrals for services that should be provided to older people through the health system.

If a service provider is approached before the client has contacted My Aged Care, they can assist clients with the My Aged Care registration process by:

- Calling My Aged Care with the person to help them register and be screened. This is the quickest method to registering a client.
- Recording client details in an inbound referral form, accessed from My Aged Care that is sent to the contact centre for actioning.

Aged care assessment

Where a face-to-face assessment is required, this will be conducted in the client's home or other appropriate location by the RAS (using the NSAF), building on the information collected by the contact centre during the screening process. Face-to-face assessments are best practice and conducted whenever possible. Where face-to-face contact between the assessor and a client is not possible, for example, when assessing a client in a remote area or the client is inaccessible due to a seasonal weather event or pandemic - a phone, video conference, telehealth or teleconference assessment may be undertaken.

The assessment will focus on the strengths and immediate needs of the individual client, rather than be specific to a particular program or care type. RAS assessors are appropriately skilled and trained to undertake assessments and identify services appropriate for a diverse range of clients. Their training requirements are set out in the My Aged Care Workforce Learning Strategy 2023 which defines and sets the minimum training requirement for the Assessment Workforce.

The national training resources for staff conducting screening and assessment includes consideration of the needs of people from Culturally and Linguistically Diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander people, LGBTIQA+ people, and working with Carers and Care Relationships. The screening and assessment process, facilitated through the NSAF, ensures diverse needs groups are appropriately considered and provided with culturally appropriate support.

RAS assessors will approach assessment in a way that maximises client independence and autonomy, supporting their desire and capacity to make gains in their physical, social and emotional wellbeing by optimising physical function and active participation in the community.

Where a client may benefit from a short period of more intensive supports, as part of a wellness and reablement approach recommended by a RAS assessor, a goal orientated support service can be delivered under the CHSP for a time-limited period. The nature of these services should be identified in the support plan agreed with the RAS, including the duration of the intensive supports.

Review of client needs

Changes in a client's circumstances or an increase in the client's service delivery needs will require a support plan review to be undertaken by the RAS which may result in a new assessment.

A support plan review refers to a check of the effectiveness and on-going appropriateness of the services the client is receiving. A review of a client may take place where:

- a client has received restorative care interventions under CHSP and has made a functional gain or improvement to remain independent.
- short-term or time-limited support/coordination utilising a wellness and reablement approach has been undertaken by the RAS.
- the My Aged Care assessor sets a review date in the support plan for a short-term service. For example, where the client is referred for time limited support under the CHSP whilst a client is waiting for access to a Home Care Package.
- a service provider identifies a change in the client's needs or circumstances that affects the existing support plan. Such as informal care arrangements have changed/ceased.
- a client identifies a change in their needs or circumstances or seeks assistance to access new services or change their service provider.

CHSP service providers have an on-going responsibility to monitor and review the services they provide to their clients under the client's care plan to ensure that the client's needs are being met. Where the My Aged Care assessor recommends short term or time limited services, service providers should incorporate suitable review points in the client's care plan or equivalent. Where there is no recommended review date included in the client's My Aged Care support plan, service providers must undertake a review of services they are delivering at least every 12 months. The outcome of this review is to be recorded on the My Aged Care client record.

Where the client requires a different service or a significant increase in services, or where the service provider's review highlights needs or goals not identified on the client's support plan, the service provider must request a Support Plan Review to refer the client to the RAS (or the latest assessment organisation) through the service and support portal. A client completing a restorative care program may also be referred to the RAS, for identification of any on-going services needed following the end of the program.

Service providers should include clear and detailed information on the request for a support plan review, justify the reason for the review request and, if necessary, outline the urgency for the review. These actions will assist assessors with managing high volumes of review requests, reduce the risk of the assessor cancelling the request or the need for the assessor to follow up individual requests with the provider. Service providers follow the My Aged Care Service and Support Portal User Guide for Team Leaders and Staff Members for further guidance on how to request a support plan review and refer to the When to Request a Support Plan Review from an Assessor Fact Sheet for more information.

The outcomes of the review may include:

- no change
- an increase or decrease in services or a new service recommendation
- a new assessment to be conducted by the RAS
- a referral to an ACAT for a comprehensive review for services accessed under the Aged Care Act 1997.

If there is a significant change in the client's needs and/or circumstances that affect the scope of the support plan, a new assessment must be undertaken by an assessor. This may be initiated by an assessor's support plan review following a request for review by a service provider or by a client. Clients will be referred to the assessment organisation that last undertook the assessment.

Implementing a wellness and reablement approach

RAS assessors meet with consumers to determine eligibility for Commonwealth subsidised aged care services, and work with the client to identify areas of concern and set goals as part of developing the client's support plan. Where appropriate, they can refer clients to available service providers.

Service providers then interpret the Home Support Assessment and support plan with a wellness and reablement approach in mind and in consultation with the client by translating each identified goal into smaller steps to enable clients to progress their goals.

RAS assessors will be responsible for developing support plans with the client that may result in referral to services that will support their independence utilising a wellness and reablement approach. Such a plan might include some of the following:

- need for assistive devices or equipment
- in-home or community linked exercise and daily activity program
- strategies to reduce falls
- improved awareness and understanding of the use of medication
- ways of managing chronic disease, including improved ways of self-management.

Because of the nature of these services, it is possible there will be several items in the support plan that need to be delivered in a coordinated way over a limited time period. In these circumstances, the assessor could refer a client to a lead provider, the organisation or individual provider who will deliver the key services in the support plan.

More detail on implementing a wellness and reablement approach, to support independence under the CHSP is provided under Chapter 2 of this manual and resources on the wellness and reablement webpage.

Avenues for client complaints about assessment

If a client has a complaint about the assessment process or outcome, the client should contact the RAS in the first instance. The RAS will document the complaint and attempt to resolve the complaint within their internal complaints system. (RAS providers are required by the Department to develop and document their own internal complaints system). If a client is not satisfied that their complaint has been resolved by the RAS, they can escalate the complaint by contacting My Aged Care. Complaints relating to assessment organisations are escalated to the Department for investigation. Complaints about service providers are covered under 6.1.7.

4.4.2 Service provider requirements for interacting with My Aged Care

CHSP service providers must:

- provide and update their service data regularly via the My Aged Care Service and Support Portal.
- accept/reject client referrals via the My Aged Care Service and Support Portal in a timely way specified by the referral priority. Please refer to the Aged Care Assessment Manual for timelines for managing referrals.
- accept referrals where they have capacity to provide the services in a timely manner.
- refer or help clients to access My Aged Care where clients have approached them directly, as all clients who receive CHSP services need to be registered with My Aged Care and assessed for services.
- enter and regularly update service information (including commencement date and frequency/volume of services, waitlist availability) and update client details on the client record.
- undertake a review of services being delivered, at least every 12 months with the outcome of the review recorded on the client record.
- maintain up to date service information for the organisation within the provider portal to support accurate and timely referrals and access for clients.
- deliver services within the scope of the service recommendations specified on the support plan.
- refer clients back to My Aged Care when their needs have changed through support plan review request functionality.
- discharge clients whose needs and goals specified on the support plan have been met and who no longer require care and services.
- Encourage clients whose needs are no longer met by entry level CHSP to have a reassessment (through a support plan review request) for other aged care programs that could be more suitable to their changing needs.
- participate in assessment, referral and client record processes as appropriate to support data integrity within My Aged Care.

CHSP providers can refer to the My Aged Care Service and Support Portal resources on the Department of Health and Aged Care website.

The use of waitlists

The decision to use and the responsibility for managing waitlists for CHSP services is an internal business decision for individual service providers. CHSP providers should not accept

clients to waitlists where services are not imminently available as this may prevent other local CHSP service providers with capacity from meeting client needs.

4.4.3 Assessment functions undertaken by CHSP service providers

Assessment for eligibility and CHSP services is undertaken by RAS or ACAT assessors who after completing the assessment, refer the client to services delivered by approved service providers.

This separation of assessment from service provision allows for the application of a nationally consistent and standardised approach to assessment delivery. Organisations with service provision and assessment arms must demonstrate operational separation between these different services.

However, CHSP service providers are also required to undertake a small number of assessment functions, where they are intrinsic to the service being delivered.

These include:

- Service level assessment activities relating to the service provider, such as undertaking Work Health and Safety assessments (for both the care worker and client).
- Specialised assessment based on professional expertise (e.g. Nursing, Allied Health and Therapy Services; and face-to-face malnutrition risk assessments by Meals providers where organisations have this knowledge and capacity).
- On-going monitoring of the client, the home environment; and appropriateness of service arrangements.
- A formal review of services must be undertaken at least once every 12 months (these may be done over the phone or face to face with the client).
- Support Plan Review request to an assessor through the My Aged Care service provider portal if the client's care needs change significantly (e.g. high levels of additional services are required or new service types are needed). This will likely lead to a new assessment.

In addition, service providers must follow requirements identified at Section 4.4.2 of this program manual.

Reporting time spent on assessment and client care coordination:

Where the service level assessment functions involves direct client interaction, the amount of assistance provided by a CHSP service provider can be recorded in DEX as a session of that service sub-service type i.e. nursing, occupational therapy, garden maintenance etc.

Time spent arranging services without direct client interaction (except under the Assistance with Care and Housing sub-programme) should not be reported in DEX.

4.4.4 My Aged Care interactions

Service level assessment

All review and assessment functions undertaken for the CHSP must incorporate the eligibility and service information and Work Health and Safety requirements outlined in this program manual.

Privacy and confidentiality

Assessment and provider practices must be in accordance with processes to protect client privacy and confidentiality.

Sensitive information

With the client's consent, notify My Aged Care if there is sensitive information concerning the client that could affect the health and safety of other My Aged Care workforces. This information is recorded as a sensitive note in the client record that is visible to assessors and contact centre staff.

Sensitive notes or attachments are not visible through the provider portal. Instead, a message will display on the client's record stating "The client has a sensitive note/attachment on the

record". If you see this message on your client's record, you should contact the assessor directly, or call the My Aged Care service provider and assessor helpline on 1800 836 799. They will be able to provide you with any relevant information, if it impacts on services you provide.

Recording deceased clients

When a provider becomes aware a client has passed away, a record must be made in the My Aged Care Service and Support Portal.

Ceasing a client's service with the reason of **'Client Deceased'** will change the client's status to **'Deceased'** and make the client record *READ ONLY*. Any unaccepted service referrals will be recalled and the client's access to the client portal will be revoked.

Changing the client's status in this way will also remove the client from the Home Care Package national priority system (the queue) and withdraw any assigned Home Care Packages. This is important to prevent distress for grieving family members caused by correspondence received regarding deceased loved ones.

Instructions on how to discontinue a deceased client's service in My Aged Care are available in the My Aged Care Service and Support Portal User Guide – Recording and updating client service delivery information.

Chapter 5 – Client contribution framework

5.1 Operation of the framework

In October 2015, a principles-based Client Contribution Framework (the Framework) was introduced for the CHSP. CHSP service providers must adhere to this principles-based approach to the charging, collecting and reporting of client contributions.

The Framework outlines the principles service providers should adopt in setting and implementing their own client contribution policy with a view to ensuring that those who can afford to contribute to the cost of their care do so, whilst protecting those most vulnerable. It is designed to support the financial sustainability of the CHSP whilst creating fairness and consistency in the way both new and existing clients contribute to the cost of their care.

5.2 Exclusions from the framework

Some CHSP activities and services are specifically excluded from this Framework:

Assistance with Care and Housing Sub-Program

Sector support and development activities

5.3 Framework objectives

For all other services provided under the CHSP, it is expected that contributions towards the cost of care will move towards a nationally consistent approach over time.

Other than for those services outlined under section 5.2, all CHSP service providers are required to have a documented and publicly available client contribution policy in place that aligns to this Framework and balances the following objectives:

- **To move towards national fairness and consistency in client contributions**

Service providers should move towards collecting contributions if they are not already doing so. Service providers will need to disclose their contribution policy across their range of services and agree contribution amounts with clients in advance of care being provided. The creation and application of a client contribution framework for the provision of CHSP services provides an opportunity to address a number of inconsistencies and financial anomalies inherent in the existing fees and charges for services provided to assist frail older people to remain in their own homes.

- **Improve the sustainability of the CHSP**

Those service providers who have not previously required clients to make a contribution for the services they receive must have in place a contribution policy with a view to supporting ongoing service delivery and utilising the additional revenue to expand their services.

- **Provide appropriate safeguards for financially disadvantaged clients**

Client contributions policy should ensure that those least able to contribute towards the cost of their care are protected.

5.4 Client contribution principles

Contribution policies for the provision of CHSP services should incorporate the principles below. Further explanation and case studies are provided in the separate *National Guide to the Client Contribution Framework*.

1. **Consistency:** All clients who can afford to contribute to the cost of their care should do so. Client contributions should not exceed the actual cost of service provision.
2. **Transparency:** Client contribution policies should include information in an accessible format and be publicly available, given to, and explained to, all new and existing clients.
3. **Hardship:** Individual policies should include arrangements for those who are unable to pay the requested contribution.

4. **Reporting:** Grant agreement obligations include a requirement for service providers to report the dollar amount collected from client contributions.
5. **Fairness:** The Client Contribution Framework should take into account the client's capacity to pay and should not exceed the actual cost to deliver the services. In administering this, service providers need to take into account partnered clients, clients in receipt of compensation payments and bundling of services.
6. **Sustainability:** Revenue from client contributions should be used to support ongoing service delivery and expand the services providers are currently funded to deliver.

5.5 Guide to the framework

The *National Guide to the CHSP Client Contribution Framework* (the Guide) was also introduced in October 2015. The Guide complements the Framework and has been developed for service providers to assist with the establishment of flexible options for client contribution arrangements and updated in June 2022.

5.6 CHSP reasonable client contributions

A CHSP reasonable client contribution range for each service type is available under 3.2 – CHSP national unit price ranges. These ranges were developed along with the unit prices and have been provided as a guide to assist CHSP providers to implement or review their client contribution policy.

Please note that these reasonable client contribution ranges are provided as a guide and may not be suitable for all client contribution policies. CHSP providers will still need to follow the guidance in this chapter.

Part B – Administration of the CHSP

Chapter 6 - Service provider and departmental responsibilities

6.1 Service provider responsibilities

In entering into a Grant Agreement with the Department, the service provider must comply with all requirements outlined in the suite of documents that comprise the Agreement, including:

- the CHSP Extension Grant Opportunity Guidelines
- the Commonwealth Standard Grant Agreement (including the Commonwealth Standard Grant Conditions and any Supplementary Terms from the Clause Bank)
- the Grant Details (including any other document referenced or incorporated in the Grant Details including the Activity Work Plan)
- this CHSP Program Manual
- the Aged Care Quality Standards
- other documents incorporated by reference into the above documents.

Service providers are responsible for ensuring:

- the requirements of the CHSP Grant Agreement are met
- service provision is effective, efficient and appropriately targeted
- My Aged Care service availability is up to date and accurate
- services delivered to clients are in line with individual goals, recommendations and assessment outcomes as identified in their individual My Aged Care support plan
- wellness and reablement, and restorative approaches to service delivery support older people improve their function, independence and quality of life
- highest standards of duty of care are applied
- services are operated in line with, and comply with, the requirements as set out within all state and territory and Commonwealth legislation and regulations
- that staff and volunteers in direct care roles with responsibility for the safe delivery of services to clients or groups of clients, receive current and accredited first aid certification
- that up-to-date infectious disease controls and emergency preparedness policies are in place and enforced
- older people with diverse needs have equal and equitable access to available services and are delivered in line with the Aged Care Diversity Framework
- they work collaboratively with stakeholders to deliver services
- they contribute to the overall development and improvement of service delivery such as sharing best practice
- they assist clients to transition to another provider (where required) and continue providing supports to those clients until they have fully transitioned
- they manage and keep up-to-date their client records and service information via the My Aged Care Service and Support Portal.

CHSP providers can refer to the CHSP My Aged Care Provider Journey infographic on the Department of Health and Aged Care website for further information.

This chapter outlines service provider and Departmental responsibilities relating to the administration of the CHSP, including:

- Quality arrangements (Section 6.1.1)
- Funding arrangements (Section 6.2)
- Reporting requirements (Section 6.3).

6.1.1 Quality arrangements for service delivery

All CHSP service providers must operate in line with the Aged Care Quality Standards (the Standards) and have appropriate procedures in place to meet these. The Quality Standards relate to quality of care and quality of life for the provision of aged care in the community. A link to the Standards is provided in Appendix A of this program manual. The Standards require service providers to demonstrate effective management processes based on a continuous improvement approach to service management, planning and delivery. A provider's plan for continuous improvement, if requested, must be provided to the department.

This includes policies for managing staff and volunteers, regulatory compliance with funded program guidelines, relevant legislation including work health and safety legislation and professional standards and having complaint mechanisms in place. Some of the Home Care Standards relate to service access and assessment and referral practices.

The Standards apply to all aged care services including residential care, home care, flexible care and services under the CHSP.

There are eight Standards including:

- Standard 1 Consumer dignity and choice
- Standard 2 Ongoing assessment and planning with consumers
- Standard 3 Personal care and clinical care
- Standard 4 Services and supports for daily living
- Standard 5 Organisation's service environment
- Standard 6 Feedback and complaints
- Standard 7 Human resources
- Standard 8 Organisational governance

Each of the eight Standards includes:

- a statement of outcome for the consumer
- a statement of expectation for the organisation
- organisational requirements to demonstrate that the standard has been met.

The Standards have been structured so that aged care providers will only have to meet those Standards that are relevant to the type of care and services they provide and the environment in which services are delivered. For more information, providers should visit the Aged Care Quality and Safety Commission website.

My Aged Care undertakes the registration, screening and assessment of clients requiring aged care services. Although the responsibility of assessments for services under the CHSP resides with My Aged Care and RAS, service providers are expected to continue to monitor and review the client's circumstances to ensure the service delivery is appropriate for the client in meeting their care needs. Service providers must comply with all requirements relating to access and assessment as outlined in Chapter 4 of this program manual.

Service providers must report through the Data Exchange that they have a client contribution policy in place that is consistent with the Client Contribution Framework as detailed in Chapter 5 of this program manual.

Quality reviews

The Aged Care Quality and Safety Commission undertakes all quality reviews of aged care services provided in the community, including the CHSP service providers. In accordance with the CHSP Grant Agreement, service providers are obliged to provide the Aged Care Quality and Safety Commission with access to a service delivery site or service outlet, for the purpose of undertaking a quality reporting site visit.

The Aged Care Quality Standards support service providers to maintain the high quality of service delivery expected by all providers of aged care. Only the CHSP sub-programs which deliver direct care to clients will be subject to Quality Reviews by the Aged Care Quality and Safety Commission.

Further information about the Quality Review process is available at the Aged Care Quality and Safety Commission website. Service providers must address any non-compliance and return to compliance as quickly as possible.

Note: the Sub-Programs Assistance with Care and Housing and the Sector Support and Development are not subject to Quality Reviews.

6.1.2 Client rights and responsibilities

Service providers must comply with the *Charter of Aged Care Rights* within the User Rights Amendment (Charter of Aged Care Rights) Principles 2019 under the *Aged Care Act 1997*.

Respect for, and promotion of, the rights of clients is integral to the consumer choice philosophy that underpins the CHSP, which also includes a strong emphasis on wellness and reablement.

New CHSP clients

CHSP service providers must meet all of the requirements of the Charter for all new clients before they enter the CHSP service. For all new clients, CHSP service providers have a responsibility to:

- give the client a copy of the Charter signed by a staff member of the provider;
- assist the client to understand information about consumer rights and responsibilities in relation to the aged care service and consumer rights under the Charter;
- ensure the client, or their authorised person, are given a reasonable opportunity to sign a copy of the Charter;
- keep a record of the Charter given to the client, including:
    - the signature of provider's staff member; and
    - the date on which the provider gave the client a copy of the Charter; and
    - the date on which the provider gave the client (or their authorised person) the opportunity to sign the Charter; and
    - the full name and signature of the client (or authorised person) if they choose to sign).

The purpose of seeking the client's signature is to allow them to acknowledge they have received the Charter and have been assisted to understand it and their rights.

Clients are not required to sign the Charter and can commence, and/or continue to receive care and services, even if they choose not to sign the Charter.

Where a client, or authorised person, has not signed a copy of the Charter, providers will need to:

- set out the date on which the client, or authorised person, was given a copy of the Charter
- include the full name of the client or authorised person.

Additional information about the Charter is available on the Aged Care Quality and Safety Commission website.

Scheduling appointments

In accordance with the Aged Care Quality Standards, clients have the right to be consulted and respected, receive services that are appropriate, planned, delivered and evaluated regularly and have access to complaints and advocacy information and services.

Where possible, service providers should seek to maintain regular and consistent appointment schedules. Service providers should give their clients as much notice as possible if they have to reschedule, cancel or are running late for an appointment. Where a client is unhappy with their care plan arrangements and, they need to contact their service provider in the first instance to make alternative arrangements.

Where a client cancels their appointment within 24 hours of the visit start time, providers do not need to record the service as it was not delivered. Providers should have a clear cancellation policy as part of their client contribution policy and clients should be made aware of this as part of their care plan discussions.

6.1.3 Police checks

Service providers have a responsibility to ensure staff members working with vulnerable people, volunteers and executive decision makers undergo police (or relevant) checks.

Service providers have a responsibility to ensure that all staff, volunteers and executive decision makers working in CHSP services are suitable for the roles they are performing. Service providers must ensure that staff involved in service delivery, including sub-contractor staff meets the *CHSP Police Certificate* requirements at Appendix D of this program manual.

The CHSP Police Certificate Guidelines have been developed to assist service providers with the management of police check requirements under the CHSP (Appendix D).

Where urgent and immediate staff or volunteer recruitment is necessary, CHSP providers may allow essential workers who have applied for, but not yet received, a police check to make a statutory declaration before commencing duties. In these instances, the employee or volunteer must sign a statutory declaration stating that they have never, in Australia or another country, been convicted of a serious or violent crime. A statutory declaration template and more information about statutory declarations are available at the Attorney-General's Department's website.

The payment of the cost of obtaining a police certificate is a matter for negotiation between the service provider and the individual. Individuals may be able to claim the cost of the police certificate as a work-related expense for tax purposes. Further advice on this issue is available on the Australian Taxation Office website.

Volunteers may be eligible to obtain a police certificate at a reduced cost whether the certificate is requested by an individual or by a service provider on behalf of a volunteer. This must be confirmed with the agency issuing the police certificate.

Note: The NDIS worker screening arrangements are acceptable for employees who also deliver services under the CHSP.

6.1.4 Staffing and training

Service providers are required to meet staffing and training requirements under the Standards. Examples of desirable staff qualifications under the CHSP are outlined in the 'Staff Qualifications' sections in Chapter 3 of this program manual.

First Aid Training

To help support vulnerable, older Australians, all CHSP service providers are responsible for ensuring staff and volunteers in direct care roles receive accredited first aid training and certification as soon as practicable.

The Department regards the cost of first aid training as a reasonable and necessary expense of safe and effective aged care service delivery. As such, CHSP providers should factor the cost of first aid training into their existing grant funding in the same way as rent, utilities, personal

protective equipment and staff wages. CHSP providers can use their existing CHSP grant funding, including unspent funds, to cover the cost of staff and volunteers attending first aid training and refresher courses, where applicable.

It is the responsibility of CHSP providers to factor the level and appropriateness of first aid training needs into their business risk management plan. In considering the level of training offered to staff and volunteers, CHSP service providers should consider the specific needs of their clients and any additional risk factors they may present (e.g. dementia; falls risk; other disabilities, health problems or co-morbidities).

Where appropriate, CHSP providers may consider the option of online first aid courses to enable staff or volunteers to complete the training where it is difficult to attend a face-to-face course.

It is the responsibility of individual service providers to factor into their business risk management strategies how many and which staff/volunteers need to hold and maintain First Aid Training qualifications to ensure the safe delivery of services to their clients.

Fair Work Commission award wage increase

On 4 May 2023, the Australian Government announcement an investment of $11.3 billion to fund the Fair Work Commission's decision for a 15 per cent increase to minimum award wages.

Aged care workers who will benefit from the wage increase are:

- registered nurses
- enrolled nurses
- assistants in nursing
- personal care workers and home care workers
- head chefs and cooks
- recreational activities officers (lifestyle workers).

The award rate changes will take effect from the employee's first full pay period that starts on or after 30 June 2023.

CHSP providers can apply for funding to meet the costs associated with increases in the Fair Work Commission award wage through a grant opportunity. Funding for leave liabilities is also included. Further information is available on Grant Connect and on the department's website under CHSP News and under Better and Fairer Wages for Aged Care Workers.

6.1.5 Work Health and Safety

Legislation relating to Occupational Health and Safety (OH&S) is being replaced by legislation referring to Work Health and Safety (WHS) following the passage of the *Work Health and Safety Act 2011 Commonwealth*.

The Australian Government, Northern Territory, Queensland, New South Wales, Tasmania, South Australia and the Australian Capital Territory have implemented the new legislation. Victoria and Western Australia have not yet introduced the WHS legislation. It is intended that the term OH&S will be incrementally replaced with WHS in all Australian Government, state and territory documents.

Providing a safe and healthy workplace

CHSP service providers must provide a safe and healthy workplace for their employees and volunteers in accordance with relevant Commonwealth, and state or territory governments WHS or OH&S legislation, as well as relevant codes and standards.

In many cases, the workplace will be the client's home. Service providers are responsible for addressing the safety of employees and volunteers delivering services to a client or carer in their home. This includes operating under the provider's COVID Safe Plan and adhering to the infection control procedures. More COVID-19 information resources are available on the department's website.

Service providers are required to be aware of their obligations to comply with state and territory-based laws and regulations relevant to the safe handling and removal of asbestos when undertaking home modifications to the homes of clients. For detailed information on laws

applying to the workplace, service providers must contact the relevant work health and safety regulator in their state or territory.

Service providers must also consider and assess WHS, or OH&S, Australian Building Standards and other local requirements, as these relate to their own offices and facilities, vehicles, and other physical resources used by their staff and volunteers.

6.1.6 Client not responding to a scheduled visit or service

Service providers should refer to the *Guide for Community Care service providers on how to respond when a client does not respond to a scheduled visit* (the Guide) published in September 2009 as a set of nationally consistent protocols to deal with non-response from a client who was scheduled to receive a service.

Service providers may use the Guide when developing their own policies and procedures on the issue of clients not responding to scheduled visits.

6.1.7 Complaints mechanism

Dealing with complaints about services

CHSP clients and their carers must be actively encouraged to provide feedback about the services they receive. A client has the right to call an advocate of their choice to present any complaints and to assist them through the complaints management process.

Clients (or their representative) can raise a complaint in the following ways:

- Directly with the service provider through their publicly available complaints system.
- With the Aged Care Quality and Safety Commission on an open, confidential or anonymous basis by phoning 1800 951 822 [free call] or by visiting the website www.agedcarequality.gov.au.

The Aged Care Quality and Safety Commission provides a free service for anyone to raise concerns about the quality of care or services delivered by Australian Government funded aged care services. The Aged Care Quality and Safety Commission is independent of the Department of Health and Aged Care.

The Aged Care Quality and Safety Commission takes all complaints seriously and will work with the client (and/or their representative) and the service provider to resolve the concerns.

The Aged Care Quality and Safety Commission's process for handling complaints is outlined on their website at www.agedcarequality.gov.au.

This includes the capacity for the Aged Care Quality and Safety Commission to issue a direction to a CHSP service provider where they fail to meet their responsibilities under the CHSP Grant Agreement. In these circumstances, the direction will be issued through a Notice under the CHSP Grant Agreement. The provider is obliged to comply with any direction issued.

Service providers are also responsible for the services provided by subcontractors, including resolving any complaints made about that organisation. Should a complaint regarding a subcontractor be made, the service provider retains responsibility for liaison with the Aged Care Quality and Safety Commission and ensuring the subcontractor complies with all reasonable requests, directions and monitoring requirements requested.

In recognition that many service providers also deliver multiple services through other Australian Government and/or state and territory government programs, the Aged Care Quality and Safety Commission will, from time to time, share information with other relevant parties to ensure clients continue to receive appropriate services.

CHSP clients can also contact the Older Persons Advocacy Network (OPAN) if they would like assistance in directly engaging with Commonwealth-funded aged care services. OPAN supports consumers to access and interact with Commonwealth funded aged care services and can be contacted on (free call) 1800 700 600 or at www.opan.org.au.

If a CHSP client witnesses, suspects or experiences elder abuse, they can contact the National Elder Abuse phone line for free and confidential information, support, and referrals. Elder abuse may involve physical harm, misuse of money, sexual abuse, emotional abuse or neglect. CHSP

clients can call 1800 ELDERHelp (1800 353 374) or visit the COMPASS website at www.compass.info for information, a support directory and resources about elder abuse.

6.1.8 Service continuity

Service providers must develop Activity Continuity Plans that address any risks associated with being unable to continue to deliver services and have systems, internal policies and processes in place to appropriately manage, monitor and report incidents. The Activity Continuity Plan should include:

- Management of serious incidents such as natural disasters and emergency events (e.g. how to provide service delivery in the event of an emergency such as flood, fire or during a heatwave).Transitioning-out of service provision (e.g. transferring services to another service provider or where the CHSP Grant Agreement has expired or is terminated).

Compliance with the Standards

In line with the Aged Care Quality Standards, service providers are required to have systems and processes in place to identify, manage and respond to risks in relation to service continuity, serious incidents and other events.

Transition out

The 'transition-out' component of Activity Continuity Plans ensures clients' service standards and delivery are not compromised. The transition out plan details how service providers plan will ensure continuity of service delivery to CHSP clients in the event of termination or expiry of a grant agreement, including if an organisation requests to withdraw from providing CHSP services.

Transition out plans should include the following:

- service details, including specific services being delivered to client groups i.e. cultural or centre based activities specifically designed to meet the needs of clients;
- client details, including information about high risk or high need, CALD, Indigenous or other clients to ensure a smooth and efficient transition of services;
- specific service delivery requirements due to cultural, area specific (rural/remote) or other reasons that impact on current service delivery and transitioning services;
- client details such as the status of clients' care plans and reviews and information about client waitlists (if any);
- details of any communications with staff about services being proposed for withdrawal;
- communication details for clients about continuity of service provision and arrangements with alternative providers;
- My Aged Care and DEX data registration details, including whether information and care plans are up to date;
- information about inactive clients;
- any subcontracting arrangements; and
- detail any current issues that may impact the client transition.

Organisational information

- timeframe with activities to undertake for transition
- staffing arrangements
- assets
- information and records (including authority of release from the clients)
- communication strategy
- telephones.

Service providers must notify their Funding Arrangement Manager and the Department of Health and Aged Care in writing of their proposal to transfer all or part of their services as soon as possible with a 'draft' Transition Out Plan being provided at this time. The proposed withdrawal date must be a minimum of four months from the date of the first 'draft' transition out plan being provided to the organisation's Funding Arrangement Manager and the Department via email. service providers must negotiate with the Department on a suitable transition date with the replacement organisation. Providers can seek a copy of the transition Out template from their Funding Agreement Manager.

The transition out plan is intended to assist CHSP service providers to develop their strategic planning for a smooth transition of services to an alternative CHSP service provider. It is imperative that the standard and delivery of services do not suffer, and continuity of care is supported through the transition. The Department uses the Transition out plan as a tool in selecting incoming providers based on information including client numbers, models of care, access to facilities and regional coverage.

The service provider must assist the Department and new service provider/s in the transition of goods and/or services to achieve an effective transition. This includes client care continuum with the provision of the goods and/or services from your organisation to the new provider.

Providers are also responsible for updating their My Aged Care information relating to service provision and / or make outlets inactive.

Fully transitioning out providers are required to acquit funding associated with their contract and complete any relevant outstanding reporting milestones for the period where service provision was delivered.

CHSP grant opportunities

The Department recognises the operating environment and demand for services may change during the term of the current CHSP grant agreement. To support CHSP service providers to respond flexibly to local changes, CHSP providers may be able to access additional funding through grant funding opportunities. CHSP providers can access information about how and when to apply and any application forms on Grant Connect.

6.1.9 Acknowledging the funding

Service providers must acknowledge Commonwealth financial and other support in all applicable Grant Agreement Material that they publish. The following wording must be used:

> "Funded by the Australian Government Department of Health and Aged Care". Or
> "Supported by the Australian Government Department of Health and Aged Care".

CHSP providers should not use the Commonwealth Coat of Arms in their internal advertising and promotion of CHSP services.

Disclaimer

Publications and published advertising and promotional materials that acknowledge the CHSP funding must also include the following disclaimer:

> "Although funding for this [insert service/activity] has been provided by the Australian Government, the material contained herein does not necessarily represent the views or policies of the Australian Government."

Other options for acknowledging the funding

If for any reason service providers wish to acknowledge the funding in a different manner to the options set out in this program manual, they must obtain the Department's prior written consent.

Questions on acknowledging funding

Service providers who are unsure whether they need to acknowledge the CHSP funding or have any queries relating to acknowledgement of funding should contact their Funding Arrangement Manager.

Monitoring of the use of acknowledgements

Service providers are responsible for ensuring they and their subcontractors comply with the requirements for acknowledging the funding which are set out in this section.

The Department will notify service providers in writing if it considers that a service provider or their subcontractor has failed to comply with the CHSP Grant Agreement. In certain circumstances, the Department may, by notice in writing, revoke its permission for any person to use this wording (for example, if the service provider or subcontractor has not complied with all the requirements of this program manual).

Service providers should inform the Department if they become aware of any unauthorised use of the due recognition branding by any person.

6.1.10 Subcontracting

Service providers may select and use subcontractors in accordance with Condition 6 [Subcontracting] of Schedule 1 of the CHSP Grant Agreement.

6.1.11 Responsibilities during a national or state emergency

The Department of Health and Aged Care reserves the right to enact temporary changes to program guidelines in the event of a national or state emergency. This may include relaxing flexibility provisions, waiving or extending reporting deadlines and performance milestones or modifying service type descriptions in accordance with the nature, severity, duration and geographic scale of the emergency.

Any changes to the program will be communicated to the sector via the Department's regular newsletters and announcements. All service providers should sign up to access these resources on the Department's website under Subscribe to aged care announcements and newsletters.

For more information, please contact your Funding Arrangement Manager.

6.1.12 COVID-19 Vaccination Reporting

All CHSP providers are required to report on their staff COVID-19 vaccinations in the My Aged Care Service and Support Portal. The information reported on the in-home community care workforce COVID-19 vaccination status is used to determine worker vaccination status ensuring an accurate picture of the level of vaccination coverage across the in-home aged care workforce.

For information, refer to the department's website under Mandatory COVID-19 vaccination reporting.

6.1.13 Spending the grant

Service providers must spend the funds in accordance with their CHSP Grant Agreement.

Service providers are responsible for sustainably managing their service delivery and number of clients. Service providers are contracted to deliver a specific number of outputs and any decision to exceed these agreed outputs is taken at your own risk and cost.

For information on availability of CHSP funding, please refer to the CHSP Guidelines, and the CHSP website.

Payment in arrears

All CHSP providers, excluding providers who only deliver SSD, will receive a standard monthly payment in arrears. This standard monthly payment is the total value of the grant agreement divided by twelve. SSD providers' funding will remain upfront quarterly payments.

Payments will be released automatically in line with the CHSP grant agreement. Due to processing, it may take three to four business days before CHSP providers receive their monthly payment. Payments may be delayed if a provider is not up to date with their monthly Data Exchange reporting obligations.

6.1.14 Assets

Service providers must refer to Supplementary Term 5 [Equipment and assets] of the CHSP Grant Agreement and comply with the requirements for acquiring and managing Assets with the funds.

6.1.15 Code of Conduct Aged Care

The Code of Conduct for Aged Care will protect care recipients by ensuring a suitable standard of conduct from their aged care providers, workers and governing persons (for example, board members and CEOs).

The Aged Care Quality and Safety Commission will monitor and enforce compliance with the Code, as well as training and development of educational materials.

From 1 December 2022, new powers will allow the Aged Care Quality and Safety Commissioner to take enforcement action for breaches of the Code. Enforcement actions can include banning or restricting individuals from working in aged care.

Banning Orders under the Code of Conduct

Before employing or otherwise engaging or extending or renewing the contract or agreement of a person (whether as a staff member, volunteer or executive decision-maker), CHSP service providers have a responsibility to take reasonable steps to ensure they do not commence the employment or engagement of an individual to whom a banning order under the *Aged Care Quality and Safety Commission Act 2018* applies inconsistently with the requirements of that banning order.

For more information, go to the department's website or the Aged Care Quality and Safety Commission website and search for Code of Conduct for Aged Care.

6.2 Serious Incident Response Scheme (SIRS) responsibilities

From 1 December 2022, the Serious Incident Response Scheme (SIRS) requirements apply to providers of aged care in home or community settings. This includes providers of home care or flexible care provided in home or community settings under the CHSP.

The SIRS aims to reduce abuse and neglect in aged care. Under the SIRS, service providers have responsibilities to manage incidents and take reasonable steps to prevent incidents, including implementing and maintaining an incident management system. Service providers are also required to report certain incidents to the Aged Care Quality and Safety Commissioner (Commissioner).

CHSP service providers will also have to provide certain protections to persons who make disclosures about reportable incidents.

Incident management system

The SIRS requires service providers to have in place and maintain an effective incident management system – a set of protocols, processes, and standard operating procedures that staff are trained in and are expected to use when reporting and responding to incidents.

The incident management system is used to deal with a broad range of incidents that occur, or are alleged or suspected to have occurred, in connection with the delivery of aged care, that either have caused, or could reasonably have been expected to have caused, harm to a client or another person. For example, this would include a client assaulting a staff member of the service provider, or a staff member of the service provider using unreasonable use of force against a client. Service providers must establish and document a set of incident management procedures to be followed to support the identification, management and resolution of incidents that can occur during the course of delivering care and services to clients. The procedures must address the following:

- how incidents are identified, recorded, and reported, and to whom incidents must be reported to.
- how the service provider will provide support and assistance to those affected by an incident to ensure their health, safety, and wellbeing (e.g., providing information about access to advocates).
- how those affected by an incident (or their representatives) will be involved in managing and resolving the incident.
- when and how the service provider will require an investigation into an incident to work out the cause, any harm, and any operational issues that may have contributed to the incident occurring.
- when remedial action is required and what that action would be.
- who is responsible (e.g. a staff member) for notifying the Commissioner about reportable incidents (explained under the 'Reportable Incidents' heading below).

This set of procedures will assist service providers and their staff to have a standardised approach to identify, respond to, resolve, and learn from incidents.

The documented procedures must be made available in an accessible form to clients, their families, representatives, advocates and other significant persons, and each staff member of the service provider. The service provider should be able to assist these persons to understand how the procedures operate and ensure that all of their staff comply with the incident management system.

The service provider must also provide training for each staff member on using and complying with the incident management system including staff roles and responsibilities.

As part of the incident management system, the service provider must have a recording tool that is used to capture information about incidents. Some incident management systems use computer-based electronic tools, while others are paper-based. When recording incidents, the incident management system must include the following details, as a minimum, about each incident:

- a description of the incident including the harm that was caused, or could reasonably have been expected to have caused, to each person affected by the incident, and if known, the consequences of that harm,
- if known, the time, date, and place it happened, or was alleged or suspected to have happened,
- the time and date the incident was identified,
- the name and contact details of the person/s directly involved in the incident,
- the name and contact details of any witnesses to the incident,
- details of the assessment of the support and assistance required, and the actions taken to ensure the health, safety, and wellbeing of those affected by the incident,
- details of the assessment of whether the incident could have been prevented and how well the incident was managed and resolved,
- details of what action could be taken to improve management and resolution of future similar incidents and what actions have been taken in response to the assessment,
- details of the assessment of whether remedial action needs to be taken, and if so the details of the action taken,
- whether there were reasonable grounds to report the incident to police, and if so the details of when and how the incident was reported,
- details of the assessment of how to appropriately involve those affected by the incident in the management and resolution, the actions taken to involve those persons and any other consultations undertaken with the people affected by the incident,
- whether persons affected by the incident have been provided with any reports or findings about the incident,
- if an investigation was undertaken into the incident, and if so, the details and outcomes,

- the name and contact details of the person making the record of the incident, and
- whether the incident is a reportable incident (explained under the 'Reportable Incidents' heading below).

These records must be kept for seven years after the incident was identified. The Aged Care Quality and Safety Commission (the Commission) may request to see these records as part of its compliance and monitoring functions.

Service providers must be able to use the information collected through their incident management system to be able to identify similar incidents, and to assist with meeting other incident management responsibilities (explained under the 'Managing and responding to incidents' heading below).

While all incident management systems should have the above components in common, the detailed design of each provider's incident management system is likely to be different. This is because an incident management system should be tailored to the service size, location, the types of services provided, and the clients receiving the services.

For more information and examples on incident management systems, please review guidance on the Commission's website.

Managing and responding to incidents

Under the SIRS service providers need to manage incidents and take reasonable steps to prevent incidents with a focus on the health, safety, and wellbeing of clients.

Consistent with the incident management system arrangements, these responsibilities relate to a broad range of incidents that occur, or are alleged or suspected to occur, in connection with the delivery of aged care, that either have caused, or could reasonably have been expected to have caused, harm to a client or another person.

As part of these responsibilities, service providers must respond to incidents by assessing and providing support and assistance to persons affected by incidents to ensure their health, safety, and wellbeing. Service providers should use an open disclosure process and make sure to involve persons affected by incidents in the management and resolution process.

CHSP service providers must also assess the incident (taking into account the views of those affected), including whether:

- it could have been prevented,
- if any remedial action needs to be undertaken to prevent similar incidents and minimise harm,
- it was managed and resolved well,
- any actions could be taken to improve management of similar incidents in future, and
- other persons or bodies should be notified of the incident.

CHSP service providers must take reasonable steps to implement any remedial actions that may need to be taken to prevent similar incidents identified through this process. The service provider should also implement any actions identified through this process to improve management of similar incidents in future and must notify other persons or bodies that have been identified through this process.

CHSP service providers must also report incidents to police if there are reasonable grounds to do so (e.g. the service provider suspects that the incident may be criminal in nature, such as sexual assault). The provider must notify a police officer of the incident within 24 hours of becoming aware of the incident. If the provider later becomes aware of reasonable grounds to report the incident to police (e.g. the incident happened some time ago, although the provider has just become aware of additional detail) then the provider must report the incident to police within 24 hours of becoming aware of those grounds.

CHSP service providers must also collect data relating to incidents (e.g. through their recording tool that forms part of their incident management system) to assist with continuous improvement of their management and prevention of incidents. This data should assist the service provider to identify trends or systemic issues with the quality of care they provide and enable the provider to give feedback and provide training to staff members about the management and prevention of incidents. The provider must regularly review and analyse this data to assess the effectiveness of their management and prevention of incidents and if any actions could be taken to improve their effectiveness. This assessment should be used to take any actions that may improve their management and prevention of incidents.

For more information refer to the SIRS guidance for providers on the Commission's website.

Reportable incidents

Under the SIRS, CHSP service providers are required to report certain types of incidents to the Commissioner. This includes incidents that occur, or are alleged or suspected to have occurred, and will include incidents involving a client with cognitive or mental impairment (such as dementia). The types of reportable incidents are those listed below:

- where unreasonable use of force has been used against the client (e.g. kicking, hitting, pushing, shoving, or rough handling),
- where unlawful sexual contact, or inappropriate sexual conduct has been inflicted on the client (e.g. sexual assault, indecent assault, sexually explicit comments, or overt sexual behaviour),
- psychological or emotional abuse of the client (e.g. name calling, bullying, intimidation, or threats to withhold care or services),
- the unexpected death of a client (e.g. untreated wounds leading to a client's untimely death),
- where a staff member has stolen from, or financially coerced, a client (e.g. a staff member stealing the client's valuables, or a staff member coercing a client to change their will in favour of the staff member gaining a benefit from their will),
- neglect of a client (e.g. withholding personal care, untreated sores and wounds, lack of adequate medical care),
- where a client goes missing in the course of a service provider providing care and there are reasonable grounds to report their absence to the police.
- use of a restrictive practice in relation to a client that does not meet all of the following requirements:
    - before the restrictive practice is used, the client's care plan must detail the circumstances in which the restrictive practice may be used and the behaviours it is seeking to address,
    - the care plan must outline how the restrictive practice is to be used, including its duration, frequency and intended outcome,
    - the restrictive practice must be used in the circumstances and manner set out in the care plan and in accordance with any other provisions of the plan that relate to the use of the restrictive practice, and
    - the service provider must ensure details about the actual use of the restrictive practice are documented and is consistent with the care plan as soon as practicable after its use.

However, with respect to incidents involving neglect of a client, it is not a reportable incident if the incident results from a choice made by the client about the care or services offered by the service provider (e.g. if a client with diabetes refuses to eat a diabetic diet and as a result develops a wound with poor healing prognosis), or if it results from a choice made by the client as to how the care or services are to be provided (e.g. if a provider delivering in-home cleaning

services is directed by the client not to move item/s within the home and the client later trips over these item/s). Details of this refusal or choice by the client, as well as details of any discussions or actual or attempted interventions by the service provider, must be recorded in the client's care plan.

Further, if a reportable incident relates to a particular client who has been diagnosed with dementia and experiences delusions, and continues to report a particular event which has been investigated and is found to be based on a delusion, the service provider may contact the Commission regarding this. The Commission will consider the circumstances of the case and may decide that further repeat allegations of the same reportable incident do not need to be notified.

For more detail on what constitutes a reportable incident and examples, please review guidance on the Commission's website.

All 'Priority 1' reportable incidents occurring in home or community settings must be reported to the Commissioner, and the police where there are reasonable grounds to do so (e.g. where the service provider suspects the incident is of a criminal nature), within 24 hours of the service provider becoming aware of the incident. Priority 1 reportable incidents are:

- where the incident has caused, or could reasonably have been expected to have caused, a client physical or psychological injury, illness or discomfort that requires medical or psychological treatment to resolve, or
- any incident where there are reasonable grounds to report that incident to police.

Certain types of reportable incidents must always be reported as a Priority 1 reportable incident:

- the unexpected death of a client,
- the unexplained absence of a client,
- unlawful sexual contact, or inappropriate sexual conduct with a client.

All 'Priority 2' reportable incidents occurring in home or community settings must be reported to the Commissioner within 30 days of the service provider becoming aware of the incident. Priority 2 reportable incidents include all other reportable incidents that do not meet the criteria for a Priority 1 reportable incident. CHSP service providers must ensure that if their staff become aware of a reportable incident, they must notify one of the service provider's executive decision makers, a supervisor or manager or the person who is responsible for notifying the Commissioner of reportable incidents as soon as possible.

CHSP service providers must notify the Commissioner of reportable incidents using the form available through the My Aged Care Service and Support Portal (or any other form approved by the Commissioner). The Department of Health and Aged Care provides information and support to access and log into the My Aged Care Service and Support Portal. Fact sheets are also available with further information about My Aged Care. Alternatively, service providers can call the My Aged Care Contact Centre on 1800 200 422 between 8.00am to 8.00pm [AEST/AEDT] Monday to Friday and 10.00am to 2.00pm on Saturday (a free call from fixed lines; calls from mobiles may be charged).

When notifying the Commissioner of reportable incidents, the form must include the following details about each reportable incident:

- the name and details of the service provider,
- a description of the reportable incident, including the kind of reportable incident (e.g. unreasonable use of force or neglect) and the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected, and if known, the consequences of that harm,

- if it is a Priority 1 reportable incident, the immediate actions taken in response to the reportable incident, including actions taken to ensure the health, safety and wellbeing of the clients affected by the incident, and whether the incident has been reported to police or any other body,
- if it is a Priority 2 reportable incident, the actions taken in response to the reportable incident including actions taken to ensure the health, safety and wellbeing of the clients affected by the incident, and whether the incident has been reported to police or any other body,
- any further actions proposed to be taken in response to the incident,
- the name, position, and contact details of the person completing the form,
- if known, the time, date, and place where the incident occurred, or is alleged or suspected to have occurred,
- the names of the persons directly involved in the incident, and
- if known, the level of cognition of the clients directly involved in the incident.

If it is a Priority 1 reportable incident, the service provider does not need to include all of the above information if it is not available to them within 24 hours of becoming aware of the incident. Although if not provided within 24 hours, that information must be provided to the Commissioner within 5 days of becoming aware of the incident (or another period specified by the Commissioner).

If a CHSP service provider later becomes aware of significant new information about a reportable incident that has already been reported to the Commissioner, they must provide this information to the Commissioner in writing as soon as possible.

Under the *Aged Care Quality and Safety Commission Rules 2018* (see Part 6A – Division 2), once the Commissioner has been notified of a reportable incident by a CHSP service provider, the Commissioner may require that further information be provided, or other actions be taken by the CHSP service provider in relation to the reportable incident. This may include undertaking remedial action, conducting an investigation of the reportable incident, or providing a report to the Commissioner containing any specified information about the reportable incident. CHSP service providers must comply with these requirements or requests in the manner and timeframes required by the Commissioner. The Commissioner may also take other actions in relation to reportable incidents that the Commissioner considers reasonable in the circumstances, including referring the matter to the police or any person or body with responsibilities in relation to the incident.

If CHSP service providers have any questions or issues they can contact the Commission at SIRS@agedcarequality.gov.au or 1800 081 549 between 9.00am to 5.00pm [AEST/AEDT] Monday to Friday and 8.00am to 6.00pm Saturday to Sunday (a free call from fixed lines; calls from mobiles may be charged).

Reportable incidents involving other service providers

Where a reportable incident occurs, or is alleged or suspected to have occurred, and it is known or suspected that another service provider committed or caused the incident, the CHSP service provider that becomes aware of the incident (Provider A) should notify the provider that allegedly committed or caused the incident (Provider B).

If a CHSP service provider has concerns about another provider's behaviour, conduct or management of incidents other than reportable incidents, they are encouraged to contact the Commission via email complaints@agedcarequality.gov.au or through the online form on the Commission's website. Alternatively, service providers can call the Commission on 1800 951 822 between 9.00am to 5.00pm [AEST/AEDT] Monday to Friday, or you can leave a voice message (a free call from fixed lines; calls from mobiles may be charged). Please note that complaints can be made to the Commission anonymously or confidentially.

Protecting disclosers of information about reportable incidents

Under the SIRS, the CHSP service provider must have procedures in place to protect disclosers from being victimised. Disclosers are specified persons or bodies who disclose information about reportable incidents.

The following table summarises the disclosers that the CHSP service provider must ensure they have procedures in place to protect, and who the disclosers need to have disclosed the information about a reportable incident to in order to be protected:

Disclosers	**Persons or bodies disclosers must disclose to in order to be protected**
A person or body who is, or was, any of the following: • a service provider under the CHSP program • one of the service provider's key personnel or executive decision makers • a staff member of the service provider • a client of the service provider • a family member of a client of the service provider • a carer of a client of the service provider • a representative of a client of the service provider • an advocate of a client of the service provider • another person who is significant to a client of the service provider, or • a volunteer who provides care or services for the service provider	The disclosure is made to one of the following: • the Commission or Commissioner • the service provider • one of the service provider's key personnel or executive decision makers • a staff member of the service provider • another person authorised by the service provider to receive reports of reportable incidents, or • a police officer

The CHSP service provider's procedures must protect the discloser where:

- they have disclosed information about an incident to the persons or bodies listed in the table above,
- the discloser discloses their name before disclosing information about the incident (it is not an anonymous disclosure),
- the discloser has reasonable grounds to suspect that the information indicates that a reportable incident has occurred, and
- the discloser discloses information about the incident in good faith.

As part of the above procedures, the CHSP service provider must not engage in conduct which causes detriment, or threatens to cause detriment, to another person because that person or another person is a discloser.

The CHSP service provider must also ensure, as much as reasonably possible, that its staff members, and other parties with whom it contracts services, comply with the above requirements to protect disclosers. Specifically, they must protect the discloser from:

- conduct by a person (Person A) that is intended to cause detriment to another person (Person B) because Person B or a third person (Person C) is a discloser, and

- threats by Person A, to cause any detriment to Person B or Person C that is intended to cause fear or is reckless as to causing fear that the threat will be carried out, because Person B or Person C has or may make such a disclosure.

The CHSP service provider must also authorise specified persons to receive reports of reportable incidents (authorised report recipient), and the discloser's identity.

Where a person reports a reportable incident to the CHSP service provider, or one of the service provider's executive decision makers or authorised report recipient, the CHSP service provider must take reasonable measures (including ensuring that the executive decision makers and authorised report recipient are aware) to protect the discloser's identity, and ensure that the discloser's identity is only disclosed to:

- the Commissioner (and the Commission); or
- a person, authority or court as required by a law of the Commonwealth or a state or territory; to one of the service provider's executive decision makers, or to a police officer and is not disclosed to any other person.

The CHSP service provider must not enforce a contractual or other remedy or exercise any other right against a discloser with whom they have an agreement because that person has made a disclosure (e.g. the provider cannot terminate the person's employment, or any other person's employment, based on the disclosure).

6.3 Service provider reporting

6.3.1 Overview

Reporting elements and timing of reports

Under the CHSP, service providers will be required to submit a range of reports relating to the Activity described under Item B [Grant Activity] of the CHSP Grant Agreement.

This includes:

- Financial reporting – to facilitate acquittal of funds expended, providing assurance and evidence that public funds have been spent, as specified in the CHSP Grant Agreement.
- Performance reporting – on service delivery activities and outcomes.
- Wellness and reablement reporting – to provide service level information on wellness and reablement approaches being implemented by the service provider.

Service providers are required to submit the reports as outlined under Item E [Reporting] in the timeframes provided at Item E [Reporting] of the CHSP Grant Agreement – see table below.

Monthly performance reporting via Data Exchange

All CHSP providers, excluding providers who only deliver SSD, are required to submit monthly performance reports through Data Exchange.

Monthly performance reports will be due on the 14th day of each month (or next business day). The submission of a monthly performance Data Exchange report will be mandatory and may be linked to the release of a provider's next monthly payment. A provider can choose to submit a report more frequently, such as each fortnight, however at a minimum a report must be submitted monthly within the timeframes provided below.

CHSP providers only delivering SSD will remain on a six-monthly performance reporting schedule.

Key Reports – CHSP

Report	Reporting Period	Due date to the Department	Description
Performance Report (for service delivery) via the Department of Social Services (DSS) Data Exchange Note: this report is not applicable for Sector Support and Development Activities	Monthly	14 August 14 September 14 October 14 November 14 December 14 January 14 February 14 March 14 April 14 May 14 June 14 July Note: The DSS Data Exchange dates are defined in the Data Exchange Protocols. Service providers can enter data at any time during the reporting period.	Client and service delivery information reported via the DSS Data Exchange in accordance with the Data Exchange Protocols. Refer to CHSP Grant Agreement Item E [Reporting]
Activity Work Plan for Sector Support and Development activities only	1 July to 30 June (once per financial year)	31 July	Activity and deliverable information requiring approval, also used during biannual Performance Reporting.
Performance Report for Sector Support and Development Activities only (twice per financial year)	1 July to 31 December	31 January	Refer to CHSP Grant Agreement Item E [Reporting]
	1 January to 30 June	31 July	
Embedding wellness and reablement report	As specified in the Agreement	31 July	Refer to CHSP Grant Agreement Item E [Reporting]
Financial Declaration	1 July to 30 June	30 July	A Financial Acquittal Report in accordance with the CHSP Grant Agreement. Refer to CHSP Grant Agreement Item E [Reporting]

Note: Service providers not meeting the reporting requirements identified in the above table will be subject to non-compliance actions in accordance with their obligations under the Grant Agreement. Monthly performance reports will be due after the end of the month on the dates specified in the table above. The submission of a monthly DEX report will be mandatory and may be linked to the release of a provider's next monthly payment.

Sector Support and Development reports and Wellness and Reablement report due dates are subject to change at the discretion of the Department. Any altered due dates will be clearly articulated to affected providers and appropriate timeframes will be given for completion of reports.

6.3.2 Accounting for the grant

As specified under Condition 10 [Spending the Grant] of Schedule 1 of the CHSP Grant Agreement service providers must spend the Grant:

- Only on carrying out the Activity.
- In accordance with the CHSP Grant Agreement.

All financial information provided by service providers should relate to the relevant financial year that is being acquitted.

The financial reporting process

The Department requires service providers to provide assurance and evidence that grant funds have been spent for their intended purpose. This is in the form of financial reporting which is used to determine:

- that funding provided by the Department has been spent by the service provider in accordance with the CHSP Grant Agreement.
- expenditure only related to CHSP service delivery in accordance with the Activity Work Plan and CHSP Grant Agreement (expenses related to other funded programs or expenses related to fees collected, donations or other contributions must not be included in the service provider's financial reports).

For multi-year grant agreements, the Department acquits funding annually. Annual acquittals allow the Department to assess whether the service provider is on target with their expenditure and performance.

Service providers should refer to their CHSP Grant Agreement regarding their reporting periods.

Identified underspend through the acquittal process

Service providers must ensure that their reported outputs recorded in DEX aligns with the amount of unspent funding they are acquitting within a financial year. Unspent funds identified through the acquittal process for a financial year and within the term of the funding agreement must be returned to the Department. Only in exceptional circumstances, the Department may consider the carry-over of unspent funds where there is evidence of reasonable costs being incurred by the service provider. In these exceptional circumstances, proposals to carry over funds will need to be submitted in writing to the Department.

Service providers must not spent any unspent funds from previous financial years without the departments approval.

Service providers will not be allowed to retain unspent funds once the CHSP Grant Agreement has terminated. At the end of the CHSP Grant Agreement, service providers must repay any unspent funds identified through the acquittal process. The Department will issue the service provider with a debt collect form to return any unspent funds.

Types of financial reports

Service providers must provide financial declarations in the form provided by the Department and at the times set out in Item E [Reporting] of the CHSP Grant Agreement, or otherwise notified in writing.

Service providers should only acquit the funds that the Department has provided the organisation through the CHSP Grant Agreement within a particular financial year. Service providers must not include their own funds in the Financial Declaration.

Client contributions

Client contributions are defined in Chapter 5 of this program manual. The Data Exchange requires CHSP service providers to record all client contributions collected over the financial year. **Note**: the client contribution is a mandatory field in the Data Exchange. For details on the Data Exchange refer to 6.3.4 Activity Reporting.

6.3.3 Managing performance

The CHSP Grant Agreement requires service providers to deliver the service outputs specified in the Agreement. However, if a client's needs are changing significantly or an additional, new service type is needed, the service provider must refer the client to My Aged Care for review. This helps ensure client needs are assessed appropriately and any new services are recorded on the client record. This process is outlined in Section 4.4.1 of this program manual.

Flexibility Provision

The flexibility provision under the CHSP is designed to provide a flexible approach enabling CHSP service providers to meet changes in the demand for services, while ensuring compliance with contractual performance reporting requirements under the CHSP Grant Agreement. The flexibility provision enables service providers to re-allocate the service types they are funded for between Aged Care Planning Regions in their Activity Work Plan. This can occur when there is demonstrated client need (i.e. based on My Aged Care referral requests).

The flexibility provision applies across all CHSP service types and Sub-Programs, with the exception of Sector Support and Development and Assistance with Care and Housing (see below for more details).

It is also expected that CHSP service providers will work with the Department of Health and Aged Care, the Community Grants Hub, My Aged Care and assessment services to routinely monitor demand levels for each service type in each Aged Care Planning Region they are funded to operate in. Delivery of these outputs is recorded in the Data Exchange only and should not require any change to the service provider's CHSP Grant Agreement. Providers will have regular engagement with the Community Grants Hub as well as monitoring through the monthly DEX reporting process.

Service providers that utilise flexibility provisions to establish service types funded in their Grant Agreement in an Aged Care Planning Region must keep a footprint of a minimum of 50 per cent for the relevant service type in the Aged Care Planning Region. This ensures that those services remain in the Aged Care Planning Region and align in part to the contract.

In choosing to use flexibility provisions, CHSP service providers must not:

- Re-allocate funding to a service type or Aged Care Planning Region that is not in their Grant Agreement,
- Move more than 50 per cent of service delivery out of a service type in the Aged Care Planning Region as outlined in the Grant Agreement and in the Activity Work Plan.
- Leave a service gap in an area they are currently operating in i.e. resources may only be re-allocated out of a region where there is a clear drop in demand or need for the service.
- Suspend services or move all resources and funding for a service type out of an Aged Care Planning Region unless prior approval is granted by the Department first, and then only for a specified time limited basis.
- Use Assistance with Care and Housing or Sector Support and Development funds in other service types.

The Grant Agreement will continue to be monitored holistically across the contracted services to gauge compliance and will take into consideration unit price variance between service types delivered. Providers can only deliver CHSP subsided services they are contracted to deliver and in the Aged Care Planning Regions they are contracted for, as outlined in their Grant Agreement.

If demand decreases within a provider's contracted service type within an Aged Care Planning Region beyond the flexibility provisions outlined, providers need to engage with their Funding Arrangement Manager for further discussion and the potential for a permanent contract amendment.

Flexibility under Assistance with Care and Housing

Due to the vulnerable and disadvantaged nature of most clients in need of support under the Assistance with Care and Housing Sub-Program, the Department has implemented additional criteria around the flexibility provisions in relation to this service type.

CHSP service providers have flexibility to re-allocate funds from other service types and from other Aged Care Planning Regions into Assistance with Care and Housing but cannot re-allocate base funding from Assistance with Care and Housing to other service types or outside of an Aged Care Planning Region without prior written approval from the Department.

Flexibility under Sector Support and Development

From 1 July 2022, the objective of SSD changed to support CHSP service providers through reforms to the CHSP, in preparation for a new in-home care system, and to operate effectively in line with the objectives of the CHSP and within the context of the broader aged care system.

Given the importance of this work, the Department has implemented additional criteria around the flexibility provisions in relation to this service type.

CHSP service providers have full flexibility to re-allocate funds from other service types and from other Aged Care Planning Regions into Sector Support and Development but cannot re-allocate base funding from Sector Support and Development to other service types or outside of an Aged Care Planning Region without prior written approval from the Department.

How Flexibility Provisions Work

For example, where a service provider receives a large volume of referrals from My Aged Care for clients requiring Social Support, but less than the level of referrals expected for Personal Care, the provider may use the flexibility provision (providing it is funded to deliver both of these activities under its CHSP Grant Agreement). The provider can use funding it receives for Personal Care to deliver Social Support to meet the demand for Social Support services. However, the provider must retain 50 per cent of service delivery against the contracted outputs as outlined in the Activity Work Plan. This is to ensure funded services remain within Aged Care Planning Regions.

Funding Arrangement Managers will engage with providers where they are not meeting 50 per cent of their services in an Aged Care Planning Region.

The service provider must record their actual service delivery in the Data Exchange in order to provide the Department with visibility they are utilising the flexibility provision (please refer to 6.3.4 Activity Reporting).

Where service providers have special conditions identified in their Grant Agreement, service providers are required to deliver the services as stipulated in the special conditions prior to applying the flexibility provision. Special conditions take precedence over the flexibility provision.

Case studies – In scope

Example 1 (within a CHSP sub-program)

A service provider is funded to deliver Domestic Assistance and Personal Care in the same Aged Care Planning Region. The service provider receives more referrals from My Aged Care to deliver Domestic Assistance than Personal Care in this region.

In this instance the service provider may use funding allocated to Personal Care for Domestic Assistance, provided they deliver 50 per cent of their contacted outputs for Personal Care in the region.

Example 2 (value for money)

A service provider is funded to deliver Nursing and Personal Care. In the reporting period the organisation is receiving more referrals from My Aged Care for Nursing rather than Personal Care. The provider utilises the flexibility provision and funding allocated to Personal Care is used to meet the increased service demand in Nursing. In using the flexibility provision, the provider must also demonstrate they have achieved value for money by reporting the service delivery outputs in the Data Exchange and including the use of the flexibility provision in their financial report. 50 per cent of the provider's contracted Personal Care hours should be delivered in the contracted Aged Care Planning Region, with discussions with the Funding Arrangement Manager where potential contract variations may be required for more permanent contract changes outside the flexibility provisions.

The Department will consider the indicative unit cost of Personal Care delivered by the provider in that region (i.e. 100 hours for $1,000 is $10 per hour) and of Nursing (100 hours for $2,000 is $20 per hour). The provider has $200 available from Personal Care to use for Nursing, equating to an extra 10 hours of Nursing. The provider enters their service delivery outputs into the Data Exchange, 80 hours of Personal Care and 110 hours of Nursing, demonstrating value for money has been achieved.

Example 3 (across funded Aged Care Planning Regions)

A service provider is funded to deliver Domestic Assistance in Region 1 and Personal Care in Regions 1 and 2. In this case, the service provider can use the flexibility provision to deliver Domestic Assistance in Region 2.

Case Studies: – Out of scope:

Example 1 (new services not funded for)

A provider wants to use the flexibility provision to establish new Transport services they are not currently funded for under their Grant Agreement. The flexibility provision cannot be used in this instance.

Establishing new services in a region would need to be considered by the Department in accordance with the CHSP Guidelines and CHSP planning framework.

Example 2 (Aged Care Planning Regions not funded for)

A provider is funded to deliver Meals in one Aged Care Planning Region and wants to establish new meals services in another Aged Care Planning Region that is not in their contract. The provider cannot use the flexibility provision to deliver the meals services in this instance.

6.3.4 Activity reporting

CHSP service providers must provide activity and performance data in line with their CHSP Grant Agreement and Activity Work Plan details.

The DSS Data Exchange is an approach to program reporting that has been designed to reduce red tape for organisations by streamlining the data and providing simple and easy ways to submit data.

Data requirements are divided into two parts: a small set of priority requirements that all service providers must report, and a voluntary extended data set that service providers can choose to share with the Department in return for relevant and meaningful reports, known as the partnership approach. This will help build the evidence base regarding the effectiveness of Department of Health and Aged Care programs and service delivery approaches. Participation in the partnership approach is voluntary and there will be no negative consequences if a service provider chooses not to provide their extended data set.

There are a number of options available for service providers to report through the Data Exchange. If organisations do not currently use a client management system the Data Exchange has a web-based portal that they can access as free client management system to support service delivery. If however, service providers already have their own client management system then they can choose to submit data to the Department of Social Services (DSS) through a system-to-system transfer or bulk upload.

The Data Exchange Technical Specifications are available on the DSS grants website to support organisations that may want to use system-to-system transfers or bulk uploads. The Technical Specifications outline the initial coding changes required to meet the Department's data formats.

There is a range of other training and support material on the website to help organisations use the Data Exchange. The Data Exchange Protocols have been designed as a practical support manual to guide managers and frontline staff. The CHSP section of the Appendix B to the Data Exchange Protocols outlines CHSP-specific reporting guidance and examples of reporting. A set of task cards are also available as well as video training modules that provide a visual demonstration of the web-based portal.

Organisations have access to the CHSP Organisation Overview Report, a new and interactive tool (Qlik) to view and analyse their organisation's data that has been entered into the Data Exchange. Access to the report is available via the Data Exchange portal and further information is available on the Data Exchange website.

A dedicated Data Exchange Helpdesk for service providers is available for access and technical questions on reporting. Organisations can email dssdataexchange.helpdesk@dss.gov.au or phone 1800 020 283 for any questions.

For Developer and IT support for Data Exchange application development please email dataexchange.developersupport@dss.gov.au.

For general CHSP grant and program enquiries on reporting, providers should contact their Funding Arrangement Manager.

Reporting through the Data Exchange – Performance Management and Flexibility Provisions.

Service providers are required to report service delivery at the client and service type level. Service delivery information reported in the Data Exchange including outputs, service types and the location of service delivery (based on the outlet location) will be used to inform the performance management of service providers against the key performance indicators in their CHSP Grant Agreements. The Data Exchange is also designed to manage data from providers using the Flexibility Provision. Performance management is undertaken by Funding Arrangement Managers to ensure that the program objectives are being met and to ensure accountability of relevant program funds.

As demand for services changes, information reported in the Data Exchange will also be used as a source of evidence to inform the CHSP planning framework.

Emergency COVID-19 funding – reporting

Service providers who received emergency support through an ad hoc proposal or additional meals funding as part of the CHSP COVID-19 Emergency support round were issued with a separate grant agreement and a performance report template. These providers must report any additional outputs and increases in capacity delivered against their emergency funding in this performance report and should also report through DEX. The performance report contains a narrative section to enable service providers the opportunity to explain how these funds are being used and to account for the grant. Service providers who received additional meals funding will also be required to complete regular survey monkeys in addition to their performance report.

Sector Support and Development – reporting

Service providers with grant funding for Sector Support and Development must provide progress reports against the activities specified within the Activity Work Plan and in accordance with the CHSP Grant Agreement.

The Department will provide a reporting template for this purpose. Service providers must provide the report in the format required by the Department using the template supplied.

Embedding a wellness and reablement approach – reporting

Service providers must provide regular reports to the Department regarding their organisation's progress towards adopting a wellness and reablement approach to service delivery in accordance with the CHSP Grant Agreement. The Department has provided a reporting template for this purpose. Service providers must provide the report in the format required by the Department using the template supplied and in the timeframes outlined under Section 6.3.1.

These reports will be used to provide the Department with service level information on the service provider's progress towards embedding a wellness and reablement approach in their service delivery practices. The reports will also be used to assist the Department identify national resource gaps or strategies that could be implemented to drive continuous improvements in the delivery of wellness and reablement approaches across the sector.

6.3.5 Aged Care Workforce Census

If a service provider receives an aged care workforce census form sent by, or on behalf of, the Department then the service provider must complete the form and return it to the Department, or another address as directed, by the date specified in the form.

If a service provider for a community aged care service was not responsible for the operations of a service during all or some of a period covered by an aged care workforce census, then the service provider is taken to have complied with the census.

If a service provider's funding is less than $35,000 per annum and it receives an aged care workforce census form, the form is to be completed and returned on a voluntary basis and is not a mandatory condition of funding.

6.4 IT and system requirements

Service providers must have systems in place to allow them to meet their service delivery, data collection and reporting obligations outlined in their CHSP Grant Agreement.

6.4.1 System requirements

My Aged Care

CHSP service providers will need a computer with an internet connection and a standard internet browser that supports authenticated access via an approved authentication service - myGovID and the Relationship Authorisation Manager (RAM) or VANguard Federated Authentication Services to access the My Aged Care Service and Support Portal and the Data Exchange reporting system to meet their activity and reporting requirements.

The My Aged Care Service and Support Portal is the key tool for CHSP service providers to interact with My Aged Care regarding the services they deliver, managing referrals and updating client information.

Information about the My Aged Care Service and Support Portal (including, factsheets, videos and frequently asked questions) is available on the Department of Health and Aged Care website. For technical support, contact the My Aged Care service provider and assessor helpline on 1800 836 799.

Date Exchange reporting system

Information about the Data Exchange reporting system requirements is located on the Department of Social Services website. For IT systems access and technical enquiries, contact the Developer Support Helpdesk via email at dataexchange.developersupport@dss.gov.au

6.5 Government responsibilities

6.5.1 Planning framework

The CHSP planning framework is based on Aged Care Planning Regions. The CHSP planning framework takes into account existing services available in a given region, projected growth in the target population and other factors influencing service delivery supply and demand. Information about Aged Care Planning Regions and corresponding postcodes is available on the Gen Aged Care Data website.

Planning processes for the CHSP will also consider parallel planning cycles and processes in other related sectors, including aged care more broadly and the disability care sector.

This will ensure that the needs of various clients are considered and the funding is allocated so that growth in home support services complement and enhance services already being delivered.

6.5.2 Government reporting

As with all Government funding arrangements, the Australian Government has a responsibility to report on the planning, implementation and evaluation of the CHSP.

CHSP service providers are required to submit specific reports. The information provided through these is utilised by the Australian Government to report on the continued development, implementation and on-going evaluation of the program.

Appendix A – Additional resources

Advocacy

National Aged Care Advocacy Program (NACAP)

https://www.health.gov.au/our-work/national-aged-care-advocacy-program-nacap

Older Persons Advocacy Network (OPAN)

https://opan.org.au/

https://opan.org.au/education/education-for-professionals/

1800 700 600

Aged Care Quality Standards

Aged Care Quality and Safety Commission

1800 951 822

https://www.agedcarequality.gov.au/providers/standards

Australian Taxation Office

https://www.ato.gov.au/

Australian Privacy Principles

https://www.oaic.gov.au/privacy/australian-privacy-principles

Carers

Carer Gateway

www.carergateway.gov.au

1800 422 737

Productivity Commission – Caring for Older Australians Inquiry (2011)

http://www.pc.gov.au/inquiries/completed/aged-care/report

Continence Support

Department of Health and Aged Care Bladder and Bowel Health Information

https://www.health.gov.au/health-topics/bladder-and-bowel

Continence Foundation of Australia

https://www.continence.org.au

Continence Aids Payment Scheme

https://www.servicesaustralia.gov.au/continence-aids-payment-scheme

Dementia Support

Dementia Australia

https://www.dementia.org.au

National Dementia Helpline: 1800 100 500

Dementia Training Australia

https://www.dementiatrainingaustralia.com.au

Dementia Support Australia - DBMAS and SBRT programs

https://www.dementia.com.au

1800 699 799

DSS Data Exchange and CHSP performance reporting resources

Data Exchange https://dex.dss.gov.au/training

CHSP Reporting Requirements

https://www.health.gov.au/initiatives-and-programs/commonwealth-home-support-programme-chsp/managing-the-commonwealth-home-support-programme-chsp

Hearing services

Hearing Services Program

https://www.health.gov.au/our-work/hearing-services-program

Interpreting support for service providers

National Translating and Interpreting Service

https://www.tisnational.gov.au/

National Auslan Interpreter Booking & Payment Service

http://www.nabs.org.au/

Meals on Wheels

National Meal Guidelines

https://mealsonwheels.org.au/learn-more/national-meals-guidelines/

My Aged Care Resources

My Aged Care website – www.myagedcare.gov.au

My Aged Care includes the My Aged Care contact centre (1800 200 422) and the website. Together, they provide consumers with information on aged care, whether for the client, their family or carer.

The contact centre can be phoned on 1800 200 422 between 8.00am and 8.00pm on weekdays and between 10.00am and 2.00pm on Saturdays, local time. The contact centre is closed on Sundays and national public holidays.

The My Aged Care Service and Support Portal is the key tool for managing referrals and updating client information.

https://www.health.gov.au/resources/collections/my-aged-care-service-and-support-portal-resources

Further information to support the use of the provider portal (including fact sheets, videos, and quick reference guides) is available on the Department of Health and Aged Care website

https://www.health.gov.au/initiatives-and-programs/my-aged-care/my-aged-care-resources.

The My Aged Care service provider and assessor helpline is available on 1800 836 799 to assist service providers with technical support.

My Aged Care face-to-face services – https://www.servicesaustralia.gov.au/my-aged-care-face-to-face-services

National Elder Abuse Support

1800 ELDERHelp (1800 353 374)

https://www.compass.info/

National Public Toilet Map

https://toiletmap.gov.au/

Freecall 1800 330 066

Royal Commission into Aged Care Quality and Safety

https://agedcare.royalcommission.gov.au/

https://agedcare.royalcommission.gov.au/publications/final-report

Support for people with disability resources

Guide Dogs Australia – https://guidedogs.com.au/

National Insurance Disability Scheme – http://www.ndis.gov.au

National Disability Services – http://www.nds.org.au/

Optometry Australia - Good Vision for Life – https://goodvisionforlife.com.au/

Perkins School for the Blind eLearning – http://www.perkinselearning.org/scout

Royal Society for the Blind – http://www.rsb.org.au/

Vision Australia – www.visionaustralia.org

Volunteering

Volunteering Australia – https://www.volunteeringaustralia.org

National Strategy for Volunteering 2023–2033

https://www.volunteeringaustralia.org/wp-content/uploads/National-Strategy-for-Volunteering-2023-2033.pdf

The National Standards for Volunteer Involvement 2015

https://www.volunteeringaustralia.org/wp-content/uploads/National-Standards-Document-FINAL-3004.pdf

Appendix B – Policy and guideline resources

Aged Care Diversity Framework

https://www.health.gov.au/resources/publications/aged-care-diversity-framework

Aged Care Planning Region Maps

https://www.gen-agedcaredata.gov.au/Resources/Access-data/2018/May/Aged-Care-Planning-Region-Maps

Aged Care Quality and Safety Commission

https://www.agedcarequality.gov.au/

Assessment Quality Reviews

https://www.agedcarequality.gov.au/providers/assessment-processes/quality-review

Australian Criminal Intelligence Commission (formerly CrimTrac)

https://www.acic.gov.au/

Australian Human Rights Commission

https://humanrights.gov.au/our-work/rights-and-freedoms/publications/human-rights-record

Care Finder policy guidance for PHNs

https://www.health.gov.au/resources/publications/care-finder-policy-guidance-for-phns

Carer Recognition Act 2010

https://www.legislation.gov.au/Details/C2010A00123

Charter of Aged Care Rights

https://www.agedcarequality.gov.au/consumers/consumer-rights

CHSP Performance Management

https://www.health.gov.au/our-work/commonwealth-home-support-programme-chsp/managing-the-commonwealth-home-support-programme-chsp

DSS Data Exchange Protocols

https://dex.dss.gov.au/data-exchange-protocols/

National Guide to the CHSP Client Contribution Framework

https://www.health.gov.au/resources/publications/national-guide-to-the-chsp-client-contribution-framework

Serious Incident Reporting Scheme

https://www.agedcarequality.gov.au/sirs

Appendix C – Community Grants Hub contacts

Northern Territory

NTPerformanceHealth@communitygrants.gov.au

NSW and ACT

NSWACTCHSP@dss.gov.au

Queensland

QLDPerformanceHealth@communitygrants.gov.au

South Australia

SAPerformanceHealth@communitygrants.gov.au

Tasmania

TASperformanceHealth@communitygrants.gov.au

Victoria

CHSP.Vic@dss.gov.au

Western Australia

CHSPWA@dss.gov.au

Appendix D – CHSP Police Certificate guidelines

Commonwealth Home Support Programme - Police Certificate Guidelines

1 Introduction

The CHSP Grant Agreement sets out the conditions under which service providers are funded by the Commonwealth Government for Activities delivered under the CHSP.

The Police Certificate Guidelines form part of the CHSP Program Manual. The Guidelines have been developed to assist service providers with the management of police check requirements under the CHSP.

Police checks are intended to complement robust recruitment practices and are part of a service provider's responsibility to ensure all staff, volunteers and executive decision makers are suitable to provide services to clients of the CHSP.

2 Your obligations

Service providers must ensure that all staff, volunteers and executive decision makers working in CHSP services are suitable for the roles they are performing. They must undertake thorough background checks to select staff in accordance with the requirements under the CHSP Grant Agreement and the Standards.

As part of this, Service providers must ensure national criminal history record checks, not more than three years old, are held by:

- staff who are reasonably likely to interact with clients
- volunteers who have unsupervised interaction with clients
- executive decision makers.

Service providers must ensure they have policies and procedures in place to assess police certificates. A service provider's decision to employ or retain the services of a person with any relevant recorded convictions will need to be rigorous, defensible and transparent.
For information about assessing police certificates for staff, volunteers and executive decision makers see: 5 Assessing a Police Certificate in these Guidelines.

3 Police certificates

3.1 Police certificates and police checks

A police certificate is a report of a person's criminal history; a police check is the process of checking a person's criminal history. The two terms are often used interchangeably in aged care.

3.2 Police certificate requirements

A police certificate that satisfies requirements under the CHSP Grant Agreement and CHSP Program Manual is a nation-wide assessment of a person's criminal history (also called a "National Criminal History Record Check" or a "National Police Certificate") prepared by the Australian Federal Police, a state or territory police service, or an Australian Criminal Intelligence Commission (ACIC) accredited agency.

In place of a national criminal history record check, service providers may accept staff members and volunteers who hold a card issued by a state or territory authority following a vetting process that enables the card holder to work with vulnerable people. Executive decision makers are required to have a national criminal history record check and have additional requirements to meet, see: 5.5 Assessing information obtained from a police certificate for executive decision makers.

For more information about assessing police certificates, including the different types, please see: Section 5 Assessing a Police Certificate.

3.3 Australian Criminal Intelligence Commission checks

National Police History Checks prepared by ACIC accredited agencies are considered by the Department as being prepared on behalf of the police services and therefore meet the Department's requirements. More information about ACIC is available at: ACIC.

3.4 Statutory declarations

Statutory declarations are generally only required in addition to police checks in the following instances:

- For essential new staff, volunteers and executive decision makers who have applied for, but not yet received, a police certificate
- For any staff or volunteers who have been a citizen or permanent resident of a country other than Australia after the age of 16
- Executive decision makers who have held or hold citizenship or hold or have held permanent residency of a country other than Australia after the age of 16.

In these two instances, a staff member, volunteer or executive decision maker can sign a statutory declaration stating either that they have never, in Australia or another country, been convicted of an offence or, if they have been convicted of an offence, setting out the details of that offence. Note that a person is entitled to sign a statutory declaration stating that they have not been convicted of an offence if they have been convicted of an offence but the conviction is a 'spent' conviction (see 5.8 Spent convictions).

Statutory declarations relating to police certificate requirements must be made on the form prescribed under the *Commonwealth Statutory Declarations Act 1959* (the Declarations Act). Anyone who makes a false statement in a statutory declaration is guilty of an offence under the Declarations Act.

A link to the statutory declaration template is provided at Appendix 3b of these Police Certificate Guidelines. More information about statutory declarations is available at: Statutory Declarations.

4 Staff, volunteers and executive decision makers

4.1 Staff, volunteers and executive decision makers

Police certificates, not more than three years old, must be held by:

- staff who are reasonably likely to interact with clients
- volunteers who have unsupervised interaction with clients
- executive decision makers.tr

4.2 Definition of a staff member

A staff member is defined, for the purposes of the Guidelines, as a person who:

- has turned 16 years of age
- is employed, hired, retained or contracted by the service provider (whether directly or through an employment or recruitment agency) to provide care or other services under the control of the service provider

- interacts, or is reasonably likely to interact, with clients.

Examples of individuals who are staff members include:

- employees and subcontractors of the service provider who provide services to clients (this includes all staff employed, hired, retained or contracted to provide services under the control of the service provider whether in a community setting or in the client's own home)
- employees and subcontractors who contact the client by phone.

4.3 Definition of non-staff members

Individuals, who are not considered to be staff members, for the purposes of the Guidelines, include:

- employees who, for example, prepare the payroll, but do not interact with clients
- independent contractors.

Generally, an independent contractor is a person:

- who is paid for results achieved
- provides all or most of the necessary materials and equipment to complete the work
- is free to delegate work to others
- has freedom in the way that they work
- does not provide services exclusively to the service provider
- is free to accept or refuse work
- is in a position to make a profit or loss.

For the purposes of these Guidelines, a subcontractor who has an ongoing contractual relationship with the service provider is not taken to be an independent contractor but is regarded as a staff member. A person who is contracted to perform a specific task on an ad-hoc basis may fall within the definition of an independent contractor.

Having an Australian Business Number does not automatically make a person an independent contractor.

4.4 Definition of a volunteer

- A volunteer is defined, for the purposes of these Guidelines, as a person who:
- is not a staff member
- offers his or her services to the service provider without financial gain
- provides care or other services on the invitation of the service provider and not solely on the express or implied invitation of a client
- has, or is reasonably likely to have, unsupervised interaction with clients.

A student undertaking a clinical placement in the community who is over 18 years and has, or is reasonably likely to have, unsupervised interaction with clients would be a volunteer.

Examples of persons who are not volunteers under this definition include:

- persons volunteering who are under the age of 16 (except where they are a full-time student, then under the age of 18)
- persons who are expressly or impliedly invited into the client's home by a client (for example, family and friends of the client)
- persons who only have supervised interaction with clients.

4.5 Definition of unsupervised interaction

Unsupervised interaction is defined as interaction with a client where a volunteer is unaccompanied by another volunteer or staff member.

In regard to volunteers, if volunteers are visiting a client in pairs, it is not a requirement for either of those volunteers to have a police certificate.

4.6 Definition of an executive decision maker

An executive decision maker is:

- a member of the group of persons who is responsible for the executive decisions of the entity at that time
- any other person who has responsibility for (or significant influence over) planning, directing or controlling the activities of the entity at that time
- any person who is responsible for the day-to-day operations of the service, whether or not the person is employed by the entity.

In determining who are executive decision makers, service providers need to consider the functional role individuals perform rather than their job title.

4.7 New staff

While service providers must aim to ensure all new staff members, volunteers and executive decision makers have obtained a police certificate before they start work, there are exceptional circumstances where new staff, volunteers and executive decision makers can commence work prior to receipt of a police certificate.

A person can start work prior to obtaining a police certificate if:

- the care or other service to be provided by the person is essential
- an application for a police certificate has been made before the date on which the person first becomes a staff member or volunteer
- until the police certificate is obtained, the person will be subject to appropriate supervision during periods when the person interacts with clients
- the person makes a statutory declaration stating either that they have never, in Australia or another country, been convicted of an offence or, if they have been convicted of an offence, setting out the details of that offence.

In such cases, the service provider must have policies and procedures in place to demonstrate:

- that an application for a police certificate has been made
- the care and other service to be provided is essential
- the way in which the person would be appropriately accompanied
- how a person will be appropriately accompanied in a range of working conditions, e.g., during holiday periods when staff numbers may be limited.

4.8 Staff, volunteers and executive decision makers who have resided overseas

Staff members or volunteers who have been citizens or permanent residents of a country other than Australia since turning 16 years of age and executive decision makers who have held or hold citizenship, or hold or have held permanent residency of a country other than Australia after the age of 16, must make a statutory declaration before starting work with any CHSP service provider stating either that they have never, in a country other than Australia, been convicted of an offence or, if they have been convicted of an offence, setting out the details of that offence.

This statutory declaration is in addition to a current national police certificate, as this reports only those convictions recorded in Australian jurisdictions.

5 Assessing a police certificate

5.1 Police certificate format

Police certificates may have different formats, including printed certificates or electronic reports. Every police certificate or report must record:

- the person's full name and date of birth
- the date of issue
- a reference number or similar.

A service provider must be satisfied that a certificate is genuine and has been prepared by a police service or ACIC accredited agency. An original police certificate or a certified copy must be provided rather than an uncertified photocopy.

It is up to the service provider to be satisfied that a certificate meets the requirements and enables them to assess a person's criminal history. Any police certificate decision must be documented by the service provider. For more information on record keeping, and the sighting and storing of police certificates, see: 6 Police Check Administration.

5.2 Purpose of a police certificate

A police certificate that best satisfies requirements under the CHSP police check regime is one obtained for the purposes of aged care. However, a national criminal history record check undertaken for another purpose will generally also satisfy the requirements for the CHSP. It is best practice to specify the purpose of the police check to the police service or ACIC agency issuing the certificate.

5.3 Police certificate disclosure

A police certificate discloses whether a person:

- has been convicted of an offence
- has been charged with and found guilty of an offence but discharged without conviction
- is the subject of any criminal charge still pending before a Court.

The information on the certificate is drawn from all Australian jurisdictions and is subject to relevant state and territory spent conviction schemes. For more information about spent convictions, see: 5.8 Spent convictions.

5.4 Assessing information obtained from a police certificate for staff and volunteers

CHSP service providers may use discretion when assessing a person's criminal history to determine whether recorded offences are relevant to the job. The principle that service providers must apply is to determine the risk of harm to clients.

Service providers must ensure they have policies and procedures in place to assess police certificates. A service provider's decision to employ or retain the services of a person with any relevant recorded convictions will need to be rigorous, defensible and transparent.

For more information see: 5.7 Refusing or terminating employment on the basis of a criminal record.

A risk assessment approach

The following considerations are intended as a guide to assist service providers to assess a person's police certificate for their suitability to be either a staff member or volunteer for a CHSP service provider:

- Access: the degree of access to clients, their belongings, and their personal information. Considerations include whether the individual will work alone or as part of a team, the level and quality of direct supervision, the location of the work, i.e., community or home-based settings
- Relevance: the type of conviction and sentence imposed for the offence in relation to the duties a person is or may be undertaking. A service provider must only have regard to any criminal record information indicating that the person is unable to perform the inherent requirements of the particular job
- Proportionality: whether excluding a person from employment is proportional to the type of conviction
- Timing: when the conviction occurred
- Age: the ages of the person and of any victim at the time the person committed the offence. The service provider may place less weight on offences committed when the person is younger, and particularly under the age of 18 years. The service provider may place more weight on offences involving vulnerable persons
- Decriminalised offence: whether or not the conduct that constituted the offence or to which the charge relates has been decriminalised since the person committed the offence
- Employment history: whether an individual has been employed since the conviction and the outcome of referee checks with any such employers
- Individual's information: the findings of any assessment reports following attendance at treatment or intervention programs, or other references; and the individual's attitude to the offending behaviour
- Pattern: whether the conviction represents an isolated incident or a pattern of criminality
- Likelihood: the probability of an incident occurring if the person continues with, or is employed for, particular duties
- Consequences: the impact of a prospective incident if the person continues, or commences, particular duties
- Treatment strategies: procedures that will assist in reducing the likelihood of an incident occurring including, for example, modification of duties.

5.5 Assessing information obtained from a police certificate for executive decision makers

CHSP service providers may use limited discretion when assessing a person's criminal history to determine whether any recorded offences are relevant to performing the functions and duties of an executive decision maker.

A CHSP service provider must not allow a person whose police certificate records a precluding offence to perform the functions and duties of an executive decision maker.

The offences that preclude a person under the CHSP police check regime from performing the functions and duties of an executive decision maker are:

- a conviction for murder or sexual assault
- a conviction and sentence to imprisonment for any other form of assault
- a conviction for an indictable offence within the past 10 years.

Whether or not an offence is an indictable offence will depend on legislation within the jurisdiction. Service providers might need to seek legal advice if there is any doubt. If a conviction for what would otherwise be a precluding offence is considered 'spent' under the law of the relevant jurisdiction (see: 5.8 Spent convictions), the conviction does not preclude the person from performing the functions and duties of an executive decision maker.

While a service provider may not use discretion to allow a person whose police certificate records a conviction for a precluding offence to perform the functions and duties of an executive decision maker, service providers may use discretion in determining whether any other recorded convictions are relevant to performing those functions and duties. The risk assessment approach set out in 5.4 may be used as a guide to assist service providers to assess the relevance of any non-precluding offences to performing the functions and duties of an executive decision maker.

A service provider's decision to allow a person with any recorded convictions to perform the functions and duties of an executive decision maker must be rigorous, defensible and transparent. The overriding principle that providers must bear in mind, is to minimise the risk of harm to clients.

5.6 Committing an offence during the police certificate period

Service providers must take reasonable measures to require each of their staff members, volunteers and executive decision makers to notify them if they are convicted of an offence in the period between obtaining and renewing their police check. If an executive decision maker has been convicted of a precluding offence they must not be allowed to continue as an executive decision maker.

5.7 Refusing or terminating employment on the basis of a criminal record

If a service provider refuses or terminates employment on the basis of a person's conviction for an offence, the conviction must be considered relevant to the inherent requirements of the position. If in any doubt, service providers must seek legal advice regarding the refusal or termination of a person's employment on the basis of their criminal record.

Under the *Fair Work Act 2009* there are provisions relating to unfair dismissal and unlawful termination by employers. More information about the *Fair Work Act 2009* is available at: Fair Work Commission. In addition, under the *Human Rights and Equal Opportunity Act 1986*, the Australian Human Rights Commission has the power to inquire into discrimination in employment on the ground of criminal record.

If a person feels they have been discriminated against based on their criminal record in an employment decision of a service provider, they may make a complaint to the Australian Human Rights Commission. Further information on discrimination on the basis of criminal record is available at: Australian Human Rights Commission.

5.8 Spent convictions

Convictions that are considered 'spent' under state, territory and Commonwealth legislation will not be disclosed on a police certificate unless the purpose for the application (for example, working with children) is exempt from the relevant spent conviction scheme. If a conviction has been 'spent' the person is not required to disclose the conviction. The aim of the scheme is to prevent discrimination on the basis of old minor convictions, once a waiting period (usually 10 years) has passed and provided the individual has not re-offended during this period.

Spent conviction legislation varies from jurisdiction to jurisdiction. In some circumstances or jurisdictions certain offences cannot be spent.

Further Information on spent convictions can be found at: Spent Convictions Scheme

6 Police Check Administration

6.1 Record keeping responsibilities

Service providers must keep records that can demonstrate that:

- there is a police certificate, which is not more than three years old, for each staff member, volunteer and executive decision maker

- an application has been made for a police certificate where a new staff member, volunteer or executive decision maker does not have a police certificate
- a statutory declaration has been provided by any staff member, volunteer or executive decision maker who has not yet obtained a police certificate or was a citizen or permanent resident of a country other than Australia.

How a service provider demonstrates their compliance with record keeping requirements is a decision for their organisation to make based on their circumstances. The Aged Care Quality and Safety Commission may review this record keeping as part of Expected Outcome 1.2 Regulatory Compliance under the Home Care Common Standards.

6.2 Sighting and storing police certificates

The collection, use, storage and disclosure of personal information about staff members and volunteers must be in accordance with the *Privacy Act 1988* (Commonwealth). State and territory privacy laws can also impact on the handling of personal information such as a police certificate. Further information about privacy is available at: Office of the Australian Information Commissioner.

When individuals undertake to obtain their own police certificate, or employment agencies hold police certificates, service providers must sight an original or a certified copy of the police certificate and the information and reference number must be recorded on file.

If it is impossible to assess a person's police certificate for any reason, the individual may be required to obtain a new police certificate in order for the service provider to meet their responsibilities under the CHSP police check regime.

6.3 Cost of police certificates

Service providers have a responsibility to ensure all staff members, volunteers and executive decision makers undergo police checks. However, the payment of the cost of obtaining a police certificate is a matter for negotiation between the service provider and the individual.

Individuals may be able to claim the cost of the police certificate as a work-related expense for tax purposes. Further advice on this issue is available from the Australian Taxation Office through their website at: Australian Taxation Office.

Volunteers may be eligible to obtain a police certificate at a reduced cost whether the certificate is requested by an individual or by a service provider on behalf of a volunteer. This must be confirmed with the agency issuing the police certificate.

6.4 Obtaining certificates on behalf of staff, volunteers or executive decision makers

A person may provide a police certificate to the service provider or give consent for the service provider to obtain a police certificate on their behalf.

Service providers can obtain consent forms from the relevant police services or accredited agencies. In some jurisdictions, parental consent may be required to request a police certificate for an individual under the age of 18 years.

6.5 Police certificate expiry

Police certificates for all staff, volunteers and executive decision makers must remain current and need to be renewed every three years before they expire. If a police certificate expires while a staff member is on leave, the new certificate must be obtained before the staff member can resume working at the service. Service providers must note that the application or renewal process can take longer than eight weeks.

It is the responsibility of the service provider to ensure that staff have a new police certificate prior to the expiry date.

6.6 Documenting decisions

Any decision taken by a service provider must be documented in a way that can demonstrate to an auditor the date the decision was made, the reasons for the decision, and the people involved in the decision i.e., the service provider, the individual, a legal representative, board members etc.

6.7 Monitoring compliance with police check requirements

Service providers must have policies and procedures in place to demonstrate suitable management and monitoring of the police certificate requirements for all staff members, volunteers and executive decision makers. This includes, for example:

- three-year police check renewal procedures
- appropriate storage, security and access requirements for information recorded on a police certificate
- evidence of a service provider's decisions in respect of all individuals, or where staff are contracted through another agency, evidence of contractual arrangements with the agency that demonstrates the police certificate requirements.

Appendix D Attachment 3a – Police service contacts for police checks

Police Service	Contact Details
Australian Federal Police (for ACT and Nationally)	Phone: (02) 6140 6502 National Police Checks (https://www.afp.gov.au/what-we-do/services/criminal-records/national-police-checks)
New South Wales Police Service	Phone: (02) 8835 7888 NSW Police Force (https://www.police.nsw.gov.au/online_services/criminal_history_check)
Victoria Police	Phone: 1300 881 596 Victoria Police (https://www.police.vic.gov.au/national-police-records-checks)
Queensland Police Service	Phone: (07) 3364 6262 Queensland Police (https://www.police.qld.gov.au/documents-for-purchase/national-police-certificates)
Western Australia Police Service	Western Australia Police (https://www.police.wa.gov.au/Police%20Direct/National%20Police%20Certificates)
South Australia Police	Phone: (08) 7322 3347 South Australia Police (www.police.sa.gov.au/services-and-events/apply-for-a-police-record-check)
Tasmania Police	Phone (03) 6173 2928 Tasmania Police (https://www.police.tas.gov.au/services-online/police-history-record-checks/)
Northern Territory Police	Phone: 1800 723 368 Northern Territory Police (https://forms.pfes.nt.gov.au/safent/Apply.aspx?App=CHC)

Appendix D Attachment 3b – Statutory declaration form

Commonwealth of Australia

The statutory declaration form can be found on the Attorney General's website (https://www.ag.gov.au/legal-system/statutory-declarations).

Glossary

Term	Definition
Aboriginal and Torres Strait Islander Health Worker	Aboriginal and Torres Strait Islander health workers have completed a Certificate II or higher in Aboriginal and/or Torres Strait Islander Primary Health Care. For more information see www.health.gov.au/topics/indigenous-health-workforce/about and www.naatsihwp.org.au/what-atsi-health-workers-and-health-practitioners-do
Advocacy	The process of speaking out on behalf of an individual or group to protect and promote their rights and interests.
Aged Care Assessment Team (ACAT)	The assessment teams that determine the care needs and eligibility for aged care services (such as Home Care Packages or residential care) under the *Aged Care Act 1997* (referred to as Aged Care Assessment Services in Victoria).
Aged Care Funding Instrument (ACFI)	The ACFI is a tool to assess the level of care needed for residents of residential aged care services. The classification primarily determines the level of care funding payable for that resident. This tool consists of questions and collects information about mental and behavioural disorders, medical conditions, and other care needs. The information is used to categorise residents as having nil, low, medium or high needs in each of the three care domains.
Aged Care Quality and Safety Commission	The Aged Care Quality and Safety Commission provides a free service for anyone to raise their concerns about the quality of care or services being delivered to people receiving aged care services subsidised by the Australian Government, including residential care, Home Care Packages and CHSP services. The Aged Care Quality and Safety Commission also administers the Australian Government's Quality Review Program including conducting quality reviews of home care services.
Aged Care Quality Standards	Refers to the Aged Care Quality Standards set out in the Quality of Care Principles 2014.
Aged Care Specialist Officers (ACSO)	Aged Care Specialist Officers provide face-to-face support so people can access information about aged care, health and social services in one location. ACSOs are available throughout Services Australia offices. Information is available at www.servicesaustralia.gov.au/getting-aged-care-services.
Assistance with Care and Housing for the Aged (ACHA)	The former ACHA Program supported older people who were older or prematurely aged people on a low income who were homeless (at the time) or may have been at risk of becoming homeless as a result of experiencing housing stress, or not having secure accommodation.
Care finder program	Primary Health Networks (PHNs) will establish and maintain a network of care finders to provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community.
Care Leaver	A person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during the 20th century. Care Leavers include Forgotten Australians, former child migrants and people from the Stolen Generation.
Carer	A person such as a family member, friend or neighbour, who provides regular care and assistance to another person without payment for their caring role. The definition of carer excludes formal care services such as care or assistance provided by paid workers or volunteers arranged by formal services.
Carer Gateway	Carer Gateway provides carer specific supports and services nationally.

Term	Definition
	Carer Gateway supports and services can be accessed by calling 1800 422 737, Monday to Friday, between 8am and 5pm or by visiting www.carergateway.gov.au
Charter	Means the Charter of Aged Care Rights or any Charter that replaces it.
Charter of Aged Care Rights (the Charter)	The Charter of Aged Care Rights outlines the rights and responsibilities of care recipients when receiving home care and services.
Client	A person who is receiving care and services under the CHSP funded by the Australian Government.
Client's home	The client's home is considered to be where the client is currently living. This may be the home of both the client and their carer, in cases where the client and carer share a residence. See 1.2.13 of this program manual for settings where CHSP services will not be delivered.
Co-habiting clients	Co-habiting Clients means spouses, children and other dependants who share the housing situation of the Principal Client and whose relationship with the Principal Client requires continuation of co-habitation.
Culturally and Linguistically Diverse (CALD)	Clients may be defined as Culturally and Linguistically Diverse where they have particular cultural or linguistic affiliations due to their: • place of birth or ethnic origin • main language other than English spoken at home • proficiency in spoken English.
Day Therapy Centres (DTC) Program	The former DTC Program provided a range of therapies and services including allied health support.
Department	The Australian Government Department of Health and Aged Care.
Department of Social Services (DSS) Data Exchange	The DSS Data Exchange commenced from 1 July 2014 and is the Department of Social Services' IT system that is used for program performance reporting, including for the CHSP. Information on the DSS Data Exchange is available at https://dex.dss.gov.au/
Disability Support for Older Australians (DSOA) Program	The Disability Support for Older Australians Program (DSOA) came into effect on 1 July 2021, replacing the Continuity of Support (CoS) Programme. The DSOA Program provides support to older people aged 65 and over (and Aboriginal and Torres Strait Islander people aged 50 years and over) who received specialist disability services from states and territory governments but were ineligible for the National Disability Insurance Scheme at the time of its rollout due to their age. As a result, DSOA is a closed program with no new client entrants.
Diversity Framework	The Aged Care Diversity Framework released in December 2017 supports and extends upon the actions and initiatives already undertaken by the Australian Government and the aged care sector to build an inclusive, respectful, and person-centred aged care system. The Diversity Framework builds on the 2013-2017 National Culturally and Linguistically Diverse and the National Lesbian, Gay, Bisexual, Transgender and Intersex aged care strategies.
Financially or Socially Disadvantaged	Individuals who, for whatever reason, are without on-going financial support as a result of incurred debt, unemployment, age or a disability. These individuals may also be socially vulnerable as a result of perception or inaccessibility or have a tendency for self-isolation.
Frail	For the purposes of the CHSP, frail refers to older people who have difficulty performing activities of daily living without help due to functional limitations (for example communications, social interaction, mobility or self-care).

Term	Definition
Full cost recovery	Where access to a service is at full cost recovery, this means that the CHSP provider would charge the full cost of service provision.
Grant Agreement	Grant agreements are performance based, legally enforceable agreements between two or more parties that set out the terms and conditions governing a business relationship. The CHSP grant agreement includes the Terms and Conditions of funding and the Grant Schedule.
Hearing Services Program	The Hearing Services Program provides subsidised high-quality hearing services and devices to eligible Australians with hearing loss. More information can be found at www.health.gov.au/our-work/hearing-services-program.
Home and Community Care Program (HACC)	The former Commonwealth HACC Program and the (joint Commonwealth-State) HACC Program in Victoria and Western Australia provided basic maintenance, support and care services to assist eligible clients to remain living at home and in their communities. From 1 July 2015 the Commonwealth HACC program was consolidated into the CHSP. HACC services for older people in Victoria and Western Australia were transitioned into the national CHSP on 1 July 2016 (Victoria) and 1 July 2018 (Western Australia).
Home Care Packages	A Home Care Package is an Australian Government-funded co-ordinated package of services tailored to meet the person's specific care needs, with eligibility determined by an ACAT. There are four levels of packages.
Homeless	Homeless means people who are: • without any acceptable roof over their head e.g., living on the streets, under bridges, in deserted buildings etc. (absolute homelessness or sleeping rough) • moving between various forms of temporary or medium term shelter such as hostels, refuges, boarding houses or friends • constrained to living permanently in single rooms in private boarding houses • housed without conditions of home e.g., security, safety, or adequate standards (includes squatting).
Housing Stress	The Australian Institute of Health and Welfare defines housing stress as households which spend more than 30 per cent of their household income on housing costs. Low-income households in housing stress are of particular concern since the burden of high housing costs reduces their ability to meet their other living expenses.
LGBTIQA+	People who are lesbian, gay, bisexual, transgender, intersex, queer or questioning or asexual.
Low Income	Low Income is equivalent to: • income in the bottom two-fifths of the population • the maximum gross income or less necessary to qualify for or retain a Low Income Health Care Card, as issued by Centrelink • whichever amount is greater.
My Aged Care	My Aged Care was introduced on 1 July 2013 and assists older people, their families and carers to access aged care information and services via the My Aged Care website and My Aged Care contact centre (1800 200 422).
National Aged Care Advocacy Program (NACAP) – provided by	National Aged Care Advocacy Program services have been provided by Older Persons Advocacy Network (OPAN) since 1 July 2017. OPAN offers free aged care advocacy services that are independent and confidential, with services focused on supporting older people and their representatives

Term	Definition
Older Persons Advocacy Network (OPAN)	to raise and address issues relating to accessing and interacting with Commonwealth funded aged care services.
National Aged Care Alliance (NACA)	The National Aged Care Alliance (NACA) is a representative body of peak national organisations in aged care, including consumer groups, service providers, unions and health professionals, working together to determine a more positive future for aged care in Australia.
National Continence Program (NCP)	The National Continence Program (NCP) aims to improve awareness, prevention and management of incontinence so that more Australians and their carers can live and participate in the community with confidence and dignity.
National Disability Insurance Scheme (NDIS)	The National Disability Insurance Scheme provides community linking and individualised support for people with permanent and significant disability, their families and carers.
National Respite for Carers Program (NRCP)	The National Respite for Carers Program (NRCP) was a former Commonwealth funded respite program that was consolidated into the CHSP from 1 July 2015. The NRCP contributed to the support and maintenance of caring relationships between carers and care recipients by facilitating access to information, respite care and other support appropriate to the carer's individual needs and circumstances, and those of the care recipient.
National Screening and Assessment Form (NSAF)	The National Screening and Assessment Form has been designed to support skilled assessors to determine a client's aged care needs. There are two versions: Home Support Assessment (RAS) and Comprehensive Assessment (ACAT) located on the My Aged Care system and can be accessed via the assessor portal.
Not having secure accommodation	Not having secure accommodation refers to accommodation where the person's tenure is precarious or there is a likelihood that they will have to move on because of an escalation in rental cost, exploitation or unsuitability of the accommodation for their needs. This may include boarding and lodging arrangements, public housing and staying with friends or relatives. It may also include accommodation owned by the client for which they are in immediate circumstances of losing ownership and accommodation rights.
Older people	For the purposes of the CHSP, older people are people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.
Out-of-scope	Services and items that must not be purchased or delivered using CHSP funding.
Planned Respite	Planned respite includes a range of respite services delivered on a short-term or time-limited bases and planned in advance. Planned respite can be provided in a client's home or temporarily in another setting such as a day centre or in the community.
Planning Framework	Approach used to plan for funding and ongoing program management of aged care service delivery at a regional level. The CHSP uses Aged Care Planning Regions.
Prematurely aged people	People aged 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) whose life course such as active military service, homelessness or substance abuse, has seen them age prematurely.
Primary Health Networks (PHNs)	Australia's 31 PHNs are independent organisations working to streamline health services – particularly for those at risk of poor health outcomes – and to better coordinate care so people receive the right care, in the right place, at the right time.
Principal Clients	Principal Client means the sole client or the older client in a household.

Term	Definition
Quality Review	The process of reviewing the quality of services delivered against the Quality Standards. The process includes an onsite quality audit, a quality audit report and a performance report. Information is available on the Aged Care Quality and Safety Commission website for home services providers on the quality review process.
Reassessment	A reassessment takes place where an existing client has received an assessment and support plan and there is a significant change in a client's needs or circumstances which affect the objectives or scope of the existing support plan or care needs or following a short-term episode of restorative care or reablement service delivery. Providers can request a reassessment through the support plan review process. Assessors are best placed to make the decision as to whether a client requires a reassessment following the review. This decision is supported by the information provided by the client, the contact centre, service providers and health professionals.
Regional Assessment Services (RAS)	The RAS is responsible for assessing the home support needs of older people. The service provides timely support for locating and accessing suitable services based on the preferences of older people. Assessors are appropriately skilled to undertake assessments and identify services appropriate to a diverse range of clients.
Residential day respite	Residential day respite provided under the CHSP is defined as *day* respite provided in a residential facility – it does not include consecutive days or nights and is not considered to be the same as Residential Respite which is delivered under the *Aged Care Act 1997*
Residential respite	Residential respite that is delivered under the *Aged Care Act 1997* is defined as residential care or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short-term break from their usual care arrangement.
Restorative Care	For a smaller sub-set of older people, restorative care may be appropriate, where assessment indicates that the client has potential to make a functional gain. Restorative care involves evidence-based interventions that allow a person to make a functional gain or improvement in health after a setback, or in order to avoid a preventable injury. Interventions are provided or are led by allied health workers based on clinical assessment of the individual. These interventions may be one to one or group services that are delivered on a short-term basis which are delivered by, or under guidance of an allied health professional.
Sector Support and Development	Activities which support CHSP service providers prepare for in-home aged care reforms, and to operate effectively in line with the objectives of the CHSP and within the context of the broader aged care system.
Serious Incident	Serious incidents are defined as those which may have an adverse impact on the health, safety or wellbeing of a client, or seriously affect public confidence in the CHSP.
Short-Term Restorative Care (STRC)	The Short Term Restorative Care (STRC) Programme is an early intervention program that aims to reverse and/or slow 'functional decline' in older people and improve wellbeing through the delivery of a time-limited (up to 56 paid days), goal-oriented, multi-disciplinary and coordinated range of services designed for, and approved by, the client. STRC services may be delivered in a home care setting, a residential care setting, or a combination of both.
Service provider	Service provider refers to service providers or organisations funded to provide services under the CHSP.

Term	Definition
Single Aged Care Quality Framework	The Single Aged Care Quality Framework comprises a single set of quality standards, new quality assessment arrangements across aged care and enhanced quality information to enable consumers to make choices about the care and services they need.
Standards	Means the Aged Care Quality Standards or any standards that replace them.
Support Plan Review (SPR)	A review of services may be undertaken by the service provider to check the effectiveness and on-going appropriateness of the services a client is receiving. A Support Plan Review (SPR) of client needs is undertaken by RAS or ACAT where: • The assessor sets a review date in the support plan for a short-term service. • A service provider identifies a change in the client's needs or circumstances that affects the existing support plan. • A client identifies a change in their needs or circumstances or seeks assistance to access new services or change their service provider.
Transition Care Programme (TCP)	Transition Care Programme (TCP) provides short-term, goal oriented and therapy-focused care for older people after hospital stays either in a home or community setting or in a residential aged care setting.
Trusted Indigenous Facilitator (TIF)	A roll out of this program is expected in 2023. The CHSP Manual will include more information in a future manual update.
Veterans' Home Care (VHC)	The Veterans' Home Care program provides low level home care services to eligible veterans and war widows and widowers.
Volunteers	A volunteer is defined, for the purposes of this program manual, as a person who: • is not a staff member • offers his or her services to the service provider without financial gain • provides care or other services on the invitation of the service provider and not solely on the express or implied invitation of a client • has, or is reasonably likely to have, unsupervised interaction with clients.
Wellness and Reablement	Refer to Chapter 2 – Supporting Independence
Work Health and Safety	Workplace Health and Safety (WHS) often referred to as Occupational Health and Safety, involves the assessment and mitigation of risks that may impact the health, safety or welfare of those in your workplace. This may include the health and safety of your clients, employees, visitors, contractors, volunteers and suppliers. As a service provider there are legal requirements that you must comply with to ensure your workplace meets WHS obligations.