This document – Commonwealth Home Support Programme – Program Manual 2018 - is licensed under the Creative Commons Attribution 4.0 International Licence

Licence

URL: https://creativecommons.org/licenses/by/4.0/legalcode

Please attribute: © Commonwealth of Australia (Department of Health) 2018

Notice:

1. If you create a derivative of this document, the Department of Health requests the following notice be placed on your derivative: Based on Commonwealth of Australia (Department of Health) data.

2. Inquiries regarding this licence or any other use of this document are welcome. Please contact: Communication Branch Department of Health. Phone: (02) 6289 9188. Email: CorporateComms@health.gov.au

Notice identifying other material or rights in this publication:


2. Certain images and photographs (as marked) — not licensed under Creative Commons

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

Foreword

As part of broader aged care changes that offer frail older people and their carers more choice, easier access and better care, the Australian Government launched the Commonwealth Home Support Programme (CHSP) on 1 July 2015.

On 9 May 2017, the Australian Government announced an extension of funding arrangements for the CHSP for an additional two years to 30 June 2020, under the Strengthening Aged Care Budget Measure 2017. This announcement provides certainty to the sector and paves the way for further reform.

The CHSP builds on the strengths of the home support programs which came before it and consolidates the following programs to create a streamlined source of support for frail older people living in the community and their carers:

- 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
- The Victorian HACC Program (from 1 July 2016).

The CHSP delivers the entry-level tier of support in an increasingly responsive, integrated and client-centred aged care service system. It is designed to provide a relatively small amount of care and support to a large number of frail older people to help them to remain living at home and in their communities.

CHSP services can be delivered on a short-term, episodic or ongoing basis and have a strong focus on activities that support independence and social connectedness and provide more choice to consumers.

The CHSP is supported by My Aged Care through:

- A central client record to allow client information to be appropriately shared with assessors and service providers
- A consistent, streamlined assessment process
- Better access to relevant and accurate information (for clients, carers and family members, service providers and assessors)
- Appropriate referrals for assessments and services.

These supports aim to improve client outcomes by providing more consistent and integrated care.

From 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 will transition to the CHSP delivering a national entry-level home support program across all states and territories.
# Table of contents

Foreword .......................................................................................................................... ii  
Table of contents ................................................................................................................ iii  
Part A – The Program ........................................................................................................ 1  
Chapter 1 – Overview of the Program ............................................................................... 1  
1.1 What is the purpose of the Program Manual? ............................................................... 1  
More information ............................................................................................................... 1  
1.2 The Commonwealth Home Support Programme ....................................................... 1  
1.2.1 The Commonwealth Home Support Programme ................................................... 1  
1.2.2 Entry-level support ................................................................................................. 2  
1.2.3 History of the Commonwealth Home Support Programme ................................... 3  
1.2.4 Position in the Australian Government’s end-to-end aged care system ................. 4  
1.2.5 Objectives ............................................................................................................ 7  
1.2.6 Outcomes ............................................................................................................. 8  
1.2.7 Key features .......................................................................................................... 8  
1.2.8 Service delivery principles ..................................................................................... 9  
1.2.9 Target groups ........................................................................................................ 10  
1.2.10 Carers ................................................................................................................ 11  
1.2.11 Older people with diverse needs ........................................................................... 13  
1.2.12 What services are funded under the Commonwealth Home Support Programme? ........................................................................................................ 15  
1.2.13 What Commonwealth Home Support Programme funding must not be used for ........................................................................................................ 18  
1.2.14 Where will Commonwealth Home Support Programme services not be provided? ........................................................................................................ 18  
Chapter 2 – Maximising independence .......................................................................... 20  
2.1 Introduction ............................................................................................................... 20  
2.2 A wellness approach ................................................................................................... 20  
2.3 Reablement and Restorative Care .............................................................................. 22  
2.3.1 Reablement ........................................................................................................ 22  
2.3.2 Restorative Care Services .................................................................................... 22  
2.4 Why implement a wellness approach in the Commonwealth Home Support Programme? ........................................................................................................ 24  
2.4.1 Key principles of the wellness approach ................................................................. 24  
2.5 Implementing wellness and reablement approaches in the Commonwealth Home Support Programme .......................................................................................... 25  
2.5.1 Assessment and support planning ......................................................................... 25  
2.5.2 Service delivery ................................................................................................... 27  
2.5.3 Delivering increased choice for consumers ............................................................ 29  
2.6 Service provider responsibilities ................................................................................. 30  

April 2018 – iii
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6.1 Embedding wellness – reporting requirements</td>
<td>30</td>
</tr>
<tr>
<td>2.6.2 Embedding a wellness approach in service delivery practices</td>
<td>31</td>
</tr>
<tr>
<td>2.6.3 Strategies to assist with embedding a wellness approach</td>
<td>32</td>
</tr>
<tr>
<td>Chapter 3 – Sub-Programs: Eligibility and Services</td>
<td>33</td>
</tr>
<tr>
<td>3.1 Program framework – Commonwealth Home Support Programme</td>
<td>33</td>
</tr>
<tr>
<td>3.2 Sub-Program – objective, target population, eligibility and services</td>
<td>34</td>
</tr>
<tr>
<td>3.2.1 Community and Home Support Sub-Program</td>
<td>34</td>
</tr>
<tr>
<td>3.2.2 Care Relationships and Carer Support Sub-Program</td>
<td>61</td>
</tr>
<tr>
<td>3.2.3 Assistance with Care and Housing Sub-Program</td>
<td>65</td>
</tr>
<tr>
<td>3.2.4 Service System Development Sub-Program</td>
<td>69</td>
</tr>
<tr>
<td>Chapter 4 – Access and interactions</td>
<td>70</td>
</tr>
<tr>
<td>4.1 Interaction between the Commonwealth Home Support Programme and other programs</td>
<td>70</td>
</tr>
<tr>
<td>4.1.1 Interaction with specific programs and services</td>
<td>70</td>
</tr>
<tr>
<td>4.1.2 Transition Arrangements for Existing Clients</td>
<td>73</td>
</tr>
<tr>
<td>4.2 Equity of access</td>
<td>74</td>
</tr>
<tr>
<td>4.3 Prioritisation of referral</td>
<td>75</td>
</tr>
<tr>
<td>4.4 Assessment for entry to the Commonwealth Home Support Programme</td>
<td>75</td>
</tr>
<tr>
<td>4.4.1 Assessment functions undertaken by My Aged Care</td>
<td>75</td>
</tr>
<tr>
<td>4.4.2 Service provider requirements for interacting with My Aged Care</td>
<td>80</td>
</tr>
<tr>
<td>4.4.3 Assessment functions undertaken by Commonwealth Home Support Programme service providers</td>
<td>80</td>
</tr>
<tr>
<td>4.4.4 My Aged Care interactions</td>
<td>81</td>
</tr>
<tr>
<td>Chapter 5 – Client Contribution Framework</td>
<td>83</td>
</tr>
<tr>
<td>5.1 Operation of the Framework</td>
<td>83</td>
</tr>
<tr>
<td>5.2 Exclusions from the Framework</td>
<td>83</td>
</tr>
<tr>
<td>5.3 Framework Objectives</td>
<td>83</td>
</tr>
<tr>
<td>5.4 Client Contribution Principles</td>
<td>84</td>
</tr>
<tr>
<td>5.5 Guide to the Framework</td>
<td>84</td>
</tr>
<tr>
<td>Part B – Administration of the Commonwealth Home Support Programme</td>
<td>85</td>
</tr>
<tr>
<td>Chapter 6 - Service provider and Departmental Responsibilities</td>
<td>85</td>
</tr>
<tr>
<td>6.1 Service provider responsibilities</td>
<td>85</td>
</tr>
<tr>
<td>6.1.1 Quality arrangements for service delivery</td>
<td>86</td>
</tr>
<tr>
<td>6.1.2 Client Rights and Responsibilities</td>
<td>86</td>
</tr>
<tr>
<td>6.1.3 Police checks</td>
<td>87</td>
</tr>
<tr>
<td>6.1.4 Staffing and training</td>
<td>87</td>
</tr>
<tr>
<td>6.1.5 Work Health and Safety</td>
<td>87</td>
</tr>
<tr>
<td>6.1.6 Client not responding to a scheduled visit or service</td>
<td>88</td>
</tr>
<tr>
<td>6.1.7 Complaints mechanism</td>
<td>88</td>
</tr>
</tbody>
</table>

April 2018 – iv
5.2 Purpose of a police certificate ................................................................. 108
5.3 Police certificate disclosure ........................................................................ 108
5.4 Assessing information obtained from a police certificate for staff and volunteers........................................................................................................... 108
5.5 Assessing information obtained from a police certificate for executive decision makers ............................................................................................................. 109
5.6 Committing an offence during the three year police certificate expiry period ................................................................................................................. 110
5.7 Refusing or terminating employment on the basis of a criminal record ....... 110
5.8 Spent convictions ....................................................................................... 110
6 Police Check Administration ......................................................................... 111
  6.1 Record keeping responsibilities ................................................................. 111
  6.2 Sighting and storing police certificates .................................................... 111
  6.3 Cost of police certificates .......................................................................... 111
  6.4 Obtaining certificates on behalf of staff, volunteers or executive decision makers ............................................................................................................... 111
  6.5 Police certificate expiry ............................................................................ 112
  6.6 Documenting decisions ............................................................................. 112
  6.7 Monitoring compliance with police check requirements ........................ 112
Glossary ........................................................................................................... 115
Part A – The Program

Chapter 1 – Overview of the Program

1.1 What is the purpose of the Program Manual?
This Manual outlines the operational requirements of the CHSP. It is primarily designed for use by CHSP funded service providers and forms part of their CHSP Grant Agreement.

Part A – The Program provides an overview of the CHSP – including the service types funded and the requirements regarding the delivery of CHSP services.

Part B – Administration of the CHSP – detailing CHSP funded service provider and Departmental obligations for administration of the CHSP, including funding and reporting arrangements.

The CHSP Program Manual 2018 replaces the 2017 and 2015 versions of this Manual. The ongoing operation of the CHSP will continue to be reviewed and monitored by the Department of Health. This Manual may be updated or varied in the future from time to time.

A range of scenarios have been provided within this Manual to demonstrate how the CHSP may be implemented and the interface between this and other programs.

A glossary of terms is provided at the back of this Manual.

More information
This Manual is available on the Department of Health website.

Service provider enquiries about individual services or funding matters must be referred to the relevant CHSP Grant Agreement Manager in the respective state or territory.

Individuals can access information about CHSP services from the My Aged Care website and by calling the My Aged Care National Contact Centre (the contact centre) on 1800 200 422.

Information on My Aged Care for service providers is available on the Department of Health website.

1.2 The Commonwealth Home Support Programme

1.2.1 The Commonwealth Home Support Programme
The CHSP provides funding for a broad range of entry-level support services to assist frail older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and who have functional limitations (including cognitive), to remain living independently at home and in their community.

CHSP services are delivered on a short-term, episodic or ongoing basis, with a strong focus on activities that support independence and social connectedness and taking into account each person’s individual goals, preferences and choices.
The CHSP is designed to provide small amounts of support services in a timely manner to frail older people who have difficulty performing activities of daily living without help due to functional limitations. Services funded under the CHSP include domestic assistance, transport, meals personal care, home maintenance and modifications, social support, nursing and allied health.

In recognition of the vital role that carers play, the CHSP also supports care relationships through providing planned respite care services for frail older people which allows carers to take a break from their usual caring responsibilities.

The full list of CHSP services is provided under section 1.2.12.

1.2.2 Entry-level support

As an ‘entry-level’ program, the CHSP is designed to provide relatively low intensity (small amounts) of a single service or a few services to a large number of frail older people who need only a small amount of assistance or support to enable them to maintain their independence, continue living safely in their homes and participating in their communities.

The CHSP is not designed for older people with more intensive, multiple or complex needs, nor is it intended to replace or fund support services provided for under other systems such as the health care system. People with higher needs are supported through other aged care programs including the Home Care Packages (HCP) program, residential aged care and through the health care system, including through early intervention, rehabilitation, subacute, transition and restorative care programs.

CHSP services delivered to a client are expected to be, in total, lower than the Government subsidised cost for services provided under a Level 1 home care package (less than $8,000 per annum). For example, the significant majority of CHSP clients should only require small amounts of one or two support services.

A higher intensity of episodic or short-term services may also be provided where improvements in function or capacity can be made, or further deterioration avoided. For example, where a client experiences a temporary setback such as a fall and requires a period of more intensive support to regain their independence. These services should be delivered with the aim of getting a client ‘back on their feet’ and able to resume previous activities without the need for ongoing service delivery or with a reduced level of service delivery.

Higher intensity services should only be provided on a short-term basis under the CHSP. Clients who require higher intensity levels of ongoing care and support are considered to be out-of-scope for this program.

In addition, where a client requires ongoing case management to provide a coordinated package of care and services, this is out-of-scope for the CHSP.
Client scenario – Entry-level support (social engagement)

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 face-to-face 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 dietician 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 Commonwealth Home Support Programme

The CHSP was developed and implemented by the Australian Government as part of the broader changes to the aged care system aimed at streamlining access to support services for frail older people living in the community and their carers.

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 will also transition to the CHSP creating a nationally accessible program.

The initial design of the CHSP was informed through a comprehensive consultation process, which 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.

Since this time, the operation of the CHSP has been further refined through ongoing consultations with peak representative bodies, service providers and individuals through targeted consultation and review processes.

These consultations have further informed the changes to funding conditions to be implemented under the extension of funding arrangements for the CHSP from 1 July 2018 (1 July 2019 in Victoria) to 30 June 2020, as announced in the 2017-18 Federal Budget.

More information on the development of the CHSP is available on the Department of Health website.
1.2.4 Position in the Australian Government’s end-to-end aged care system

Assessment for the CHSP is through My Aged Care, the entry point to the aged care system for older people, their families and carers. 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 introduced 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 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 by enabling them to maintain their independence and autonomy within their 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 which can be provided through the CHSP. It provides consumers with higher intensity, ongoing services and case management as well as an individualised budget that is 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 require higher levels of ongoing support are also able to access Australian Government subsidised residential aged care places.

The diagram on the following page represents the aged care system that has been in place since July 2015, noting that an expanded National Aged Care Advocacy Program (NACAP) provided by the Older Persons Advocacy Network (OPAN) was implemented on 1 July 2017. It should also be noted that the delivery of respite services depicted in the diagram through the Care Relationships and Carer Support service types may also be delivered on an ongoing basis over a longer time period, as well as on a short-term and episodic basis.
Aged care system as at February 2018

The aged care quality and regulatory framework ensures older people receive safe, quality aged care services, through setting, assessing and monitoring care standards and provider responsibilities, and administering regulation.

* Home support assessment and some home support services may be different in Western Australia as these services are still administered by the Western Australian state government.

Home support services for older people in Western Australia will transition to the Commonwealth from 1 July 2018. My Aged Care can assist older people in Western Australia to access state specific home support assessment and these services.

The Department of Veterans’ Affairs also provides Australian Government subsidised aged care services. The Department of Social Services has responsibility for carers policy and service delivery.
Descriptive text for above diagram

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 independently in their own homes with assistance
- a range of care options and accommodation for older people who are unable to continue living independently 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 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.

In addition to these programs, the Innovative Care Program provides care to a limited number of people as an extension of a pilot established in 2003 to support people with aged care needs who live in state or territory-funded supported accommodation facilities who were at risk of entering residential aged care at the time the pilots commenced. This is a ceasing program, with no new entrants being accepted into the program.

Aged care services are underpinned by the aged care quality and compliance framework, which ensures older people receive safe, quality aged care services, through setting and monitoring care standards and provider responsibilities and administering regulation.
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 home care packages, 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 National Aboriginal and Torres Strait Islander Flexible Aged Care and Multi-Purpose Services programs.

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 are to advise CHSP clients of any client contributions payable. More detail on the CHSP Client Contribution Framework is provided under Chapter 5.

HCP program clients require an Income Assessment by the Department of Human Services and/or the Department of Veterans’ Affairs.

Residential aged care clients require a Combined Assets and Income Assessment by the Department of Human Services 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, 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 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 or episodic 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 care recipients, which will allow carers to take a break from their usual caring duties.

4. 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.

5. Ensure that all clients have equal access to services that are socially and culturally appropriate and free from discrimination.
6. Ensure compliance with all relevant codes of ethics, industry quality standards and
guidelines, to ensure that clients receive high quality services.

7. Facilitate client choice to enhance the independence and wellbeing of older people
and ensure that services are responsive to the needs of clients.

8. Provide a standardised assessment process which encompasses a holistic view of client
needs.

9. 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, 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 Aged Care.
- 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 carer’s 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:

- Provide clients with a copy of the Charter of Rights and Responsibilities - Home Care or any charter that replaces the existing charter (collectively referred to in this document as ‘the Charter’.
- Comply with the Charter (excluding the rights expressed at 3A in the Charter of Rights and Responsibilities – Home Care).
- Manage their service information via the My Aged Care provider 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 provider 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 Guidance for Providers* document available on the Department’s website.
- Where a client is accepted for service, update the client record through the My Aged Care provider portal with service delivery information, including commencement date, frequency and volume of services.

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.
- CHSP service providers and their client base that will benefit from a range of activities that are designed to support, develop and strengthen the service system and the sector.

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.
- The Commonwealth determines that other circumstances justify the delivery of services to a younger person.
Specific eligibility requirements apply for each sub-program. Chapter 3 of this Program Manual provides more detail on sub-programs and eligibility.

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 contributing funding towards a range of planned respite services delivered to frail older people. These services are provided under the Care Relationships and Carer Support Sub-Program.

Support is also available through other carer-specific programs and services funded through the Department of Social Services, as follows:

- information and advice through Carer Gateway
- access to emergency respite services provided through the Commonwealth Respite and Carelink Centres
- National Carer Counselling Program
- Carer Information Support Service
- Dementia, Education and Training for carers
- Carer Directed Respite Care
- Counselling, Support, Information and Advocacy – Carer Support
- assistance for young carers to continue with or commence study through the Young Carer Bursary Program.

Over the past three years the Government, through the Department of Social Services, has been developing an Integrated Plan for Carer Support Services (the Plan). The Plan is about ensuring that carers’ needs are recognised and are supported in their own right.

The first stage of the Plan was the commencement of Carer Gateway in December 2015. Carer Gateway consists of a website and a national contact centre (1800 422 737) to help carers access practical information and resources to help them in their caring role.

Stage Two of the Plan focussed on a two year process with carers and the sector to design a draft Service Delivery Model for a proposed new Integrated Carer Support Service.

The third and final Stage of the Plan is the implementation of an integrated carer support service (ICSS). The ICSS will be rolled out in two stages commencing from October 2018.

From October 2018, carers will be able to access a range of new digital services through Carer Gateway including:

- national phone and online counselling services to help carers manage daily challenges, reduce stress and strain, and plan for the future;
- online peer support, connecting carers with other carers for knowledge and experience sharing, emotional support and mentoring;
- online coaching resources with simple techniques and strategies for goal-setting and future planning, and
- educational resources to increase skills and knowledge of carers relating to specific caring situations, to build confidence and improve wellbeing.
From September 2019, a new network of Regional Delivery Partners will be established across Australia to help carers access new and improved local and targeted services including:

- needs assessment and planning;
- targeted financial support packages with a focus on employment, education, respite and transport;
- in-person and phone-based coaching, counselling and peer support;
- information and advice;
- access to emergency crisis support; and
- assistance with navigating relevant, local services available to carers through federal, state and local government and non-government providers, including the National Disability Insurance Scheme, My Aged Care and palliative care.

Further information on the ICSS, as well as supports and services for carers is available on the Department of Social Services website.

The CHSP reflects priorities and principles identified within the National Carer Recognition Framework and The Carer Recognition Act (Commonwealth) 2010.

CHSP service provision is expected to embody the principles incorporated in the Statement for Australia’s Carers under the Carer Recognition Act 2010, including the following:

1. All carers should have the same rights, choices and opportunities as other Australians, regardless of age, race, sex, disability, sexuality, religious or political beliefs, Aboriginal or Torres Strait Islander heritage, cultural or linguistic differences, socioeconomic status or locality.
2. Children and young people who are carers should have the same rights as all children and young people and should be supported to reach their full potential.
3. Carers should be acknowledged as individuals with their own needs within and beyond the caring role.
4. The relationship between carers and the persons for whom they care should be recognised and respected.
5. Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers.
6. Carers should be treated with dignity and respect.
7. Carers should be supported to achieve greater economic wellbeing and sustainability and, where appropriate, should have opportunities to participate in employment and education.
8. Support for carers should be timely, responsive, appropriate and accessible.

All CHSP service providers are to take all practicable measures to ensure that:

a. their officers, employees and agents have an awareness and understanding of the Statement for Australia’s Carers; and
b. they, and their officers, employees and agents, take action to reflect the principles of the Statement in developing, implementing, providing or evaluating care supports.
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, medical and 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*, however acknowledges this is not an exhaustive list and there are other groups such as people with a disability, people with mental health problems and mental illness and people living with cognitive impairment including dementia:

- 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 and intersex
- 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 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 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.

**Interpreting services**

Information on how service providers and clients can access interpreting services is available at [Translating and Interpreting Service (TIS National)](https://tis.gov.au). Victorian CHSP service providers are also able to continue to access the Victorian Interpreting and Translation Service (VITS) until 30 June 2019.

Victorian service providers who transitioned to the CHSP from 1 July 2016 are to continue to undertake diversity planning and practice reviews from 1 July 2016 to 30 June 2019.
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.

Client scenario — accommodating client choice and cultural preference

<table>
<thead>
<tr>
<th>INKA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inka is a 76 years 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.</td>
</tr>
</tbody>
</table>

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. |
1.2.12 What services are funded under the Commonwealth Home Support Programme?

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

<table>
<thead>
<tr>
<th>Sub-program</th>
<th>Service type</th>
<th>Service sub-type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community and Home Support Services</strong></td>
<td><strong>Allied Health and Therapy Services</strong></td>
<td>Podiatry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speech Pathology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accredited Practising Dietitian or Nutritionist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aboriginal and Torres Strait Islander Health Worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing Allied Health and Therapy Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Restorative Care Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diversional Therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exercise Physiology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Allied Health and Therapy Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hydrotherapy</td>
</tr>
<tr>
<td><strong>Domestic Assistance</strong></td>
<td><strong>General House Cleaning</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unaccompanied Shopping (delivered to home)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Linen services</td>
</tr>
<tr>
<td><strong>Goods, Equipment and Assistive Technology</strong></td>
<td><strong>Self-care Aids</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support and Mobility aids</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Care Aids</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication Aids</td>
</tr>
<tr>
<td>Category</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Other Goods and Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading Aids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car Modifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>Minor Home Maintenance and Repairs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Major Home Maintenance and Repairs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Garden Maintenance</td>
<td></td>
</tr>
<tr>
<td>Home Modifications</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Meals</td>
<td>At Home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>At Centre</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Other Food Services</td>
<td>Food Advice, Lessons, Training, Food Safety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food Preparation in the Home</td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td>Assistance with Self-Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assistance with Client Self-administration of Medicine</td>
<td></td>
</tr>
<tr>
<td>Social Support Individual</td>
<td>Visiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telephone/Web Contact</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accompanied Activities, e.g. Shopping</td>
<td></td>
</tr>
<tr>
<td>Social Support Group</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Specialised Support Services</td>
<td>Continence Advisory Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dementia Advisory Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vision Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hearing Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Support Services</td>
<td></td>
</tr>
<tr>
<td>Client Advocacy¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct (driver is volunteer or worker)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect (through vouchers or subsidies)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assistance with Care and Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance with Care and Housing</td>
</tr>
<tr>
<td>Assessment - Referrals</td>
</tr>
<tr>
<td>Advocacy – Financial, Legal</td>
</tr>
<tr>
<td>Hoarding and Squalor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Relationships and Carer Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible Respite</td>
</tr>
<tr>
<td>In-home Day Respite</td>
</tr>
<tr>
<td>In-home Overnight Respite</td>
</tr>
<tr>
<td>Host Family Day Respite</td>
</tr>
<tr>
<td>Host Family Overnight Respite</td>
</tr>
<tr>
<td>Community Access – Individual respite</td>
</tr>
<tr>
<td>Other Planned Respite</td>
</tr>
<tr>
<td>Mobile Respite</td>
</tr>
<tr>
<td>Cottage Respite</td>
</tr>
<tr>
<td>Overnight Community Respite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centre-based Respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre-based Day Respite</td>
</tr>
<tr>
<td>Community Access – Group</td>
</tr>
<tr>
<td>Residential Day Respite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector Support and Development</td>
</tr>
<tr>
<td>Sector Support and Development</td>
</tr>
</tbody>
</table>

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 Only applicable until 30 June 2019 in WA
1.2.13 What Commonwealth Home Support Programme funding must not be used for

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

- purchase of land
- coverage of retrospective costs
- costs incurred in the preparation of a grant application or related documentation
- major construction/capital works
- 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
- other activities as outlined in this Program Manual and updated from time-to-time.

The following services are delivered under My Aged Care:

- Assessment – undertaken via initial phone-based screening by the contact centre and face-to-face assessments conducted by the RAS (or ACAT).
- Case Management – short-term case management services are available for vulnerable CHSP clients and 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 Commonwealth Home Support Programme 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.
- 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 an HCP as outlined in 4.1.1.
- To Commonwealth Continuity of Support (CoS) Programme clients, unless they were already accessing CHSP services prior to transition to the CoS Programme, or choose to move to the CHSP instead of COS (including providing their consent). If an existing CoS client accepts new aged care services (such as CHSP) it is seen as an exit from the CoS Programme.
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.

The My Aged Care screening process will help identify what existing services a client is receiving including accommodation services subsidised by Government.
Chapter 2 – Maximising independence

2.1 Introduction

Maximising clients’ independence and autonomy is a key objective of the CHSP. In addition, service providers delivering support services under the CHSP are required to focus on implementing innovative ways of working with frail older people in order to maximise their autonomy and enable them to remain living independently and safely in their own homes. These ways of working with clients are often described in the aged care literature as wellness, reablement or restorative care approaches.

For some providers, embedding these approaches into practice represents a significant change from the way many entry-level care services have previously been delivered. It involves a cultural shift from a model that may have fostered dependence to one that actively promotes independence and involves working in a manner that assists but does not take over tasks that a person can do for themselves. In addition, although these approaches have been shown to assist older people to improve their functions of daily living, independence and quality of life, there is still some confusion as to what is meant by each of these terms and how they should be applied in the context of the CHSP.

At the request of CHSP service providers and related stakeholders, this chapter of the CHSP Program Manual 2018 has been developed to provide additional information on wellness, reablement and restorative care approaches to assist with embedding these approaches in the CHSP. This includes:

- a broad overview of wellness, reablement and restorative care approaches;
- the reasons for implementing a wellness approach under the CHSP, including the key principles of the approach;
- an outline of the specific roles and responsibilities of both assessment teams and CHSP service providers in delivering these approaches under the CHSP; and
- the specific requirements for CHSP funded service providers under the terms and conditions of their CHSP grant agreement from 1 July 2018\(^2\).

This chapter also includes a range of client scenarios which detail some practical examples of how these approaches can work in practice.

2.2 A wellness approach

Wellness or ‘a wellness approach’ is used to describe an overarching way of thinking about and providing support to frail older people, that can be applied across all service outcomes with the aim of promoting greater independence and autonomy. It is based on the premise that even with frailty, chronic illness or disability most people have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and as independently as possible.

In the context of the CHSP, implementing a wellness approach is about building on an individual’s strengths, capacity and goals to help them remain independent and to live safely at home. It is meant to be embedded at all levels of the program including assessment, support planning and service delivery and should be applied even when the need for assistance is episodic, fluctuates in intensity or type over time, or is of an ongoing nature.

---

\(^2\) Note: These arrangements will not apply to service providers in Victoria in 2018-19. Wellness and Reablement Planning (formerly known as the Active Service Model) will continue to apply to Victorian CHSP service providers in 2018-19.
From a client’s perspective, a wellness approach means the client can expect service providers to offer to do more ‘with them’ rather than just ‘for them’. While a client might be experiencing some challenges in their overall functioning, a wellness approach starts from the point of view that the client continues to have goals to achieve and can continue to feel that they can make an active and meaningful contribution to society.

A wellness approach means listening to what the client wants to do, looking at what they can do (their abilities) and focusing on regaining or retaining their level of function and minimising the impact of any functional loss so that they can continue to manage their day to day life. It supports clients to be independent in their homes and to continue to actively participate in their communities.

Under the CHSP, applying a wellness approach to service delivery can benefit all clients referred for and receiving services because it is about building capacity and recognising that all people have abilities that they wish to regain, retain and/or minimise the loss of, regardless of their level of frailty.

However, it should be noted that assessment teams (including RAS and ACAT), CHSP service providers and the clients themselves will all play a role in integrating a wellness approach into the ‘real life’ of how the CHSP operates on the ground.

**Client scenarios — applying a wellness approach**

**HARRY**

Harry is a 70 year old man who lives alone. After contacting My Aged Care, a face-to-face RAS assessment was undertaken which identified that Harry needed some assistance with clothes-washing and cooking. 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.

After applying a wellness approach to Harry’s situation, the provider 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.

At the same time, the support worker identified that Harry loved cooking, but had lost his confidence after his wife passed away. 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 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 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 Reablement and Restorative Care

For a sub-set of frail older people short-term or time limited interventions will be appropriate, where assessment indicates that the client has potential to make a functional gain. These reablement or restorative care type services should be delivered with the aim of getting a client “back on their feet” and able to resume previous activities without the need for on-going service delivery, or with a reduced need for services.

2.3.1 Reablement

Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. However, whereas a wellness approach can be applied to all CHSP clients, reablement is a short-term or time limited intervention that is more targeted towards a person’s specific goal or desired outcome to adapt to changed circumstances such as functional loss, or to regain confidence and capacity to resume activities.

Reablement approaches tend to engage clients in a process of identifying their own strengths and capabilities in the context of setting their own functional goals or targets. Clients are encouraged to focus on what they can do (safely) and what they value, instead of focusing on things that they cannot do anymore. Supports could include training in a new skill or actively working to regain or maintain an existing skill, modification to a person’s home environment or having access to equipment or assistive technology.

2.3.2 Restorative Care Services

Restorative care services may also be appropriate, where assessment indicates that the client has 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.

Under the Community Home Support Sub-Program of the CHSP, eligible clients can receive specific time limited restorative care services under the Allied Health and Therapy service type. These services are coordinated by providers of allied health and therapy services based on clinical assessments of the clients that will help clients set (functional) goals and review their progress after a defined period.

In addition, restorative care for an individual may involve primary health care providers (separately or in addition to CHSP funded services) such as hearing, vision and dental care, or specialist mental health or disability services. It may also require a multidisciplinary approach with assessors, CHSP service providers and primary health care providers working in an integrated way.
**Client scenarios — short-term reablement and restorative interventions**

**DAVID – Reablement**

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 – Restorative Care**

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.
2.4 Why implement a wellness approach in the Commonwealth Home Support Programme?

A key objective of the CHSP as an entry-level home care program is to enable eligible clients to remain living independently at home and in their community for as long as they can and wish to do so.

However, traditional models of service delivery for many home support services and programs have substantially focused on client’s difficulties and what they are unable to do. This approach has led to the development of a task-orientated, dependency model of ongoing service delivery whereby support workers tend to do as much as they can for the client because that is how they see their role and because that has become the expectation of clients, their families and carers. Over time, more services are added in response to further functional decline, with clients becoming increasingly reliant on services and gradually doing less and less for themselves.

Over the past decade, emerging research and the successful implementation of independence-focussed home care programs both within Australia and overseas, has demonstrated the efficacy of moving away from the traditional approach of doing things for people and replacing this with an approach that seeks to enable people to do as much as possible for themselves. Available evidence suggests that implementing a wellness approach at the earliest opportunity, focussing on maintaining or regaining 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 and
- increased ability to remain living independently and safely in their own homes for longer.

For an individual client this means that the services they receive under the CHSP should focus on maximising their capacity to remain independent and improve their overall quality of life. This ensures services delivered are based on need and not want.

For both service providers and clients, this approach can represent a significant change from traditional models of service delivery. However, evidence has shown that these approaches can also provide significant benefits to service providers as well as to clients, such as:

- increased staff satisfaction from actively helping clients to remain more independent
- gives organisations greater scope to meet a broad range of client needs
- reduces wait times for services
- allows service providers to deliver services to more clients and
- enables better targeting of limited resources to those who need it most.

2.4.1 Key principles of the wellness approach

The wellness approach is based the following key principles:

Independence is highly valued by people and its loss can have a devastating effect:

- Maintaining a person’s independence requires more than just providing a service to help them remain at home. It needs to go beyond maintaining a client at their current capacity and should actively work towards achieving improved outcomes wherever possible.

---

3 Key principles as outlined in the Wellness Approach to Community Home Care Information Booklet July 2018 produced by the Western Australian Department of Health
Independence is not limited to physical functioning but should include both social and psychological functioning.

Most people want to retain their autonomy and build capacity, which in turn will have a positive impact on their self-esteem and ability to manage day-to-day life.

- Being an active participant, rather than a recipient of services, is an important part of being physically and emotionally healthy.

Assessment cannot be defined by a one-off assessment but may require monitoring over a period of time:

- Includes outcome focused/set goals.
- Assesses the appropriateness of ongoing services.

Identifies a person’s abilities up front and doesn’t focus only on their difficulties:

- Service seen as regaining or retaining skills, not creating dependencies.
- Involves working in a manner that assists but doesn’t take over tasks that a person can do for themselves i.e. helps people ‘to do’, rather than ‘doing to or for’ people.
- Ensures success by supporting an individual to start with what they can do and then gradually extend themselves.
- Challenges individuals to reach their potential.

Recognises that independence will be promoted by the way assessors and support staff behave towards a client and the attributes they portray:

- Involves a mindset change.
- Ensure that every opportunity to promote a person’s highest level of involvement in daily activities is sustained.

2.5 Implementing wellness and reablement approaches in the Commonwealth Home Support Programme

National and international evidence has shown that the successful implementation of independence-focused models of care is dependent on a whole-of-system approach, with all parties understanding not only the benefits of these approaches but also their own roles and responsibilities in adopting them.

Under the CHSP, a wellness approach is expected to underpin all aspects of the client journey from the initial assessment and support planning stages through to service delivery and regular reviews. For this to work in practice assessment services, CHSP service providers and CHSP clients (along with their families and carers) must also understand how these approaches can support greater independence and wellbeing and can provide more choice for consumers. This understanding is essential if we are to move from a model of dependence to one that focuses on activities that promote independence.

2.5.1 Assessment and support planning

Independent assessment and support planning for eligible CHSP clients is undertaken by the My Aged Care RAS (or ACATs in some circumstances). In line with their contractual requirements, RAS must adopt a wellness approach to assessment delivery which emphasises the provision of whole-of-system support to clients for the purpose of maximising their independence and autonomy.

It is the role of the RAS to work with the client to identify their needs and concerns, as well as their goals and aspirations. A Home Support Assessment, a component of the National Screening and Assessment Form (NSAF), is completed by the RAS to document 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 on the client's areas of concern, goals and the formal and informal supports to assist them to achieve their goals.

In developing a support plan with a client the RAS will:

- Focus on elements of functional tasks that a client can complete, and discuss what specific assistance they would benefit from in order to complete tasks that are more difficult.
- Discuss strategies a client can employ in order to more easily manage day-to-day tasks (e.g. transport planning to meet goals around the use of public transport to maintain usual activities).
- Explore client’s opportunity for reablement (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 in turn will increase the likelihood that the client will be motivated to work towards the goals they have identified, including the wellness approach and where appropriate, reablement interventions identified throughout the assessment. The Home Support Assessment provides additional detail to illustrate the client’s situation which will in turn help providers to better understand the client's needs and preferences.

In some circumstances, where the assessment has identified that a short-term reablement intervention is appropriate, the RAS assessor might also 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 in the time frame of the overall reablement period agreed with the client.

For clients receiving reablement support, assessors may include review dates on the client’s support plan for the purposes of reviewing the client’s progress towards their goals and desired outcomes, requirement for ongoing services, or whether to adjust the services required. In these circumstances, CHSP service providers are required to provide time limited services in line with the support plan.

More information on the My Aged Care assessment and support planning process is provided under Section 4.4 of this manual and in the My Aged Care Assessment Manual: For Regional Assessment Services and Aged Care Assessment Teams.
Client scenario – reablement-focused assessment and support planning

CECELIA
Cecelia is an 81 years 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 face-to-face 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. Cecelia was also delighted to find that the new raised garden beds enabled her to access and maintain her garden more safely without affecting her enjoyment of the garden.

2.5.2 Service delivery
Under the CHSP, service providers maintain responsibility for service provision and client monitoring. Following on from the assessment and support planning stage, CHSP service providers are responsible for working directly with clients and assisting them to achieve their goals through providing innovative methods of service delivery. They are also responsible for updating a client’s information and referring them back to My Aged Care should their needs change.

Service providers are required to review the outcomes of the client’s assessment and support plan and to work in partnership with the client to identify strategies and solutions to achieve their goals and promote client choice and decision making. In addition, where the assessment and support plan recommends that short-term or time limited interventions are required to assist with meeting a client’s goals, CHSP service providers must ensure that they respond by time limiting service provision. This should be reflected by incorporating suitable review points into the client’s care plan.

In applying a wellness approach to service delivery, CHSP service providers are required to:

- Work directly with individual clients to break down the broader goals in their support plan (e.g. being able to shower independently) into achievable steps and strategies that will assist the client to reach their goals (e.g. undertaking strength building and balance classes and installing grab rails in the shower).
• Reconsider current service delivery approaches and implement innovative strategies that are better tailored to individual clients to achieve their goals.
• View all clients as having abilities and the potential to improve and gradually encourage those having difficulty with activities of daily living to increase their ability and do more for themselves rather than simply taking over and ‘doing for’ the client.
• Involve clients in the planning and delivery of services and supports provided, in order to promote increased self-confidence, dignity and a sense of control over their lives.
• Accept referrals to deliver short-term or time limited services as well as for ongoing services (depending on client needs).
• Enter the service provider service information into My Aged Care, including start date, volume and frequency of services and end date (where applicable).
• Undertake regular reviews and implement changes to support services to accommodate client progress. Noting that while there is no set timeframe for undertaking regular reviews, at a minimum all clients should have their support services reviewed annually by their service provider and if there are any significant changes to a client’s needs identified, this must be referred to My Aged Care to undertake a formal support plan review.

A wellness approach can be applied to all service types delivered under the CHSP regardless of whether they are short-term or ongoing. It requires the service provider to work with each client individually to identify what they can still do for themselves and then encouraging them to continue with these activities. For example, a client who is having difficulties making their own bed could be encouraged to replace heavier blankets with a light-weight doona enabling them to continue undertaking this task independently, or a client who is no longer able to drive could be assisted to use public transport to remain socially connected.

In general, CHSP services that support a wellness approach:
• Address a client’s needs in a holistic way considering their strengths, abilities and difficulties.
• Build client’s capacity, self-management and confidence.
• Focuses on re-enabling and maintaining function and minimising the impact of functional loss.
• Enables a client to set their own goals and make decisions about the support they receive.
• Ensures the support is delivered in partnership with the client.
• Encourages clients to remain involved in their community and maintain social connections.
• Supports client choice and decision making.
• Looks at ongoing appropriateness of service.

It should also be acknowledged that the level of client motivation to engage in wellness and reablement strategies also plays an important role in overall client outcomes and may require service providers to work alongside clients to educate and build their motivation in the first instance.

For further information, the Living well at home: CHSP Good Practice Guide provides examples of good practice and draw on the communications, capacity-building and training products that have been developed over a number of years in all jurisdictions and overseas.
Client scenarios – supporting greater independence

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 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.

2.5.3 Delivering increased choice for consumers
In the context of providing increased choice for consumers, embedding a wellness approach in the CHSP delivers an approach to planning and management of care services which involves clients in the development of a goal orientated support plan which is based around the client’s needs. Clients should also be able to exercise choice in the design and delivery of the needs-based services they receive, ensuring these services are tailored to a client’s preferences, where possible, as well as allowing greater flexibility in the timing and scheduling of services and in how care is shared between informal and formal carers.

---

4 Wellness Approach to Community Home Care Information Booklet July 2008 produced by the Western Australian Department of Health
2.6 Service provider responsibilities

Since its implementation in July 2015, service providers funded under the CHSP have been required to work towards adopting a wellness approach in their service delivery practices. To assist with this process, the Department developed and published the *Living well at home: CHSP Good Practice Guide* in June 2015. The Good Practice Guide was developed to complement the CHSP Program Manual and support the take up of wellness approaches in home support services.

In addition from 1 July 2018, the Department has implemented new funding conditions under the CHSP to provide a greater focus on activities that support independence and wellness and provide more choice for consumers.

From 1 July 2018, service providers funded under the CHSP must:

- actively work towards embedding a wellness approach in their service delivery practices,
- review the client’s Home Support Assessment and support plan documentation and ensure that service provision is targeted towards assisting clients to achieve their agreed goals,
- offer choice to clients, where practicable, on their service delivery preferences,
- accept referrals to deliver short-term services as well as ongoing services,
- enter the service provider service information in the My Aged Care client record (including start date, volume and frequency of services and the service end date if applicable),
- review all client’s support services (12 monthly as a minimum), and
- comply with wellness reporting requirements as outlined under sections 2.6.1 and 6.3.4 [Embedding a wellness approach – reporting] of this manual.

CHSP service providers should develop an implementation plan outlining their service’s approach to embedding wellness in service delivery. The implementation plan should be commensurate with the overall size of the organisation and the types of CHSP services delivered.

2.6.1 Embedding wellness – reporting requirements

Although a requirement since July 2015, the Department is aware that nationally many service providers are at different stages of implementing a wellness approach in their service delivery practices. Therefore, in order to review progress towards embedding wellness approaches in service delivery, CHSP providers will be required to submit a wellness report to the Department annually outlining service level information regarding the implementation of a wellness approach within their organisation. A specific reporting template will be provided by the Department for this purpose.

Service providers will be required to submit the first wellness report to the Department by 31 October 2018. This report will seek to clarify the current status of CHSP funded organisations in implementing a wellness approach. It will also seek to identify any implementation issues and supports needed. Subsequent wellness reports will be required annually and will be used to measure overall progress towards embedding a wellness approach in the CHSP.

In addition from 1 July 2018, the Department will implement an internal audit process to review available data relating to the service delivery practices of individual CHSP service providers. The audit will include a review of the service provider service information in My Aged Care, related client support plans and service provider data in the DSS Data Exchange. The audit will

---

5 From 1 July 2019 in Victoria.
review a random sample of up to ten per cent of CHSP providers nationally per annum. Depending on outcomes of the internal audit, the Department may contact individual service providers to discuss their service delivery patterns. Service providers will be required to comply with any reasonable requests for additional data arising from the audit process.

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

2.6.2 Embedding a wellness approach in service delivery practices
Embedding a wellness approach in service delivery practices will require service providers (and their staff) to be able to:

- interpret a client’s support plan with a wellness approach in mind and in consultation with the client;
- work with individuals and their carers as they seek to maximise their independence and autonomy;
- build on the strengths, capacity and preferences of clients, and encourage actions that promote self-sufficiency;
- embed a cultural shift from ‘doing for’ to ‘doing with’ across service delivery;
- apply a short-term or time limited intervention approach that supports full independence (where appropriate);
- be alert to changing circumstances and goals of the client and consult with My Aged Care where appropriate to review the client’s support plan; and
- consult the *Living well at home: CHSP Good Practice Guide* to assist in the development of good practices within a wellness approach.
2.6.3 Strategies to assist with embedding a wellness approach

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

- Requires a whole-of-organisation approach, including commitment from both management and staff.
- Is reflected in organisational policy and procedures, especially in recruitment, employment, orientation and induction practices.
- Is a focus of staff training and education programs.
- Requires a changed 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.
- Communication materials need to reflect the wellness approach to assist with setting client and staff expectations.

Additional information is provided in the *Living well at home: CHSP Good Practice Guide* that may assist service providers to embed a wellness approach into organisational practice.
Chapter 3 – Sub-Programs: Eligibility and Services

3.1 Program framework – Commonwealth Home Support Programme

The CHSP Program Framework includes four distinct sub-programs based on the Program’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, and
- Service System 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.

Program Framework – Commonwealth Home Support Programme

<table>
<thead>
<tr>
<th>Sub-Program</th>
<th>Community and Home Support</th>
<th>Care Relationships and Carer Support</th>
<th>Assistance with Care and Housing</th>
<th>Service System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>To provide entry-level support services to assist frail older people to live independently at home and in the community</td>
<td>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</td>
<td>To support those who are homeless or at risk of homelessness, to access appropriate and sustainable housing as well as community care and other support services, specifically targeted at avoiding homelessness or reducing the impact of homelessness.</td>
<td>To support the development of the home support service system and enable CHSP service providers to operate effectively in line with the objectives of the CHSP and within the context of the broader aged care system.</td>
</tr>
<tr>
<td>Target Group</td>
<td>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</td>
<td>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</td>
<td>Frail older people or prematurely aged people aged 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) who are on a low income and are homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation</td>
<td>Service providers funded under the CHSP and their clients</td>
</tr>
</tbody>
</table>
3.2 Sub-Program – objective, target population, eligibility and services

3.2.1 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.
Client scenario — supporting frail older people

**MABEL**

Mabel is 82 years old and lives alone. She has been diagnosed with macular degeneration and is losing her vision. Mabel no longer drives and is finding it increasingly difficult to access activities and services in her community. She wants to remain as independent as possible. Mabel calls My Aged Care to see what support is available.

Screening undertaken by the contact centre identifies that she would benefit from a RAS face-to-face 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 and goals and develops a support plan 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.

The community transport provider sends drivers who have experience with vision-loss clients. Ultimately, the support provided to Mabel addresses the challenges facing her, while also helping her to retain as much independence as possible.

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

<table>
<thead>
<tr>
<th>Objective</th>
<th>To provide services that restore, improve or maintain frail older people’s health, wellbeing and independence.</th>
</tr>
</thead>
</table>
| 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 providing 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. The focus of these services is assisting older people to regain or maintain physical, functional and cognitive abilities which support them to either 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):
- podiatry
- occupational therapy
- physiotherapy
- social work
- formal counselling from a qualified social worker or psychologist
- speech pathology
- exercise physiology
- nutritional advice from an Accredited Practising Dietitian or a qualified nutritionist
- Aboriginal and Torres Strait Islander Health worker
- diversional therapy
- hydrotherapy
- other allied health and therapy services. 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 subtypes 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 episodic nature, are delivered on an individual or group basis and provided at a low intensity or frequency, with a maintenance or preventative...
<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th><strong>To provide services that restore, improve or maintain frail older people’s health, wellbeing and independence.</strong></th>
</tr>
</thead>
</table>
| 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 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. |
<p>| <strong>Out-of-scope activities under this service type</strong> | Specialist post-acute care and rehabilitation services are out-of-scope and must not be purchased using CHSP funding. |
| <strong>Service delivery setting e.g. home/centre/clinic/community</strong> | Services may be delivered in a client’s home, a clinic, at a day centre, a group environment or other community setting. |
| <strong>Legislation</strong> | Service providers must adhere to any relevant Commonwealth and/or state/territory legislation or regulations. |
| <strong>Output measure</strong> | 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). |
| <strong>Staff qualifications</strong> | 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. |</p>
<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>To provide services that restore, improve or maintain frail older people’s health, wellbeing and independence.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fees</strong></td>
<td>Client contribution amount recorded in the Data Exchange (in Fees field).</td>
</tr>
</tbody>
</table>

## Service type: Domestic Assistance

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>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.</th>
</tr>
</thead>
</table>
| **Service type description** | Domestic Assistance is normally provided in the home and refers to:  
- general house cleaning  
- unaccompanied shopping (delivered to home)  
- linen services.  

It can include:  
- dishwashing  
- house cleaning  
- clothes washing and ironing  
- shopping (unaccompanied)  
- bill paying (unaccompanied)  
- collection of firewood (in remote areas)  
- help with meal preparation (where this is not the primary focus of service delivery)  
- washing of household linen or provision and laundering of linen, usually by a separate laundry facility.  

Services may also include demonstrating and encouraging the use of techniques or specific aids and equipment 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** | 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. |
| **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. |
<p>| <strong>Legislation</strong> | Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations, for example relating to safe food handling and laundering practices. |
| <strong>Output measure</strong> | Time (recorded in hours and minutes as appropriate). |
| <strong>Staff qualifications</strong> | Where additional services are performed, such as personal care, in conjunction with domestic assistance, requirements relating to that additional service apply. |</p>
<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th><strong>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.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fees</strong></td>
<td><strong>Client contribution amount recorded in the Data Exchange (in Fees field).</strong></td>
</tr>
</tbody>
</table>
### Service type: Goods, Equipment and Assistive Technology

<table>
<thead>
<tr>
<th>Objective</th>
<th>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.</th>
</tr>
</thead>
</table>
| 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.  
  
Goods, equipment and assistive technologies that can be purchased under the CHSP fall under the following service sub-types:  
- self-care aids  
- support and mobility aids  
- medical care aids  
- communication aids  
- reading aids  
- car modifications  
- other goods and equipment.  
  
and include a wide range of items such as:  
- assistive technologies such as robotic vacuum cleaners  
- dressing aids  
- shower chairs  
- sensor mats  
- over-toilet frames  
- walking frames  
- adapted utensils  
- low vision aids such as binoculars, electronic magnifiers and magnifying/reading software.  
  
Older people 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.  

In general it is expected that clients who are unable to purchase the item/s independently will be able to access up to $500 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. 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 for a total combined cost of $450.  

These items include those which pose a low risk to the client or worker.  

Where a provider assesses it to be necessary, however, the provider has the discretion to increase the cap to $1,000 per client per financial year.  

**Note:** Service providers must record the amount spent in the ‘Notes’ section of the My Aged Care central client record.
<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-scope activities under this service type</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Items that are not related to the functional impairment (e.g. general household or furniture or appliances)</td>
</tr>
<tr>
<td>• Items that are likely to cause harm to the participant or pose a risk to others.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service delivery setting e.g. home/centre/clinic/community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varied settings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of funds including any target areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>These hours must be reported as Allied Health and Therapy Services hours if they were delivered by an Allied Health professional.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific funding advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CHSP is not designed to replace existing state managed schemes which provide medical aids and equipment (e.g. Medical Aids Subsidy Scheme).</td>
</tr>
<tr>
<td>CHSP service providers are encouraged to access these state and territory aids and equipment programs where appropriate.</td>
</tr>
<tr>
<td>Access to informed, independent information on the types of equipment available, and which equipment best meets the client’s needs, is an important part of the service delivery system. Service providers are encouraged to seek advice from their state or territory Independent Living Centre which can assist.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of items purchased or loaned.</td>
</tr>
<tr>
<td>Cost in dollars – of the amount service provider spent.</td>
</tr>
<tr>
<td>Hours of Allied Health and Therapy Services delivered must be recorded separately in the Data Exchange if applicable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training for clients in the use of goods, equipment and assistive technology should be provided by people with appropriate knowledge and skills. For example, speech pathology assessment is required to assess clients for communication aids and equipment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client contribution amount recorded in the Data Exchange (in Fees field).</td>
</tr>
</tbody>
</table>
**Service type: Home Maintenance**

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 reablement goals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type description</th>
</tr>
</thead>
</table>
| 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 goals. Services refer to:  
  - major home maintenance and repairs  
  - minor home maintenance and repairs  
  - garden maintenance.  
  
A home based assessment by a RAS is important for developing initial home and yard maintenance plans.  

Activities funded can include a range of maintenance or repair tasks such as:  
  - Repair of internal flooring and external access pathways to address slip and trip hazards  
  - Minor plumbing, electrical & carpentry repairs where client safety is an issue  
  - Working-at-height related repairs or cleaning for client health and safety i.e. gutters, roofs, windows, ceilings, smoke alarms  
  - Secure access issues for clients’ personal safety  
  - Accessible, low maintenance garden redesign to support wellness and reablement goals  
  - Yard maintenance – 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. These are basic services primarily for function and safety rather than for aesthetic effect. |

<table>
<thead>
<tr>
<th>Out-of-scope activities under this service type</th>
</tr>
</thead>
</table>
| 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 or where damage to a property is covered by insurance. |
<table>
<thead>
<tr>
<th>Objective</th>
<th>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 reablement goals.</th>
</tr>
</thead>
</table>
| 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 (recorded in hours and minutes as appropriate).
Cost in dollars – Cost of service provided (amount service provider spends). Note that costs are GST exclusive. |
| 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

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 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:

- grab rails in the shower
- ramps (permanent and temporary)
- step modifications
- access and egress pathways through a property
- appropriate lever tap sets or lever door handles
- internal and external hand rails next to steps
- installation and fitting of emergency alarms and other safety aids and assistive technology
- client engagement and support.

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.

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
<table>
<thead>
<tr>
<th>Objective</th>
<th>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 reablement and restorative practices.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>as consider alternative solutions that may be more suitable (for example assistive technology and equipment).</td>
</tr>
</tbody>
</table>

April 2018 – 46
<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>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 reablement and restorative practices.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-scope activities under this service type</strong></td>
<td>General renovations of the home are not in the scope of the CHSP. The intent of the CHSP is to primarily fund simple home modifications (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. Service providers must record the amount spent in the ‘Notes’ section of the My Aged Care central client record.</td>
</tr>
<tr>
<td><strong>Service delivery setting e.g. home/centre/clinic/community</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Use of funds including any target areas</strong></td>
<td>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 or small goods and equipment that may be prescribed through the Occupational Therapy assessment that may either support the installation or, where clinically appropriate, may mitigate/negate the need for more complex home modification installations. These hours must be reported as Allied Health and Therapy Services hours if they were delivered by an Allied Health professional.</td>
</tr>
<tr>
<td>Objective</td>
<td>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 reablement and restorative practices.</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Specific funding advice</td>
<td>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 including measurement of the home, planning processes and for project management of the modification.</td>
</tr>
<tr>
<td>Legislation</td>
<td>Service providers must comply with relevant Commonwealth and/or state/territory legislation and local Council 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.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Cost in dollars. Types of modification activity provided. <strong>Note:</strong> Hours of Allied Health and Therapy Services delivered as part of the overall service to the client must be reported in the Data Exchange under the Allied Health and Therapy Services.</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>Providers must comply with Commonwealth and state and territory legislation regarding who can undertake home modifications.</td>
</tr>
<tr>
<td>Fees</td>
<td>Client contribution amount recorded in the Data Exchange (in Fees field).</td>
</tr>
</tbody>
</table>
### Service type: Meals

<table>
<thead>
<tr>
<th>Objective</th>
<th>To provide frail older people with access to meals.</th>
</tr>
</thead>
</table>
| Service type description | This service type refers to:  
- meals prepared and delivered to the client’s home  
- 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. |
| 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 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 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, the |
<table>
<thead>
<tr>
<th>Objective</th>
<th>To provide frail older people with access to meals.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>meals may be reported separately within the Data Exchange but cannot be counted under both service types.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>By contrast, if a provider delivered dinners intended for two meals across the week, this would be considered two meals.</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>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.</td>
</tr>
<tr>
<td>Fees</td>
<td>Client contribution amount recorded in the Data Exchange (in Fees field).</td>
</tr>
</tbody>
</table>
**Service type: Nursing**

<table>
<thead>
<tr>
<th>Objective</th>
<th>To provide short-term or episodic treatment and monitoring of medically diagnosed clinical conditions to support frail older people to remain living at home.</th>
</tr>
</thead>
</table>
| 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 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. After this, support services must be reviewed to determine whether the client’s current needs are being met. |
<p>| 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. |</p>
<table>
<thead>
<tr>
<th>Objective</th>
<th>To provide short-term or episodic treatment and monitoring of medically diagnosed clinical conditions to support frail older people to remain living at home.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fees</td>
<td>Client contribution amount recorded in the Data Exchange (in Fees field).</td>
</tr>
</tbody>
</table>
**Service type: Other Food Services**

<table>
<thead>
<tr>
<th>Objective</th>
<th>To educate, train and re-skill frail older people in preparing and cooking a meal in their own home to promote their independence.</th>
</tr>
</thead>
</table>
| 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-skillling 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.  
Advice on nutrition 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. |
<p>| Fees | Client contribution amount recorded in the Data Exchange (in Fees field). |</p>
<table>
<thead>
<tr>
<th>Service type: Personal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
</tbody>
</table>
| **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  
- 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. |
| **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 take into account 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 – individual

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>To assist frail older people to participate in community life and feel socially included through meeting their need for social contact and company.</th>
</tr>
</thead>
</table>
| **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. |
| **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. |
| **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). |
| **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: Social Support – group

<table>
<thead>
<tr>
<th>Objective</th>
<th>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.</th>
</tr>
</thead>
</table>
| Service type description | Social support – Group (formerly known as Centre-Based Day Care) provides an opportunity for clients to attend and participate in 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.  
Services may include light refreshments and associated transport and personal assistance (e.g. help with toileting) involved in attendance at the centre. |
<p>| Out-of-scope activities under this service type | Social gatherings that do not specifically aim to support older people’s social inclusion and independence. |
| 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 provide both community transport and Social Support – Group, they should record the transport to/from the centre separately to the Social Support – Group activity. 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. Where transport is provided (separate to any excursion) to a carer accompanying the frail older client this should be counted separately within the Data Exchange. |
| 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 |</p>
<table>
<thead>
<tr>
<th>Objective</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>safe food handling practices including personal hygiene and cleanliness.</td>
</tr>
<tr>
<td>Fees</td>
<td>Client contribution amount recorded in the Data Exchange (in Fees field).</td>
</tr>
<tr>
<td>Service type: Specialised Support Services</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Objective</strong></td>
<td><strong>To provide services that meet the specialised needs of older people living at home.</strong></td>
</tr>
</tbody>
</table>
| **Service type description** | This service type refers to specialised or tailored services for older people who are living at home with a particular condition such as dementia or vision impairment.  
These services help clients, and their carers and families, to manage these conditions and maximise client independence to enable them to remain living in their own homes.  
They comprise a mix of direct service delivery, tailored support and expert advice.  
They also provide support to other service providers to meet the specialised needs of those clients through awareness raising, information sharing and education.  
Specific service sub-types delivered include:  
- continence advisory services  
- dementia advisory services  
- vision support services  
- hearing support services  
- other support services. |
| **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 conditions. |
| **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. |
| **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). |
**Service type: Transport**

<table>
<thead>
<tr>
<th>Objective</th>
<th>To provide frail older people with access to transport services that supports their access to the community.</th>
</tr>
</thead>
</table>
| 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 appointments with their general practitioner, enabling them to keep active and socially engaged.  
  
  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 or territory administered patient transport services. |
| 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. |
| 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. |
<p>| Staff qualifications | Drivers of transport services must hold an appropriate licence. |</p>
<table>
<thead>
<tr>
<th>Objective</th>
<th>To provide frail older people with access to transport services that supports their access to the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service providers must also take reasonable care to ensure the safety of all concerned where paid staff or volunteers are providing transport services.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Fees</td>
<td>Client contribution amount recorded in the Data Exchange (in Fees field).</td>
</tr>
</tbody>
</table>
3.2.2 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**

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>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.</th>
</tr>
</thead>
</table>
| **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. 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** | 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).  
  Any transport provided as part of the main service of centre-based respite being delivered within the centre’s program should 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

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th><strong>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.</strong></th>
</tr>
</thead>
</table>
| **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** | **Cottage settings.** |
| **e.g. home/centre/clinic/community** | |
| **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

<table>
<thead>
<tr>
<th>Objective</th>
<th>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.</th>
</tr>
</thead>
</table>
| 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.  
  - **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). |
3.2.3 Assistance with Care and Housing Sub-Program

Objective
To support those who are homeless or at risk of homelessness, to access appropriate and sustainable housing as well as community care and other support services, specifically targeted at avoiding homelessness or reducing the impact of homelessness.

Target population and eligibility
The target group is frail older people or prematurely aged people aged 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) who are on a low income and who are homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation.

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.

Service considerations
To ensure older people are supported in being housed appropriately and to receive the care they need to continue living in the community, service providers funded to deliver Assistance with Care and Housing must follow the principles below.

Assistance with Care and Housing services:
- Will coordinate and link support for clients in a goal focussed client management relationship.
- Provide opportunities for all associated services and programs to work cooperatively to meet the essential housing, social support and community care needs of extremely vulnerable and disadvantaged members of the community.
- Coordinate a service response that is directed to ensuring appropriate housing is secured for the older person and that their care needs are met so they can continue to live in the community.
- Interact and work with multiple services across a range of sectors.
- Ensure a rapid response to older people who are homeless or 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.
Client scenario — accommodation and linking to community support

Pete

Pete is 55 years old and has been sleeping rough for several years. His latest accommodation is a boarding house, where his bedroom is unable to be locked and he is exposed to harassment from other boarders. Pete feels increasingly isolated and fearful for his safety and his health is starting to be impacted.

He has been receiving some help from a local charity which suggests that Pete contact a CHSP service that provides Assistance with Care and Housing support. He visits the CHSP provider and they call My Aged Care together and establish he is eligible to receive support.

With Pete’s consent, he is registered as a client. The contact centre refers him to the RAS and notes on the client record that the Assistance with Care and Housing provider can be contacted to assist in arranging an assessment with Pete. Upon contact, the RAS and Assistance with Care and Housing provider organise a time to meet with him at his boarding house. They work together during the assessment and develop a support plan with Pete. The RAS records this information on the client record.

Pete’s support plan includes finding better accommodation and other community care and support services to prevent a relapse into homelessness.

He gives his consent to receive these linking services through the Assistance with Care and Housing provider and a formal referral for service is sent by the RAS to the provider. The Assistance with Care and Housing provider helps Pete find more secure accommodation in his local area. The small bedsit is self-contained and private, and he feels safer and begins to invite his friends to visit him again which helps him feel connected. The accommodation is also located close to public transport and shops so he can maintain his links with the community, such as continuing to visit the charity which first assisted him.

Regular follow-up visits by the Assistance with Care and Housing provider to check on Pete’s progress shows that his physical and emotional wellbeing has improved with secure accommodation, support for his health and continuing links to the community through social support.

This gives him a renewed sense of optimism and control.
## Service type: Assistance with Care and Housing

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>To support those who are homeless or at risk of homelessness, to access appropriate and sustainable housing as well as community care and other support services, specifically targeted at avoiding homelessness or reducing the impact of homelessness.</th>
</tr>
</thead>
</table>
| **Service type description** | Assistance with Care and Housing services do not provide direct care or ongoing support, but do link clients to the most appropriate range of housing and care services in order to meet their immediate and ongoing needs. Service sub-types are:  
- Assessment – Referrals  
- Advocacy – Financial, Legal  
- Hoarding and Squalor  
  In practice, Assistance with Care and Housing provider engagement with the client and the gradual development of trust, leading to a supportive professional relationship, may take numerous interactions.  
  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 and advocacy to assist them to remain linked with those services.  
  Assistance with Care and Housing support may also be required at times after linkages have been established to conduct early intervention and prevent relapse into homelessness or estrangement from support services and a resultant decline in the person’s welfare.  
**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.  
CHSP 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 Hoarding and Squalor services may include: developing a client plan; one-off clean-ups; review care plans and linking clients to specialist support services.  
Service providers are required to develop links with other local care services and provide a referral service for clients to those agencies that offer care and support 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  
- veteran’s home care services  
- health services  
- local government services  
- other services appropriate to the needs of the client, such as community care and other support services. |
<table>
<thead>
<tr>
<th>Objective</th>
<th>To support those who are homeless or at risk of homelessness, to access appropriate and sustainable housing as well as community care and other support services, specifically targeted at avoiding homelessness or reducing the impact of homelessness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirements for service providers funded under this sub-program in relation to interacting with My Aged Care are outlined at Section 4.4.1 of this Program Manual.</td>
<td></td>
</tr>
<tr>
<td>Out-of-scope activities under this service type</td>
<td>Permanent support and/or direct care provision are out-of-scope. Funding to purchase accommodation for clients.</td>
</tr>
<tr>
<td>Service delivery setting</td>
<td>Varied – including a client's home, at a centre or clinic, in the community.</td>
</tr>
<tr>
<td>Use of funds including any target areas</td>
<td>Service providers are funded to link clients to appropriate specific services in their area. They may provide clients with direct contact details for these services, or where judged necessary, provide active liaison and representation on behalf of clients. Service providers are also funded to assist the Principal Client to locate, apply for, and relocate to housing in an area suitable to the needs of the Principal and co-habiting Client.</td>
</tr>
<tr>
<td>Legislation</td>
<td>Service providers must comply with relevant Commonwealth and/or state/territory legislation and regulations.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours and minutes as appropriate).</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>Staff must possess an appropriate level of knowledge and skills in relation to socially isolated and/or disadvantaged people.</td>
</tr>
</tbody>
</table>
### 3.2.4 Service System Development Sub-Program

#### Objective
To support the development of the home support service system and enable CHSP service providers to operate effectively in line with the objectives of the CHSP and within the context of the broader aged care system.

#### Target population
CHSP service providers and consumers.

#### Service type: Sector Support and Development

<table>
<thead>
<tr>
<th>Objective</th>
<th>To support the development of the home support service system and enable CHSP service providers to operate effectively in line with the objectives of the CHSP and within the context of the broader aged care system.</th>
</tr>
</thead>
</table>
| Service type description | The CHSP will support a range of activities to support, develop and strengthen the home support service system. The types of activities may include:  
- Developing and disseminating information on the CHSP and its interaction with the broader aged care system.  
- Embedding wellness, reablement and restorative care approaches into service delivery.  
- Strengthening the capacity of CHSP service providers to deliver quality services that are responsive to client needs, including clients with diverse needs.  
- Brokering, coordinating and delivering training and education to service providers, workforce and consumers.  
- Developing and promoting collaborative partnerships within the CHSP and across the broader aged care service system.  
- Supporting and maintaining the volunteer workforce. |
| Out-of-scope activities under this service type | Activities delivered under this service type must not include provision of advocacy services or direct service delivery to clients. This includes activities that primarily focus on providing social support type services which should be funded under the Community and Home Support Sub-Program. |
| Service delivery setting e.g. home/centre/clinic/community | Activities can be across a range of settings as appropriate. |
| 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 activity described in the organisation’s approved Sector Support and Development Activity Work Plan. |
Chapter 4 – Access and interactions

4.1 Interaction between the Commonwealth Home Support Programme 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

The care needs of a person receiving a home care package should be addressed through their home care package, and 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 home care package client’s individualised budget.

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 home care package clients already receive Government subsided home care package services. Clients can purchase additional services above the value of their package for an agreed fee with their provider.

There are four defined circumstances in which a home care package client may be able to access some specific CHSP subsidised services in addition to the services they are receiving from their home care package budget. The additional CHSP services will not be charged to the client’s individualised home care package budget, however, the client will be expected to contribute to the cost of these services in line with the CHSP provider’s client contribution policy.

In all four circumstances the additional CHSP services must only be provided on a short-term, time limited basis, which should be monitored and reviewed by the client’s most recent assessment service. The four defined circumstances include:

1. For clients on a Level 1 or 2 home care package: where the client’s home care package budget is already fully allocated, the client can access additional, short-term or episodic Allied Health and Therapy services or Nursing services from the CHSP, where these specific services may assist the client to get back on their feet after a setback (such as a fall).

2. For clients on a Level 1 to 4 home care package: where the client’s home care package budget is already fully allocated and a carer requires it, a home care package client can access additional planned respite services under the CHSP (on a short-term basis).
3. For clients on a Level 1 to 4 home care package: in an emergency (such as when a carer is not able to maintain their caring role), where the client’s home care package budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short-term basis. These instances must be time limited, monitored and reviewed.

4. For clients on an interim Level 1 or 2 package who are waiting for a Level 3 or 4 home care package; where the client’s home care package budget is already fully allocated, a client can access additional home modifications from the CHSP.

All home care package clients must be assessed through My Aged Care to receive these additional CHSP services. 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 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 home care package clients 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 home care package.

Where a new client has been assessed and approved as eligible for a home care package but is waiting to receive that package, the client may be eligible to receive some services under the CHSP as an interim arrangement, but only to an entry-level of support consistent with the CHSP, not at the level of support of the home care package they are eligible for.

**Residential Care**

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

**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 will be able to access the CHSP if they are eligible, but within its scope as the entry tier of aged care (see the Scenario at Section 3.2.1 of this Program Manual as an example).

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.

**Continuity of Support**

The Commonwealth has developed Continuity of Support (CoS) arrangements to meet the Council of Australian Government’s commitment to provide continuity of support to older people aged 65 and over (and Aboriginal and Torres Strait Islander people aged 50 years and over) who are accessing state-administered, specialist disability services and who will be ineligible for the National Disability Insurance Scheme (NDIS) at the time of NDIS implementation in a region.

The arrangements will see a closed cohort of around 8,500 older people who are currently receiving state-administered specialist disability services receive ongoing support, either through the new CoS Programme or an existing aged care program such as the CHSP.
The CoS Programme will ensure that older people with disability continue to be supported to achieve similar outcomes to those they were achieving prior to the transition.

The CoS Programme clients have been transitioning to the new arrangements since 1 December 2016 in some states and territories and will be phased in across all state and territory regions, with full client transition by 30 June 2019. Until the CoS Programme is implemented in a region, clients will continue to access the current state-managed disability system. This staged approach will see minimum disruption to care and services for both older people with disability and their service providers.

Further information on the CoS Programme may be found on the Department of Health website by searching ‘Continuity of Support’. More detail on interactions between the CoS and CHSP programs will be available in the coming months on the CoS website and in the CoS Program Manual.

**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 GP, 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 are able to 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 from 1 July 2016 and those in the Western Australian HACC program will be transitioned directly into the CHSP from 1 July 2018.

Existing clients are considered to be those clients who had a current booking for service or who were currently accessing a service as at 1 July 2015 and including Victorian clients as at 1 July 2016 and Western Australian clients as at 1 July 2018; who accessed services at least three times over the previous financial year (e.g. three episodes of respite); or who received care for a continuous period of six months or more in the previous financial year (see Glossary).

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. This includes existing Western Australian clients who have not accessed a HACC service under the Western Australian HACC Program in the past twelve months.

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). It was agreed that these clients would be grandfathered into the program and supported to transfer to more appropriate services (such as the NDIS or HCP Program) when these services became available.

It was anticipated that these clients would be transitioned to more appropriate forms of care in a timely manner and within the life of the initial CHSP Grant Agreement. Service providers are expected to transition any remaining grandfathered clients whose needs are outside the scope of the CHSP to more appropriate services as they become available.

Residential Care
Prior to 1 July 2015, services funded under the DTC Program were available to residents with an Aged Care Funding Instrument (ACFI) ‘low’ score 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 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 the 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

Since 1 July 2015, entry and assessment for the CHSP has been 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 levels of service, the client must be referred to My Aged Care for an assessment before any additional services can be provided.

From July 2018, all new clients must enter into the CHSP through My Aged Care. In addition, all existing and grandfathered clients receiving services under the CHSP that have not yet been registered with My Aged Care will need to be registered and have a client record in place within a timeframe and mechanism to be determined by the Department. Further information on this process will be provided by the Department.

Information gathered from My Aged Care and the Data Exchange indicates that, as at 31 December 2017, a significant number of CHSP clients have not yet been registered or assessed by My Aged Care. To address this issue, under the terms and conditions of the CHSP Grant Agreement, service providers will be required to provide data to the Department (in a format and timeframe to be determined by the Department), on all existing CHSP clients that are not yet registered with My Aged Care. The Department will use this information to register all existing clients on My Aged Care and to develop a client record without an assessment being undertaken. However as outlined above, where an existing client’s needs change significantly the client must be referred to My Aged Care for an assessment before any additional services can be provided.

More information regarding the required reporting of existing client information is provided under Section 6.3.4

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/or 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 and intersex status, disability or whether they have the ability to pay for services.
In addition:

- 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 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 provider portal. The priority timeframes are referenced in the *My Aged Care Guidance for Providers* 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.

4.4 Assessment for entry to the Commonwealth Home Support Programme

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 provider portal is available on the Department of Health website.

My Aged Care incorporates a website and contact centre. The contact centre registers clients and via a phone-based screening process will determine 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 face-to-face home support assessment to be conducted by a RAS, if the client can be supported by the CHSP.
- refer the client for a face-to-face 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 face-to-face 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).

**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.
- involvement by family and their carers, representatives or other advocates as appropriate.
- awareness of cultural and/or religious values, beliefs, gender identity or sexual preferences.
- a focus on 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, financial and aged care services.
- Short-term case management to assist a client undertaking a reablement program designed to restore their independence and reduce their need for ongoing CHSP services.
- the provision of information regarding client contributions for CHSP Services.
- 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:** As part of the assessment process in Victoria, HACC Assessment Services participate in Victoria’s emergency management practices to identify and protect vulnerable people who live in high risk areas. Victorian HACC Assessment Services and service providers are encouraged to continue to participate in these procedures and practices.

**Clients approaching service providers directly**

People seeking access to aged care services for the first time must contact My Aged Care to discuss their aged care needs and have a client record created. New clients will need to follow the My Aged Care assessment process.

New clients (and existing clients seeking new service types or significantly increased services) should not access CHSP services directly by approaching a service provider unless the client has an urgent need for a health or safety intervention that can be delivered by a service provider.

Where it is clear that urgent care is required, for example the delivery of meals due to the unplanned absence of a carer, service delivery may be provided before a client has contacted My Aged Care to ensure the safety of the client. The delivery of these services should be time-limited with the service provider assisting the client to contact My Aged Care, register, have a
client record created and have an assessment scheduled. In all other circumstances, services should not commence before an assessment.

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.
- Sending a fax with information about the person to My Aged Care for actioning.

**Direct referral by My Aged Care to CHSP service delivery including urgent circumstances**

The client can be referred by My Aged Care directly to a CHSP service, only:

- If the client has a need for an immediate health or safety intervention that is unsupported through other means

The services referred to should be:

- For a one-off intervention (such as transport to a GP appointment)
- For a direct health or safety intervention that needs to occur before a face-to-face assessment can take place (such as for Nursing, Personal Care or Meals).

Any clients that are referred by My Aged Care directly to service providers, before the completion of a face-to-face assessment, will receive time-limited services only.

The following describes circumstances where service delivery could commence prior to completion of the My Aged Care face-to-face assessment by either a RAS or ACAT:

- Where a client calls My Aged Care and identifies an urgent need for service because they require a health or safety intervention that cannot be supported by any other means. In these cases, a client will be referred to both a face-to-face assessor and a service provider (with time limited approvals) to begin receiving services whilst they wait for a face-to-face assessment to be completed.
- Where a client approaches a service provider directly and it is clear that urgent care is required, for example the delivery of meals due to the unplanned absence of a carer. In these cases, service provision can occur, however clients will still need to be registered with My Aged Care, and have their broader needs considered via a face-to-face assessment.
- Where an ACAT or an authorised RAS refers a client for CHSP services pending an assessment. This may occur, for example, where the client is in remote or very remote area and where an assessment is not able to be undertaken within the normal timeframes.

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.

There are established performance indicators including timeframes for RAS in managing referrals, conducting an assessment and finalising the assessment including making referrals, if required.

**Face-to-face assessment**
Where 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 - a phone, video conference, telehealth or teleconference assessment may be undertaken.

The assessment may result in referring clients to more specialised assessments undertaken under the CHSP where required, such as allied health professionals. The central client record will ensure clients do not need to unnecessarily repeat their story as Commonwealth-funded service providers will have access to this information.

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. The My Aged Care training requirements are set out in the My Aged Care Assessment Workforce Training Strategy which defines and sets the minimum training requirement for the My Aged Care 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 and the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community 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.

My Aged Care 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 reablement approach recommended by a My Aged Care 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 or new assessment to be undertaken by the RAS.

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 case management for reablement services 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 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 refer the client to the RAS (or the latest assessment organisation) for a support plan review. 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. The outcomes of the review may include:

- no change
- an increase or decrease in services
- 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 face-to-face assessment.

**Assistance with Care and Housing Sub-Program service providers**

It is recognised that a specialised approach is required for Assistance with Care and Housing clients due to their particular circumstances. For these clients, Assistance with Care and Housing service providers may be a point of entry and assessment in addition to My Aged Care. Assistance with Care and Housing providers can help clients contact My Aged Care and work with the My Aged Care RAS, particularly during the assessment process. It is also appropriate for the RAS to refer suitable clients identified during the assessment process to the Assistance with Care and Housing Sub-Program 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.

**Implementing a reablement approach**

The My Aged Care RAS assessors meet face-to-face 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 approach in mind and in consultation with the client by translating each identified goal into smaller steps to enable clients to progress their goals.

The My Aged Care RAS assessors will be responsible for developing support plans with the client that may result in referral to services that will provide a reablement intervention. 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 reablement 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.

The assessor might also need to take on a coordination role to ensure that all services in the support plan are linked to a provider and that they will all be delivered in the time frame of the overall reablement service.

More detail on implementing a wellness approach, including reablement, under the CHSP is provided under Chapter 2 of this manual and in the publication Living well at home: CHSP Good Practice Guide.

4.4.2 Service provider requirements for interacting with My Aged Care
CHSP service providers must:
• provide and update their service data via the My Aged Care online provider portal.
• accept/reject client referrals via the My Aged Care online provider portal in a timely way specified by the referral priority. Please refer to the department’s website for timelines for managing referrals.
• refer or help clients to access My Aged Care where clients have approached them directly.
• enter service information (including commencement date and frequency/volume of services) 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.
• refer clients back to My Aged Care when their needs have changed.
• discharge clients whose needs and goals specified on the support plan have been met and who no longer require care and services.
• participate in assessment, referral and client record processes as appropriate to support data integrity within My Aged Care.

The My Aged Care Guidance for Providers and My Aged Care Provider Portal User Guide are available on the Department of Health website. These documents provide service providers with detailed information on the My Aged Care system.

4.4.3 Assessment functions undertaken by Commonwealth Home Support Programme service providers
Assessment for eligibility and CHSP services is undertaken by My Aged Care. The RAS (or ACAT) conduct face-to-face home support assessments by determining a client’s needs and their goals using the NSAF and developing a My Aged Care support plan in consultation with the client. The RAS also offers a linking service which provides short-term case management and care coordination for vulnerable older people with complex needs and undertakes reviews and reassessments where client’s needs change. The RAS may also provide short-term case management to supervise the delivery of intensive support designed to assist a client regain their independence.
The above separation of assessment from service provision allows for the application of a nationally consistent and standardised approach to assessment delivery.

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).
- Referral to My Aged Care 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.

### 4.4.4 My Aged Care interactions

CHSP service providers must adhere to the following principles when undertaking the functions outlined in Section 4.4.3 of this Program Manual and in interacting with My Aged Care as per Section 4.4.2.

**Review and refer**

Accept referrals in a timely way. Do not accept clients to waitlist where services are not imminently available.

Where a client’s circumstances have altered (e.g. carer status has changed) and/or the client’s needs are changing to a point where new service types may be required or current levels of service are no longer sufficient, service providers must refer clients to My Aged Care. This may lead to adjustment of the My Aged Care support plan or a new assessment.

**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.

**My Aged Care**

The publications [My Aged Care Guidance for Providers](https://www.health.gov.au) and My Aged Care Provider Portal User Guide are available on the Department of Health website and provide CHSP service providers with detailed information on the My Aged Care system. For all relevant up to date information on My Aged Care, service providers should refer to the department’s website.
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 practices must be in accordance with processes to protect client privacy and confidentiality.

Sensitive information
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. Where a sensitive note exists, a provider will be presented with an indicator when viewing the client information through their My Aged Care portal, prompting them to contact the assessor or the contact centre who will disclose the information contained within the sensitive note should it be applicable to the provider. For example, where it is recorded that a client is HIV positive, an assessor may receive a call from a garden maintenance provider and choose not to disclose the information within the note whilst a call from a personal care provider may result in the assessor disclosing the 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.
Part B – Administration of the Commonwealth Home Support Programme

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 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 Program Manual
- the Home Care Standards [to be replaced by the Aged Care Quality Standards from 1 July 2019]
- 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
- 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, 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
- 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 manage and keep up-to-date their service information via the My Aged Care web-based provider portal.

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 Home Care Standards and have appropriate procedures in place to meet these. The Home Care 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 Home Care Standards require service providers to demonstrate effective management processes based on a continuous improvement approach to service management, planning and delivery.

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.

From 1 July 2019, a new single set of standards, called the Aged Care Quality Standards, will replace the Home Care Standards. The Aged Care Quality Standards will apply to all aged care services including residential care, home care, flexible care and services under the Commonwealth Home Support Programme. For more information, please go to https://agedcare.govcms.gov.au/quality/single-set-of-aged-care-quality-standards

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 Home Care 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 at https://www.agedcarequality.gov.au/providers/assessment-processes/quality-review. 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 Service System Development are not subject to Quality Reviews.

6.1.2 Client Rights and Responsibilities

Service providers must comply with the Charter (excluding the rights expressed at 3A in the Charter of Care Recipients’ Rights and Responsibilities – Home Care) within the User Rights Principles 2014 under the Aged Care Act 1997, and provide their clients with a copy of the Charter.

Service providers must:

- develop and maintain internal policies and practices that support clients’ rights and responsibilities in accordance with the Charter and the Home Care Standards
• ensure these policies support and explain their responsibilities to clients
• make this information available to clients and assist with clients’ understanding of the policies
• respond to the needs of each individual client
• involve each individual when determining the support to be provided.

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

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 Commonwealth Home Support Programme 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).

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.

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.

The Department encourages Victorian service providers to continue to maintain their skilled and qualified workforce.

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.

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.

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.

Dealing with complaints about the assessment process is covered in Section 4.4.4 of this Program Manual.

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 flood or fire).
- 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 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. More information about practices and processes relating to incident reporting can be found in Home Care Standard 1: Effective Management.

Transition out

The 'transition-out' component of Activity Continuity Plans ensures that the standard and delivery of services do not suffer. Plans should cover: specific requirements for different service types; the service provider’s individual arrangements; and the outcome of any negotiations with other service providers.

This component should also include the following:

- service details
- subcontracting arrangements

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 the Department in writing of their proposal to transfer all or part of their services. The service provider must negotiate with the Department on a suitable transition date with the replacement organisation.

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. Including, client care continuum with the provision of the goods and/or services from your organisation to the new provider.
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". Or
“Supported by the Australian Government Department of Health”.

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 Grant Agreement 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 use subcontractors in accordance with Condition 6 [Subcontracting] of Schedule 1 of the CHSP Grant Agreement.

6.2 Funding

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

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

6.2.2 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.
6.3 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.

Key Reports – CHSP

<table>
<thead>
<tr>
<th>REPORT</th>
<th>REPORTING PERIOD</th>
<th>DUE DATE TO THE DEPARTMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Report (for service delivery) via the Department of Social Services (DSS) Data Exchange</td>
<td>1 July to 31 December</td>
<td>30 January</td>
<td>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]</td>
</tr>
<tr>
<td>Note: this report is not applicable for Sector Support and Development Activities</td>
<td>1 January to 30 June</td>
<td>30 July</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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. The Data Exchange system is closed after the prescribed dates above, after which data cannot be entered or edited for the reporting period.</td>
</tr>
<tr>
<td>Performance Report for Sector Support and Development Activities only</td>
<td>1 July to 31 December</td>
<td>31 March</td>
<td>Refer to CHSP Grant Agreement Item E [Reporting]</td>
</tr>
<tr>
<td></td>
<td>1 January to 30 June</td>
<td>31 October</td>
<td></td>
</tr>
<tr>
<td>Embedding wellness Report</td>
<td>As specified in the Agreement</td>
<td>31 October</td>
<td>Refer to CHSP Grant Agreement Item E [Reporting]</td>
</tr>
<tr>
<td>REPORT</td>
<td>REPORTING PERIOD</td>
<td>DUE DATE TO THE DEPARTMENT</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Financial Declaration</td>
<td>1 July to 30 June</td>
<td>31 October</td>
<td>A Financial Acquittal Report in accordance with the CHSP Grant Agreement. Refer to CHSP Grant Agreement Item E [Reporting]</td>
</tr>
</tbody>
</table>

**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.

### 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 acquires 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

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. Proposals to carry over funds will need to be submitted in writing to the Department.

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 to ensuring compliance with contractual performance reporting requirements under the CHSP Grant Agreement whilst enabling CHSP service providers to meet short-term changes in the demand for services. It is not intended to change the funding arrangements in the longer term. Where there is demonstrated client need (based on My Aged Care referral requests) service providers may use the flexibility provision to deliver additional services needed within the same CHSP sub-program and the same Aged Care Planning Region by using up to 20 per cent of their allocated funds to deliver activities they are funded for.

The flexibility provision applies only within the Community and Home Support Sub-Program or within the Care Relationships and Carer Support Sub-Program. The CHSP sub-programs and service types are outlined in Chapter 3 of this Program Manual. Funded service types are set out in the service provider’s CHSP Grant Agreement.

Under the flexibility provision, service providers may deliver services within the same sub-program using up to 20 per cent of funds (from activities they are currently funded for), provided they can demonstrate they are delivering value for money and there is client demand for these services. 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.

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 in the same Aged Care Planning Region, then 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 up to 20 per cent of the funding it receives for Personal Care to deliver Social Support for a short period of time to meet the demand for Social Support services where these services are funded in the same 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 that 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 up to 20 per cent of the funding allocated to Personal Care for Domestic Assistance, provided they are still meeting the service demand 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 20 per cent of Personal Care funding 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.

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.

**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 that 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 (across CHSP sub-programs)**

A provider is funded to deliver Nursing and Centre Based Respite. The demand for Centre Based Respite exceeds the activity's allocated funding in their Agreement. The provider identifies there are unused funds in Nursing and wants to use the flexibility provision to meet the increased demand in services for Centre Based Respite.

Flexibility provisions do not apply across the CHSP sub-programs. Funds from Community and Home Support Sub-Program cannot be used for services in the Care Relationships and Carer Support Sub-Program. In this instance the provider cannot use the flexibility provision to provide these services.

**Example 3 (across Aged Care Planning Regions)**

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. 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 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, please contact your Grant Agreement Manager.

Reporting flexibility provision through the Data Exchange

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 Grant Agreement
 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.

**Service System Development – reporting**

Service provider’s with grant funding for Service System Development must provide regular progress reports against the activities specified within the Activity Work Plan and in accordance with 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 approach – reporting**

Service providers must provide regular reports to the Department regarding their organisation’s progress towards adopting a wellness approach to service delivery 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 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 approach in their service delivery practices. The reports will also be used to assist the Department to identify national resource gaps or strategies that could be implemented to drive continuous improvements in the delivery wellness and reablement approaches across the sector.

From 1 July 2018, the Department will implement a random audit process to review current service delivery practices in the context of providing a wellness approach to service delivery and to monitor compliance with My Aged Care Guidelines. The audit will be undertaken by the Department through a review of My Aged Care and Data Exchange information, including a review of My Aged Care support plan information and the related service provider service information.

The purpose of the audit is to provide the Department with a more detailed understanding of the support and care planning process at the service provider and client level. It will also be used as a tool to review the effectiveness of support services provided under the CHSP in assisting clients to meet their goals as identified in the client’s support plan.

The information gathered through the audit process will be communicated directly to service providers with a focus on client outcomes, continuous improvement and building capacity to deliver services in line with wellness and reablement principles.

Up to ten per cent of service providers may be audited nationally per annum.

**Existing clients not registered on My Aged Care - reporting**

Service providers with existing clients who are not yet registered on My Aged Care are required to provide information on these clients to the Department as outlined under 4.1.2. This data will be used to create a My Aged Care client record for all CHSP clients to assist with program management and planning.

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

As noted in the CHSP Guidelines, 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 (currently AUSkey a secure login to government online services), manage ABN Connections or VANguard Federated Authentication Services to access the My Aged Care provider portal and the Data Exchange reporting system to meet their activity and reporting requirements.

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

Data 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.

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 – Useful resources

Publications
Productivity Commission inquiry – Caring for Older Australians

Websites
Australian Taxation Office

Australian Privacy Principles

Advocacy
National Aged Care Advocacy Program (NACAP)
Each state and territory operates an advocacy information and advice line, which is a free call on 1800 700 600 available between 9.30-4.30pm Monday to Friday.

Advocacy and Elder Abuse

Carers
Carer Gateway
www.carergateway.gov.au
National contact centre (1800 422 737) Freecall

CHSP Interpreting support for service providers
TIS National website
Fact Sheet: Translating and Interpreting Service (TIS National)

NationalAuslan Interpreter Booking & Payment Service
http://www.nabs.org.au/

Commonwealth Department of Health

Dementia
Dementia Services and Support
National Dementia Helpline: 1800 100 500 (freecall 9am to 5pm, Monday to Friday)
Dementia Australia
https://www.dementia.org.au

Alzheimer’s Western Australia
https://www.alzheimerswa.org.au

Dementia Training Program
Dementia Training Australia
https://www.dementiatrainingaustralia.com.au

Behavioural advisory services
Dementia Support Australia delivers:

Dementia Behaviour Management Advisory Services
Severe Behaviour Response Teams
1800 699 799 (freecall 24 hours, 7 days)
https://www.dementia.com.au

National Meal Guidelines
Meals on Wheels developed National Meals Guidelines

Home Care Standards
Home Care Common Standards

National Continence Program
Bladder and Bowel

Continence Foundation of Australia
https://www.continence.org.au

The National Public Toilet Map
Freecall 1800 330 066
Resources relating to My Aged Care

My Aged Care
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.

My Aged Care provider portal
The My Aged Care provider portal will be the key tool for managing referrals and updating client information.


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

National Guide to the CHSP Client Contribution Framework (The Guide)

Resources relating to the DSS Data Exchange and CHSP Performance Reporting

Resources relating to support for people with disability
Guide Dogs Australia
http://www.guidedogsaustralia.com/

National Disability Services

Optometry Australia

Perkins Scout
http://www.perkinselearning.org/scout

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

Vision Australia
www.visionaustralia.org
Appendix B – Policies and Guidelines

**Aged Care Planning Regions**

**Aged Care Quality and Safety Commission**

**Carer Recognition Act 2010**

**Charter of Care Recipients’ Rights and Responsibilities - Home Care**

**Australian Criminal Intelligence Commission (formerly CrimTrac)**

**Aged Care Diversity Framework**

**DSS Data Exchange Protocols**

**Home Care Quality Review Guidelines**

**My Aged Care Concept of Operations**

**Quality Indicators Guidance for Service providers**

**On the record – Guidelines for the prevention of discrimination in employment on the basis of criminal record**
Appendix C – Contacts

Queensland
QLDHSN.Grant.Programs@dss.gov.au

South Australia
SA.CHSP@dss.gov.au

Tasmania
TAS.AgedCare@dss.gov.au

New South Wales and Australian Capital Territory
NSWACT.CHSP@dss.gov.au

Northern Territory
NTCHSP@dss.gov.au

Victoria
CHSP.HACC.VIC@dss.gov.au

Western Australia
CHSPWA@dss.gov.au
Appendix D – 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 a 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.

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
  • 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 service providers must bear in mind is to minimise the risk of harm to clients.

5.6 Committing an offence during the three year police certificate expiry 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 three year 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 Conviction 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 a CrimTrac accredited agency. 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.

For more information see: 6.1 Record keeping responsibilities.
### Appendix D Attachment 3a – Police service contact details

<table>
<thead>
<tr>
<th>State/Service</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Federal Police (for ACT and Nationally)</td>
<td>Phone: (02) 6140 6502 <a href="www.afpgov.au/what-we-do/police-checks/national-police-checks.aspx">National Police Checks</a></td>
</tr>
<tr>
<td>New South Wales Police Service</td>
<td>Phone: (02) 8835 7888 <a href="https://www.police.nsw.gov.au/online_services/criminal_history_check">NSW Police Force</a></td>
</tr>
<tr>
<td>Western Australia Police Service</td>
<td>Phone: (08) 7322 3347 <a href="https://www.police.wa.gov.au/Police%20Direct/National%20Police%20Certificates">Western Australia Police</a></td>
</tr>
<tr>
<td>South Australia Police</td>
<td>Phone: (08) 7322 3347 <a href="www.police.sa.gov.au/services-and-events/apply-for-a-police-record-check">South Australia Police</a></td>
</tr>
<tr>
<td>Tasmania Police</td>
<td>Phone (03) 6173 2928 <a href="http://www.police.tas.gov.au/services-online/police-history-record-checks/">Tasmania Police</a></td>
</tr>
<tr>
<td>Northern Territory Police</td>
<td>Phone: 1800 723 368 <a href="www.pfes.nt.gov.au/Police/Publications-and-forms.aspx">Northern Territory Police</a></td>
</tr>
</tbody>
</table>
Appendix D Attachment 3b - Statutory declaration form
Commonwealth of Australia

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>The process of speaking out on behalf of an individual or group to protect and promote their rights and interests.</td>
</tr>
<tr>
<td>Aged Care Assessment Team (ACAT)</td>
<td>The assessment teams that determine the care needs and eligibility for a home care package or residential care (referred to as Aged Care Assessment Services in Victoria).</td>
</tr>
<tr>
<td>Aged Care Funding Instrument (ACFI)</td>
<td>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.</td>
</tr>
<tr>
<td>Aged Care Quality and Safety Commission</td>
<td>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 Reporting Program including conducting quality reviews of home care services.</td>
</tr>
<tr>
<td>Assistance with Care and Housing for the Aged (ACHA)</td>
<td>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.</td>
</tr>
<tr>
<td>Care Leaver</td>
<td>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.</td>
</tr>
<tr>
<td>Carer</td>
<td>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.</td>
</tr>
<tr>
<td>Carer Gateway</td>
<td>Carer Gateway consists of a website (<a href="http://www.carergateway.gov.au">www.carergateway.gov.au</a>) and a national contact centre (1800 422 737) to help carers access practical information and resources to help them in their caring role.</td>
</tr>
<tr>
<td>Charter</td>
<td>Means the Charter of Rights and Responsibilities – Home Care or any charter that replaces it.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Charter of Rights and Responsibilities - Home Care (the Charter)</td>
<td>The Charter of Care Recipients’ Rights and Responsibilities - Home Care outlines the rights and responsibilities of care recipients when receiving home care and services.</td>
</tr>
<tr>
<td>Client</td>
<td>A person who is receiving care and services under the CHSP funded by the Australian Government.</td>
</tr>
<tr>
<td>Client’s home</td>
<td>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.</td>
</tr>
<tr>
<td>Co-habiting Clients</td>
<td>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.</td>
</tr>
<tr>
<td>Commonwealth Respite and Carelink Centres (CRCC)</td>
<td>Commonwealth Respite and Carelink Centres provide a link to carer support services and assist carers with options to take a break through short-term and emergency respite, based on assessed need. CRCC services target carers of frail older people, people with dementia and younger people with moderate, severe or profound disabilities who are living at home, and people with a terminal illness in need of palliative care.</td>
</tr>
</tbody>
</table>
| 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. |
<p>| 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 (DoH).                                                                                   |
| 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 <a href="https://dex.dss.gov.au/">https://dex.dss.gov.au/</a> |
| 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. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail</td>
<td>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).</td>
</tr>
<tr>
<td>Full cost recovery</td>
<td>Where access to a service is at full cost recovery, this means that the CHSP provider would charge the full cost of service provision.</td>
</tr>
<tr>
<td>Grant Agreement</td>
<td>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.</td>
</tr>
<tr>
<td>Home and Community Care Program (HACC)</td>
<td>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).</td>
</tr>
<tr>
<td>Home Care Packages</td>
<td>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.</td>
</tr>
<tr>
<td>Home Care Quality Review Guidelines</td>
<td>A guide that has been developed to assist service providers to prepare for and participate in a quality review using the Home Care Standards for ensuring quality in community care. The Home Care Quality Review Guidelines provide information about the home care quality processes including quality reviews, assessment contacts and continuous improvement. The guidelines are designed to assist service providers to prepare for visits and to demonstrate continuous improvement in their care and services for care recipients.</td>
</tr>
<tr>
<td>Home Care Standards</td>
<td>Refers to the Home Care Standards set out in the Quality of Care Principles.</td>
</tr>
</tbody>
</table>
| 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...
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Lesbian, gay, bisexual, transgender and intersex people (LGBTI)</td>
<td>People who are lesbian, gay, bisexual, transgender and intersex.</td>
</tr>
<tr>
<td>Low Income</td>
<td>Low Income is equivalent to:</td>
</tr>
<tr>
<td></td>
<td>• incomes in the bottom two-fifths of the population</td>
</tr>
<tr>
<td></td>
<td>• the maximum gross income or less necessary to qualify for or retain a Low Income Health Care Card, as issued by Centrelink</td>
</tr>
<tr>
<td></td>
<td>• whichever amount is greater.</td>
</tr>
<tr>
<td>My Aged Care</td>
<td>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).</td>
</tr>
<tr>
<td>National Aged Care Advocacy Program (NACAP) – provided by Older Persons Advocacy Network (OPAN)</td>
<td>National Aged Care Advocacy Program services have been provided by Older Persons Advocacy Network (OPAN) since 1 July 2017. OPAN organisations offer free aged care advocacy services that are independent and confidential, with services focused on supporting older people and their representatives to raise and address issues relating to accessing and interacting with Commonwealth funded aged care services.</td>
</tr>
<tr>
<td>National Aged Care Alliance (NACA)</td>
<td>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.</td>
</tr>
<tr>
<td>National Continence Program (NCP)</td>
<td>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.</td>
</tr>
<tr>
<td>National Disability Insurance Scheme (NDIS)</td>
<td>The National Disability Insurance Scheme provides community linking and individualised support for people with permanent and significant disability, their families and carers.</td>
</tr>
<tr>
<td>National Respite for Carers Program (NRCP)</td>
<td>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.</td>
</tr>
<tr>
<td>National Screening and Assessment Form (NSAF)</td>
<td>To ensure a nationally consistent and holistic screening and assessment process, the NSAF will be used by My Aged Care staff, the RAS and existing ACATs.</td>
</tr>
<tr>
<td>Not having secure accommodation</td>
<td>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</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>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.</td>
</tr>
<tr>
<td>Out-of-scope</td>
<td>Services and items that must not be purchased or delivered using CHSP funding.</td>
</tr>
<tr>
<td>Planned Respite</td>
<td>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.</td>
</tr>
<tr>
<td>Planning Framework</td>
<td>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.</td>
</tr>
<tr>
<td>Prematurely aged people</td>
<td>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.</td>
</tr>
<tr>
<td>Principal Clients</td>
<td>Principal Client means the sole client or the older client in a household.</td>
</tr>
<tr>
<td>Quality review</td>
<td>The process of reviewing the quality of services delivered against the Standards. The process includes notification of a quality review, self-assessment, a site visit, a Quality Review Report, a Plan for Continuous Improvement and if applicable a timetable for improvement and/or monitoring/follow-up activities.</td>
</tr>
<tr>
<td>Reablement</td>
<td>Reablement refers to an approach to service delivery which aims to assist people to maximise their independence and autonomy. Reablement supports are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Supports could include training in a new skill, modification to a person's home environment or having access to equipment or assistive technology.</td>
</tr>
<tr>
<td>Reassessment</td>
<td>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.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>Regional Assessment Services (RAS)</td>
<td>The My Aged Care RAS is responsible for assessing the home support needs of older people. The service will provide timely support for locating and accessing suitable services based on the preferences of older people. Assessors will be appropriately skilled, and trained by My Aged Care, to undertake assessments and identify services appropriate to a diverse range of clients.</td>
</tr>
<tr>
<td>Residential day respite</td>
<td>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 consider to be the same as Residential Respite which is delivered under the Aged Care Act 1997</td>
</tr>
<tr>
<td>Residential respite</td>
<td>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.</td>
</tr>
<tr>
<td>Restorative Care</td>
<td>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.</td>
</tr>
<tr>
<td>Review</td>
<td>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 of client needs is undertaken by My Aged Care RAS or ACAT where:</td>
</tr>
<tr>
<td>Sector Support and Development</td>
<td>Activities that support and improve service delivery to clients and build the capacity of service providers and the sector.</td>
</tr>
<tr>
<td>Serious Incident</td>
<td>Serious incidents are defined as those which may:</td>
</tr>
<tr>
<td>Short-Term Restorative Care (STRC)</td>
<td>The Short-Term Restorative Care (STRC) Programme is an early intervention program that aims to reverse and/or slow ‘functional decline’</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>Service provider</td>
<td>Service provider refers to service providers or organisations funded to provide services under the CHSP.</td>
</tr>
<tr>
<td>Single Aged Care Quality Framework</td>
<td>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.</td>
</tr>
<tr>
<td>Standards</td>
<td>Means the Home Care Standards or any standards that replace them.</td>
</tr>
<tr>
<td>Transition Care</td>
<td>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.</td>
</tr>
<tr>
<td>Veterans’ Home Care (VHC)</td>
<td>The Veterans’ Home Care program provides low level home care services to eligible veterans and war widows and widowers.</td>
</tr>
<tr>
<td>Volunteers</td>
<td>A volunteer is defined, for the purposes of this Program Manual, as a person who:</td>
</tr>
<tr>
<td>volunteers</td>
<td>• is not a staff member</td>
</tr>
<tr>
<td>volunteers</td>
<td>• offers his or her services to the service provider</td>
</tr>
<tr>
<td>volunteers</td>
<td>• provides care or other services on the invitation of the service provider and not solely on the express or implied invitation of a client</td>
</tr>
<tr>
<td>volunteers</td>
<td>• has, or is reasonably likely to have, unsupervised interaction with clients.</td>
</tr>
<tr>
<td>Wellness</td>
<td>Wellness is a philosophy based on the premise that even with frailty, chronic illness or disability people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and as independently as possible. A wellness approach in aged care services aims to work with individuals and their carers, as they seek to maximise their independence and autonomy.</td>
</tr>
<tr>
<td>Work Health and Safety</td>
<td>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.</td>
</tr>
</tbody>
</table>