Commonwealth Continuity of Support (CoS) Programme – Specialist Disability Services for Older People

Updated Programme Manual – as at April 2017
Commonwealth Continuity of Support (CoS) Programme - Specialist Disability Services for Older People

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Foreword

The new Commonwealth Continuity of Support (CoS) Programme has been established to meet the Council of Australian Governments’ (COAG) commitment that older people with disability who are currently receiving state-administered specialist disability services, but who are ineligible for the National Disability Insurance Scheme (NDIS), will be provided with continuity of support.

In this context, continuity of support means supporting clients to achieve similar outcomes to those they were achieving prior to transitioning to the new arrangements. Continuity of support will apply to a broad range of people considered ineligible for the NDIS, including those accessing Commonwealth programs that are transitioning or ceasing.

The Commonwealth CoS Programme is an ongoing, grandfathering programme for older people with disability accessing state-administered services only. Once the NDIS completes its rollout in a region, there will be no new entrants to the CoS Programme and once all existing clients transition out, the programme will cease.

Under the 2011 National Health Reform Agreement between the Commonwealth and States and Territories (excluding Western Australian and Victoria), the Commonwealth has held funding responsibility for this group of older people. Updated aged care and disability funding arrangements (which now include Victoria and Western Australia) agreed to in the context of introducing the NDIS signal the Commonwealth’s new administrative responsibility for these services and this cohort.

The Commonwealth Government has a strong and ongoing commitment to supporting people with disability and older people. The new CoS Programme will ensure that over 9,000 older people with disability will continue to receive supports that are responsive to their needs and goals and benefit their families and carers.
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Introduction

CoS Programme documentation

As outlined in the CoS Programme Guidelines, the Commonwealth Department of Health will enter into Funding Agreements with organisations funded to deliver CoS services to clients. The Guidelines provide additional information on funding under the Programme including how service providers have been selected. Individual Funding Agreements with Grant Recipients will outline the terms and conditions of CoS Programme funding.

This Programme Manual outlines the requirements supporting the delivery and management of the CoS Programme and forms part of the Funding Agreement for service providers.

Operational and administrative requirements for Grant Recipients are outlined at:

- Part A – The CoS Programme (and Appendices) – detailing the delivery of CoS Programme services including operational requirements; and
- Part B – Administration of the CoS Programme (and Appendices) – detailing Grant Recipient and Departmental obligations for the administration of the CoS Programme, including funding and reporting arrangements.

Period this Programme Manual covers

This Programme Manual applies to the transition period from commencement of the CoS Programme in 2016 until full implementation on 1 July 2020. In the interim, as noted below, the Programme will be reviewed and this Manual updated to reflect any changes.

Monitoring and review

The ongoing implementation of the CoS Programme will be monitored and reviewed at key stages and consider specific areas, for example quality and safeguard arrangements, service models transitioning to community based alternatives, the language used to describe CoS services, client contributions, service pricing and the interface with aged care reforms. Review dates will include mid-transition on 1 July 2018 and post full implementation which occurs on 1 July 2020. This Manual will be updated as required and in response to any review outcomes and Grant Recipients notified.

Bilateral Agreements relating to Continuity of Support arrangements

The CoS Programme is guided by Bilateral Agreements signed between the Commonwealth and participating states and territories in relation to Transition to a National Disability Insurance Scheme (NDIS). This Manual provides details of how continuity of support arrangements for older people will be delivered under the Commonwealth CoS Programme.

Relationship to disability reforms

As part of the National Disability Strategy 2010-2020, the Productivity Commission undertook a public inquiry into a long-term disability care and support scheme for people with disability. COAG subsequently agreed to the need for major reform of disability services through an NDIS. The CoS Programme will contribute to disability reform by providing community access and support services identified as priority areas under the Strategy and supporting older people with disability to achieve similar outcomes to those they were achieving prior to new arrangements.

Consultation

Consistent with priorities within the National Disability Strategy, consultation on the development of this Manual has occurred with representatives from a range of national disability peak bodies and state disability peaks, advocacy organisations and consumer peak bodies identified by states and territories. Input has also been received from State and Territory
Governments, National Disability Services, the National Aged Care Alliance and the National Disability Insurance Agency (NDIA).

**Terminology**

In this Manual, the term ‘Grant Recipient’ refers to those organisations funded to deliver services under CoS as per the definition provided in their Funding Agreement. This term is used interchangeably with ‘service provider’ (see Glossary at the back of this Manual).

**More information**

This Manual and general information about CoS, including a CoS Client Handbook, are also available on the Department of Health website. Appendix C lists Grant Manager details in each jurisdiction.
PART A - The Commonwealth Continuity of Support (CoS) Programme

Chapter 1. Overview

1.1. Aim

The CoS Programme aims to provide continuity of support to older people with disability who are receiving state-administered specialist disability services at the time of implementation of the CoS Programme but are ineligible for the NDIS.

In delivering against this COAG commitment, the CoS Programme, which will be consistent with the Convention on the Rights of Persons with Disabilities, promotes, protects and ensures the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and promotes respect for their inherent dignity.

Continuity of support will benefit older people with disability, their families and carers.

1.2. Objectives

The objectives of the Commonwealth CoS Programme are to:

- deliver high quality care, support and services to clients to assist them to achieve similar outcomes to those they were achieving prior to transitioning to the new arrangements;
- support clients through the delivery of accommodation support; community support; community access; respite services; and Individual Support Packages;
- support clients through the direct service delivery of respite services which allow families and other regular carers to take a break from their usual caring duties and support and maintain the care relationship, while providing a positive experience for the person with disability;
- provide services that are socially and culturally appropriate and free from discrimination to all clients, including those with special needs;
- facilitate client choice and enhance the independence and wellbeing of clients and ensure services are responsive to their needs;
- provide flexible, timely services that are responsive to local needs;
- take into account the protection and promotion of the human rights of persons with disabilities in all policies of the CoS Programme; and
- support clients to be informed about aged care service options and support their transition into this care where appropriate.

1.3. Outcomes

The intended outcomes of the CoS Programme are that:

- this cohort of older people with disability:
  - achieve similar outcomes to those they were achieving prior to the introduction of the CoS Programme;
  - is supported to be as independent as possible; and
  - have their human rights upheld in the provision and receipt of services.
- the wellbeing of this cohort of older people with disability is maintained through the delivery of consistent, timely, high quality services and supported transition into appropriate
programmes such as aged care as their circumstances change and following consultation with the older person and their carer/advocate/nominee; and

• carers and care relationships are supported through the provision of respite services to older people with disability.

1.4. Programme principles

The Commonwealth will meet its commitment to providing continuity of support through the following programme principles:

• **Administrative simplicity** – The CoS Programme has been designed to minimise administrative burden for service providers and promote participation in simple performance reporting;

• **Minimal disruption** – Design and implementation of the CoS Programme will focus on minimising disruption to both clients and service providers; and

• **Minimal red-tape** – The CoS Programme will align with the Australian Government’s commitment to red-tape reduction.

1.5. Service delivery principles

CoS Programme Grant Recipients will deliver services as per the service delivery principles below when developing, delivering or evaluating CoS funded services:

Grant Recipients will promote each client’s opportunity to maximise their capacity and quality of life through:

• implementing client-centred practice and providing opportunities for each client to be actively involved in addressing their goals;

• maximising each client’s functional and cognitive capability and psychosocial independence;

• building on the strengths and capacity of individuals;

• providing services tailored to the unique circumstances and cultural preferences of each client, their family and carers;

• ensuring choice and flexibility is optimised for each client, their family and carers;

• emphasising responsive service provision with agreed review points;

• supporting community participation that provides valued roles, a sense of purpose and personal confidence;

• developing and promoting strong partnerships between the client, their family and any carer/advocate/nominee; and

• working collaboratively with other Grant Recipients and service providers from other systems to achieve the best service outcomes for clients.

1.6. Target group and eligibility

To be eligible for the CoS Programme the following criteria must be met:

A person with disability:

• is 65 years and over when the NDIS commences implementation in their region and has not been assessed as eligible for the NDIS under “becoming a participant rules”; or

• is an Aboriginal and Torres Strait Islander person aged 50-64 years at the time the NDIS commences implementation in their region and has been assessed as being ineligible for the NDIS; and

• is an existing client of state-administered specialist disability services at the time the CoS Programme commences in their region.
Depending on the NDIS Becoming a Participant rules in each state and territory, people who will turn 65 years of age close to the date the NDIS commences in their region can make an access request to the NDIS before they turn 65 years of age. If accepted into the NDIS, they would access this Scheme instead of the CoS Programme.

1.6.1. Further detail

An existing client means the person:

- is receiving state-administered specialist disability services or has a booking/s for these services with a service provider at the time the CoS Programme is implemented in their region. This could include where the state has approved funding and the client and provider have agreed a set date and time when services will be delivered even though services may not have commenced, or
- has received State-administered specialist disability services in the twelve months prior to implementation of the CoS Programme in their region.

Upon the completion of the NDIS rollout in a region, there will be no new entrants to the CoS Programme.

Full rollout of the NDIS across all participating jurisdictions is planned for 1 July 2020.

1.6.2. Additional information

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people aged 50-64 years currently receiving supports will meet the age access requirements for the NDIS (i.e. aged below 65 years). If, however they do not meet other access requirements for the Scheme, they may be eligible to access the CoS Programme. Access requirements for the NDIS are outlined in the National Disability Insurance Scheme Act 2013 (NDIS Act 2013).

Clients accessing supports on an episodic basis

The CoS Programme recognises that some clients will access services on an episodic basis, and will continue to provide funding for these supports as needed, including any emergency or after-hours service provision. However, if a client does not access any CoS Programme services for a period of twelve months or more they will be considered to have left the programme. Should they wish to in the future, these clients can be assisted to access services through the aged care system.

Families and carers of older people with disability

The families and carers of older people with disability receiving services under CoS will benefit from continuity of support provided, particularly through the provision of respite services that allow family and other carers to take a break from their usual caring duties and support and maintain the care relationship, while providing a positive experience for the person with disability.

People who are not eligible

The CoS Programme does not include people on waiting lists for state-administered specialist disability services at the time of implementation of CoS. That is, people who have not been assessed or who have been assessed but are waiting for services and do not have a booking for service with a provider.
Once implementation has occurred in their region, older people with disability who are not eligible for the CoS Programme will be assisted to access the aged care system if they require support.

**People ageing under the NDIS**

Continuity of support arrangements including the CoS Programme are separate to the funding and administrative arrangements agreed for NDIS participants who age (people who are 65 years and over and Indigenous Australians 50 to 64 years) within the NDIS. The Commonwealth will hold full funding responsibility for this group of older people, who may choose to remain in the NDIS or enter the aged care system.

### 1.7. Special needs groups

The Commonwealth CoS Programme will recognise people with cultural or other special needs by providing appropriate services which reflect the diversity of the population.

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

- People from Aboriginal and Torres Strait Islander communities;
- People from culturally and linguistically diverse backgrounds;
- People who live in rural and remote areas;
- People who are financially or socially disadvantaged;
- Veterans;
- People who are homeless, or at risk of becoming homeless;
- People who are lesbian, gay, bisexual, transgender and intersex;
- People who are care leavers; and
- Parents separated from children by forced adoption or removal.

The concept of special needs within the CoS Programme is not intended as a principle for prioritising access to services for one individual client over another. Rather, the identification of particular groups recognises that each person is unique and has different beliefs, values, preferences and life experiences, and that for some people these differences may result in barriers to accessing or using services.

### 1.8. Carers

Carers make a significant contribution to the lives of the older people with disability they care for and an important economic contribution to the community. CoS Programme 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:

- 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.
- 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.
- The valuable social and economic contribution that carers make to society should be recognised and supported.
- Carers should be supported to enjoy optimum health and social wellbeing and to participate in family, social and community life.
• Carers should be acknowledged as individuals with their own needs within and beyond the caring role.
• The relationship between carers and the persons for whom they care should be recognised and respected.
• Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers.
• Carers should be treated with dignity and respect.
• Carers should be supported to achieve greater economic wellbeing and sustainability and, where appropriate, should have opportunities to participate in employment and education.
• Support for carers should be timely, responsive, appropriate and accessible.

All Grant Recipients are to take all practicable measures to ensure that:

• their officers, employees and agents have an awareness and understanding of the Statement for Australia’s Carers; and
• they and their officers, employees and agents take action to reflect the principles of the Statement in developing, implementing, providing or evaluating care supports.

1.9. CoS Programme implementation timeframe

Implementation of the CoS Programme will be staged and commence from 1 December 2016 in line with the roll-out of the NDIS. Full implementation across all participating states and territories will occur by 1 July 2020.

All start dates and full implementation dates are published on the CoS Programme web page.

Until the NDIS and CoS Programme are implemented in their region, clients will continue to access the current state-administered disability system.

1.10. What services are funded under the CoS Programme?

The CoS Programme will fund care and services that support older people to achieve similar outcomes to those they were achieving prior to transition. These supports will be provided under two Sub-Programmes:

• Block-funded activities; and
• Individual Support Packages (ISP).

Each CoS Sub-Programme reflects a different funding model and is detailed in Chapter Two of this Programme Manual (see Appendix D for a summary of CoS Programme Sub-Programmes and the services available under each). Where there are state differences under the Programme to help achieve continuity of support for clients and minimise disruption to providers, these are noted.

In addition to providing the continuity of support received prior to transition to new arrangements, the CoS Programme promotes flexibility and responsiveness to changing needs through a range of options outlined in Chapter Three.

1.11. What services are not funded under the CoS Programme?

Given the identified target group, the CoS Programme does not fund specialist disability services aimed at supporting people to gain employment or access early childhood services.

It also does not fund those supports that have been previously funded by State and Territory governments that do not provide direct care services to older clients, such as state advocacy, information and alternative forms of communication, or supports such as research and evaluation.
CoS Programme grants are not provided for:

- purchase of land;
- retrospective costs;
- costs incurred in the preparation of a grant application or related documentation;
- major or new construction/capital works;
- overseas travel;
- payment to immediate family members for the client’s care or support (unless there are exceptional circumstances such as limited access to care workers in rural and remote areas); and
- services that would generally be purchased from the client’s income or pension (e.g. daily living expenses such as the purchase of ingredients/food).

1.12. Pricing and levels of support

The CoS Programme will fund equivalent care and services that support older people to achieve similar outcomes to those they were achieving prior to transition.

For individual service providers, pricing of individual units of service or supports (service outputs) will generally reflect the historical level of funding provided under state-based specialist disability services. All unit prices will be benchmarked against similar service providers and against comparable NDIS pricing to ensure they are within acceptable ranges.

In the short term this will mean that the price paid for similar units of service will differ between CoS providers, possibly due to different service models, cost components (for example regional differences) or client profiles. Moving towards a more consistent pricing framework will be considered as part of the 2019 CoS Programme review.

Additional funding may be available for non-government CoS providers of accommodation support. This funding will be additional to that provided for the care and support services delivered to CoS clients in supported accommodation settings. Additional funding will be similar to the Specialist Disability Accommodation funding provided for eligible NDIS participants. Further information will be made available on the CoS website.

For clients on ISP, budget amounts will generally reflect the historical level of funding provided under state-based specialist disability services.

1.13. Client contributions

Arrangements operating under state-administered specialist disability services should be maintained under the CoS Programme to provide continuity to clients. That is, service providers will continue the client contribution arrangements that were in place prior to transitioning (and may increase these annually in line with the Consumer Price Index where this has been established practice).

This includes maintaining arrangements where, in some states, clients currently do not pay any client contributions. Prior financial hardship provisions should also be available to clients.

Client contributions for ISP funded services should continue to be negotiated between the client (and their carer/advocate/nominee) and the provider delivering their supports. Client contributions are not to be paid using funds from the ISP budget.

Client contributions under CoS should be maintained where a CoS Grant Recipient is accessing Additional Support options (as per Chapter Three of this Manual). In these circumstances contributions should be monitored to ensure clients are not experiencing financial hardship as a result of additional services being received (and their associated costs).
CoS Grant Recipients should adopt the following principles in their client contribution approaches:

- **Continuity**: Client contribution policies that were in place before transitioning to the CoS Programme should be maintained.
- **Transparency**: Client contribution policies should include information in an accessible format and be publicly available, provided to and explained to all clients.
- **Hardship**: Individual policies should include arrangements for those who are unable to pay the requested contribution.

## 1.14. Programme Framework

As noted earlier, the CoS Programme is structured to include two Sub-Programmes based on distinct funding models – block-funded services and ISP. The target group, eligibility and objectives of both Sub-Programmes are the same, but activities delivered under each may vary, with ISP allowing more flexibility (see Chapter Two of this Manual).

Under the Department’s Funding Agreement, Grant Recipients receive funding to deliver specified outputs against one or a combination of service types under block-funded activities, and a range of flexible supports per client under ISP.

## 1.15. Quality arrangements

As outlined in Chapter Five of this Manual, during the NDIS transition to full scheme, Grant Recipients will continue to operate within existing state-based quality systems and safeguarding arrangements for CoS clients. Maintaining different arrangements in each jurisdiction over the transition period recognises infrastructure and systems already in place and aims to reduce red tape for CoS Programme service providers.

From 1 July 2018, the Commonwealth Continuity of Support (CoS) Programme will transition to nationally consistent quality and safeguard arrangements, under the jurisdiction of the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission (the NDIS Commission). All CoS Programme clients and providers under these arrangements transition commencing as states and territories reach full Scheme with:

- New South Wales and South Australia from 1 July 2018;
- Queensland, Victoria, Tasmania, Northern Territory and the Australian Capital Territory from 1 July 2019; and
- Western Australia from 1 July 2020.

In the interim transition period, quality and safeguards arrangements for CoS are outlined in sections 5.5.1 – 5.5.9 of the Programme Manual, as well as Grant Recipients’ Funding Agreements.

## 1.16. Support for Grant Recipients

To ensure Grant Recipients receive support from the Department of Health (the Department), departmental Grant Managers will be operating in each participating jurisdiction. The Department is also funding a national CoS Advisor to assist Grant Managers in their role and where necessary provide clinical expertise.

The CoS Advisor will also perform functions such as - assessment of Additional Support applications; assisting providers to manage crisis or unplanned situations for more complex clients; and manage complaints about programme administration that require clinical expertise.

Grant Recipients must contact their Grant Managers as their first point of contact for access to the CoS Advisor.
Chapter 2. Programme Framework and Services

2.1. Block-Funded Activities Sub-Programme

This Sub-Programme provides funds to Grant Recipients for service provision.

The supports delivered under the CoS Programme match those specialist disability service types that were delivered prior to transitioning to new arrangements and included in the previous National Minimum Data Set categories.

However some output measures have changed. Data on outputs delivered against the following service types were generally not previously collected, but will now be required under the CoS Programme:

- Supported Accommodation service types of large institutions, small institutions, hostels and group homes - will now report against number of clients supported;
- Supported Accommodation service types of In-home Accommodation Support and Other Accommodation Support – will now report against time (recorded in hours);
- All Community Support service types will now report against time (recorded in hours) (previously only Case Management, local coordination and development reported outputs); and
- Community Access service type of Recreation/Holiday Program will now report against time (recorded in hours).

Not all service types are delivered in every jurisdiction and some clients may be funded under this Sub-Programme and the ISP Sub-Programme. A summary of services delivered under this Sub-Programme is at Appendix D.

2.1.1. Service descriptions

Across ALL service types under this Sub-Programme, Grant Recipients must:

- have an Approved Client Plan (see Glossary) for each client – this is a document maintained by the Grant Recipient identifying the sub-programme, service type/s, region services will be delivered in, currently expected annual outputs and annual funding attributable to meeting each client’s identified support needs. For example:

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Service type</th>
<th>Aged Care Planning Region</th>
<th>Client ID</th>
<th>Outputs</th>
<th>Funding 2016-17</th>
<th>Total Outputs</th>
</tr>
</thead>
</table>

- comply with relevant Commonwealth and/or State/Territory legislation and regulations;
- ensure that appropriately qualified and/or trained staff deliver services/conduct activities; and
- comply with the National Standards for Disability Services or comparable state and territory quality standards as outlined in the Grant Recipient’s Funding Agreement.

Accommodation Support

Services that meet a person’s basic living needs through providing accommodation to older people with disability and providing support needed to enable a person with disability to remain in their existing accommodation or move to more suitable or appropriate accommodation. These services include support with the basic needs of living such as meal preparation, dressing, transferring etc.
<table>
<thead>
<tr>
<th>Service type</th>
<th>Large residential/institutions (&gt;20 places)</th>
<th>Service type description</th>
<th>Number of clients supported.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Large residential/institutions are usually located on large parcels of land and provide 24-hour residential support in a congregate setting of more than 20 beds. Where other services are funded separately to this service type but provided on the one site, each of these additional services should be reported against as a separate service type. Where a large residential accommodation support service also provides some other limited assistance, for example help with banking once a week or short-term respite for family members, this is considered to be large residential/institutional accommodation as it is the primary focus of the support provided.</td>
<td>Large residential/institutions are usually located on large parcels of land and provide 24-hour residential support in a congregate or cluster setting of 7 to 20 beds. Where other services are funded separately to this service type but provided on the one site, each of these additional services should be reported against as a separate service type. Where a small residential support service also provides some other limited assistance, this is considered to be small residential/institutional accommodation as it is the primary focus of the support provided.</td>
<td>Number of clients supported.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Number of clients supported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Small residential/institutions (7–20 places)</th>
<th>Service type description</th>
<th>Number of clients supported.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output measure</td>
<td>Number of clients supported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Hostels</th>
<th>Service type description</th>
<th>Number of clients supported.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output measure</td>
<td>Number of clients supported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| Service type                          | Hostels provide residential support in a congregate setting of usually less than 20 beds, and may or may not provide 24-hour residential support. Many are situated in an institutional setting and also have respite beds included on the premises. In contrast to residential/institutions, hostels usually do not provide segregated specialist disability support services. However, where this is the case, each additional service type should be funded and/or reported against as a separate service type outlet. Where a hostel support service also provides some other limited assistance, for example help with banking once a week or short-term respite for family members, this is considered to be hostel accommodation, as it is the primary focus of the support provided. | Hostels provide residential support in a congregate setting of usually less than 20 beds, and may or may not provide 24-hour residential support. Many are situated in an institutional setting and also have respite beds included on the premises. In contrast to residential/institutions, hostels usually do not provide segregated specialist disability support services. However, where this is the case, each additional service type should be funded and/or reported against as a separate service type outlet. Where a hostel support service also provides some other limited assistance, for example help with banking once a week or short-term respite for family members, this is considered to be hostel accommodation, as it is the primary focus of the support provided. | Number of clients supported. |</p>
<table>
<thead>
<tr>
<th>Service type</th>
<th>Group homes (usually &lt;7 places)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Group homes generally provide combined accommodation and community-based residential support to people in a residential setting. Usually no more than 6 service users are located in any one house, although this can vary. Group homes are generally staffed 24 hours a day. Where a group home support service also provides some other limited assistance, for example help with banking once a week, this is considered to be group home accommodation as it is the primary focus of the support provided.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Number of clients supported.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Attendant care/personal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>An attendant care programme provides for an attendant(s) to assist people with daily activities that they are unable to complete for themselves because of physical, intellectual or any other disability. The service is provided to people across a range of settings.</td>
</tr>
<tr>
<td>Legislation</td>
<td>Grant Recipients must comply with relevant Commonwealth and/or State/Territory legislation and regulations. Relating to this service type, State and Territory legislation governs medication management. Grant Recipients must take into account all relevant legislation and guidelines in developing policies and procedures around any assistance with client self-administration of medicine provided under the CoS Programme (including from dose-administration aids and reporting of failure to take medicines).</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>Appropriately qualified and/or trained staff must deliver services/conduct activities.</td>
</tr>
<tr>
<td></td>
<td>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 (by staff with nursing qualifications) to personal care workers, which is permitted under the CoS Programme.</td>
</tr>
<tr>
<td></td>
<td>Any nursing care must be provided by a Registered Nurse or an Enrolled Nurse. Registered nurses and enrolled nurses can delegate to other workers, to provide elements of care from the nursing care plan. This care must be supervised and assessed by the registered nurse to ensure the delegation is appropriate and consistent with the Nursing and Midwifery Board of Australia’s regulatory requirements.</td>
</tr>
<tr>
<td>Service type</td>
<td>In-home accommodation support</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Service type description</td>
<td>Support involves individual in-home living support and/or developmental programming services for people with disability, supplied independently of accommodation. Where an in-home accommodation support service also provides some other limited assistance, for example help with banking once a week or short-term respite for family members, this is considered to be in-home accommodation as it is the primary focus of the support provided.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>Appropriately qualified and/or trained staff must deliver services/conduct activities. Where staff or volunteers are involved in other activities as part of In-home accommodation support, they must have relevant qualifications and/or training, for example any food handling and meal preparation must adhere to safe food handling practices including personal hygiene and cleanliness. Where additional services are performed, such as personal care, in conjunction with in-home accommodation support, requirements relating to that additional service apply and these supports should be recorded separately as a primary focus of service delivery.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Alternative family placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>These are placements of a person with disability with an alternative family who will provide care and support. It includes shared-care arrangements and host family placements. Where an alternate family placement also provides some other limited assistance, for example help with banking once a week or short-term respite, this is considered to be alternate family placement as it is the primary focus of the support provided.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Other Accommodation support</th>
</tr>
</thead>
</table>
| Service type description     | Accommodation support services that provide short-term, one-off instances of accommodation such as:  
  accommodation provided so that individuals or families can access specialist services or further education;  
  emergency or crisis accommodation support (for example, following the death of a parent or carer); and  
  holiday accommodation (within Australia).  
If the accommodation support is primarily for respite (that is, involves the separation of the service user from their usual |
Service type | Other Accommodation support
---|---
| support arrangements or the addition of extra support in their current environment), that type of support should be reported as respite services (not Accommodation Support).
Output measure | Time (recorded in hours).

Community Support
These include supports to improve functional abilities, education in behaviour support and team-based resources that support the older person to maximise their independence.

<table>
<thead>
<tr>
<th>Service type</th>
<th>Therapy support for individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Specialised, therapeutic care services including occupational therapy, physiotherapy, dietetics and speech therapy. These services are intended to improve, maintain or slow deterioration of a person’s functional abilities, and/or assist in the assessment and recommendation of equipment to enable people to function as independently as possible in their environment.</td>
</tr>
</tbody>
</table>
Output measure | Time (recorded in hours). |
Staff qualifications | Appropriately qualified and/or trained staff must deliver services/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 under the supervision of a qualified and credentialed allied health practitioner. |

<table>
<thead>
<tr>
<th>Service type</th>
<th>Behaviour/specialist intervention</th>
</tr>
</thead>
</table>
| Service type description | These include the range of services relating to supporting people with challenging behaviours, including dangerous antisocial behaviour. Services include intensive intervention support, training and education in positive behaviour support and consultancy services for other professionals. Behaviour/specialist intervention is often provided in the context of other services. Service providers are encouraged to continue practices that were in place prior to transitioning to the CoS Programme, including:  
- protocols for supporting clients with challenging behaviour;  
- ensuring appropriate qualifications and/or training are held by relevant staff; and  
- continuing to work with clients and their carer/advocate/nominee and practitioners on |

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<table>
<thead>
<tr>
<th>Service type</th>
<th>Behaviour/specialist intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>undertaking re-assessments as needed and 12 month reviews of Positive Behaviour Support plans including any redevelopment of plans if needed.</td>
</tr>
<tr>
<td>Legislation</td>
<td>Grant Recipients must comply with relevant Commonwealth and/or State/Territory legislation and regulations.</td>
</tr>
<tr>
<td></td>
<td>Grant Recipients must comply with legislation on restrictive practices that may be used by a service provider in response to an adult’s behaviour that causes physical harm or serves risk of physical harm.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>Appropriately qualified and/or trained staff must be used to conduct activities of a specific nature, such as restrictive behaviour interventions. Any nursing care must be provided by a Registered Nurse or an Enrolled Nurse. Registered nurses and enrolled nurses can delegate to other workers, to provide elements of care from the nursing care plan. This care must be supervised and assessed by the registered nurse to ensure the delegation is appropriate and consistent with the Nursing and Midwifery Board of Australia’s regulatory requirements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Counselling (individual/family/group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Services that provide counselling to individuals, families or groups.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Regional resource and support teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Regional resource and support teams are generally interdisciplinary teams that provide a combination of services in the community support service types above, that cannot be broken down into the component parts. Regional resource and support teams may also assist service users to access mainstream services and/or support mainstream funded agencies. These teams usually have an individual, rather than a family, focus.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>Appropriately qualified and/or trained staff must deliver services/conduct activities.</td>
</tr>
<tr>
<td></td>
<td>Where staff or volunteers are involved in other activities as part of regional resource and support teams, such as nursing care, they must have relevant qualifications and/or training.</td>
</tr>
</tbody>
</table>
### Service type description

This is a broad service type category, including elements of individual or family-focused case management and brokerage, as well as coordination and development activity within a specified geographical area.

Services assist people with disability to maximise their independence and participation in the community through working with the individual, family and/or carers in care planning and/or facilitating access to appropriate services. If the service provided is community development only (that is, the service is not working with an individual), then it should be classified under service type ‘Community support Other’.

Case management services are targeted to individuals who require assistance, for a period of time, to access necessary supports, including help with service coordination and with assisting services to respond to their service needs.

Other forms of local coordination and development generally involve working with the individual, family and/or carers and at the community level to facilitate positive changes that assist people with disability to live and participate in the community and assist families in their continued provision of care. Local coordination does not generally involve management of individuals’ funds and does not generally involve ongoing case management.

However, the service provider may use their funding (if it meets requirements outlined in the Flexibility Provisions at Chapter Five of this Programme Manual) to make one-off purchases (for example, respite, therapy) for a client to enable a quick response until longer term supports can be put in place.

### Output measure

Time (recorded in hours).

### Staff qualifications

 Appropriately qualified and/or trained staff must deliver services/conduct activities.

Where staff or volunteers are involved in other activities as part of regional resource and support teams, such as nursing care, they must have relevant qualifications and/or training.

For example, any nursing care must be provided by a Registered Nurse or an Enrolled Nurse.

Registered nurses and enrolled nurses can delegate to other workers including personal care workers to provide elements of care from the nursing care plan. This care must be supervised and assessed by the registered nurse to ensure the delegation is appropriate and consistent with the Nursing and Midwifery Board of Australia’s regulatory requirements.
<table>
<thead>
<tr>
<th>Service type</th>
<th>Other community support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Community support services other than those outlined above are included in this service group. If services can be defined above, for example, if community development is provided as part of working with an individual, then the service should be classified under the service type of ‘Case management, local coordination and development’.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
</tbody>
</table>

**Community Access**

Relates to services designed to provide opportunities for older people with disability to participate in their community and enjoy their full potential for social independence. These services:

- are flexible and responsive to personal needs and interests;
- range from educational to leisure and recreational pursuits;
- include activities in the community, a facility or home-based activities;
- include participation in mainstream activities;
- include supervision and physical care, and models which link people to activities which are offered to the whole community; and
- range from long-term day support to time-limited and goal-oriented education that maximises personal independent functioning and may complement other community services.

<table>
<thead>
<tr>
<th>Service type</th>
<th>Learning and life skills development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>These programmes provide ongoing day-to-day support for service users to gain greater access to community-based activities. Programmes may focus on continuing education to develop skills and independence in a variety of life areas (for example self-help, social skills) or enjoyment, leisure and social interaction. They are often called ‘day programmes’. Activities may include:</td>
</tr>
<tr>
<td></td>
<td>• undertaking trips to art galleries, libraries, movies, parks and nature reserves or outings that involve fishing or other recreational activities;</td>
</tr>
<tr>
<td></td>
<td>• undertaking tours to familiarise individuals with their local area and develop confidence in using public transport or visits to facilities such as hospitals, designed to alleviate the stress of future visits;</td>
</tr>
<tr>
<td></td>
<td>• participating in volunteer programmes such as helping at the RSPCA or landscaping and gardening programmes;</td>
</tr>
<tr>
<td></td>
<td>• attending social clubs, for example, book, music or sporting clubs; and</td>
</tr>
<tr>
<td></td>
<td>• going on shopping trips or eating out in various venues from food halls to restaurants.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
<tr>
<td>Service type</td>
<td>Recreation/holiday programmes</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>Service type description</td>
<td>Recreation services and holiday programmes aim to facilitate the integration and participation of people with disability in recreation and leisure activities available in the general community. These services may also enhance the capacity and responsiveness of mainstream sport and recreation agencies and community organisations to provide for people with disability.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Other community access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>These are community access services other than those outlined above - for example, services offering activities designed to improve service users’ physical, cognitive and perceptual abilities; encourage self-esteem growth; and provide opportunities to socialise. This is considered as Other Community Access where the services ‘Learning and life skills development’ or ‘Recreation/holiday programmes’ are not suitable.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
</tbody>
</table>

**Respite**

Relates to respite services delivered to older people with disability that provide a positive experience for the older person and a short-term and time-limited break for families and other carers of people with disability while supporting and maintaining the primary care giving relationship (see [Glossary](#) for definition of carer).

<table>
<thead>
<tr>
<th>Service type</th>
<th>Own home respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Respite care provided in the individual’s own home.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Centre-based respite/respite homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Respite care provided in a home-like environment in the community. This service type is for overnight respite stays.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in days).</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>Appropriately qualified and/or trained staff must deliver services/conduct activities.</td>
</tr>
<tr>
<td></td>
<td>Overnight respite can have unique risks for Grant Recipients and clients. Grant Recipients need to identify and manage risk through consistent use of the National Standards for Disability</td>
</tr>
<tr>
<td>Service type</td>
<td>Centre-based respite/respite homes</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td></td>
<td>Services, the Funding Agreement and relevant State and Territory legislation. Where additional services are performed as part of centre-based respite/respite homes, such as nursing care, staff or volunteers must have relevant qualifications and/or training.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Host family respite/peer support respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Host family respite provides a network of 'host families' matched to the age, interests and background of the client and their carer.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Flexible respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service type description</td>
<td>Flexible respite is services that offer any combination of own home, community based (including holidays), recreation activities and overnight centre-based respite. Flexible respite to meet an individual's needs may include brokerage (i.e. sub-contracting) for respite, only when the funding dollars come from respite resources. Outlets providing centre-based respite services should be recorded separately under that service type and not this category.</td>
</tr>
<tr>
<td>Output measure</td>
<td>Time (recorded in hours).</td>
</tr>
<tr>
<td>Staff qualifications</td>
<td>Appropriately qualified and/or trained staff must deliver services/conduct activities. Overnight respite can have unique risks for Grant Recipients and clients. Grant Recipients need to identify and manage risk through consistent use of the National Standards for Disability Services, the Department's Funding Agreement and relevant State and Territory legislation. Where additional services are performed as part of flexible respite, such as nursing care, staff or volunteers must have relevant qualifications and/or training.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service type</th>
<th>Other respite</th>
</tr>
</thead>
</table>
| Service type description | Other respite describes all other respite not included in the previous services described including:  
- crisis respite; and holidays for the person with the disability where the primary intention of the service is to provide respite support (rather than primarily a holiday experience) and the service user is generally separated from their usual |

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### Service type | Other respite
--- | ---
 | support arrangements, for example, family.
Output measure | Time (recorded in hours).
Staff qualifications | Appropriately qualified and/or trained staff must deliver services/conduct activities.
 | Overnight respite can have unique risks for Grant Recipients and clients. Grant Recipients need to identify and manage risk through consistent use of the National Standards for Disability Services, the Department’s Funding Agreement and relevant State and Territory legislation. Where additional services are performed as part of other respite, such as nursing care, staff or volunteers must have relevant qualifications and/or training.

Respite services provided under CoS are complemented by access to planned respite under a range of aged care programmes and emergency respite services currently provided through the Commonwealth Respite and Carelink Centres. As part of the 2015-16 Budget, the Commonwealth Government announced its commitment to the development of an Integrated Plan for Carer Support Services (the Plan).

A key priority for the Plan is to streamline and better coordinate carer support services, which are currently fragmented and difficult to navigate, and ensure that carers’ needs are recognised and supported as major reforms occur in the aged care, mental health and disability service systems. The Plan has two stages:

- **Stage One, Carer Gateway** commenced on 14 December 2015. Carer Gateway is a new service that guides carers to the support and resources they need through a website, national phone service and interactive service finder.
- **Stage Two of the Plan** is focussed on co-designing a model for a new integrated carer support service system with the sector. As part of this work, the provision of emergency respite under a future model will be considered.

#### 2.2. Individual Support Packages (ISP) Sub-Programme

The ISP Sub-Programme provides funding to Grant Recipients that is allocated to a nominated individual client with disability to purchase services that respond to their support needs and goals in a flexible and client-centred way.

**2.2.1. Transition arrangements**

Only clients who were receiving individualised budgets under state-administered arrangements prior to transition to the CoS Programme will receive these services. This includes, but is not limited to, older people with disability who were accessing Your Life Your Choice supports in Queensland, clients receiving Funded Support Packages in the Northern Territory and Self-Managed Packages clients in South Australia.

Where clients were already receiving services under an ISP, this will continue under the CoS Programme through three different models:

- Service Provider;
- Intermediary; and
- Direct Funding.

These models consolidate the broad range of individual funding arrangements operating across jurisdictions prior to transitioning to new arrangements (although some prior arrangements may have features from one or more of these models).
Clients will benefit from funding in line with their previous allocation or budget. How these clients receive their supports will also continue, for example through a service provider or financial intermediary, and with continuing flexibility offered to clients, such as being able to change the mix of supports as long as they are within the agreed funding amount and align with the client’s goals.

In some cases CoS clients may receive services that are funded under both ISP and block-funding arrangements.

2.2.2. CoS Programme ISP Models:

The following three ISP models will operate under the CoS Programme.

- **Service provider** (service provision and fund holder): Under this model, the CoS Grant Recipient is responsible for providing services, in addition to holding and managing the ISP funding on behalf of a client (and their carer/advocate/nominee) in a client-centred way, with consideration to their support needs, goals and service delivery preferences. A clear outline of roles, responsibilities and any processes for changing who delivers services is required to minimise any conflict of interest. The Grant Recipient also provides regular reports to the client on expenditure.

- **Intermediary** (fund holder): The Intermediary organisation (the Grant Recipient) holds and manages the ISP funds. They also provide regular reports to the client (and their carer/advocate/nominee) on expenditure. The level of client and intermediary responsibility for the management of ISP funding and purchase of services is negotiated and agreed to by the parties and outlined in the ISP Service Agreement.

- **Direct funding** (funds dispenser): Under this model, a national CoS Direct Funding Grant Recipient selected by the Commonwealth will dispense ISP funding to the client’s nominated bank account. As under previous arrangements, the client (and where relevant their legal representative) has control of managing their budget and purchasing services and supports to meet their needs.

<table>
<thead>
<tr>
<th>Key features of ISP models</th>
<th>Service Provider</th>
<th>Intermediary</th>
<th>Direct Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client choice and control</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Some service provision by Grant Recipient</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Holding and managing the client’s budget</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Agree the Service Agreement with the client (and their carer/advocate/nominee)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dispense funding directly to the bank account of the client (or their carer/advocate/nominee)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Grant Recipient holds administrative and reporting responsibility</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: under the Direct Funding model clients will agree within...
Key features of ISP models

<table>
<thead>
<tr>
<th>Feature</th>
<th>Service Provider</th>
<th>Intermediary</th>
<th>Direct Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>their signed Service Agreement to provide detailed records on expenditure to the Grant Recipient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration component paid to Grant Recipient</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

This will vary across jurisdictions - where this was already occurring - clients will continue to pay an agreed amount from their budget to the Grant Recipient for administrative functions. As a guide, the Department estimates this amount should not exceed 15% of the client’s budget.

The Commonwealth (not the client) will pay this component to the Direct Funding organisation if required.

2.2.3. New arrangements for direct funding models

Where clients were receiving direct cash budgets from state or territory governments (Queensland, New South Wales, Victoria, Northern Territory, South Australia, Western Australia and Tasmania), new arrangements will apply as states and territories withdraw from providing this function. At no disadvantage to these clients, a Direct Funding ISP model will be delivered under the CoS Programme.

To continue with a direct funding model a client must have the capacity to manage their own budget and sign an individualised Service Agreement. Alternatively, a legal representative can sign on their behalf to receive and manage the client’s budget. If a client is not satisfied with this arrangement, they will have the option to move to an alternative ISP model under the CoS Programme.

Clients will not receive any reductions in support through these new arrangements and will retain their prior levels of choice and control. They will also be supported by states and territories and the Department (for example through targeted communication material) to transition to the national Direct Funding Grant Recipient that is replacing states in providing this function.

Clients supported under the CoS Direct Funding model must ensure that the services purchased are considered as in-scope with the CoS Programme. Clients must also provide detailed records of expenditure and supports to the Grant Recipient so it can meet its reporting requirements under the Programme.

The Direct Funding organisation will ensure that these roles are outlined in the ISP Service Agreement with the client and that there is a shared understanding of these arrangements with the client and their carer/advocate/nominee.

If direct-funded clients in other states prefer, they can (in conjunction with their carer/advocate/nominee) choose to move to a Service Provider or Intermediary model rather...
than the National Direct Funding model. This can be decided either before transitioning to CoS (through negotiations with their state/territory government) or after they have transferred (consistent with portability arrangements outlined in Chapter Three of this Manual).

2.2.4. **Role of the client or nominee**

The client, in partnership with their carer/advocate/nominee, is to work with the Grant Recipient to develop, review or update their ISP Service Agreement. The level of choice and control held by the client is decided by the client.

Responsibilities could range from limited involvement in arranging their own services and supports to, for direct funded clients, confirming that invoices for services are correct and providing records on expenditure to the Grant Recipient so they can meet reporting requirements.

**ISP Direct Funding model clients**

Clients under the Direct Funding model will have full choice and control over their services. A CoS Service Agreement template has been developed by the Department specifically for ISP Direct Funding clients. The Service Agreement between the Client and the national Direct Funding organisation will outline the roles and responsibilities of clients and the Direct Funding Organisation.

These responsibilities are similar to those existing between the Direct Funding clients and State and Territory governments prior to transition.

This Service Agreement will be a legally binding agreement and must be signed before any direct payments to the client commence. This Agreement should be based on the client’s previous agreement, plan or contract with their state or territory government.

Client roles will include but not be limited to:

- Establishing a (or maintaining their existing) separate bank account which must be used for the sole purpose of receiving direct payments and making payments for supports and services that achieve the goals and outcomes identified in the ISP Service Agreement;
- accounting for expenditure of any interest earned from the budget amount which will be considered funds which are to be used for the purpose of meeting the client’s goals as outlined in the Service Agreement and acquitted as per Chapter Five of this Manual;
- ensuring that the bank account does not have a credit card or overdraft facility, cannot be linked to any other bank account or go into overdraft and the client cannot make personal contributions or ‘top-up’ payments to the bank account;
- granting viewing access to the bank account if requested by the Grant Recipient;
- keeping detailed records of all funds and how they are used and providing to the Grant Recipient at agreed intervals;
- ensuring that payments for services that are not provided for under the ISP Service Agreement are managed from a separate account; and
- accepting responsibility for any risk/liability relating to quality of the care and supports purchased as outlined in the Service Agreement.

2.2.5. **Role of the Grant Recipient**

All ISP Grant Recipients are required to meet the following requirements regardless of which model they administer:

- Agree **ISP Service Agreement documentation** with the client;
- Involve the client and their **carer/advocate/nominee** in its development and review;
• Undertake or purchase a review of client supports every 12 months;
• Administer the ISP model to the extent outlined in the Service Agreement; and
• Support the client to transition out of the CoS Programme as appropriate.

**Detailed information on each requirement:**

**CoS ISP Service Agreement documentation** should be developed (or current agreements or plans updated) to reflect the CoS Programme. The Service Agreement must be signed by both the client (and their carer/advocate/nominee where relevant) and the Grant Recipient prior to the commencement of service delivery.

The CoS Service Agreement should include (but not be limited to) the following:

- the client’s goals and planned outcomes;
- planned supports to meet those goals and outcomes and who will deliver these and how (e.g. one hour per week of therapy support, the 12 month review of supports);
- noting of any specific exceptions in place or agreed by the Grant Manager such as employment of a family member;
- costs of the supports including management of any additional charges that could arise;
- client contribution amounts;
- for clients supported through the direct funding model only, confirmation that the client is maintaining a separate account and meeting any conditions in the Service Agreement related to use of that account;
- agreed amounts to be paid to the Grant Recipient from the client’s budget for administration costs (only where this arrangement was occurring before transition to the CoS Programme e.g. 10 per cent of the client budget);
- administration arrangements such as frequency and form of statements of funding and expenses against the budget,
- planned review dates (12 month review of supports are required under CoS);
- agreed roles and responsibilities of the client and the CoS Grant Recipient including:
  — the level of responsibility the client wishes to have (e.g. who will hold responsibility for employment of workers); and
  — clear outlining of duties where a Grant Recipient both manages the client budget and delivers services to that client to minimise any conflict of interest;
- processes for review of decisions, complaints, and how any issues will be resolved should they arise. These must be in line with processes outlined in Part B of this Programme Manual;
- processes for how to change service provider or intermediary details;
- details of shared support arrangements (with other recipients of disability supports), including formal agreements between the parties, and contingency arrangements should one party leave;
- emergency support arrangements (e.g. for when a service is cancelled or a support worker does not show up to an appointment, illness of the client or their carer, or extreme weather events);
- a risk-based assessment of safeguards required to ensure the safety and wellbeing of the client in the case of unplanned events, such as changes in informal support arrangements and quality and safeguards regulations and complaints mechanisms that are relevant to both the individual and the organisation providing the services;
- a provision that the purchase of one-off supports must be within the client’s funding allocation (Grant Recipients may explore Additional Support options outlined in Chapter
Three of this Manual if there is a crisis or circumstances requiring additional funding); and

- the signatures of both parties agreeing to the terms of the Service Agreement.

- **The Grant Recipient must invite the participation** of the client and their carer/advocate/nominee (where appropriate) in the development and review of the Service Agreement.

- **A Review of client supports and the Service Agreement** must be conducted every 12 months after a client transitions to CoS. The Grant Recipient is responsible for initiating this review with the client. The client may also seek a review at any time.

  In some jurisdictions, this will be a new role for some Grant Recipients, such as the Financial Intermediary organisation. Where the Grant Recipient does not have the expertise or capacity to undertake these reviews (or other assessments as needed) they should be purchased from an organisation with the appropriate skills and capacity.

  Where the client pays the Grant Recipient an administration component from their budget, the cost of the review should be paid for from this. Where there is no administration component, the Grant Recipient must contact their Grant Manager to discuss options. This may include the Commonwealth agreeing to meet these costs on a one-off basis only, noting that the provider must make their own arrangements for future assessments and reviews of support (e.g. through staff development or recruitment, or establishment of partnerships with other organisations to provide the service).

  If a client does not agree with this arrangement they should discuss alternatives with their Grant Recipient. Should these discussions not result in agreement, the complaint mechanisms outlined at Chapter Five of this Manual are available to the client.

  Where the client is managing their own budget, and a reduction in capacity is suspected, the Grant Recipient should ensure that the client has capacity to undertake this role. Where a potential reduction is suspected, a review of this capacity may be undertaken or purchased from from an organisation with the appropriate skills and capacity.

  The client and their carer/advocate/nominee should discuss the outcomes of this process with the Grant Recipient and adjust any roles in the Service Agreement if required. For example, a client may wish to change the model of ISP model they are accessing. Should these discussions not result in agreement, the complaint mechanisms outlined in Chapter Five of this Manual are available to the client.

- **Administration of the ISP** is required to the level agreed with the client in the Service Agreement. For example, providing regular budget balance reports to the client and ensuring services purchased are in accordance with those outlined in the Service Agreement and within the client’s allocated funding.

- Supporting the client to **transition out of the CoS Programme** where appropriate. The Department will support the Grant Recipient (through communication material) to assist clients to exit the Programme where appropriate (as per Chapter Three of this Manual). This role includes providing, with the client’s permission, a copy of the Service Agreement to My Aged Care as part of any inbound referral processes.

- **The Department may request a copy of the ISP Service Agreement** at any time. Grant Recipients must provide a copy within 5 days of the request.

### 2.2.6. In-scope services

ISP funding may only be used to access supports that are directly related to the person’s support needs and to achieve the goals identified in their ISP Service Agreement. These goals may include consideration of the needs of the client’s carer. Examples of support outcomes a person may seek to achieve may include:

- to remain living independently and/or in the community;
improving skills and capabilities;
• improving well-being; and
• improving function for activities of daily living.

Any unspent funds must be returned to the Department in accordance with the CoS Funding Agreement. Although ISP Grant Recipients may not carry forward or ‘bank’ unused funding, the Additional Support options outlined in Chapter Three of this Manual will be available should clients need extra support.

**Conditional in-scope services**

**Aids and equipment**

As noted in Chapter Four of this Manual, in the first instance, aids and equipment (including vehicle modifications) should be accessed through available State programmes (see Appendix A).

In some cases, such as the Northern Territory, other schemes may also be accessed, such as the Home and Community Care Aged Care Equipment Programme.

Where it is urgent, a State scheme does not supply the required aid or equipment or does not fully fund the purchase or purchase of aids and equipment is already included in a client’s Service Agreement prior to transition to CoS, the client may use ISP funding to lease, purchase (or part purchase) the aids or equipment.

Any purchase or lease of aids and equipment must be added to the client's approved ISP Service Agreement, and be in accordance with this Programme Manual.

**Home Modifications and Maintenance**

State and Territory home modification schemes or alternative programmes should be exhausted before consideration of using ISP funds for such services. These programmes will not be available for older people in all jurisdictions.

**Transport costs**

All available transport subsidy options including Mobility Allowance and state-specific schemes such as the Northern Territory Taxi Subsidy Scheme and the Victorian Multipurpose Taxi Program should be exhausted before consideration of using ISP funds for such services. However, where previous arrangements permitted this and were included in the client’s Service Agreement, such as in the Australian Capital Territory, clients can continue to use ISP funds for transport services.

**Family members**

Payment to immediate family members living in the same residence as the CoS client is considered out of scope for the CoS Programme.

**Exceptions:**

In exceptional circumstances the client may employ a family member living in the same residence, for example in the Northern Territory where housing shortages exist. Service providers should contact the Grant Manager to seek approval of this arrangement.

In exceptional circumstances a family member who does not live at the same residence could be employed to provide CoS supports, for example if a client lives in a remote area and there are no alternative and appropriate providers available. Service providers should contact the Grant Manager to seek approval of this arrangement.
Where a family member is subsequently employed, or was employed under arrangements prior to the transition to the CoS Programme, this should be identified in the ISP Service Agreement, including the reason for this exception (e.g. living in a remote area).

The Grant Recipient must ensure that any arrangements meet the requirements outlined in this Programme Manual, such as meeting quality standards, operating according to requirements under Fair Work Australia and any support people employed having appropriate training.

2.2.7. Out-of-scope services

Out-of-scope activities are listed in Chapter One of this Manual. Additional out-of-scope activities relating to ISP funding only include:

- supports that have not been approved in the client's ISP Service Agreement (noting that the agreed range of supports may be adjusted over time to reflect any urgent purchases or a different mix of supports that remain within the allocated budget and client goals);
- the purchase of vehicles;
- supports purchased from a business or other legal entity where the client, their carer or a family member has a financial interest;
- employment of, or payment to, a family member living at the same residence as the CoS client (noting the exceptions outlined at Chapter Two); and
- client contributions for ISP supports (these cannot be paid from ISP funding).

2.2.8. Principles for purchasing services and supports using ISP funding

Services and supports purchased using ISP funding must:

- be directly related to the client's goals as outlined in the client's ISP Service Agreement; represent value for money;
- be effective and beneficial; and
- consider planning for unexpected events, including funding and support arrangements that may be required should these arise (e.g. illness of a carer).

2.2.9. Employment of workers

A client may directly employ support workers (noting this was not occurring in all jurisdictions under previous arrangements). The client, being the employer, must meet the obligations as an employer, for example:

- complying with work health and safety legislation, including providing a safe working environment and risk management;
- complying with obligations under Fair Work Australia;
- any person employed must have a job description, Work, Health and Safety training and be subject to all necessary employment checks (as outlined in the quality and safeguard arrangements of the Grant Recipient’s Funding Agreement);
- meeting financial obligations, such as paying wages as agreed, complying with tax and superannuation requirements and record keeping; and
- complying with relevant State/Territory requirements.

2.2.10. Shared Support Arrangements

A shared support arrangement is when two or more clients purchase services or supports by using joint funding. Supports purchased under shared arrangements must be in scope and in accordance with the CoS Programme Manual.
Arrangements in place for older clients prior to transitioning to the CoS Programme should continue where possible, including any that were agreed with clients aged under 65 years who will be accessing NDIS supports. This will help provide clients with continuity of support.

Once agreed between the Grant Recipient and relevant clients (and their carer/advocate/nominees), the joint funding and service arrangements, including processes should one party exit the agreement, should be outlined in writing in the CoS ISP Service Agreement.

In the event that NDIS recipients within a shared living arrangement with a CoS client wish to change providers to a non-CoS ISP provider, the CoS client should contact their Grant Manager to discuss any options available to them.

2.2.11 Vacancy Management in Specialist Disability Accommodation

The CoS Programme has a closed cohort, therefore the department will not fund vacancies in specialist disability accommodation, as no new CoS clients will enter into these supported homes.

2.2.12. Legislation

Grant Recipients must comply with relevant Commonwealth and/or State/Territory legislation and regulations.

2.2.13. Output measures

Measures for recording the purchase of activities under an ISP should correspond to the measures listed for block-funded services under Chapter Two of this Programme Manual. For example:

- Personal care – hours
- Case management, local coordination and development - hours

For activities purchased that are not listed in these tables, the output used should be the cost of the service/item.

These outputs must be outlined in the client's Service Agreement and reported against through activity reporting as per the Grant Recipient’s Funding Agreement.

2.2.14. Staff qualifications and training

Providers delivering services under an ISP must have appropriately qualified and/or trained staff and comply with Commonwealth and State and Territory legislation regarding who can undertake specific activities.

Where block-funded service types (as listed in this chapter of the Programme Manual) are purchased using ISP funds, qualifications and/or training relating to that service type should be applied.

Where a client is managing their own budget under the Direct Funding model, the client must have the capacity and skills to undertake these functions and be receiving the supports that assist them to do so. It is expected that clients transitioning from direct funding models to the CoS Programme will have been assessed as having appropriate capacity.

2.2.15. Costing of Support

In relation to costing of components in ISP, supports are required to be costed on an annual basis, taking into consideration the known cost of the service, frequency of delivery and any additional charges (as advised by the chosen service delivery provider).
Services purchased with ISP funding can be altered within the client’s allocated funding, based on changing client goals and support needs identified in the client’s ISP Service Agreement, and in line with this Manual.
Chapter 3. Client Pathways

The support options available to older people exiting specialist disability services and CoS clients with changing needs are outlined in the diagram below and explained in detail in this Chapter.
3.1. Transition to aged care instead of the CoS Programme

The needs and level of support accessed by older specialist disability services clients vary widely from low-intensity supports to higher levels of care such as accommodation support services.

For older people accessing lower levels of care, continuity of support may be provided through the CoS Programme or through appropriate aged care programmes. The Commonwealth Home Support Programme (CHSP), for example, may offer some older people an opportunity to both receive similar supports and maintain positive outcomes and enable people to access additional aged care supports as their needs increase.

Further information is available on the Department’s CoS website to help clients and service providers make a decision about this option.

Where older people receiving specialist disability services indicate to their provider they wish to transition to the CHSP instead of CoS, if eligible, these older people and their provider (if they choose) will be supported in this process by the departmental Grant Manager.

Under this arrangement, the older person will continue to receive the same level of support as under their existing arrangements. This includes transitioning any existing client contribution arrangements to the CHSP as a provider under that Programme, to help ensure continuity of support for those older people.

At the time of entering the CHSP, clients will not need assessment through My Aged Care and will continue receiving support with the same provider with a CHSP Funding Agreement in place.

Older people will not be transitioned to the CHSP without their consent and that of their carer/advocate/nominee, where relevant.

Should the provider not wish to transfer to the CHSP, older people will be supported to enter the CHSP through an existing CHSP provider offering the same supports and client contribution arrangements.

3.2. Entry to the CoS Programme

Eligible clients accessing state-administered specialist disability services at the time of CoS implementation in a region will enter the CoS Programme. They will not need to be re-assessed and will generally move into the programme on their current support level.

Service providers managing requests for service from people aged 65 years and over who are not current clients (those not already receiving state-administered specialist disability services at the time of implementation) should refer these people to My Aged Care for screening and assessment for aged care supports.

3.3. Annual Review of services and supports

All CoS clients, including those supported through ISP, must have an annual review of current services (or more frequently if required). The review process must include participation by the client and their carer/advocate/nominee and consider whether the services and supports delivered are continuing to meet the client’s needs and goals, rather than reassessing their ongoing eligibility for services. In cases where support needs remain stable, the review may take the form of a brief discussion with the client over the phone.

Where a client receives services from multiple providers, the client (in partnership with their carer/advocate/nominee where relevant) should select a ‘lead’ provider to undertake this review and incorporate input from all service providers delivering their support.
Reviews should include consideration of:

- whether the client’s goals are being met;
- what strategies are working and what elements of the client’s services could be improved;
- whether the supports being accessed are meeting the client’s needs, or identifying different or additional support needs; and
- whether there are any changes in client circumstances.

3.3.1. Purchase of reviews

Where a Grant Recipient does not have the expertise or capacity to undertake these annual reviews, assessment services should be purchased from an organisation with expertise in this area, for example another CoS service provider from within the Block-funded Grant Recipient’s CoS funding.

Where current funds cannot support these costs, the service provider must contact their Grant Manager to discuss options. This may include the Commonwealth agreeing to meet these costs on a one-off basis only, noting that the provider must make their own arrangements for future assessments and reviews of support (e.g. through staff development or recruitment, or establishment of partnerships with other organisations to provide the service).

Where the client is receiving an ISP, assessment services should be purchased from the administration component paid by the client to any ISP Grant Recipient. Where the client receiving an ISP does not pay an administration component, the Grant Recipient should contact their Grant Manager for options around accessing these assessment services.

3.3.2. Outcomes of reviews

In the case of ISP clients, the Grant Recipient should discuss outcomes of the review process and agree any change in supports required with the client and adjust services within the allocated budget accordingly. Any revisions to the ISP Service Agreement must be agreed by both the client and Grant Recipient prior to a change in services.

Should the outcome of this review be referral to My Aged Care for screening and assessment for aged care services, support will be provided (for example through information material) to CoS Grant Recipients to initiate a guided, inbound referral process. This may include helping clients to access information on options for accessing financial hardship assistance for people who may have difficulty paying aged care fees and charges.

3.3.3. Support to conduct reviews

Grant Recipients are able to access the National Translating and Interpreting Service (TIS National) to access interpreting services to assist them and their clients in the review process, including developing or reviewing ISP Service Agreements (Chapter Five of this Manual provides further information on TIS).

3.4. Changes in support needs

The CoS Programme aims to support clients to continue to achieve similar outcomes to those they were achieving prior to the transition to new arrangements. Where possible, services will provide flexibility for providers to achieve this objective. However, after older people transition to CoS and over time, they may experience changes in their support needs, and these can occur along a continuum from minor to significant change. Such changes will signal a need for review and assessment of how clients, with support from their carer/advocate/nominee, can be supported to access the most appropriate care for their needs.

For ISP clients, the current mix of supports may be adjusted to better suit their needs. This can occur within their current budget and include services that are in-scope with the Programme and
still align with their goals. The ISP Service Agreement must be updated to reflect the change in supports.

For others, it may be possible to remain in CoS while accessing Additional Support options, while some clients will be supported to transition to aged care programmes (if eligible) which can offer opportunities to receive similar services and access additional aged care supports as their needs increase.

### 3.4.1. Minor changes

If, following a review, a CoS service provider and the client (and their carer/advocate/nominee) agree that a minor change in supports is needed by the client, the CoS service provider will adjust services accordingly within their current funding.

For clients on ISP, where a change in needs is minor, the provider should discuss this with the client (and their carer/advocate/nominee) and adjust supports within the allocated budget to allow for the extra services. The ISP Service Agreement should be updated, agreed and signed to reflect any changes.

Minor changes are defined as:

- A short term (less than three months) increase in support only, including emergency circumstances; or
- A longer term increase in support BUT only requiring less than $8,000 in additional supports per annum.

### Responding to minor changes in supports - Additional support

The CoS Programme provides a range of flexibility for clients with changing needs.

Where the increase in supports is minor and the Grant Recipient cannot accommodate the increase within their existing funding on an ongoing basis (within the client’s individual budget for ISP Grant Recipients), they can make an application to the Grant Manager for Additional Support through the Commonwealth Home Support Programme (CHSP), subject to available funds and under the following circumstances:

- Changes in support fall within the scope of the CHSP i.e. the client must be living in the community (this includes older people in group homes but excludes people living in small or large residential institutions or hostels); and
- Changes in support fall within the level of the CHSP – i.e. the additional amount of support needed is below a Level One Home Care Package (i.e. under $8,000).

### Scenario:

Mary is 68 and lives at home. Following a stroke, she has received a small amount of CoS therapy support to help her maintain her functional capacity and stay as independent as possible.

Her daughter, who provides some informal care and support, has accepted a new job which means she is unable to help Mary as often with some personal care assistance. As a result, Mary requires support in showering a few times during the week when her daughter cannot help her. The Grant Recipient delivers this service type to other clients and estimates the annual cost of providing this additional support to be just over $5,000 per annum.

As Mary is living in the community and the estimated cost of her (ongoing) additional support is below $8,000, the Grant Recipient submits an application for Additional Support through the CHSP. The application is successful.
As the organisation is also a CHSP provider, the Grant Recipient receives the funding to provide this additional care to Mary and support her to remain living at home through a variation to their CHSP funding agreement.

**The Application Process**

Grant Managers will provide applicants with an application template to complete which will require Grant Recipients to address specific criteria relating to:

- Evidence of how the client’s needs have changed, why the client requires the additional support, the type of additional services required, how they will support the client to achieve agreed outcomes, an estimated cost (supported by any unit cost information used by the Grant Recipient) of the Additional Support and how this presents value for money for the Commonwealth.

The CoS Advisor (see Chapter One) will assess the case and notify the Grant Recipient of the outcome in writing within fourteen days (including, where relevant, feedback on the reasons the application was unsuccessful). Cases for Additional Support will be assessed in the order in which they are received and on their individual merit.

If the application is not successful, the client should be referred by the Grant Recipient to My Aged Care for assessment for aged care supports.

The CoS Grant Recipient will temporarily provide the additional levels of care within their existing budget until the client starts receiving aged care supports. Where this is not possible Grant Recipients should contact their Grant Manager to discuss options.

**Accessing Additional Support funding**

Where the application is successful, and the client wishes to receive the Additional Supports from their existing provider, the CoS Grant Recipient may be sub-contracted by the CHSP provider to deliver the additional supports to the client. In this case, the CoS Grant Recipient will not need to enter a CHSP Funding Agreement with the Department.

Where a service type is needed but not delivered by the CoS provider, the department will identify local CHSP providers that deliver those services. The client will choose the CHSP provider to deliver the Additional Support.

The older person with disability becomes a CHSP client through these arrangements in addition to remaining under the CoS Programme. As such, the client does not need to be screened, assessed or have a client record created through My Aged Care.

For ISP direct funded clients, any approved additional funding will need to go through a CHSP provider of your choice and will not be cashed out.

**3.4.2. Significant changes**

Once they commence in the CoS Programme, clients may experience significant changes in the supports they require over time. These older people with disability will be assisted to access the care that best meets their needs and the outcomes they wish to achieve.

In the context of the CoS Programme, significant change is defined as a change in supports:

- that is ongoing or long term in nature (e.g. longer than three months); and
- that requires an additional level of supports that is higher than $8,000 per annum.

If, following the annual review process (or a review as needed), a CoS service provider and the client (and their carer/advocate/nominee) agree that a significant change in supports is needed by the client, the provider should refer the client for assessment for aged care services through visiting the [My Aged Care](http://www.myagedcare.gov.au) website or by contacting 1800 200 422. Results from the
assessment process should, with the client’s permission, be provided as part of this guided, inbound referral process from the Grant Recipient to My Aged Care.

In addition to the streamlined pathway to aged care supports provided under My Aged Care, support to access aged care services is available under the National Aged Care Advocacy Programme, which can be contacted on 1800 700 600.

Scenario:

Julio is 69 and lives alone at home. He has some vision impairment and suffers from depression. Through community support and community access services received under a CoS Individual Support Package valued at approximately $20,000, Julio is able to stay connected with his community and volunteer at his local library. After a bad fall at home, the Grant Recipient managing Julio’s ISP undertakes an assessment to review his supports. This indicates a significant change in services is required to respond to his new, ongoing needs as a result of the fall.

The additional supports, including regular physiotherapy and assistance with personal care over coming months, will significantly exceed Julio’s ISP budget. As his primary goal is to remain living at home, the Grant Recipient recommends that he is assessed for an (aged care) Home Care Package (HCP). The flexible, consumer directed model of care this provides to clients at home is similar to the ISP and appeals to Julio.

With his permission the Grant Recipient passes his assessment information to My Aged Care through an inbound referral process. Julio is subsequently assessed by an Aged Care Assessment Team as eligible for, and accepts, a Level 3 HCP place. Once he selects his HCP provider Julio begins to receive social support services, attendant care, short-term counselling, low vision aids and technologies and allied health.

Through the range of aged care services and models available, Julio is able to transition smoothly from CoS to a similarly client-centred model of care that enables him to achieve his outcomes and access additional support as his needs increase over time.

Responding to significant changes in supports-Exceptional circumstances

For some CoS clients experiencing significant changes in supports, exiting the Programme may lead to reduced outcomes, for example where a specialised model of care is not available in another system. Additional support may be available for these clients which allows them to remain in the CoS Programme and receive services to meet their increased needs. This option is subject to availability of Programme funds and only available in the following exceptional circumstances:

- The client is living in CoS funded supported accommodation (i.e. a small or large institution, hostel or group home); and
- Exiting the CoS Programme could lead to reduced outcomes for the client, particularly where an alternative service system is unlikely to provide a similar model of care or comparable client outcomes.

Scenario:

Joe is 72 and has an intellectual disability and MS. He has lived in the same group home for over twenty years where he receives a range of support with his activities of daily living. Recently, Joe’s MS has moved out of remission and his symptoms are accelerating. As a result, he cannot access day programmes as frequently and needs increased support to toilet, shower and dress, in addition to a new need for therapy supports.

The group home provider estimates the therapy support alone, based on their organisation’s staffing costs, could cost an additional $10,000 per year. As Joe is a supported accommodation client and moving from his current living and support arrangements could lead to reduced
outcomes such as stress-related intensified symptoms, his service provider submits a case for Additional Support under exceptional circumstances through the CoS Programme.

The application is successful, and the Grant Recipient receives additional funding through a variation to the CoS Funding Agreement to better support Joe. His needs will continue to be monitored and officially assessed at the next annual review point under the Programme.

**Application process**

Grant Managers will provide applicants with an application template to complete which will require Grant Recipients to address specific criteria relating to:

- Evidence of the client’s current accommodation and support arrangements and how the client’s needs have changed significantly, why the client requires the additional support, how the client may experience reduced outcomes from exiting CoS, the type of additional services required and how they will better meet the client’s needs and help them to achieve better outcomes, an estimated cost (supported by any unit cost information used by the Grant Recipient) of the additional support, and how this presents value for money for the Department.

The CoS Advisor (see Chapter One) will assess the application and notify the Grant Recipient of the outcome in writing within fourteen days (including, where relevant, feedback on the reasons the application was unsuccessful). Applications for Additional Support will be assessed in the order in which they are received and on their individual merit.

If the application is not successful, the client should be referred by the Grant Recipient to My Aged Care for assessment for aged care supports.

The CoS Grant Recipient will temporarily provide the additional levels of care within their existing budget until the client starts receiving aged care supports. Where this is not possible, Grant Recipients should contact their Grant Manager to discuss options.

**Accessing Additional Support funding**

Where the application is successful, the Grant Manager will arrange for the client to receive the Additional Supports through their existing CoS provider via an increase to the Grant Recipient’s Funding Agreement. Should the CoS provider not provide the service types required, these supports may be sub-contracted by the Grant Recipient.

The client will not be receiving aged care supports therefore will not need to access My Aged Care.

**3.5. Clients choosing to enter aged care**

Over time, clients may signal an interest in accessing aged care supports instead of the CoS Programme. Grant Recipients can support clients through referring them to My Aged Care on 1800 200 422 for screening and assessment for aged care services. Clients transitioning into aged care will be further supported through access to advocacy services under the National Aged Care Advocacy Programme, which can be contacted on 1800 700 600.

**3.6. Client consent to enter aged care**

Where a client has been assessed as eligible for aged care but does not wish to accept aged care supports, the client may choose to remain in the CoS Programme at their current level of service.

**3.7. Suspension of service**

Where a client has a leave of support for a short-term period only (defined as under three months), for example due to a stay in hospital, the client’s need for services should be reviewed by the service provider (or third party) after they return and supports adjusted appropriately.
Notice of any suspension for a period of over 3 months should be provided in writing to the Grant Manager within fourteen days (of the suspension) so they can adjust the provider’s Funding Agreement accordingly to reflect the reduction in services required over that period.

For ISP clients, any planned or unplanned absences should be discussed with their Grant Recipient including any subsequent impacts on ISP funding and direct service delivery (particularly for regular services or direct debit arrangements). Provisions for temporary suspension of services should be included in the Service Agreement and reflected in reporting (e.g. financial acquittal and performance reporting).

3.8. Portability

3.8.1. ISP clients

A client may change the Grant Recipient managing their ISP to another CoS ISP Grant Recipient of their choice, for example if the client is moving interstate or to a region where the Grant Recipient does not operate. This should be done in conjunction with the Grant Manager and in partnership with the client’s carer/advocate/nominee. Clients on the Service Provider or Financial Intermediary ISP model can transfer between the two models, but cannot transfer to the CoS Direct Funding model.

The Grant Recipient that was managing the client’s budget should transfer any relevant client information to the new provider selected by the client, for example the CoS ISP Service Agreement, with the client’s permission. The client must notify the Grant Manager in writing, where possible, at least six weeks in advance of their decision and advise the Grant Manager of their preferred CoS provider who must be willing to accept them as an additional client. Any notification of less than six weeks may result in a delay in transfer of their ISP.

ISP Grant Recipients are required to have a process in place and provide information to the client about their rights to change providers if they wish to do so.

3.8.2. Block-funded activities clients

These clients may move from their current provider to another CoS provider of their choice with the Grant Manager’s prior advice and approval and subject to the chosen provider accepting them as a client. They may not, however, move from block-funding to an ISP funding model if they were not receiving an ISP prior to transitioning to CoS.

In addition to this flexibility for clients, Grant Recipients funded under the Block-funded Activities Sub-Programme can use up to 20 per cent of their existing budget to provide alternate services to respond to changing client needs (see Chapter Five of this Manual).

3.9. Exiting the Programme

3.9.1. Notification of client exits

When a client has not accessed services for over twelve months, no longer requires a support or for other reasons permanently exits the CoS Programme, the CoS service provider is responsible for advising their Grant Manager in writing within fourteen days of the exit as per their Funding Agreement. Key details to be provided in this notification include:

- identification number for the client (both ISP and/or block-funded clients);
- sub-programme they were receiving services under (e.g. ISP and/or block-funded);
- service type/s the client was receiving;
- actual service outputs (service hours, client numbers) per annum;
- actual or notional amount of funding allocated to the exiting client per annum;
- date of exit; and
• reason for exit.
Grant Managers will reduce future Grant payments from the quarter following notification.

In the case of block-funded clients, the details above, such as service outputs, should be drawn from the exiting client’s Approved Client Plan.

In the case of an ISP, these details should be drawn from the ISP Activity Work Plan and ISP Service Agreement. The service provider must ensure that payments for services to this client have ceased (including any automated payments). Funding for that client will cease from the next quarter (not from the client exit date). Any surplus funds between these dates may be retained by the Grant Recipient for meeting any additional needs supported by a review process.

As per the Funding Agreement, the service providers must update the next Activity Work Plan if a client or clients have exited. They should also include the reasons for client’s exit. Reasons for clients exiting the CoS Programme may include:

• a client dies
• a client chooses to exit the Programme
If the client chooses to be assessed for entry to aged care, they may contact My Aged Care or an officer from the National Aged Care Advocacy Programme if they require assistance to access the aged care system.

• a client moves to alternative services due to a significant change in supports required
Where a client’s needs have changed and Additional Support options are not available clients will be supported to exit the Programme on a permanent basis.

• a client does not require or access CoS Programme supports for 12 months or more
Where a client does not access CoS services for 12 months or more, the Grant Recipient will consider that client to have exited the Programme. Service providers should notify all clients, particularly those accessing services on an episodic basis, of this requirement and assist exiting clients to access My Aged Care for assessment for aged care services.

• an Aboriginal and Torres Strait Islander client under CoS aged 50-64 years becomes eligible for the NDIS
Where an Aboriginal and Torres Strait Islander client has had a change in circumstances which means that they meet NDIS access requirements, the person may exit the CoS Programme. The person may forward an access request to the National Disability Insurance Agency (NDIA) to become a participant at any time.
Chapter 4. Interaction with other programmes

Details on the CoS Programme’s interaction with other programmes and services are provided below.

4.1. Commonwealth Aged Care

4.1.1. Commonwealth Home Support Programme (CHSP)

Where some CoS clients are already accessing CHSP services, this may continue. Other situations where clients may access CHSP services are noted in Chapter Three of this Manual.

4.1.2. Residential Aged Care

Residential aged care clients receiving state-administered specialist disability services at the time of implementation in a region will continue to receive these supports, but through the CoS Programme.

In addition to this interface, it is possible that some CoS clients who exit the Programme over time will move to residential aged care. For example some clients may experience a change in circumstances that triggers an assessment by an Aged Care Assessment Team (ACAT) and approval by an ACAT delegate as being eligible for a residential aged care place. Should a CoS client permanently enter residential aged care this will be seen as an exit from the Programme and the client will no longer receive supports under CoS.

Access to residential respite is not viewed as permanent entry to aged care. CoS clients may therefore access this respite and continue receiving services under CoS.

4.1.3. Home Care Packages (HCP)

Where CoS clients are accessing HCP services prior to their transition to the CoS Programme, this may continue.

As above, some CoS clients may experience a change in circumstances that triggers an assessment and subsequent approval by an ACAT delegate as being eligible for a HCP place. Should a CoS client accept a HCP place and begin to receive services, this will be seen as an exit from the Programme and the client will no longer receive supports under CoS.

4.1.4. Supports for 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 services to older people, given its prevalence amongst older people. The Government funds a range of advisory services, education and training, support programmes and other services for people with dementia, their families and carers. CoS Programme clients and providers may access these supports if appropriate to their needs, under existing client contribution arrangements for each programme. More information is available on the Department of Health website.

4.1.5. Transition Care Programme

CoS clients may be eligible for the Transition Care Programme if they meet the eligibility criteria. Transition Care provides time-limited, goal-oriented and therapy-focused packages of services to older people after a hospital stay. These packages include low intensity therapy, such as physiotherapy and occupational therapy, social work and nursing support or personal care. Transition Care is designed to improve older peoples’ independence and confidence after a hospital stay. It allows them to return home rather than prematurely enter residential care.
4.1.6. **Short Term Restorative Care Programme**

If eligible, CoS clients may also be able to access supports under the **Short-Term Restorative Care Programme** which aims to reverse and/or slow ‘functional decline’ in older people and improve their wellbeing. Wellness, reablement and restorative approaches are emerging as powerful ways to help older people improve their function, independence and quality of life.

4.2. **Advocacy Programs**

4.2.1. **National Aged Care Advocacy Programme (NACAP)**

CoS clients who are considering a move to aged care or exiting the CoS Programme will be able to access the NACAP for assistance in accessing, and transitioning to, aged care supports. NACAP providers can be contacted on 1800 700 600. The following groups can access NACAP services:

- Recipients of Australian Government subsidised residential aged care, Home Care Packages or flexible care services;
- Potential recipients of Australian Government subsidised residential aged care services, Home Care Packages or Flexible Care Services; and
- Representatives or families of the above.

4.2.2. **National Disability Advocacy Program (NDAP)**

The NDAP provides people with disability of all ages with access to effective disability advocacy that promotes, protects and ensures their full and equal enjoyment of all human rights enabling community participation. CoS clients can continue to access the NDAP for support.

4.3. **Carer Gateway and Integrated Plan for Carer Support**

If CoS clients do not already receive emergency respite under the CoS Programme, they may be able to access this support through Commonwealth Respite and Carelink Centres or other services delivered under the Integrated Plan for Carer Support. Carers should contact the Carer Gateway for more information.

4.4. **National Disability Insurance Scheme (NDIS)**

All people with disability, including those aged 65 years and over, their families and carers and the broader community can benefit from Information, Linkages and Capacity Building (ILC) supports under the NDIS. Although there are no access requirements to be met under the ILC Policy Framework, some ILC supports will be targeted to certain groups of people. ILC is the component of the NDIS that provides information, linkages and referrals to efficiently and effectively connect people with disability, their families and carers, with appropriate disability, community and mainstream supports.

For older people, this will include referral to services under aged care. Activities funded through ILC will need to work effectively with services and supports provided through the aged care system. However it will not replace those services.

4.5. **Mobility Allowance**

Subject to legislation passing, from 1 January 2017 eligibility and entitlement rules for new and existing Mobility Allowance customers will change. Existing Mobility Allowance customers will be grandfathered and remain on the payment based on the current eligibility criteria. If they cancel their payment, they will lose their grandfathered status and be subject to the new eligibility criteria. Further information can be found on the Department of Human Services website.
4.6. State and Territory Aids and Equipment Schemes

In signed Bilateral agreements between the Commonwealth and States/Territories under Transition to a National Disability Insurance Scheme (Schedule C, Clause 3), States/Territories have agreed to continue to deliver supports that fall within their universal service obligation. This includes responsibilities around supplying aids and equipment to people who are not eligible for the NDIS, including older people.

Therefore, in the first instance, aids and equipment should be accessed through available State programmes (see examples of these provided at Appendix A). Service providers and clients should contact their state governments directly to identify what state schemes and programmes can be accessed.

4.7. Veterans’ services

A person’s eligibility for Department of Veterans’ Affairs-funded services such as the Veterans’ Home Care Programme, community nursing, transport or respite does not exclude that person from also being a CoS Programme client (as long as they meet CoS eligibility criteria).

4.8. Health system

CoS services are not intended to replace supports funded and provided for under other systems including the health system. For example, the Programme supports client independence but is not a substitute for rehabilitation/subacute/transition programmes provided under the health system. Post-acute care is also not funded under CoS. Where a client was receiving CoS services prior to hospitalisation, additional short-term CoS support services can be provided following a hospital stay, for a short period of time (minor change in supports). These must, however, be consistent with guidance provided in Chapter Three of this Manual.

4.9. Palliative Care

CoS Programme clients are able to receive palliative care services from their local health system in addition to their CoS services, but this should be arranged by the person’s clinician. Decisions on the funding and delivery of palliative care and hospice services in each jurisdiction are the responsibility of individual State and Territory governments.
PART B — Administration of the Commonwealth CoS Programme

Chapter 5. Departmental and Grant Recipient Responsibilities

5.1. Summary of departmental responsibilities

In managing the CoS Programme, the Department will:

• meet the terms and conditions of the Funding Agreement established with organisations;
• ensure that services provided under the CoS Programme meet the terms and conditions agreed in the Funding Agreement;
• administer the operation of the CoS Programme in a timely manner;
• identify suitable providers to deliver the activities required as per the Funding Agreement;
• work in partnership with the provider to ensure the CoS Programme is implemented;
• provide the service provider with constructive feedback;
• ensure that the outcomes contained within the CoS Programme Guidelines are being met and evaluate the provider’s performance against the CoS Programme outcomes; and
• publish information on the successful grants on the Department’s website within the required timeframes.

5.2. Summary of Grant Recipient responsibilities

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

• the CoS Programme Guidelines;
• the Funding Agreement Terms and Conditions (Terms and Conditions);
• any Supplementary Conditions;
• the Schedule (including any annexures or attachments to the Schedule);
• this Programme Manual; and
• other documents incorporated by reference into the above documents.

Grant Recipients are responsible for ensuring:

• the Terms and Conditions of the Funding Agreement are met;
• service delivery aligns with the objectives, outcomes and service delivery principles in this Manual;
• service provision is effective, efficient and appropriately targeted;
• 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;
• staff have appropriate qualifications and/or training as per Chapter Two of this Manual;
• special needs groups have equal and equitable access to services;
• they work collaboratively to deliver services; and
• they contribute to the overall development and improvement of services such as sharing best practices.
In addition, this chapter outlines Grant Recipient responsibilities in the administration of the Commonwealth CoS Programme relating to quality arrangements; funding arrangements; and reporting requirements.

5.3. Monitoring and review functions

All Grant Recipients must undertake the following functions as integral parts of their service delivery:

- service-level assessments to ensure the ongoing safety of clients (e.g. Work, Health and Safety assessments);
- on-going monitoring of the client, home environment (where applicable) and appropriateness of service arrangements; and
- a regular 12 month review of current services provided to clients in partnership with their carer/advocate/nominee where appropriate, including review of ISP Service Agreements and any Behaviour Support Plans (see Chapter Three of this Programme Manual).

5.4. Equity of access

Australia’s Multicultural Access and Equity Policy: Respecting Diversity. Improving Responsiveness obliges Australian Government agencies to ensure that cultural and linguistic diversity is not a barrier for people engaging with government and accessing services to which they are entitled by, for example, providing access to language services where appropriate.

CoS service providers should consider whether services, projects, activities or events may require the use of professional translating or interpreting services in order to communicate with non-English speakers. If required, CoS providers are able to access interpreting services through the Government’s National Translating and Interpreting Service to support them in any review and planning processes for CoS clients from non-English speaking backgrounds.

5.4.1. Translating and Interpreting Service (TIS National)

To ensure that all clients can participate fully in the review of their services, Grant Recipients are able to access Government-funded interpreting services through TIS National to support them in this process with clients from culturally and linguistically diverse backgrounds. Detailed information to support CoS service providers access this support is available on the CoS website.

Under this arrangement, TIS National provides on-site and phone interpreting services to the Government’s subsidised home care, home support and residential aged care providers. This subsidised arrangement is a provider entitlement that is not directly linked to individual clients.

CoS service providers are able to contact TIS National to access, free of charge, interpreting services in their review of service supports for CoS clients, including review of Service Agreements for ISP clients.

The Department encourages CoS providers to use telephone interpreting services wherever possible, unless there is a genuine need for an on-site interpreter.

Service providers can access interpreting services through a non-transferable TIS National code issued to the individual CoS service provider. The Department of Health is subsequently billed for those services by TIS National.
Registering for TIS National services

Before using TIS National to review service supports for CoS clients, you must register online for a TIS National Code. If you already have a TIS National code in the delivery of a different Commonwealth-funded program, a separate CoS Programme code is still needed to ensure services are funded correctly.

Completing the TIS National registration form

The first four fields in the registration form should be completed as follows:

Category: Commonwealth Government Agency
Sub-Category: Other Commonwealth Government agency
Name of Agency – [insert your individual organisation name in this field]
Section Name – Commonwealth Continuity of Support

The remaining fields in the online registration form will request address, contact and service preference details.

Submitting TIS National registration forms

When you submit a registration form through the TIS National website, you will receive an automated response with the client code.

CoS providers should not use this code until they receive a welcome email from TIS National confirming their eligibility for the client code, or they may be charged directly for services.

Please note the TIS National client code is not transferrable between organisations.

If TIS National services are required urgently, before a TIS National client code has been allocated, call TIS National directly on 1300 655 820 (within Australia) during business hours for assistance.

Interpreting support outside the operational requirements of the CoS Programme

If you require an interpreter for your client outside of operational requirements (for example, as part of an agreed service delivery in the client’s care plan), the above registration steps are not required and all costs incurred should be paid for through:

- the service provider’s budget (for block-funded clients); or
- the client’s available funds (for clients accessing Individual Support Packages). All costs must be made clear to the client prior to these services being included in the client’s budget.

5.5. Quality arrangements

From 1 July 2018, the Commonwealth CoS Programme will transition to nationally consistent quality and safeguard arrangements, under the jurisdiction of the NDIS Quality and Safeguards Commission (the NDIS Commission). All CoS Programme clients and providers will be covered under these arrangements with transition commencing as states and territories reach full Scheme with:

- New South Wales and South Australia from 1 July 2018;
- Queensland, Victoria, Tasmania, Northern Territory and the Australian Capital Territory from 1 July 2019; and
- Western Australia from 1 July 2020.

All Grant Recipients will be required to be registered under the NDIS Commission. For Grant
Recipients who are already registered with the NDIA, existing registration will be automatically transferred from the NDIA to the NDIS Commission. Registered Grant Recipients will be required to comply with the *NDIS (Code of Conduct) 2018* and all applicable *NDIS Key Rules*.

Where a Grant Recipient, delivering supports to a CoS client, is unable to meet the requirements for registration with the NDIS Commission, they may apply to the Department of Health for consideration to remain exempt. All applications for exemption will be considered on a case by case basis. Organisations granted registration exemption will still be required to adhere to the *NDIS (Code of Conduct) 2018*, including for the management of complaints.

Grant Recipients should refer to their updated Supplementary Conditions in their Funding Agreement for further information on responsibilities associated with the NDIS Commission.

During the transition to full scheme, Grant Recipients will continue to operate under existing state and territory based quality and safeguards systems. In these instances, Grant Recipients are required to comply with the quality and safeguard arrangements detailed in 5.5.1 to 5.5.9 in this Programme Manual, in addition to requirements outlined in their Supplementary Conditions in their Funding Agreement relevant to their specific state or territory.

Under the ISP Direct Funding model, clients who employ their own support staff or purchase their own services and supports will assume responsibility for the quality of these services and supports. This will be made clear in the Service Agreement that the client (and/or their carer/advocate/nominee) signs with the Direct Funding organisation. Given this, clients may wish to consider accessing services from NDIS registered providers who are required to have certain experience, qualifications, processes and expertise (as determined by the jurisdiction in which they operate) to be providers of those specific supports.

### 5.5.1 Quality Standards

Grant Recipients are required to:

- adhere to the **Quality Standards** as outlined in the *National Standards for Disability Services* (‘National Standards’) or State/Territory Quality and Safeguards requirements in their jurisdiction (as outlined in the Grant Recipient’s Funding Agreement);
- support and recognise **User Rights** as outlined in the National Standards or State/Territory requirements; and
- undertake service planning and delivery which is **responsive to diversity** including disability, age, gender, cultural heritage, language, faith, sexual identity, relationship status and other relevant factors, as outlined in the National Standards.

### 5.5.1 Quality Reviews

Grant Recipients must meet the requirements outlined in their Funding Agreement in relation to quality reviews and must provide the Department with a full copy of the audit report if requested.

### 5.5.2 Workforce Screening

Grant Recipients have a responsibility to ensure that all staff, volunteers and executive decision makers delivering CoS Programme services are suitable for the roles they are performing. This includes being responsible for meeting current State/Territory government requirements in relation to staff members, volunteers and executive decision-makers working with vulnerable people.

The payment of the cost of obtaining relevant documentation such as a police check certificate is a matter for negotiation between the Grant Recipient and the individual. Individuals may be able to claim the cost of the police check certificate as a work-related expense for tax purposes.
Further advice on this issue is available on the Australian Taxation Office (www.ato.gov.au) website.

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

5.5.3. Staffing and Training
Grant Recipients are required to ensure staff are appropriately qualified to deliver the type of specialist support services they are employed to deliver. Examples of desirable staff qualifications under the CoS Programme are outlined in Chapter Two of this Programme Manual.

5.5.4. Work Health and Safety
Legislation relating to 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 (Cth).

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.

CoS Programme Grant Recipients must provide a safe and healthy workplace for their employees and volunteers in accordance with relevant Commonwealth, and State/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. Grant Recipients are responsible for addressing the safety of employees and volunteers delivering services to a client or carer in their home.

Grant Recipients 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.

5.5.5. Critical/serious/reportable Incidents
Grant Recipients are required to comply with relevant State/Territory government policies and guidelines and all legal requirements relating to the reporting, documenting and dealing with critical/serious incidents (see Glossary for definition). For the purposes of the CoS Programme, these incidents include emergencies, deaths, assaults or abuse, serious unexplained injuries and incidents that impact the safety of clients.

5.5.6. Complaint Mechanisms

Managing complaints about service providers
Grant Recipients must meet any State/Territory legislation relating to handling of complaints and have an internal complaints process in place. All CoS clients must be provided with information about complaints mechanisms from their commencement in the Programme, including all available internal and external complaint mechanism processes.

Most complaints relating to the provision of services delivered under the CoS Programme will be resolved between the Grant Recipient and the client in the first instance. Mechanisms developed by Grant Recipients must ensure that CoS Programme clients and their carer/advocate/nominee are 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. Most states have independent
statutory authorities (in Victoria for example this is the Disability Services Commissioner) that provide a free, confidential and supportive complaint resolution process.

Clients (or their representative) can raise a complaint directly with the Grant Recipient through the Grant Recipient’s internal complaints process. Such complaints could be about the quality of the service provider, the timing of the service delivered or the refusal by the provider to deliver the required service. If complaints are not able to be resolved at this level, they should continue to be escalated within existing State/Territory arrangements for management of service provider complaints. Grant Recipients must provide clients with information about the options for external complaint resolution arrangements.

Once the Grant Recipient’s state or territory is covered by the NDIS Commission, CoS clients will be able to make complaints to the Commission with respect to the quality or any other matters relating to the services being delivered by the Grant Recipient.

Grant Recipients are also responsible for the services provided by subcontractors, including resolving any complaints made about subcontracted organisations. Should a complaint regarding a subcontractor be made, the Grant Recipient retains responsibility for liaison with the relevant state-based complaints agency and ensuring the subcontractor complies with all reasonable requests, directions and monitoring requirements requested by the agency.

Managing complaints about CoS Programme administration

By way of example, complaints relating to programme administration could include complaints relating to access to the programme, the conduct of a Commonwealth employee in engaging with a client or rejection of an application for additional funding due to increased needs of a client.

Complaints about CoS Programme administration should be raised first with the Department by contacting the Grant Manager in the relevant state office. If the complaint is not able to be resolved at this level it will be escalated within the Department for further consideration.

Thereafter, if a complaint is not able to be resolved, the complainant may choose to take the matter to the Commonwealth Ombudsman. Clients can contact the Ombudsman via the website www.ombudsman.gov.au or on 1300 362 072. Any decision of the Commonwealth Ombudsman is final and cannot be appealed.

In recognition that many Grant Recipients also deliver multiple services through other Australian Government and/or State and Territory government programmes, the Department will, from time-to-time, share information with other relevant parties to ensure clients continue to receive appropriate services. This includes sharing information to resolve disputes that occur in accessing and delivering the CoS Programme.

5.5.7. Restrictive Practices

Arrangements for behaviour support services and for obtaining approval, consent and authorisation in relation to the use of restrictive practices and mandatory reporting requirements will continue to be managed by State/Territory governments and undertaken in accordance with relevant State/Territory legislation, policies and guidelines during the transition period.

All service providers should employ positive behaviour supports to safeguard people with disability and to help reduce or eliminate the need for restrictive practices when a client exhibits risk behaviour. On occasions and to manage risk, it may be necessary to use restrictive practices to prevent a client’s behaviour from causing harm to themselves or to others.

Restrictive practices include chemical and mechanical restraint, physical restraint, restricted access to objects, containment and seclusion.
Restrictive practices must only be used in accordance with state and territory legislation and policy regulating its use.

Grant Recipients are required to adhere to best practice as set out in guidelines, protocols and frameworks available in their jurisdiction that provide advice around delivery of behaviour intervention e.g. the QLD Positive Behaviour Support and Restrictive Behaviours Framework and in NSW, the Behaviour Support: Policy and Practice Guide, Behaviour Support Policy and The Restricted Practices Authorisation Mechanism Operation Guide.

Appropriately qualified and trained staff must be used to conduct restrictive behaviour interventions.

5.5.8. Service Continuity

At all times Grant Recipients must do whatever is reasonably necessary to ensure clients continue to receive CoS Programme services. If there is a risk that a Grant Recipient is no longer in a position to provide services for any reason, for example, due to a serious incident such as a natural disaster, they must work with their Grant Manager to ensure service provision continues for their clients.

Grant Recipients must develop Activity Continuity and Transition Out Plans within two months of commencing as a CoS service provider that address any risks associated with being unable or unwilling (for example through a decision to relinquish) to continue to deliver services, including in the event of a serious incident.

Any plans to amalgamate services with other organisations, merge legal entities or relinquish should be included (and in these cases the Grant Manager provided with six weeks notice).

The Continuity and Transition Out Plan could cover:

- management of emergency situations such as natural disasters (e.g. how to continue service delivery in the event of flood or fire)
- transitioning out of service provision (e.g. moving services to another Grant Recipient where the CoS Programme Funding Agreement has expired or is terminated).

Grant Recipients must make the Continuity and Transition Out Plan available to the Grant Manager on request or as soon as they become aware that an event that is subject to the continuity or transition requirements is likely to occur.

Emergency Situations

As part of ensuring service continuity at all times, it is the Grant Recipient's responsibility to have appropriate business processes in place to coordinate and manage emergency situations that may unexpectedly arise or occur outside of business hours. Emergency situations may include where:

- you may be unable to continue providing care for a client;
- the client exhibits challenging behaviours and requires behaviour management support
- the client’s primary carer or guardian is temporarily unable to care for the client due to illness or medical emergency
- a service is cancelled or a support worker does not show up to an appointment or
- extreme weather events.

Grant Recipients are expected to contact emergency services, where required, in the event of a critical incident (i.e. ambulance, police and/or fire) involving the abuse, neglect or harm of a client.
For CoS Individual Support Packages (ISP) clients, their Service Agreement should also outline emergency support arrangements, including arrangements for emergency support outside of business hours.

Respite services provided under CoS are complemented by access to unplanned short-term and emergency respite services currently provided through the Commonwealth Respite and Care Link Centres (CRCCs). CRCCs provide a link to carer support services and assist carers with options to take a break through unplanned short-term and emergency respite, based on priority, based on priority and assessed need. Centres can be contacted by phoning 1800 052 222 during business hours or 1800 059 059 for emergency respite support outside of standard business hours.

Grant Recipients are encouraged to contact their Grant Agreement Manager at the Department of Health with any questions or if any further information is required. The relevant contact details can be found in the Grant Recipient’s CoS Funding Agreement.

Transitioning Out
The 'transitioning out' component of Activity Continuity and Transition Out Plans aims to ensure that the standard and delivery of services do not suffer during the cessation of the organisation as a CoS service provider and should cover specific requirements for different service types, the Grant Recipient’s individual arrangements and the outcome of any negotiations with other Grant Recipients.

This component should also include the following:

- client details;
- service details;
- arrangements to ensure smooth transition for clients to a new provider;
- subcontracting arrangements;
- organisational information;
- timeframe for transition (at least six weeks notice to the Grant Manager is required);
- staffing arrangements;
- assets;
- information and records; and
- relevant contact details for the provider including telephone numbers.

5.6. Funding

5.6.1. Spending the Grant
Grants payments will be made as per the Funding Agreement payment schedule. Grant Recipients must use the Grant to carry out activities in accordance with the Funding Agreement.

5.6.2. Assets
Assets are defined in the Funding Agreement. Grant Recipients must comply with the conditions relating to assets as outlined in Section 5.1. of their Funding Agreement Schedule.

For example, Grant Recipients must not use the grant to purchase assets unless the Grant Manager has given their prior written consent and must include the asset in a register of assets and provide that register to the Grant Manager within 7 days of any request.

5.6.3. Funding Flexibility Provisions
Within the Block-Funded Activities Sub-Programme:

- Grant Recipients must meet their target activity performance indicators as described in the Funding Agreement OR
• Grant Recipients must meet no less than 80 per cent of their target activity performance indicators as described in the Funding Agreement AND
• deliver additional needed services to existing CoS clients within the same sub-programme with the remaining 20 per cent.

The alternative CoS service outputs delivered (i.e. the remaining 20 per cent) must be of similar or comparable value in terms of unit price and must be additional outputs of services the Grant Recipient is already funded to deliver under their CoS Funding Agreement, not new service types not already included in the provider’s Funding Agreement.

All outputs must represent value for money and respond to identified client needs.

Where a Grant Recipient has received additional funding relating to supported accommodation as per Chapter One of this Programme Manual, the flexibility provisions cannot be applied to this funding component.

5.7. Grant administration
Refer to Appendix C of this Programme Manual for Grant Manager contact details.

5.8. Acknowledging the Funding (Due recognition)
In all Agreement Material published Grant Recipients must acknowledge the Department’s financial and other support as follows:


5.8.1. Disclaimer
Publications and published advertising and promotional materials that acknowledge CoS Programme 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.”

5.8.2. Other options for acknowledging the funding
If for any reason Grant Recipients wish to acknowledge the funding in a different manner to the options set out in this Programme Manual, or have questions about acknowledging the Programme, they should contact their Grant Manager for advice.

5.8.3. Transition arrangements for existing publications
The Department understands that Grant Recipients will have existing stocks of promotional materials which used previous state-based acknowledgements. Where applicable, providers are encouraged to replace these acknowledgements over time with the new prescribed wording identified above.

5.8.4. Monitoring the use of acknowledgements
Grant Recipients are responsible for ensuring they and their subcontractors comply with the Funding Agreement requirements for acknowledging the financial and other support received from the Australian Government. The Department will monitor acknowledgments of funding and, in particular, the use of the prescribed wording and notify Grant Recipients in writing if it
considers that a Grant Recipient or their subcontractor has failed to comply with the Funding 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 Grant Recipient or subcontractor has not complied with all the requirements of this Programme Manual). Grant Recipients should inform the Department if they become aware of any unauthorised use of the due recognition branding by any person.

5.9. Subcontracting

Grant Recipients (including those funded under the ISP Sub-Programme) may subcontract any of their obligations in accordance with their Funding Agreement. However, a detailed register of subcontractors must be maintained and provided to the Grant Manager on request. All subcontractors must provide services in line with the Agreement and the Grant Recipient remains responsible for any omissions of the subcontractor.

5.10. Reporting elements and timing of reports

Under the CoS Programme, Grant Recipients will be required to submit reports relating to the Activity described in their Funding Agreement. The Activity means any tasks, activities, services or other purposes for which the grant is provided.

There will be two aspects of reporting:

- **Financial reporting** – reports to facilitate acquittal of funds expended, providing assurance and evidence that public funds have been spent, as specified in the Funding Agreement; and
- **Performance reporting** – reports on service delivery activities.

The type and frequency of performance reports due are outlined in the Grant Recipient’s Funding Agreement. In an effort to reduce the reporting burden for Grant Recipients, the frequency of submitting financial reports has been confined to annual reporting, except for the Direct Funding Grant Recipient and unless otherwise stated in a Grant Recipient’s Funding Agreement. Key reports are noted in the following table.

**Key Reports – CoS Programme**

<table>
<thead>
<tr>
<th>Report</th>
<th>Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial acquittal report</td>
<td>Activity commencement date - -30 June</td>
</tr>
<tr>
<td></td>
<td>To be provided by 31 October each financial year</td>
</tr>
<tr>
<td>Performance Report via a Departmental</td>
<td>Activity commencement date - 30 June (transition period)</td>
</tr>
<tr>
<td>template</td>
<td>To be provided by 31 July each financial year</td>
</tr>
<tr>
<td>Update of Activity Work Plan (AWP)</td>
<td>If required under the funding agreement</td>
</tr>
</tbody>
</table>
5.11. Accounting for the Grant

Financial reports should include details of any Additional Support funding (as outlined in Chapter Three of this Programme Manual) that has been provided to the Grant Recipient. It should also identify where clients are no longer accessing supports from the Grant Recipient and/or have exited the CoS Programme and the Grant Manager has adjusted the CoS Grant Recipient’s funding accordingly.

5.11.1. The financial reporting process

The Department requires Grant Recipients to provide assurance and evidence that grant funds have been spent for their intended purpose. In the case of the ISP Direct Funded Grant Recipient, this should include acquitting of any interest earned from the budget amount paid into the client’s account.

This is provided in the form of a financial acquittal report, which is used to determine that funding provided by the Department has been spent by the Grant Recipient in accordance with the Funding Agreement.

For multi-year Funding Agreements it is normal Departmental practice to acquit funding annually. The purpose of an annual acquittal within multi-year agreements is to assist in assessment of the Grant Recipient’s targets for funds expenditure and performance.

Most funding acquitted in the Department is based on a financial year cycle, however activity periods in Funding Agreements are either for set periods or for a calendar year cycle. Grant Recipients should refer to their Funding Agreements to ascertain their reporting periods.

5.11.2. Types of Financial Reports

Grant Recipients must provide financial acquittal reports in the form of, and at the times set out in their organisation’s Funding Agreement, or as otherwise notified in writing.

5.11.3. Client contributions

Client contributions received by Grant Recipients for services they have delivered under the CoS Programme will be a voluntary part of the financial acquittal process. However, only acquittal of the grant funding provided by the Department is required (not acquittal of client contributions).

Other contributions are to be reported on as outlined in the Funding Agreement and should separately identify revenue received from client contributions from other funding sources.

5.12. Performance Reporting

Grant Recipients must provide on an annual basis (except for the ISP Direct Funding Grant Recipient) a performance report in a template provided by the Department. Each performance report must be provided at the times specified in the Funding Agreement.

Grant Recipients must provide performance reports at the times and in the format required by the Department as specified in their CoS Funding Agreement. Details of any Additional Support provided to the Grant Recipient (as per Chapter Three of this Programme Manual), including additional outputs that the Grant Recipient has been funded to deliver, must also be included in activity reporting.

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.
This will help build the evidence base regarding the effectiveness of programmes. Participation in the extended data set is entirely voluntary and there will be no negative consequences if a Grant Recipient chooses not to provide this data.

5.13. **IT and system requirements**

Grant Recipients will need internet access and a suitable internet browser and appropriate systems in place to meet their service delivery, data collection and reporting obligations outlined in their Funding Agreement.
Appendix A – Useful resources

Websites

Commonwealth Continuity of Support (CoS) Programme

National Disability Insurance Scheme

National Standards for Disability Services

National Disability Services

NDIS Bilateral Agreements

My Aged Care
www.dss.gov.au/MyAgedCare

Australian Taxation Office

Australian Privacy Principles

Centrelink

Commonwealth Department of Social Services
www.dss.gov.au

Commonwealth Department of Health
www.health.gov.au

Commonwealth Ombudsman

Crimtrac – Police Checks

Dementia Services and Support

Dementia Behaviour Management Advisory Services
http://dbmas.org.au/

Dementia Training Study Centres
Dementia Care Essentials training information – by State/Territory

Western Australia/South Australia
http://dementia.acswa.org.au/

New South Wales/ACT

Victoria

Queensland

Alzheimer’s Australia Helpline and Counselling Services
https://fightdementia.org.au/

Northern Territory

Tasmania

www.tastafe.tas.edu.au

Resource for accessing aged care supports

My Aged Care
www.MyAgedCare.gov.au

My Aged Care is made up of the My Aged Care contact centre (1800 200 422) and website. Together they can provide consumers with information on aged care, whether for the client, their family or carer. The My Aged Care 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. The My Aged Care contact centre is closed on Sundays and national public holidays.

Resources relating to support for people with disability

Australian Federation of Disability Organisations

Australian Human Rights Commission
www.humanrights.gov.au

Carers Australia
www.carersaustralia.com.au

Carer Gateway

Disability Advocacy Network Australia
www.dana.org.au/

Guide Dogs Australia
www.guidedogsaustralia.com/

MS Australia
www.ms.org.au/
National Relay Service
National Disability Advocacy Program
Older Persons Advocacy Network
www.opan.org.au
Optometry Australia
www.optometry.org.au/your-eyes/your-eye-health/vision-and-ageing
Perkins Scout
www.perkinselearning.org/scout/tips-working-seniors-vision-loss
Polio Australia
Royal Society for the Blind
www.rsb.org.au/
Spinal Cord Injuries Australia
Translating and Interpreting Service National
Vision Australia
www.visionaustralia.org

State and Territory Aids and Equipment Schemes

ACT
ACT Equipment Service
Oxygen and Equipment Services

NSW
NSW Aids and Equipment Program

NT
Disability Equipment Program
Seating Equipment Assessment and Technical Service

QLD
Medical Aids Subsidy Scheme

TAS
Tasmanian Community Equipment Scheme
www.dhhs.tas.gov.au/service_information/services_files/RHH/treatments_and_services/community_equipment_scheme

VIC
Victorian Aids and Equipment Program
Statewide Equipment Program

SA
Equipment and assistive technology for people with disability

State and Territory Government Departments

NSW Government
Department of Family and Community Services (Ageing, Disability and Home Care)

NT Government
Department of Health (Office of Disability)

QLD Government
SA Government
Department for Communities and Social Inclusion

Tasmanian Government
Department of Health and Human Services

Victorian Government
Department of Health and Human Services

WA Government
Disability Services Commission

ACT Government
Department of Community Services
Appendix B – Policies and Guidelines

Aged Care Planning Regions

APS Code of Conduct

Australian Government’s ‘National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse Backgrounds

Carer Recognition Act 2010

CrimTrac

National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy

National Disability Strategy 2010-2020
Appendix C – Commonwealth Department of Health Grant Manager contacts

Queensland
Switchboard: 07 3037 4770
Freecall: 1800 177 099

South Australia
Switchboard: 08 8237 8111
Freecall: 1800 188 098

Tasmania
Switchboard: 03 6221 1411
Freecall: 1800 005 119

New South Wales/ACT
Switchboard: 02 9263 3555
Freecall: 1800 048 998

Northern Territory
Switchboard: 08 8919 3444

Victoria
Switchboard: 03 9665 8888
Freecall: 1800 020 103
### Appendix D – Commonwealth CoS Programme Framework

<table>
<thead>
<tr>
<th>Sub-Programme</th>
<th>Block-funded activities</th>
<th>Individual Support Packages (ISP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service types funded</strong></td>
<td><strong>BLOCK-FUNDED ACTIVITIES SUB-PROGRAMME</strong></td>
<td><strong>INDIVIDUAL SUPPORT PACKAGES SUB-PROGRAMME</strong></td>
</tr>
<tr>
<td></td>
<td><em>Accommodation Support</em></td>
<td><em>Individual Support Packages (ISP)</em> is funding allocated to a client (and managed in accordance with the Service Agreement between the client and Grant Recipient) to purchase services that respond to the client’s support needs and goals in a flexible and client-centred way.</td>
</tr>
<tr>
<td></td>
<td>• Large residential/institution (&gt;20 places)—24-hour care</td>
<td>These may include, but are not limited to, any of the services listed under block-funded activities.</td>
</tr>
<tr>
<td></td>
<td>• Small residential/institution (7–20 places)—24-hour care</td>
<td>Three models operate:</td>
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<td></td>
<td>• Hostels—generally not 24-hour care</td>
<td>• Service Provider;</td>
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<tr>
<td></td>
<td>• Group homes (usually &lt;7 places)</td>
<td>• Intermediary; and</td>
</tr>
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<td></td>
<td>• Attendant care/personal care</td>
<td>• Direct Funding.</td>
</tr>
<tr>
<td></td>
<td>• In-home accommodation support</td>
<td>Only clients who are already accessing ISP models will be funded through the ISP model.</td>
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<tr>
<td></td>
<td>• Alternative family placement</td>
<td></td>
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<tr>
<td></td>
<td>• Other accommodation support</td>
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<tr>
<td></td>
<td><strong>Community Support</strong></td>
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<tr>
<td></td>
<td>• Therapy support for individuals</td>
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<td></td>
<td>• Behaviour/specialist intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Counselling (individual/family/group)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Regional resource and support teams</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Case management, local coordination and development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Other community support</td>
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<tr>
<td></td>
<td><strong>Community Access</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Learning and life skills development</td>
<td></td>
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<tr>
<td></td>
<td>• Recreation/holiday programs</td>
<td></td>
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<tr>
<td></td>
<td>• Other community access</td>
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<tr>
<td></td>
<td><strong>Respite</strong></td>
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<tr>
<td></td>
<td>• Own home respite</td>
<td></td>
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<tr>
<td></td>
<td>• Centre-based respite/respite homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Host family respite/peer support respite</td>
<td></td>
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<tr>
<td></td>
<td>• Flexible respite</td>
<td></td>
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<tr>
<td></td>
<td>• Other respite</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<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>
<td></td>
</tr>
<tr>
<td>Aged Care Assessment Team (ACAT)</td>
<td>The assessment team that will determine the care needs and eligibility for a Home Care Package or residential care (referred to as Aged Care Assessment Services in Victoria).</td>
<td></td>
</tr>
<tr>
<td>Approved Client Plan</td>
<td>This refers to block-funded clients only and means the plan provided and approved by the Department that shows how the Activity’s Grant funding and Performance Targets were attributed to each Client in that Activity as at the Activity Start Date.</td>
<td></td>
</tr>
<tr>
<td>Broker</td>
<td>A broker is an individual person that arranges transactions between a buyer and a seller for a commission when the deal is executed. In the context of the CoS Programme, this is an intermediary or service provider who arranges services to be delivered to a client of the CoS Programme on that person’s behalf.</td>
<td></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>
<td></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>
<td></td>
</tr>
<tr>
<td>Carer/advocate/nominee</td>
<td>For the purposes of this Programme Manual, the term carer/advocate/nominee refers to and includes individuals identified by the older person with disability as performing an official or unofficial support role for them. This could include being a family member who provides regular care and assistance; advocates promoting the rights of the older person; and individuals nominated to receive an individual budget under the ISP model on the client’s behalf. It refers to official and unofficial support people who should be included in all decision-making processes such as any reviews of support undertaken. Identified representatives also include nominees under federal law and appropriately empowered representatives under relevant enduring powers of attorney, as well as people appointed by tribunals as guardians or administrators (financial managers) under state and territory guardianship legislation. It is expected that some clients will transition to the CoS Programme with identified carers/advocates/nominees. Where this has not occurred and a support person is required by the client, a formal assessment should be undertaken in partnership with the client’s family (see Chapter Two of this Manual) to assess the client’s capacity and any subsequent need for a carer/advocate/nominee. Grant Recipients should contact their Grant Manager to discuss options.</td>
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<td>Term</td>
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<tr>
<td>Client</td>
<td>An older person with disability who is eligible under the CoS Programme Guidelines and receiving services under the CoS Programme and who may act through his or her legal representative and/or with the assistance of his or her carer, advocate or nominee.</td>
<td></td>
</tr>
<tr>
<td>Client contribution</td>
<td>The financial amount or fee a client is asked to contribute towards the cost of their care and support and/or their accommodation in the case of clients receiving supported accommodation services.</td>
<td></td>
</tr>
<tr>
<td>Client's home</td>
<td>The client’s home is considered to be where the older person is currently living. This may be the home of both the older person and their carer, in cases where the client and carer share a residence.</td>
<td></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.</td>
<td></td>
</tr>
<tr>
<td>Continuity of support</td>
<td>In the context of this Programme, continuity of support means supporting clients to achieve similar outcomes to those they were achieving prior to transitioning to the new arrangements.</td>
<td></td>
</tr>
<tr>
<td>CoS</td>
<td>The Commonwealth Continuity of Support (CoS) Programme which delivers continuity of support to older people receiving state-administered specialist disability services who are ineligible for the NDIS.</td>
<td></td>
</tr>
<tr>
<td>CoS ISP Service Agreement</td>
<td>ISP documentation agreed between the Grant Recipient and client and their carer/advocate/nominee as detailed in Chapter Two of this Manual.</td>
<td></td>
</tr>
<tr>
<td>Critical/serious/reportable incidents</td>
<td>Grant Recipients must comply with relevant State/Territory government policies and guidelines and all legal requirements relating to the reporting, documenting and dealing with critical incidents. For the purposes of the CoS Programme these incidents are defined as those which may:</td>
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<td></td>
<td>• have an adverse impact on the health, safety or wellbeing of a client; and</td>
<td></td>
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<td></td>
<td>• seriously affect public confidence in the CoS Programme.</td>
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<tr>
<td></td>
<td>These incidents, which may be further defined in the Funding Agreement Schedule, include emergencies, deaths, assaults or abuse, serious unexplained injuries and incidents that impact the safety of clients.</td>
<td></td>
</tr>
<tr>
<td>Culturally and Linguistically Diverse (CALD)</td>
<td>Clients may be defined as Culturally and Linguistically Diverse where they have particular cultural or linguistic affiliations due to their:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• place of birth or ethnic origin</td>
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</tr>
<tr>
<td></td>
<td>• main language other than English spoken at home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• proficiency in spoken English.</td>
<td></td>
</tr>
<tr>
<td>Department, the</td>
<td>The Australian Government Department of Health.</td>
<td></td>
</tr>
<tr>
<td>Existing client</td>
<td>An existing client means the person:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• is receiving State administered specialist disability services or has a booking/s for these services with a service provider at the time the CoS Programme is implemented in their region. This could include</td>
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</tr>
<tr>
<td>Definition</td>
<td>having an agreed date and time when services will be delivered even though services may not have commenced), or • has received state-administered specialist disability services in the twelve months prior to implementation of the CoS Programme in their region.</td>
<td></td>
</tr>
<tr>
<td>Financially or Socially Disadvantaged</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Full implementation (of CoS)</td>
<td>This refers to the point at which the CoS Programme has been implemented across all participating states and territories on 1 July 2020.</td>
<td></td>
</tr>
<tr>
<td>Funding Agreement</td>
<td>Funding Agreements are performance based, legally enforceable agreements between two or more parties that set out the terms and conditions governing a business relationship. The Departmental Funding Agreement includes the Terms and Conditions of CoS funding and the Grant Schedule.</td>
<td></td>
</tr>
<tr>
<td>Grant Manager</td>
<td>The Department of Health’s contact person for managing the service provider’s funding agreement (see Appendix C).</td>
<td></td>
</tr>
<tr>
<td>Grant Recipient</td>
<td>An organisation funded to deliver services under CoS as per the definition provided in their Funding Agreement.</td>
<td></td>
</tr>
<tr>
<td>Home Care Packages (HCP)</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 Aged Care Assessment Team. There are four levels of packages.</td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>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).</td>
<td></td>
</tr>
<tr>
<td>Individual Support Packages (ISP)</td>
<td>Individual Support Packages provide individual funding to older people with disability via a service provider, financial intermediary or direct funding organisation, to purchase services that respond to the client’s support needs in a flexible and client-centred way.</td>
<td></td>
</tr>
<tr>
<td>ISP Direct Funding</td>
<td>The amount of funding paid by the Direct Funding organisation which the client is responsible for using to acquire services and supports in accordance with their Direct Funding Service Agreement. It includes any interest that is earned on the ISP funding while it is in the client’s bank account and indexation.</td>
<td></td>
</tr>
<tr>
<td>Legal representative</td>
<td>The person who is legally authorised to sign and perform any responsibilities on behalf of the client. Identified legal representatives include nominees under federal law and appropriately empowered</td>
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<tr>
<td>representatives under relevant enduring powers of attorney, as well as people appointed by tribunals as guardians or administrators (financial managers) under state and territory guardianship legislation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesbian, gay, bisexual, transgender and intersex people (LGBTI)</td>
<td>People who identify as lesbian, gay, bisexual, transgender and intersex.</td>
<td></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, services, screening and assessment.</td>
<td></td>
</tr>
<tr>
<td>National Aged Care Advocacy Program (NACAP)</td>
<td>The National Aged Care Advocacy Programme is funded by the Australian Government and provides individual advocacy support and promotes the rights of people who are seeking or are receiving Australian Government funded residential aged care or Home Care Packages.</td>
<td></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, providers, unions and health professionals, working together to determine a more positive future for aged care in Australia.</td>
<td></td>
</tr>
<tr>
<td>National Disability Advocacy Program (NDAP)</td>
<td>The NDAP provides people with disability of all ages with access to effective disability advocacy that promotes, protects and ensures their full and equal enjoyment of all human rights enabling community participation. CoS clients can continue to access the NDAP for support.</td>
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<td>National Disability Insurance Agency (NDIA)</td>
<td>The NDIA is an independent statutory agency established by the National Disability Insurance Scheme Act 2013 (NDIS Act). The NDIA’s core role is to implement the National Disability Insurance Scheme which will support a better life for hundreds of thousands of Australians with a significant and permanent disability and their families and carers.</td>
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<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>
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<tr>
<td>Older people</td>
<td>In the context of this Programme Manual, ‘older people’ refers to people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.</td>
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<tr>
<td>Out-of-scope</td>
<td>Services and items that must not be purchased using Commonwealth CoS Programme funding.</td>
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<tr>
<td>Region</td>
<td>For the purposes of this Programme Manual, region refers to how this is interpreted in each state and territory’s Bilateral Agreement.</td>
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<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>
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<td>Review</td>
<td>A review is undertaken (or purchased by) the Grant Recipient and refers to a check of the effectiveness and on-going appropriateness of the</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<td>services the client is receiving. A review may take place where:</td>
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<td>• There is a review date set in the client’s care plan or ISP Service Agreement (e.g. the annual review required).</td>
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<td>• A service provider identifies a change in the client’s needs or circumstances that affects existing supports.</td>
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<td>• A client identifies a change in their needs or circumstances, or seeks assistance to access new services or change their service provider.</td>
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<td>Service Agreement</td>
<td>For the purposes of this Programme, the CoS ISP Service Agreement refers to documentation that is developed (or current agreements or plans updated) that reflects the CoS Programme, is agreed between the client (and their carer/advocate/nominee) and the Grant Recipient and includes, but is not limited to, an outline of the client’s goals and planned outcomes and planned supports to meet those goals and outcomes and who will deliver these and how. The Direct Funding ISP Service Agreement is legally binding and establishes an Individual Support Package (Direct Funded) arrangement between the CoS Programme’s Direct Funding organisation and the client. Chapter Two of this Manual provides more detail on the Service Agreement.</td>
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<td>Special Needs Groups</td>
<td>Under the CoS Programme Special Needs groups are:</td>
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<td>• people from Aboriginal and Torres Strait Islander communities</td>
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<td>• people from culturally and linguistically diverse backgrounds</td>
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<td>• people who live in rural and remote areas</td>
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<td>• people who are financially or socially disadvantaged</td>
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<td>• veterans</td>
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<td>• people who are homeless, or at risk of becoming homeless</td>
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<td>• people who are lesbian, gay men, bisexual, transgender and intersex</td>
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<td>• people who are care leavers</td>
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<td>• parents separated from children by forced adoption or removal.</td>
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<td>Volunteers</td>
<td>A volunteer is defined, for the purposes of this Programme Manual, as a person who:</td>
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<td>• is not a staff member;</td>
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<td>• offers his or her services to the service provider;</td>
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<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; and</td>
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<td>• has, or is reasonably likely to have, unsupervised interaction with clients.</td>
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<tr>
<td>WH&amp;S</td>
<td>Work Health and Safety.</td>
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