Support at Home Funding Explained | Bloom Healthcare

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Details:

Support at Home funding can feel confusing at first. There are classifications, quarterly budgets, service categories, contributions, care management, short-term pathways, equipment funding and provider pricing, and most people meet all of it at once at a difficult moment.

The underlying idea is simpler than the vocabulary. Funding is based on what an older person is assessed as needing in order to keep living safely at home. Once someone is assessed and approved, they are assigned a funding classification or pathway, and that funding is used to buy approved services.

Information in this article is current as at November 2026. Individual approvals, funding and service arrangements depend on assessed needs and current Australian Government requirements.

It starts with an aged care assessment

Nobody chooses their own funding level. The first step is to apply for an aged care assessment through My Aged Care , online or by calling 1800 200 422 .

The assessment looks at the person's strengths, the areas they are finding difficult, their goals, and their ageing-related care needs. If they are eligible, a support plan is developed setting out the services they are approved for under the Support at Home service list.

This is worth being clear about: no provider decides funding , and no provider can get someone a higher classification. A provider can supply evidence that informs a support plan review, but the decision sits with the assessment process.

Ongoing classifications and the quarterly budget

For ongoing services, Support at Home uses eight funding classifications . The classification reflects the person's assessed level of care need, and funding is provided as a quarterly budget covering three months.

How much a person receives depends on their classification. Some unspent budget can be carried over from the previous quarter, up to a set limit — which is useful to know, because it means a quiet quarter is not entirely lost, but also that the budget is not an account that accumulates indefinitely.

What the budget pays for

The budget pays for the approved services in the person's care plan and individualised budget, across three categories.

Clinical supports may include nursing and allied health — occupational therapy , physiotherapy , exercise physiology , speech pathology , psychology and counselling and dietetics .

Independence services may include personal care, respite and transport.

Everyday living services may include domestic assistance, home maintenance and repairs.

The category matters because the contribution rules differ. The Department of Health, Disability and Ageing states that participants do not contribute to the cost of clinical supports . Most participants will contribute to independence and everyday living services depending on their circumstances, which are assessed on income, assets and pension status.

Why provider prices matter

Each Support at Home provider sets its own prices for services and care management, and those charges come out of the person's quarterly budget. Providers are required to publish their full price list.

The practical consequence is that the same funding buys different amounts of service depending on what is being charged. When comparing providers, it is worth asking:

What services am I approved for?

How often will they be delivered?

What does the provider charge for each?

How much of the quarterly budget will each service use?

Will there be a personal contribution, and for which services?

The short-term pathways

Support at Home also includes pathways that sit outside the ongoing quarterly budget.

The Restorative Care Pathway provides coordinated allied health and nursing services to help someone regain function and delay the need for longer-term care. It is often the right pathway after a decline in function, an illness, an injury or a hospital stay.

The End-of-Life Pathway supports people in the last stage of life.

The Assistive Technology and Home Modifications (AT-HM) scheme funds equipment and changes to the home. Its funding is separate and upfront , separate from the ongoing services budget. See what the AT-HM scheme covers .

Where allied health fits

Allied health sits in clinical supports. In practice that means the disciplines that address function — mobility, balance, daily activities, communication, swallowing, nutrition, psychological wellbeing — are the part of the package most directly aimed at keeping someone independent at home.

It also means allied health is the part a participant does not contribute to. That is worth knowing, because people sometimes decline an assessment they are entitled to on the assumption it will cost them.

Care management, and what it costs you

Care management is the coordination work: arranging services, reviewing the plan, liaising with clinicians and keeping the arrangement on track. It is funded from the same budget as services, which means it is not free in the sense people sometimes assume — it consumes part of the quarterly allocation.

That is not an argument against it. Coordination done well is often what makes the rest of a package work, particularly where several services and clinicians are involved. But it is worth asking your provider how much of the budget care management will use, what it covers, and who specifically will be doing it.

Reading a monthly statement

The statement is the only place where the whole picture is visible: what was delivered, what it cost, what was drawn from the budget, what contribution was charged and what remains.

Three things are worth checking each month. Were the services actually delivered as recorded? Does the pricing match the published price list you were given? Is the remaining budget tracking in a way that will last the quarter? A problem is much easier to fix in month one than in month three.

When a hospital stay changes things

Function often drops after an admission, and the support that suited someone beforehand may no longer fit. This is one of the clearest triggers for a support plan review, and it is also where the Restorative Care Pathway is designed to help, because a short, intensive period of coordinated allied health can recover function that would otherwise be lost permanently.

Raise it early rather than waiting to see how things settle. Recovery work is generally more effective closer to the event.

Where Bloom Healthcare fits

Bloom does not decide anyone's Support at Home funding. That is determined through the aged care assessment and the government process.

What Bloom provides is the allied health that may form part of an approved support plan: physiotherapy , occupational therapy , exercise physiology , speech pathology , psychology and counselling and dietetics .

The role is to turn funding and care plans into practical support that improves safety, function and quality of life at home. The Support at Home hub covers the programme, aged care services covers what each discipline does, and the aged care FAQs answer the questions that come up most often.

What to ask, and when

Ask at the assessment stage about everything you are finding difficult, not only the most obvious thing. An assessment can only approve what it hears about.

Ask your provider for the full price list, not a headline rate, and ask how much of your quarterly budget a proposed schedule will actually consume.

Ask about review if circumstances change. A fall, a hospital admission, a change in medication or a change in who is at home are all reasons to request a support plan review rather than waiting for a scheduled one.

How to start

Call 1300 771 465 , email hello@bloom-healthcare.com.au , or use the referrals page . Anyone can refer: the person themselves, a parent or carer, a GP or paediatrician, a support coordinator, a plan manager, a school, a SIL provider, another health professional, or a nominee or guardian.

Useful information to include is the person's age, the main concerns, any existing reports or assessments, relevant history, the goals that matter to the family, and the best contact details.

A member of the team will be in contact within 24 hours of receiving a referral. The referral is then triaged and matched to a clinician on capacity, location, skill set and the specific need. A welcome pack

and intake form follow, and nothing is scheduled until the intake form is completed and returned. Bloom aims to schedule the initial meeting within 5 business days where possible. Rates, hours, travel and reporting are set out in a service agreement that is discussed and signed before service delivery and billing begin.

If something is not working once services start, the feedback page explains how to raise it, the advocacy policy covers your right to an advocate, and the incident management policy sets out how incidents are handled and reported.

What is Support at Home?

Support at Home is the Australian Government's in-home aged care program designed to help older Australians remain independent, safe and well at home for as long as possible.

How does the Support at Home funding process begin?

The process begins with an aged care assessment through My Aged Care, which can be done online or by calling 1800 200 422. No provider decides funding levels. Funding is based on what the assessment determines an older person needs to keep living safely at home.

What does the aged care assessment evaluate?

The assessment evaluates the person's strengths and capabilities, areas they find difficult, their personal goals, and their ageing-related care needs.

What happens after someone is found eligible through the assessment?

Once eligible, a support plan is developed that outlines the services the participant is approved for under the Support at Home service list.

How many funding classifications does Support at Home use, and how is funding provided?

Support at Home uses eight funding classifications for ongoing services. Each classification reflects the person's assessed level of care need, and funding is provided as a quarterly budget covering three months of services.

Can unspent Support at Home budget carry over between quarters?

Yes, limited carry-over is permitted between quarters, so unspent budget can roll forward up to a set limit. This prevents a quiet quarter from being entirely lost, but the budget does not accumulate indefinitely.

What are the three service categories covered by the Support at Home quarterly budget?

Clinical Supports, Independence Services and Everyday Living Services. The category matters because contribution rules differ between them: participants do not contribute to Clinical Supports, and most contribute to the other two.

What services fall under the Clinical Supports category?

Clinical Supports may include nursing and allied health services such as occupational therapy, physiotherapy, exercise physiology, speech pathology, psychology and counselling, and dietetics.

What are the three short-term pathways?

Assistive Technology and Home Modifications, the Restorative Care Pathway, and the End-of-Life Pathway. They sit outside the eight ongoing classifications and are accessed through your aged care assessment.

Why do provider prices matter to my budget?

Because providers set their own prices, and the price charged is what draws down your quarterly budget. A higher hourly rate buys fewer hours of the same service. Prices must be reasonable and clearly explained, so ask for a full price list and compare like with like.

What should I look for on my monthly statement?

The services actually delivered, the amount drawn from your quarterly budget, any contribution charged, and what remains. Providers are required to be transparent about pricing, so ask about anything you cannot reconcile.

What happens if I go into hospital?

Tell your provider and My Aged Care. A hospital stay often changes what you need afterwards, and the Restorative Care Pathway exists to help regain function following a change in health. Quarterly budgets are designed to be adjusted as circumstances change.

How do I start?

Register with My Aged Care at myagedcare.gov.au or on 1800 200 422, have the assessment, receive your support plan, then choose a provider. Once you are approved, call Bloom on 1300 771 465 to arrange allied health services.