NDIS Services Questions | FAQs | Bloom Healthcare

Canonical: https://bloom-healthcare.com.au/faq/

Details:

The questions above answer what each therapy does. This section answers the other half: who pays, who decides, what happens when the funding runs out, what to do when a decision goes against you, and where the NDIS stops and Medicare or aged care starts. These are the questions that come up once you are actually in the system. Call 1300 771 465 if you want to talk any of it through.

Some of what follows depends on your individual plan. Where that is the case it says so, rather than guessing.

Who does what: plan manager, support coordinator, local area coordinator

These three are constantly confused, and getting them straight saves a lot of wasted phone calls.

Role	What they do	Who employs them
Plan manager	Handles the money. Pays provider invoices on your behalf, tracks your budget, gives you statements, and can refer you to services.	A plan management provider, funded in your plan
Support coordinator	Handles the services. Helps you understand the scheme, choose and connect with providers, and keeps multiple providers aligned. Does not deliver therapy.	A support coordination provider, funded in your plan
Local area coordinator (LAC)	Handles access and planning. Connects you to supports, helps you through assessment, and works with you at the planning meeting to build the plan.	The NDIA

A fourth role you may meet is the Early Childhood Partner , who does the LAC job for young children. LACs support children from about age nine, teenagers and adults.

If you need money moved or an invoice paid, that is the plan manager. If you need a provider found or two providers talking to each other, that is the support coordinator. If you need the plan itself changed, that starts with the NDIA.

What the NDIS will not pay for

Plans get declined or underspent because people assume the NDIS covers things it never covers. Four exclusions do most of the damage.

Anything that is another government system's responsibility. The NDIS will not fund what the health system should be funding. If you need treatment, that is health. If you need functional capacity built, that is disability.

Anything unrelated to your disability. Funding is for the additional support you need because of the disability, not general healthcare.

Day-to-day living costs not linked to disability support needs. Groceries, utilities and ordinary household expenses are not NDIS costs, even when money is tight.

Anything likely to cause harm or risk to you or to someone else.

The boundary that catches people most often is mental health. For psychosocial disability, the mental health system is generally responsible for clinical services, including diagnosis and treatment of symptoms. The NDIS is generally responsible for the non-clinical side: functional ability, independence, and social and economic participation. Treating or stabilising symptoms is excluded from the NDIS and belongs to the health system.

The same logic applies to physiotherapy. Recovery from surgery is usually a mainstream health responsibility, commonly through Medicare. Ongoing impact of a permanent disability, where it meets the NDIS criteria, may be NDIS-funded. The question is not what the therapy is, it is what it is for.

Eligibility questions that do not have a simple yes or no

I have a diagnosis but was told I might not be eligible. Diagnosis is not the test. Permanence and significant functional impact are. Two people with the same condition can get very different answers because the scheme looks at what daily life is actually like.

I have no diagnosis and my child is small. For children younger than 6, the NDIS early childhood approach supports developmental delay without a formal diagnosis. Children younger than 9 with permanent disability are covered. Early connections can also link families to some supports before an NDIS decision.

My child has mild to moderate needs and is under 9. From 1 October 2026, Thriving Kids services begin rolling out for children aged 8 and under with developmental delay or autism and low to moderate support needs. From 1 January 2028 that program reaches full scale and NDIS access changes for that group. Children with permanent and significant disability or high support needs stay with the NDIS. Children already on the NDIS before 1 January 2028 are intended to be assessed under the criteria that applied when they enrolled.

I am close to 65. You must be under 65 when you apply. After 65, aged care is the entry point through My Aged Care on 1800 200 422.

I am already on the NDIS and turning 65. You are not automatically moved into aged care. Existing NDIS participants continue receiving NDIS-funded services rather than being transferred to Support at Home. There can be some overlap for older Australians, and how it works for you depends on your individual situation, so confirm it with your planner or the NDIA on 1800 800 110 rather than assuming either way.

I am not a citizen. You need to be an Australian citizen, a permanent resident, or hold a Protected Special Category Visa, and be living in Australia.

I am regional or remote. There is no geographic eligibility test, but provider availability differs. Ask about telehealth and about which disciplines have clinicians near you.

Plan reviews, changes and running out of funding

Plans are normally reviewed annually , but that is not your only option.

A change of circumstances review can be requested at any time. Reasons that support one include a health decline, a new diagnosis, a change in living arrangements, or goals that have shifted. You do not have to wait for the scheduled review date.

Evidence is what moves it. Submit updated assessments with the request. A functional capacity assessment or updated therapy report that documents what has changed, and links it to daily activity, does far more than a description of how you feel about it. Incomplete evidence is the main cause of slow processing.

Do not wait until the budget is empty. If your funding is going faster than expected, raise it early, with your plan manager or support coordinator first and with the NDIA if a plan change is needed. What options exist once a budget is genuinely exhausted depends on your individual plan and circumstances; there is no general rule. Contact your plan manager or support coordinator, or the NDIA on 1800 800 110.

Ask your therapist for the reports early. An end-of-plan report should summarise the therapy provided, the outcomes achieved and recommendations for the next plan. It cannot be written the week before your review meeting.

If you disagree with an NDIS decision

There are two stages.

Internal review. Ask the NDIA to reconsider its own decision. This is your chance to put forward information that was missing and to challenge the reasoning. Many decisions change here.

External review. If you are still not satisfied, the decision can be appealed to the Commonwealth tribunal that reviews NDIS decisions, generally within 28 days of the internal review outcome. Time limits are strict and the name of the tribunal has changed in recent years, so confirm the current body and the deadline with the NDIA on 1800 800 110 or with a disability advocacy service before you rely on a date.

Advocacy services can help at either stage, and providers are required to cooperate with advocates.

NDIS, Medicare or aged care: which one is yours

	NDIS	Medicare	Aged care (Support at Home)
Who	Permanent, significant disability, applied under 65	Anyone with a GP referral and an eligible condition	65+, or 50+ for Aboriginal and Torres Strait Islander people
Entry	NDIA, 1800 800 110	Your GP	My Aged Care, 1800 200 422
What it funds	Capacity building, core supports, capital supports	A capped number of rebated sessions per calendar year	Clinical supports, independence services, everyday living services
Therapy category	Usually Capacity Building, Improved Daily Living	Better Access, or GP Chronic Condition Management Plan	Clinical supports are fully funded by government
Limits	Reasonable and necessary test, plan budget	Up to 10 individual and 10 group mental health sessions a year; up to 5	Contributions may apply to non-clinical categories

		allied health services under a chronic condition plan, or 10 for Aboriginal and Torres Strait Islander patients	
Purpose	Building functional capacity	Treating a diagnosed condition	Staying independent at home

Under Better Access, referrals are usually written in blocks of up to 6 sessions and then up to 4 more, and the annual count resets on 1 January. From 1 November 2025, Mental Health Treatment Plan preparation, referrals and reviews are linked to your MyMedicare-registered practice or your usual medical practitioner, with exceptions for direct psychiatrist or paediatrician referrals. Patients with a GP management plan or team care arrangement made before 1 July 2025 can keep using it until 30 June 2027.

Costs, travel and service agreements

What you pay is set out in your service agreement, within the NDIS Pricing Arrangements and Price Limits for NDIS participants. Get it in writing before you sign.

Clinician travel to your home or community location is charged against your plan. The NDIS caps how much provider travel can be claimed, and the cap is higher for regional locations than metropolitan ones. Telehealth carries no travel cost. Scheduling appointments on the same day as other participants in your area reduces the travel share allocated to you.

Notice periods for changing or cancelling an appointment, and any charge that applies, are set out in your service agreement within the same NDIS pricing rules. Ask the intake team on 1300 771 465 to confirm the terms that apply to you. Figures published on other providers' websites are not Bloom's.

Assessments before you have a plan are generally paid by the applicant, because there is no plan to claim against. Bloom's NDIS Access Readiness Package covers this stage with a consultation plus a brief functional capacity assessment report across the NDIS eligibility domains and funding recommendations for a first plan. Current pricing is confirmed before you book.

Non-face-to-face time such as report writing, planning and liaison with your other providers is real work and is claimable. So are multidisciplinary care team meetings, because progress on complex goals is not achievable by disciplines working separately.

Common questions about funding, plans and eligibility

Does having an NDIS plan mean therapy is free?

It means it is paid from your plan rather than by you, up to the budget in the relevant category. It is not unlimited. Session costs, non-face-to-face time and clinician travel all draw on the same budget, which is why the mix of in-person and telehealth matters.

Which budget pays for therapy?

Usually Capacity Building, under Improved Daily Living. Some allied health can be funded from Core Supports where it directly supports daily functioning. Equipment, assistive technology and home modifications come from Capital Supports. Positive behaviour support generally requires Improved Relationships funding in the plan.

Can I use both Medicare and the NDIS?

They fund different things rather than topping each other up. Medicare funds treatment of a diagnosed condition. The NDIS funds building functional capacity related to a permanent disability, and specifically excludes treating or stabilising symptoms. Talk to your GP and your planner about which applies to which need.

Do I need a referral?

Not for NDIS therapy. If you have an active plan with capacity building funding you can refer yourself. Medicare-rebated psychology does require a referral and a Mental Health Treatment Plan or equivalent. Aged care requires a My Aged Care assessment.

What if my plan is NDIA-managed?

You must use registered NDIS providers. Bloom is registered. The provider claims directly through the NDIS portal, so no invoice comes to you.

Can I change providers mid-plan?

Choice of provider is yours. What notice you need to give is in your service agreement with your current provider, so read that before you move.

My plan is about to expire and nothing has been organised. What do I do?

Contact your support coordinator or LAC immediately, and ask your therapists for their end-of-plan reports now rather than later. The report needs to explain the therapy provided, outcomes achieved and recommendations for the next plan.

My circumstances have changed badly. Do I have to wait for the annual review?

No. You can request a change of circumstances review at any time. Send updated assessments with it. A significant health event, a new diagnosis, a change in living arrangements or changed goals all support one.

My access request was refused. Is that final?

No. Ask for an internal review by the NDIA first, adding whatever evidence was missing, particularly evidence that links the condition to daily functional impact. If that fails there is an external appeal path with a strict time limit, so check the current tribunal and deadline with the NDIA on 1800 800 110.

Who pays for the assessment I need to apply?

Generally you do, because there is no plan yet. This surprises people and it is worth budgeting for. Ask Bloom about the NDIS Access Readiness Package on 1300 771 465.

What happens to my NDIS plan when I turn 65?

Existing participants are not automatically moved to Support at Home and continue receiving NDIS-funded services. How it works in your case depends on your individual circumstances. Confirm

with your planner or the NDIA before making any change.

Can I get aged care allied health without a Home Care Package?

Support at Home replaced the Home Care Packages Program from 1 November 2025. Register with My Aged Care on 1800 200 422 and get an ACAT or Regional Assessment Service assessment. The Commonwealth Home Support Programme also continues as entry-level support.

Is travel charged if I come to a clinic?

No. Travel charges apply to the clinician coming to you. Clinic-based appointments are considered case by case, and telehealth removes travel cost entirely.

Who can I complain to if something goes wrong?

Raise it with your clinician or with Bloom on 1300 771 465 or through the feedback form . You can complain anonymously and you can have an advocate act for you. If it is not resolved, the NDIS Quality and Safeguards Commission handles complaints about registered providers independently.

How do I start with Bloom?

Call 1300 771 465 , email hello@bloom-healthcare.com.au, or make a referral . Have ready the person's age, the main functional difficulties, any existing reports, the top three goals, an NDIS number if there is one, and a preferred session location. Someone contacts you within 24 hours.

Information about NDIS rules, Medicare items and aged care programs on this page comes from the National Disability Insurance Agency, Services Australia and My Aged Care. Several rules referred to here change between 2026 and 2028, and program details are still being finalised in places. Confirm anything that affects a funding decision with your planner, plan manager, GP, or Bloom on 1300 771 465.

More background

About Bloom Healthcare — who Bloom supports, where, and how to start

All services and locations

Pricing and funding streams

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