Support at Home Changes from 1 October 2026 | Bloom

Canonical: https://bloom-healthcare.com.au/blog/support-at-home-funding-changes-october-2026/

Details:

Support at Home has been running since 1 November 2025 , when it replaced the Home Care Packages Program and the Short-Term Restorative Care Programme. Since then the programme has continued to be adjusted, and the changes that took effect from 1 October 2026 affect how some services are categorised and therefore what participants contribute towards them.

Information in this article is current as at November 2026. Contribution arrangements depend on individual circumstances and current Australian Government requirements — check the participant contributions page or ask My Aged Care about your own situation.

Why the service category matters

Support at Home groups services into three categories, and the category determines the contribution rules.

Clinical supports. The Department of Health, Disability and Ageing states that participants do not contribute to the cost of clinical supports. Its published description of clinical support services names nursing, physiotherapy and personal care.

Independence services and everyday living services. Most participants contribute to these, with the amount depending on an assessment of income, assets and pension status.

That is the whole mechanism. A service moving between categories changes what a participant pays, without anything about the service itself changing.

What this means in practice

If a service you receive has moved into clinical supports, the practical effect is that your contribution towards it should no longer appear. If you are still being charged a contribution for a service you believe is now a clinical support, that is a question for your provider and, if needed, for My Aged Care.

The place to check is your monthly statement . It should show the services delivered, the amounts drawn from your budget, and any contribution charged. If the statement does not make that clear, ask for it to be explained — providers are required to be transparent about pricing and what is charged.

What has not changed

Several things people assume change at these moments have not.

The assessment pathway. Access still begins with an aged care assessment through My Aged Care on 1800 200 422 . No provider decides funding.

The eight ongoing classifications and the quarterly budget. Funding for ongoing services is still allocated by classification and provided as a quarterly budget, with limited carry-over between quarters.

The AT-HM scheme. Assistive technology and home modifications still run through a separate, upfront funding pathway, and all home modifications must still be prescribed by an occupational therapist. See

what the AT-HM scheme covers .

The short-term pathways. The Restorative Care Pathway and the End-of-Life Pathway continue to sit outside the ongoing budget.

Allied health. It remains within clinical supports, which is why allied health has been the part of a Support at Home package that participants do not contribute to.

Why categories move at all

It can look arbitrary from the outside, but the logic is about what a service is for rather than who delivers it. Services aimed at clinical need — assessment, treatment, and the care that depends on clinical judgement — sit in clinical supports. Services aimed at making daily life manageable sit in independence or everyday living.

As the programme settles, services get reclassified when the original placement does not match that logic in practice. For participants, the visible effect is on contributions rather than on what is delivered.

What to tell a family member who helps manage your care

Where an adult child or another family member helps with the administration, make sure they know three things: that the monthly statement is the document that matters, that providers must publish their prices, and that My Aged Care on 1800 200 422 is the independent line when a provider's answer does not resolve a question.

With consent, a family member can be included in conversations about services and reports. Bloom can share information with family, a Care Partner, a registered provider or a GP through the agreed pathway, and consent is confirmed at intake rather than assumed.

What to do if something looks wrong

Read the monthly statement rather than only the invoice total. The detail is where a problem becomes visible.

Ask your provider to explain any contribution charged, and against which service category.

Ask for the full price list if you have not seen one. Providers are required to publish their prices.

Call My Aged Care on 1800 200 422 if the answer does not make sense. This is what the line is for.

Request a support plan review if your needs have changed rather than waiting for a scheduled one.

If you need support to raise a concern, an advocate can help — see the advocacy policy for how that works and who can be involved. If something has gone wrong with a service Bloom provides, the feedback page explains how to raise it.

Three questions worth asking this quarter

"Which category is each of my services in?" Ask it service by service rather than in general. The answer determines what you contribute, and a provider should be able to give it without hesitation.

"How much of my quarterly budget is committed?" Between services and care management, a budget can be more committed than it looks. Knowing the figure in the first month of a quarter leaves room to adjust; knowing it in the last month does not.

"Has anything about my situation changed since the assessment?" Falls, a hospital admission, a change in medication, a change in who is at home, or simply a gradual decline all justify a support plan review. The assessment that set your classification reflected a moment in time, and nobody will notice

that it has gone out of date on your behalf.

If you are helping an older person with this

Start from function rather than from the programme. What is becoming harder at home? Is the person falling more often, struggling to shower safely, becoming weaker after a hospital stay, having difficulty swallowing, or becoming reluctant to leave the house?

Those answers determine which services should be prioritised and what capability to look for. They are also what an allied health referral actually needs: current functional concerns, recent health changes, falls, existing assessments and the outcomes the person wants at home.

Where allied health fits after the change

Nothing about the clinical case for allied health changes with a contribution rule. The disciplines that address function remain the ones most directly aimed at keeping someone independent at home:

Physiotherapy for mobility, balance, falls prevention and recovery

Occupational therapy for daily activities, home safety, equipment and modifications

Exercise physiology for strength and endurance

Speech pathology for communication and swallowing

Psychology and counselling for wellbeing, adjustment and confidence

Dietetics for appetite, weight and nutrition

What a change in contribution rules does affect is the decision-making. People decline assessments they are entitled to because they assume a cost, and a service they do not contribute to is worth asking about rather than ruling out.

Where Bloom Healthcare fits

Bloom does not decide anyone's Support at Home funding or contributions. It provides the allied health that may form part of an approved support plan, and it can explain what a service involves and what it is intended to achieve.

The Support at Home hub covers the programme, aged care services covers each discipline, Support at Home funding explained covers classifications and budgets, and the aged care FAQs answer the questions that come up most often.

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 this Bloom Healthcare article about?

The article explains what changed for Support at Home participants from 1 October 2026, how the service categories affect participant contributions, and what participants should check on their own monthly statement.

What did Support at Home replace, and when did it start operating?

Support at Home has been operating since 1 November 2025, when it replaced the Home Care Packages Program and the Short-Term Restorative Care Programme.

What changed in Support at Home from 1 October 2026?

From 1 October 2026, significant changes took effect affecting how services are categorized under Support at Home, which in turn affected what participants contribute towards those services.

What are the three service categories under Support at Home?

Support at Home groups services into three categories: Clinical Supports, Independence Services, and Everyday Living Services. Each category determines the participant contribution arrangements.

Do participants contribute towards clinical supports?

No, participants do not contribute to clinical supports. The Department of Health, Disability and Ageing identifies clinical support services as including nursing, physiotherapy, and personal care.

Is allied health considered a clinical support under Support at Home?

Yes, allied health services remain within clinical supports, which is why allied health has continued to be the part of a Support at Home package that participants do not contribute to.

Do participants contribute to Independence Services and Everyday Living Services?

Most participants contribute to these categories, and the contribution amount depends on an assessment of their income, assets, and pension status.

What happens to a participant's contribution if a service is reclassified into clinical supports?

When a service moves into clinical supports, participants should no longer be charged a contribution for that service.

What should a participant do if they believe they are being incorrectly charged after a service reclassification?

If a service has been reclassified and the participant believes they are still being charged incorrectly, this should be raised with their provider and, if necessary, with My Aged Care.

What document should participants check to track changes in their Support at Home contributions?

The monthly statement is the critical document for tracking these changes. It should clearly show the services delivered, amounts drawn from the budget, and any contribution charged, since providers are required to be transparent about pricing.