Care finder service eligibility

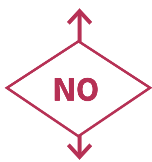
Please consider when referring to care finders:
This service is intended for older people who need intensive support to access My Aged Care and other relevant supports in the community who could otherwise fall through the cracks

Is the person:

- 65 years and over, or 50 years and older for an Aboriginal or Torres Straits Islander person, **OR**
- 50 years or older (45 years or older for Aboriginal or Torres Strait Islander people) and on a low income and homeless or at risk of being homeless.

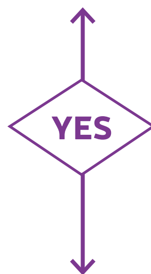
AND

- Does the person require help (either with an aid or assistance from another person) to undertake one or more tasks of daily living (e.g. walking, dressing, preparing meals, making decisions, eating, managing medication, managing with house work, transportation, social connections) **OR** they are frail or prematurely aged and are experiencing housing stress/not having secure accommodation.



DOESN'T MEET ELIGIBILITY CRITERIA

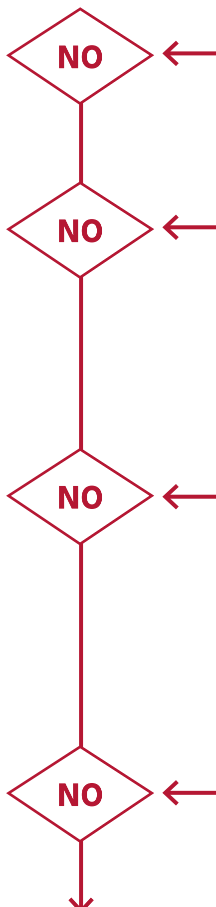
Other services may be available



Care finder target population - should meet this threshold:
Is the person without family, friends, carer or a representative they would be comfortable to receive help from and who is willing and able to help them access aged care services?

MEETS ELIGIBILITY CRITERIA

And ONE or more of the below

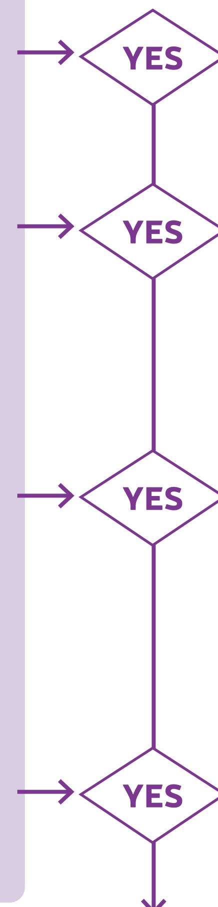


Does the person experience communication barriers such as limited English language or literacy skills?

Does the person experience difficulty processing information to make decisions?

Is the person's **safety at immediate risk** or they may end up in a **crisis situation** (within approx. the next year) but they are also **resistant to engaging** with aged care? (if a person has identified their safety is at immediate risk, connect them with the appropriate emergency service)

Does the person have past experiences that mean they are hesitant to engage with aged care, institutions or government?



DOESN'T MEET ELIGIBILITY CRITERIA

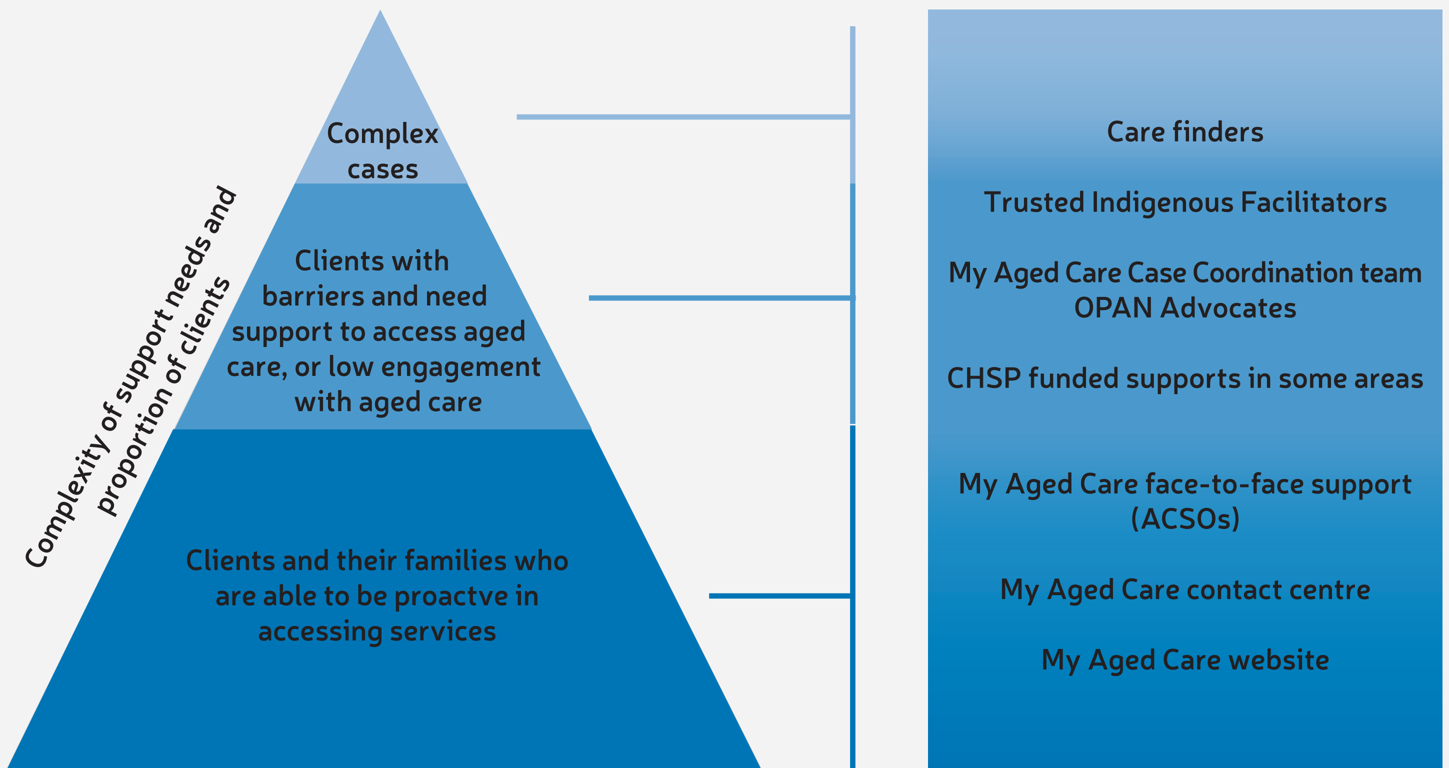
Other services may be available

MEETS ELIGIBILITY CRITERIA

For care finder

Referral pathways for support to access aged care

The referral pathways assist staff to find the most suitable services to provide support to older people to access aged care and other supports in the community



The referral pathways are for staff in the following services:	
My Aged Care contact centre	Care finders
My Aged Care Specialists Officers (ACSO)	Trusted Indigenous Facilitators
Assessors	Aged Care services
Health Professionals	Advocates
Primary Health Networks	Other community services

There are three levels of support to access aged care services (and other supports in the community)

Meet **Mary**

About Mary

Meet Mary

- Mary is 82, her husband died five years ago and her three children have all moved away. She has **deteriorating hearing** and has been diagnosed as being in the **early stages of dementia** by her GP. Her GP has said she can get help through My Aged Care but Mary thinks this means she will have to go into a home so has not called. She speaks to her children regularly but is not willing to admit she is **having trouble keeping the house clean** and has not told them about her diagnosis. She is **less connected** to her community now and is not confident to drive. She doesn't know how to use a computer or have access to the internet.

Engagement

- When Mary visits **the GP**, the GP asks if she'd like to be contacted by someone called Louise from [organisation] who could help her get support to stay at home for as long as posssible. Mary says ok.
- **Louise calls Mary and introduces herself** as the person the GP said would call and arranges a time to visit the talk about how she can help.
- **Louise visits Mary and they have a chat** over a cuppa. Louise tells Mary about herself.

Supporting the process

- Mary says she could do with some **help to clean the house** and Louise says she might be able to get some help with cleaning. She asks if Mary would like to see what she is eligible for. Mary agrees.
- They **complete the apply for an assessment online form together** on Louise's iPad and Mary is happy to nominate Louise as her 'agent'.
- Louise asks Mary if she would like her to **be there for the assessment** and Mary is keen to have her there. She is assessed as eligible for transport and social support.

Post-assessment

- Mary **completes the means test form with support** from Louise at her home and they call Services Australia together to work out answers to some of the questions
- They look for local providers together on the My Aged Care website and make appointments for them to visit. **Louise helps Mary choose providers and understand the agreements**.
- They also call the National Dementia Helpline together and learn about a local support group for people living with dementia.

Check-in

- After a month, Louise calls Mary to **see how things are going.**
- Mary says the transport to the social group is working well but **doesn't like** that she gets a different care worker each visit and they don't come at the time they say they will. Last week she cancelled the service.
- Louise arranges a time to visit Mary and **they talk about Mary's concerns.**
- Louise suggests they could **talk to the provider about the issues** and Mary agrees.

Follow up

- They call the provider but they **can't resolve the issue**.
- Louise asks Mary if she would like to be in touch with an advocate to help but Mary doesn't want to talk to anyone else.
- Louise suggests that Mary could **change provider** and Mary agrees.
- They call one of the other providers in the area who promises to only send two different care workers on to be on time. **They set up the service together.**
- Louise checks in again a few weeks later and all is going well. She **checks in** around every three months after that.

Meet **John**

About John	**Meet John** • John is 66, he has experienced **mental health issues** all his life, he has not been able to work for many years and has lived with his sister most of his adult life. His sister is in her seventies and has recently moved into residential aged care and given up her rented flat. He doesn't have **any financial support** from the Government as he is **afraid** of them knowing his business but his sister can no longer support him. He has moved in with an old friend as a **short-term solution** but she doesn't have much space.
Engagement	• John's friend calls the **local council** and explains John's circumstances without giving his name, and asks about how he can get more permanent housing. She is given the number of a **local care finder organisation**. • She calls and describes the situation. **A care finder called Pete** calls her back and offers to talk to John. • John agrees to talk on the phone and is reassured that Pete says he doesn't need to give any personal information. • After many conversations, including at his friend's place, John says **he wants to visit his sister at her care home regularly**.
Supporting the process	• Pete says John can get transport through **My Aged Care** but, while they're arranging that, a volunteer from his organisation can drive him there. • John is really happy and soon after agrees to reconnect with his **GP for a medication review**. A few weeks afer seeking support from his GP, John is feeling well and interested in more help. • Pete helps him **apply for financial support** through Services Australia and social housing. This takes some time as John remains fearful of providing information. • Eventually **John moves into social housing**.
Post-assessment	• Pete suggests John might benefit from some further support such as **help with cleaning** and a **social group.** • John is wary of people coming into his space but he acknowledges he would like the help and have more company. • They apply for an **assessment on the My Aged Care website** and promises he will be there when the assessor comes. Pete ensures the assessor is aware of John's fears before the meeting. • After the assessment, **Pete helps John contact local providers** and over a few months gets the services organised.
Check-in	• After a **couple more months**, Pete calls John to see how he is going. • John is still living in the apartment but is **no longer getting cleaning or going to the social group**. • Pete offers to **come around to talk.** When he gets there, John says the cleaner stopped coming and he doesn't know why. • Pete calls the provider and is told the apartment is too cluttered and dirty for the cleaner. • John says he left the support group after a few visits because he had nothing in common with the others.
Follow up	• With John's consent, **Pete arranges** a deep clean of the apartment through a hoarding and squalor specialist provider and they **work with John on strategies** to avoid the same situation. • Pete also talks to the cleaning provider about coming more frequently and helping John to decide what to throw away at each visit. • Pete **explores other options** for community support and puts John in touch with a local men's shed. John thinks this will be a better fit for him. • Pete **stays in regular touch** with John and **helps adjust his support** as needed.

Meet **Amir**

About Amir

Meet Amir

- Amir is 74, he is an **Arabic speaker with no immediate family and limited supports**. Both his **physical and mental health were compromised** and he had a recent history of falls. He is living in a private rental property that was **not suitable** for his needs.

Engagement

- **Amir's friend** called **Merri Outreach Support Service** (MOSS) where he had been a previous client of their Assistance with Care and Housing program.
- When **care finders first contacted Amir** he was not aware that his friend had referred him to the program, but was very grateful for the contact. He agreed to an in-person assessment of his needs and **an interpreter was engaged for this meeting.**
- At assessment Amir disclosed that his **health was severely compromised;** he was suffering from osteoarthritis with nerve compression, diabetes, reduced muscle strength and weakness in his feet. There had been several hospital admissions over the preceding 6 months, due to falls. On one occasion Amir had spent 4 hours trying to get out of the bath, following a fall onto the bath taps.
- Amir had been in his rental property for 30 years but there was **no possibility of modifying the bathroom** for his needs.

Supporting the process

- Amir had received personal care support following his last hospital admission, but this support was only **short term and had ended**. Amir was **not confident** to contact My Aged Care directly to discuss the possibility of continuing this support.
- With **Amir's approval**, care finders contacted the previous service provider to check if there was capacity to re-engage. The service provider advised that the support was short term and Amir needed to go through MAC for re-assessment.

Post-assessment

- **Care finders assisted Amir** to contact MAC and referred him for assessment.
- Amir was well linked for his medical needs but his housing was clearly unsuitable and he required immediate assistance to source suitable alternative accommodation. Care finders contacted the Department of Families, Fairness and Housing and discovered that a public housing application had been approved for Amir in 2011.
- Through internal MOSS networks, care finders learnt of a vacant property that would be suitable for Amir. **This property was modified**, with a free-standing shower and support rails in the bathroom. The property was **located in an area that he was familiar with** and there was also support onsite that Amir could access for any issues that might arise during his tenancy.
- To assist with the move, **care finders sourced funds for the moving costs and engaged Amir's nephew to assist** with the packing of Amir's personal items.
- After moving into his new home, Amir was introduced to the **support service** on-site via a warm referral and care finders updated his new address with MAC.

Check-in

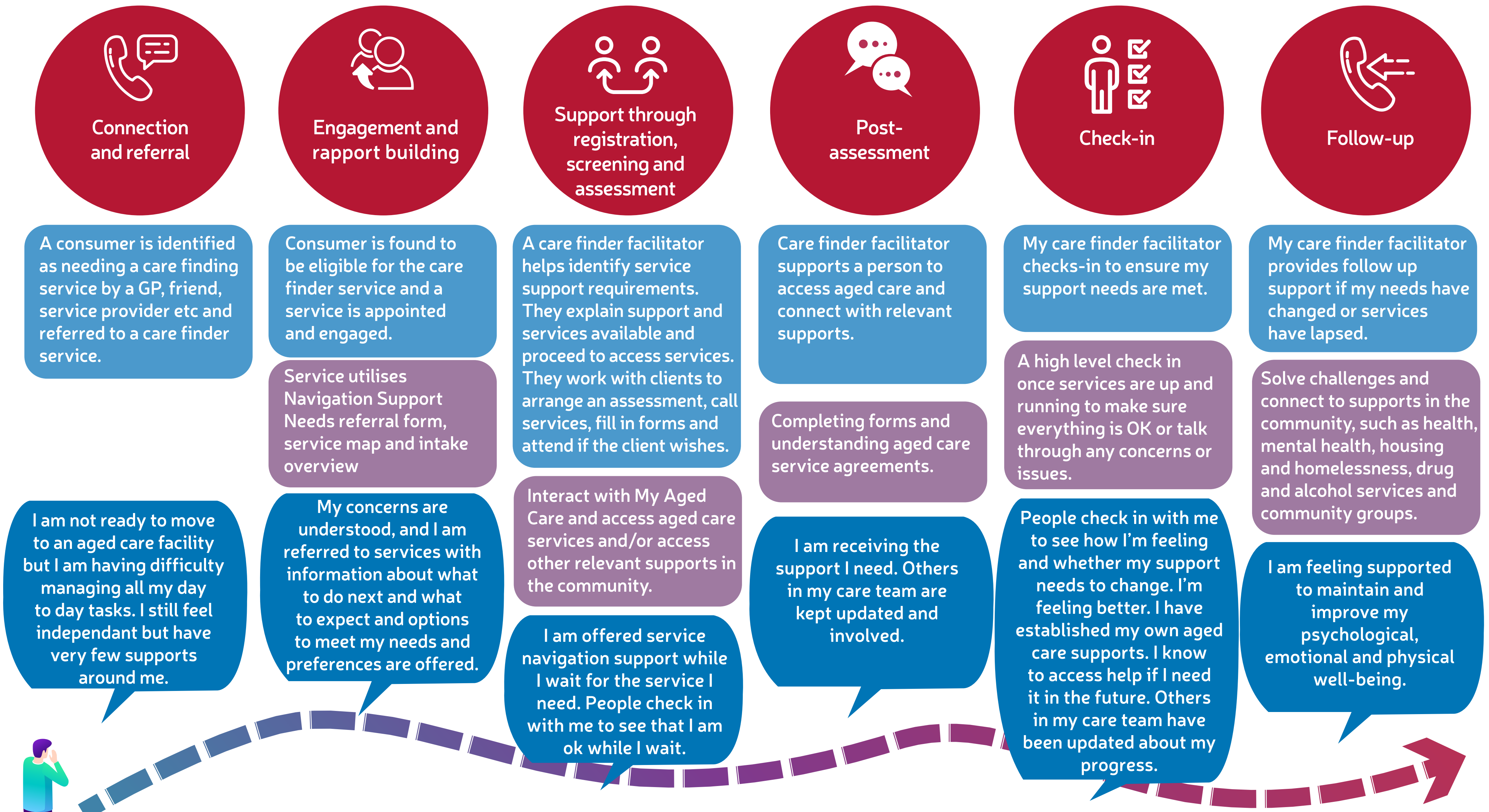
- Care finders are **regularly checking in with Amir** to ensure that he is confident to connect with the supports on-site, where needed. Care finders are also monitoring his referral to My Aged Care and will maintain contact with him through MAC assessment and post-assessment, to assist him with choosing service providers if required.

Care finder service navigation providers

Location (LGA)	Organisation	Service name	Email	Contact details	Website	Specialising in
Banyule	healthAbility	Service connector	contact@healthability.org.au	9430 9100	healthability.org.au	Care finder navigation service
Banyule	MOSS*	HSAP	connections@merri.org.au	9359 5493	merri.org.au	Homelessness & risk of homelessness
Banyule	Wintringham	Outreach Services	adviceandinfo@wintringham.org.au	9034 4824	www.wintringham.org.au	Homelessness & risk of homelessness
Boroondara	healthAbility	Service connector	contact@healthability.org.au	9430 9100	healthability.org.au	Care finder navigation service
Boroondara	Salvation Army	Home Care	hssreferrals@salvationarmy.org.au	9890 7144	www.salvationarmy.org.au	Homelessness & risk of homelessness
Knox	Care Connect	Care connect	referralenquiries@careconnect.org.au	1800 692 464	www.careconnect.org.au	Care finder navigation service
Knox	Wintringham	Outreach Services	adviceandinfo@wintringham.org.au	9034 4824	www.wintringham.org.au	Homelessness & risk of homelessness
Knox	Villa Maria	HCC	marisa.servaes@vmch.com.au	0408 368 428	vmch.com.au	Homelessness & risk of homelessness
Manningham	Care Connect	Care Connect	referralenquiries@careconnect.org.au	1800 692 464	www.careconnect.org.au	Care finder navigation service
Manningham	MIC		carefinder@miceastmelb.com.au	9275 6906	miceastmelb.com.au	CALD
Manningham	Salvation Army	Home Care	hssreferrals@salvationarmy.org.au	9890 7144	www.salvationarmy.org.au	Homelessness & risk of homelessness
Maroondah	Care Connect	Care Connect	referralenquiries@careconnect.org.au	1800 692 464	www.careconnect.org.au	Care finder navigation service
Maroondah	Wintringham	Outreach Services	adviceandinfo@wintringham.org.au	9034 4824	www.wintringham.org.au	Homelessness & risk of homelessness
Mitchell	DPV Health	Aged Care Assist	intake@dpvhealth.org.au	1300 234 263	www.dpvhealth.org.au	Care finder navigation service
Monash	Care Connect	Care connect	referralenquiries@careconnect.org.au	1800 692 464	www.careconnect.org.au	Care finder navigation service
Monash	MIC		carefinder@miceastmelb.com.au	9275 6906	miceastmelb.com.au	CALD
Monash	Salvation Army	Home Care	hssreferrals@salvationarmy.org.au	9890 7144	www.salvationarmy.org.au	Homelessness & risk of homelessness
Monash	Wintringham	Outreach Services	adviceandinfo@wintringham.org.au	9034 4824	www.wintringham.org.au	Homelessness & risk of homelessness
Murrindindi	healthAbility	Service connector	contact@healthability.org.au	9430 9100	healthability.org.au	Care finder navigation service
Nillumbik	MOSS*	HSAP	connections@merri.org.au	9359 5493	merri.org.au	Homelessness & risk of homelessness
Nillumbik	Wintringham	Outreach Services	adviceandinfo@wintringham.org.au	9034 4824	www.wintringham.org.au	Homelessness & risk of homelessness
Nillumbik	healthAbility	Service connector	contact@healthability.org.au	9430 9100	healthability.org.au	Care finder navigation service
Whitehorse	healthAbility	Service connector	contact@healthability.org.au	9430 9100	healthability.org.au	Care finder navigation service
Whitehorse	MIC		carefinder@miceastmelb.com.au	9275 6906	miceastmelb.com.au	CALD
Whitehorse	Salvation Army	Home Care	hssreferrals@salvationarmy.org.au	9890 7144	www.salvationarmy.org.au	Homelessness & risk of homelessness
Whitehorse	Villa Maria	HCC	marisa.servaes@vmch.com.au	0408 368 428	vmch.com.au	Homelessness & risk of homelessness
Whitehorse	Wintringham	Outreach Services	adviceandinfo@wintringham.org.au	9034 4824	www.wintringham.org.au	Homelessness & risk of homelessness
Whittlesea	DPV Health	Aged Care Assist	intake@dpvhealth.org.au	1300 234 263	www.dpvhealth.org.au	Care finder navigation service
Whittlesea	MOSS*	HSAP	connections@merri.org.au	9359 5493	merri.org.au	Homelessness & risk of homelessness
Whittlesea	Wintringham	Outreach Services	adviceandinfo@wintringham.org.au	9034 4824	www.wintringham.org.au	Homelessness & risk of homelessness
Yarra Ranges	Care Connect	Care connect	referralenquiries@careconnect.org.au	1800 692 464	www.careconnect.org.au	Care finder navigation service

MIC = Migrant Information Centre | MOSS = Merri Outreach Support Service | HSAP = Housing Support for the Aged Program | HCC = Housing and Care Connections

Care finder service consumer journey



NOTE: Aged care providers are responsible for meeting client's changing needs.
Care finders' role is to confirm this is happening in not duplicating providers roles.