



Townsville
Hospital
and Health
Service

Transition Care Program

Client information

This booklet provides important information about the Transition Care Program.

It explains what you can expect when you are receiving care and the obligations of your Transition Care Service.

This booklet also provides information to support the formal agreement between you and the Townsville Hospital and Health Service Transition Care Program as required by the *Aged Care Act 2024*.



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What is the Transition Care Program (TCP)?

Transition Care provides short-term care and support for older people after leaving hospital. The program provides you with low level therapy and support to help you continue your recovery safely at home while long-term care arrangements are made if needed.

Where will I receive TCP?

Care and support can be provided:

- In your own home, or
- In the home of a friend or carer until you can return to your own home.

How long will I stay on the program?

Your TCP starts the day you leave hospital. Most people stay on TCP for about 8 weeks. The maximum time you can stay on the program is 12 weeks. In exceptional circumstances you can be approved for an extension and stay on TCP for a further six weeks. Your case manager will plan a discharge date with you once you have started on the program.

What is a Case Manager?

A case manager is one of our TCP team members who will help you (and your carer and/or supports) from the time you start on the program to when you finish. Your case manager will help you identify your goals and care needs once you are at home and will coordinate your therapy and support whilst you are on the program.

As you progress on the program and your long-term care needs can be identified, your case manager will help you to access these supports and transition you from the program to new service providers.

What care and services can I receive under TCP?

There is a range of services that TCP can provide. The exact care and services you receive will be based on your specific needs and goals.

The TCP is not a form of rehabilitation, but can include services such as:

- Case management
- Nursing support
- Domestic assistance (eg cleaning, laundry support)
- Meal assistance (help to prepare or serve meals – note: prepared meals are not provided)
- Help with showering
- Community access assistance (eg Shopping, accessing medical appointments)
- Low intensity allied health therapy
- Continence aids
- Loaned personal alarm and/or medical aid equipment (note: all equipment loaned to you by the TCP is to be returned when you are discharged from TCP).

Not everyone will need every service. Hospital and TCP staff will discuss with you what they recommend in consideration of the goals you (or your representative) have identified, and what can be provided with the available funding.

How often the TCP team members will visit you, and which staff will visit, will depend on your care plan and the services and supports you require.

The full range of care and services that can be provided are listed in the National Transition Care Programme Guidelines.

Loan equipment

You may be loaned equipment to help you at home.

You are responsible for taking reasonable care of any loan equipment supplied to you and must only use it for the purpose for which it was provided. You are also responsible for reporting any loan equipment faults to the TCP in a timely manner.

The loan equipment is owned by the supplier and must not be removed from the delivery address without prior approval from the TCP. If you no longer require the equipment or your transition care services are stopped, the equipment will be collected from you.

You may be invoiced by THHS to pay for any loss or damage to loan equipment. If you need equipment long-term, your case manager can help arrange this.

What services are not included?

The cost of general medical services such as pathology, radiology, medications and GP appointments are not covered.

If you require a meal delivery service for a short time when leaving hospital or were using a meal delivery service before your hospital stay, then you will continue to pay for this yourself.

If you need to use public transport or a transport provider to participate in social activities, you will need to pay for this yourself. Your case manager can help you to arrange this service if not already in place.

Day respite or in-home respite is not covered. If you were previously participating in day respite activities or receiving in home respite care, these services can continue under your existing arrangements.

What will I need to pay?

Townsville Hospital and Health Service receives funding from the Queensland and Australian governments, which covers most of the cost of the program; however, you are also asked to pay a fee to contribute to the cost of your care.

The Commonwealth Government sets the maximum amount you will be asked to pay which is calculated as follows:

- Home based – daily rate of 17.5% of the current single aged pension.
- Bed based – daily rate of 85% of the current single aged pension.

Generally, TCP is not covered by private health insurance. Depending on your health fund, your TCP fees may be covered. The TCP staff will be able to advise you of this.

If you are unable to pay the fee due to financial hardship, you can ask to pay a reduced amount that you are able to afford.

You cannot be refused TCP services because you are unable to pay due to financial hardship. Your TCP Fees can be reviewed and discussed with your case manager at any time.

How are fees collected?

Townsville Hospital and Health Service will send you an invoice. You will receive an invoice every two weeks.

Can I take a break from the program?

Once you have been on the program for at least one day, you are able to take up to seven days break, in total, from the TCP for hospital or social reasons.

Your break days can be taken together, or as single days. Leave does not change your TCP end date and you will still be required to pay for the days you are on leave.

If your leave from TCP is greater than 7 days in total, you will be discharged from TCP.

What happens if I return to hospital during the program?

If you return to hospital whilst you are on the TCP. Please let your case manager know. Our team can then talk with you and your treating team at hospital to discuss your return to TCP if it is appropriate.

What if I already receive aged care services?

You can receive TCP while also receiving support from the Commonwealth Home Support Programme (CHSP) or Support at Home (SaH) provided there is no duplication of services between CHSP or SaH.

It is your responsibility to notify your SaH or CHSP service provider of your intention to enter transition care, and we may talk with your provider to coordinate service and ensure your needs are met.

You will not however be able to access supports via the new Restorative Care Pathway while receiving transition care services.

What happens if my care needs change?

It is expected that your care needs will change while you are receiving TCP. As your health needs change you may require less or different services. This will be reviewed regularly with your case manager.

If TCP is no longer able to meet your care needs, your TCP will finish and your case manager will help you to arrange alternative support services. These arrangements will be confirmed in writing.

You may choose to leave the program at any time but where possible we ask you to provide enough notice to your case manager so that your discharge plan can be finalised.

What are my rights and responsibilities?

To inform you of your rights and responsibilities, we will provide you with copies of the following information brochures and we will assist you to understand them:

- Aged Care Statement of Rights
- My Healthcare Rights
- Aged Care Code of Conduct
- Collection of your My Aged Care ID
- Privacy and access to your medical record
- Do you have a concern or complaint? (How to make a complaint to the Aged Care Commission)
- Please tell us (How to make a complaint to THHS)
- Role and function of aged care advocates

We also ask that you:

- respect the rights of the TCP team to work in a safe and healthy environment
- care for your own health and well-being, as far as you are capable
- work to achieve your goals as agreed in your transition care plan
- let the TCP team know about any required changes to your care plan or agreement
- provide information to the TCP team about your wants and needs

- let the TCP team know of any special requirements
- provide constructive feedback to the TCP team about the service's performance; and
- contribute to the cost of care where appropriate.

Setting goals and participating:

When you start on the program, you will be asked to set goals that you wish to achieve. These goals are important in planning and focusing your care and therapy and will be reviewed during your time on the program. We ask you to actively participate in the program.

Staying safe at home:

A home safety assessment will be conducted by staff during the first visit and advice provided by staff to improve your safety at home.

Who will be provided with information about me?

With your consent, Information regarding your health, care needs and services will be shared with you GP, other health professionals and relevant service providers so your care plan needs are met.

Information is also required by the Commonwealth Department of Health, Queensland Health and the Townsville Hospital and Health Service for funding and evaluation purposes. Your personal information will be used and disclosed in accordance with relevant privacy legislation.

Townsville Transition Care Program is bound by the Australian Privacy Principles under the *Privacy Act 1988* (Commonwealth) and the National Privacy Principles Information *Privacy Act 2009* (QLD). These laws are about how health service providers collect, use, disclose and store your personal information. All reasonable steps will be taken to protect the confidentiality, so far as legally permissible, of information provided by you or your representative.

What is advanced care planning?

Advance care planning is the process of planning for your future health and personal care whereby your values, beliefs and preferences are made known so they can guide clinical decision making at a future time if you cannot make or communicate your decisions.

Your case manager can:

- have a conversation with you about advance care planning
- provide you with information about advance care planning
- support you to have a conversation with your GP, family and friends about what in life is important to you
- Assist you to understand the steps in preparing and formalising and advance care directive.

More information can be found at – www.advancedcareplanning.org.au

What is the serious incident response scheme (SIRS)?

The TCP must notify the Aged Care Quality and Safety Commission (the Commission) of certain reportable incidents that happen while delivering you TCP services.

A serious incident that must be reported could be:

- Unreasonable use of force – like kicking, punching or rough handling
- Unlawful sexual contact or inappropriate sexual contact – like stalking, making sexual advances or unwanted sexual touching
- Psychological or emotional abuse – like yelling, name calling or ignoring
- Stealing or financial coercion by a staff member – like stealing money or pressuring you to give money
- Neglect – like not giving you the care you need to stay well
- Inappropriate use of restrictive practices – like using physical force or medication to restrict your freedom or movement
- Missing consumers – where a care recipient goes missing
- Unexpected death – like someone dying unexpectedly because they did not receive proper care and services.

What if I have a concern or a complaint?

You have the right to make a compliment or complaint at any time. Our team respond to complaints promptly and confidentially. We recommend that you discuss your concerns with your case manager. However, if you are unable to raise your complaint with your TCP service provider or are not satisfied with the outcome of your complaint, you may wish to raise your complaint with:

The TCP Manager on (07) 4433 4500

You can also contact the Patient Feedback Service at Townsville Hospital and Health Service or an external agency to outline your concern:

Patient Feedback Service on (07) 4433 1074 or email: THHS-Feedback@health.qld.gov.au

Office of the Health Ombudsman on 133 646 (free call, 9am to 4.30pm Monday to Friday) or www.oho.qld.gov.au.

Aged Care Quality and Safety Commission on 1800 951 822 (free call, 9am to 5pm Monday to Friday)

If you require information, assistance or someone to speak on your behalf at any time during your transition care, you can contact:

National Aged Care Advocacy Network (OPAN) on 1800 700 600 (free call) or visit opan.org.au

Translating and Interpreting Service (TIS National) on 131 450

What is an Advocate?

An advocate is a person who:

- Takes the time to listen and understand your views and wishes
- Helps you understand your rights and responsibilities
- Helps you to look at all your options and make informed decisions
- Supports you to raise your concerns including helping to write a letter or speak about your concerns at a meeting
- Speaks on your behalf if you don't feel that you can speak for yourself.

An advocate can assist you to plan your transition care services by helping to establish or review your recipient agreement, request a fee reduction and raise any complaints you may have on your behalf.

If you have feedback

You will be provided with a client satisfaction form at the end of your program. This gives you an opportunity to tell us about your experience of TCP. We welcome your suggestions on how we may improve the service for you and future clients.

Transition Care Program

**Townsville Hospital and Health Service
PO Box 670, Townsville QLD 4810**

Phone: (07) 4433 4500

Fax: (07) 4433 4501

Email: TSV-transition_care_program@health.qld.gov.au