SDA eligibility in the NDIS

Applying the legal tests to Myalgic Encephalomyelitis

Niti Prakash

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THE DISTINCTION

SDA is the building—not daily living support

SDA

Housing to support people with extreme functional impairment or very high support needs.

Other home & living supports

- SIL
- ILO
- Home modifications
- Assistive technology

Participant may need both SDA and person-to-person supports—but each must satisfy its own test.

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Four design categories answer four different needs

Improved Liveability	Better physical access plus enhanced sensory, cognitive or intellectual liveability.
Fully Accessible	High physical accessibility for significant physical impairment.
High Physical Support	Fully Accessible features plus structural provision for hoists, automation and emergency power.
Robust	Resilient materials and features that reduce risk from complex or challenging behaviours.

Building type and design category are separate decisions

01

Apartment

02

Villa / duplex / townhouse

03

House (up to 3 residents)

04

Group home (4–5 residents)

The plan should identify category, building type and location. Occupancy and bedroom configuration must be justified individually.

SDA eligibility has two cumulative requirements

1	**Threshold — rule 11(a)**	Extreme functional impairment under rule 12 OR very high support needs under rule 13
2	**SDA needs — rule 11(b)**	SDA combined with other supports must satisfy the comparative outcomes and value-for-money test in rule 14

After eligibility

Rules 15–18 determine the appropriate building type, design category and location. These are later determinations if the above two threshold tests are satisfied.

Requirement 1: Threshold test

Extreme functional impairment

- Extremely reduced capacity in mobility, self-care or self-management
- Very high need for person-to-person support even with AT, equipment or modifications

Very high support needs

- Immediately available or constant person-to-person support
- Required for a significant part of each day
- Or longstanding supported accommodation creates barriers to transition

Requirement 2 asks: what does this particular building change?

Feature	Functional consequence	Outcome / avoided cost
Automation	Controls doors, blinds, lights and climate from bed	Conserves energy; may reduce direct assistance
Accessible bathroom / hoist provision	Safer transfers and semi-reclined care	Reduces falls, injury and two-person handling
Single-resident setting	Controls sound, light, odour, infection and sleep disruption	Prevents PENE and makes supports sustainable
On-site support space	Support immediately available without constant intrusion	Balances safety, privacy and cost

What must SDA achieve that other supports alone cannot?

Rule 14 consideration	Example for a person with severe ME
Better assists the person to pursue their stated goals	A goal to live more independently is supported by automation, an accessible layout and environmental controls that reduce reliance on another person.
More effective and beneficial for function, capacity and skills	A low-stimulation, temperature-controlled dwelling reduces avoidable exertion and sensory load, helping the person complete essential self-care within their energy envelope.
Reduces future support needs and supports life transitions[1]	Appropriate housing may reduce deterioration caused by unsafe transfers or unsuitable accommodation and support transition from an unsustainable family arrangement.
Provides greater stability and continuity of support[2]	An accessible dwelling with space for supports may make essential assistance safer and more reliable during severe or fluctuating episodes.
Represents better value for money	Compare SDA plus other supports with ordinary housing plus modifications, additional staffing, informal care and the foreseeable cost of risks or failed arrangements.

[1] Applies where the pathway is very high support needs. [2] Applies where the pathway is extreme functional impairment.

For ME, variability must be quantified—not averaged away

A ‘good day’ snapshot can materially understate support need.

- Frequency: how many good, bad and crash days?
- Duration: how long does PENE last after a task?
- Latency: record consequences 12–48 hours later
- Assistance: setup, prompting, standby, partial or full physical help
- Risk: falls, inadequate nutrition/hydration, toileting delay, inability to evacuate
- Sustainability: what happens when informal support is unavailable?

A strong application is a coordinated evidence package

1. Participant / nominee	Housing goal, preferences, lived experience, daily logs and risks
2. Treating team	Diagnosis, impairments, permanence, treatment history and prognosis
3. OT / allied health	FCA, 24-hour support profile, feature-to-need analysis and alternatives
4. Support coordinator / providers	Roster evidence, incident data, informal support sustainability and options explored
5. NDIA	Considers evidence; may request more; decides eligibility, category, type and location

Build the OT report around the decision-maker’s questions

- Current living arrangement, goals and why change is needed
- Diagnoses, permanent impairments and treatment / optimisation history
- Function in mobility, self-care and self-management—including fluctuation and PENE
- 24-hour support profile: frequency, duration, ratio, active / standby / overnight and risks
- Required design features, category, building type, occupancy and location
- Alternatives tested: ordinary rental, social housing, AT, modifications, SIL / ILO—and why insufficient
- Outcomes, risk reduction, independence and value-for-money comparison
- Clear recommendations tied to evidence sources; identify limitations and information gaps

ME access cases: prove the precise missing element

JSMP [2026] ARTA 770

Accepted Neurological impairment plus cognitive processing, memory, executive, sensory and PEM effects.

Failed s 24(1)(b): insufficient current, verified evidence addressing treatment scope, outcomes and whether impairment required further review. No FCA.

Crewes [2025] ARTA 695

Accepted Permanent ME/CFS impairment and global reduction in function.

Failed s 24(1)(c): evidence did not establish substantially reduced capacity in a specific statutory activity through a practical task-level assessment.

A diagnosis—and even significant hardship—does not fill an evidentiary gap in a cumulative test.

Flack: each part of the SDA outcome needs proof

Accepted	**HPS + sole occupancy + separate OOA**	Specific needs and SDA entitlement were established / conceded
Not accepted	**Freestanding house + second bedroom**	No evidence a house better controlled sensory exposure; OOA avoided duplicated carer space; storage did not justify a bedroom
Accepted	**Broader Victorian locations**	Expanded search improved the prospect of finding suitable SDA without material pricing difference
Support model	**OSS averaging 2.5 direct hours/day**	Existing 12 hours flexible 1:1 retained; 24/7 1:1 not shown to be value for money

The successful submission is not simply 'I need SDA'—it proves category, building type, occupancy, bedrooms, OOA, location and supports separately.

Article 19 strengthens—not replaces—the SDA case

UNCRPD Article 19

The equal right to live in the community, with choices equal to others—including where and with whom to live.

Use it to frame:

- choice and control
- avoiding forced shared living
- privacy, dignity and community inclusion
- why the least-restrictive workable option matters

Then return to the statutory evidence: threshold + SDA needs + funding criteria.

Access lists are going—but not tomorrow

Now

Current access criteria and operational lists continue while transition work occurs.

January 2028

New applicants begin a standardised, evidence-based functional capacity access process.

Following 3 years

Existing participants are expected to be reassessed progressively under the new access approach.

Removal of diagnosis-based streamlining affects NDIS access. It does not abolish the separate SDA Rules test.

Will standardised assessments capture ME accurately?

The risk

- One appointment captures a prepared-for or unusually good day
- Completing a task once is treated as sustainable capacity
- Delayed deterioration occurs after the assessor has left
- Averaging conceals severe days, crash days and recovery time

What the assessment must record

- Function across a representative period
- Delayed consequences, recovery time and repeatability
- Help, prompting and activities sacrificed to complete the task
- Longitudinal evidence, collateral evidence and reasonable adjustments

Functional capacity is what a person can do reliably, repeatedly and sustainably—not what they can demonstrate once.

Confirmed: new access assessments are intended from 1 January 2028. Still being developed: the tools, thresholds and detailed procedures.

The internal guide shows how ME evidence may be tested

- List A / B status only streamlines parts of access
- Decision tree focuses on each s 24 element
- Evidence must identify impairment—not merely diagnosis
- Treatment must be addressed before permanence
- Function must be substantial across the statutory domains

ME-specific opportunity

The attached internal research paper recognises PENE, orthostatic intolerance, sensory and cognitive effects, fluctuating function and major limits on daily and social participation.

But internal guidance is not law.

SUCCESS TIPS

Six avoidable reasons an SDA case becomes harder

× Diagnosis-led case	→ Start with impairment, function and support intensity
× Feature wish-list	→ Link each feature to an outcome, risk or avoided support
× Averaged function	→ Quantify good, bad and crash days plus delayed PENE
× ‘Single occupancy preferred’	→ Prove why sharing is unsafe, ineffective or unsustainable
× No alternatives analysis	→ Compare ordinary housing, AT, modifications and other supports
× Inconsistent reports	→ Reconcile hours, ratios, risks and recommendations before filing

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The core submission

This person needs this specialised dwelling—not merely housing—because…

- their impairment causes extreme functional consequences or very high daily support needs;
- the identified design features change safety, independence or support delivery;
- ordinary housing, modifications and other supports do not adequately meet the need; and
- the proposed category, building type, occupancy and location satisfy the funding criteria.

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Contact Info

- Website: www.disabilitysolutionsandoutcomes.com.au
- Email: niti@disabilitysolutionsandoutcomes.com.au
- Phone: 0404 288 983