



Australian Government



myagedcare

Assessor Portal User Guide 6 - Completing an Assessment

Aged care needs assessors (assessor) can conduct assessments using the Integrated Assessment Tool (IAT) via:

- The assessor portal (this guide), the Aged Care Assessor app and uploading information onto the assessor portal when the assessor next has internet connectivity, a printed or blank copy of the IAT and entering information onto the assessor portal after the assessment has been undertaken.
- This user guide outlines the different assessors role for non-clinical (who are able to complete home support assessments) and clinical (who are able to complete comprehensive assessments) assessor role in the system.
- If you have only been assigned an organisation or outlet administrator role, you will not be able to view or complete assessments in the assessor portal.
- For more information about completing an assessment see the [Integrated Assessment Tool \(IAT\) User Guide](#).



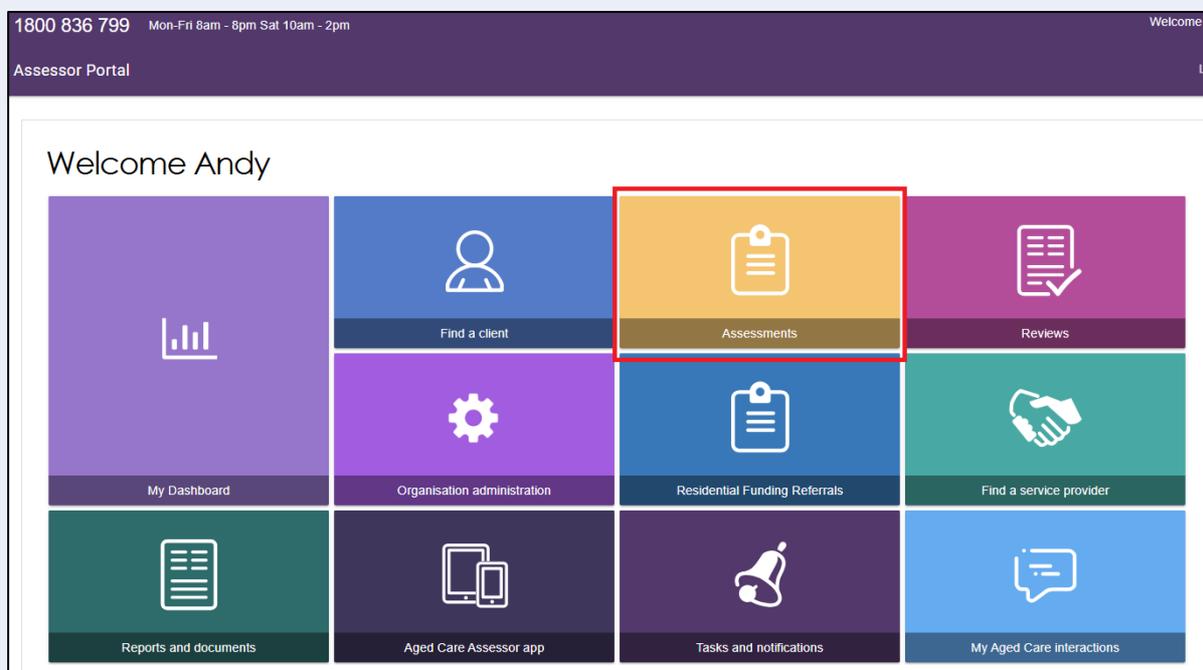
This guide is divided into sections as follows:

Viewing assessments.....	2
Starting an assessment.....	4
Completing an assessment.....	13
Assessment features.....	13
Clinical attendance (non-clinical assessor).....	15
Viewing and adding carers in the assessment	19
Adding a Sensitive Attachment in the assessment.....	22
Navigating the Validated Assessment Tools	26
Modified De Morton Mobility Index (DEMMI) and Residential Respite Care (Clinical assessor)	28
Saving an assessment.....	30
Finalising an assessment.....	32
Cancelling an assessment	36

Viewing assessments

To view an assessment, follow the steps below.

1. Select **Assessments** on the homepage.



2. From the Assessments page, Needs assessors will be able to see the assessments assigned to them in **Current assessments**.

The **Current assessments** tab contains assessments that may have the following statuses:

- Triage not started



- Assessment not started
- Assessment in progress
- Assessment completed but not yet finalised
- Assessment awaiting delegate decision (not applicable for reviews); and
- Have had a Delegate decision completed, but not finalised (not applicable for reviews).

Current assessments

Current assessments | Recent assessments

Filter by

Sort by: Assessment Priority | In order of: High to Low | GO

Current sort order is Assessment Priority

Assessment Not Started

- Mark JUNE**
Aged care user ID: AC15704125
Date accepted: 20 September 2024
Completed Triage due by: 23 September 2024
Comprehensive | 14 days overdue
Assessment Not Started | Medium
- Alistair SHARP**
ASHBURTON, VIC, 3147
Aged care user ID: AC75276568
Date accepted: 20 September 2024
Completed Triage due by: 23 September 2024
Home Support | 14 days overdue
Assessment Not Started | Low
- Patricia PRATLEY**
HARGRAVES, NSW, 2850
Aged care user ID: AC25969296
Date accepted: 24 September 2024
Completed Triage due by: 27 September 2024
Comprehensive | 10 days overdue
Assessment Not Started | Low

Assessment In Progress

- Cheyenne (Cheyenne) DUKE**
KARRATHA INDUSTRIAL ESTATE, WA, 6714
Aged care user ID: AC60468064
Date accepted: 25 September 2024
Finalised Support Plan due by: 5 October 2024
- Kendall (Kendall) FITZSIMMONS**
CROSSLANDS, NSW, 2446
Aged care user ID: AC10176576
Date accepted: 25 September 2024
Finalised Support Plan due by: 5 October 2024
- Kendall (Kendall) FITZSIMMONS**
CROSSLANDS, NSW, 2446
Aged care user ID: AC11353992
Date accepted: 25 September 2024
Finalised Support Plan due by: 5 October 2024

! To view the next Key Performance Indicator milestone (for example, Finalised Support plan) and due date for an assessment, go to the client's referral card.

The **Recent assessments** tab contains finalised, cancelled and/or closed assessments. It also contains completed and cancelled Support Plan Reviews.

Recent assessments

Current assessments | Recent assessments

Filter by

Sort by: Assessment Priority | In order of: High to Low | GO

Current sort order is Assessment Priority

1 to 15 out of 15 matching results

Finalised

- Ginana BAKER**
BRUCE, ACT, 2617
Aged care user ID: AC16568693
Date accepted: 19 November 2019
Date completed/cancelled: 19 November 2019
Comprehensive | Assessment
Finalised | High
- James NEIL**
BELCONNEN, ACT, 2617
Aged care user ID: AC84737592
Date accepted: 21 February 2020
Date completed/cancelled: 21 February 2020
Comprehensive | Assessment
Finalised | Medium
- Ginny ALBERT**
BRUCE, ACT, 2617
Aged care user ID: AC16568693
Date accepted: 18 November 2019
Date completed/cancelled: 19 November 2019
Comprehensive | Assessment
Finalised | Medium
- Zahra HAROON**
FRANKLIN, ACT, 2913
Aged care user ID: AC95231478
Date accepted: 15 December 2019
Date completed/cancelled: 15 December 2019
Comprehensive | Assessment
Finalised | Medium



! Further information about using the sort and advanced filter functions can be found in the [My Aged Care – Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews](#).

Starting an assessment

1. To start an assessment, select a client from the **Assessment Not Started** heading, and then click the double arrow icon on the top right-hand corner of the **Client card**.

The screenshot shows the 'Current assessments' section of the Assessor Portal. It features a 'Filter by' section with a 'Sort by' dropdown set to 'Assessment Priority' and an 'in order of' dropdown set to 'High to Low'. Below this, there are two client cards under the heading 'Assessment Not Started'. The first card is for 'Ezekiel SCHWAB' from NAREMBURN, NSW, 2065, with an aged care user ID of AC44300275, accepted on 5 December 2022, and a completed support plan due by 14 January 2023. The card is marked as 'Comprehensive' and '492 days overdue'. The second card is for 'Olin VETTER' from HORNSBY, NSW, 2077, with an aged care user ID of AC27988559, accepted on 2 March 2023, and a completed support plan due by 11 April 2023. This card is also marked as 'Comprehensive' and '405 days overdue'. Both cards show 'Assessment Not Started' and a 'Low' priority. A red box highlights the magnifying glass icon in the top right corner of the Ezekiel SCHWAB card.

A summary of client information will be displayed. Assessors can access read-only versions of previous screening, triage and assessments, attachments relevant to the client's referral, and the client's support plan, if available.

! When opening the client card, the Support plan status will be marked as **Triage Completed**. Assessors will also be able to view relevant details of both triage and screening by selecting the magnifying glass icon.

Jeenie SMITH

Please confirm that Jeenie SMITH, 29 April 1950, 74 Years, AC33505270 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

Aged 74 (29 April 1950), Female

Referred from UAT LCHS - East Gippsland on 4 February 2025
Accepted on 4 February 2025

Preferences
No preference was recorded

Assessment details
FNAO-preference No
Assessment type Home Support
Assessment reason Self-Referral
Assessor Louie Hinson
Triage conducted by Elissa Mazur

Completed Triage due by 7 February 2025

Client story
No client story was recorded

Comments

Support plan ● Triage Completed 
Home Support Assessment ● Triage Completed 

- For comprehensive assessments, clinical assessors are able to indicate the assessment setting before starting the assessment.

To change the assessment setting, select the **Edit** (pencil) icon next to **Assessment Setting** when the client information is expanded.

Jules ANGELSTAR

Please confirm that Jules ANGELSTAR, 19 August 1950, 74 Years, AC82048372 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

Aged 74 (19 August 1950), Female, Identifies as: Aboriginal

Referred from GRAZIER AGED CARE Outlet ACAT-RAS on 6 February 2025
Accepted on 6 February 2025

Preferences
No preference was recorded

Assessment details
FNAO-preference Yes
Assessment type Comprehensive
Assessment reason Self-Referral
Assessment setting Hospital 
Assessor Africa Green
Triage conducted by Africa Green

Completed Triage due by 9 February 2025

Client story
No client story was recorded

Comments

Support plan ● Triage Completed 
Comprehensive Assessment ● Triage Completed 

[VIEW FULL CLIENT RECORD](#) [VIEW CLIENT REPORT](#)
[REFER URGENT SERVICES](#) [START ASSESSMENT](#)

The **Assessment setting** pop up will appear. Select **Hospital** or **Non-Hospital** and select **Save**.



The **Assessment setting** that is filled out here must match the value recorded in the [IAT](#). Clinical assessors must ensure that both fields are manually updated to reflect the same value if one is changed.

3. Please note, clinical assessors will have the ability to convert Home Support Assessments to Comprehensive Assessments prior to commencing an assessment. To change the assessment type select **CONVERT TO COMPREHENSIVE ASSESSMENT**.

The reason for the change will be auto-filled. Enter in addition context for the reason or comments about converting the assessment.

Non-clinical assessors who wish to convert the home support assessment to a comprehensive assessment will also be required to enter who the supervising clinical assessor is.

4. Once completed, select **YES, CONVERT ASSESSMENT** to continue.

Please note, once you convert to a comprehensive assessment you cannot change is back to a home support assessment.

Convert to comprehensive assessment ✕

You are about to convert the assessment type from Home Support to Comprehensive for Callone Convert.

Assessments should only be converted if the client's needs exceed the level of care that can be provided through Home Support assessments (e.g. home support services). Once this assessment has been converted to a Comprehensive assessment, you can recommend for all aged care services. Please note it will not be possible to revert it back to a Home Support assessment.

Are you sure you want to proceed?

All fields marked with an asterisk (*) are required.

Reason for change *
 High level care needs ▼

Reason or comments: * 0 / 255

Supervising assessor *

YES, CONVERT ASSESSMENT
NO, CANCEL

The assessment type will now reflect a Comprehensive Assessment.

5. The assessment type will now reflect a Comprehensive Assessment. When you are ready to start the assessment, select **START ASSESSMENT**.

Jules ANGELSTAR

i Please confirm that Jules ANGELSTAR, 19 August 1950, 74 Years, AC82048372 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

Aged 74 (19 August 1950), Female, Identifies as: Aboriginal

Referred from GRAZIER AGED CARE Outlet ACAT-RAS on 6 February 2025
 Accepted on 6 February 2025

Completed Triage due by 9 February 2025

Preferences
 No preference was recorded

Assessment details

FNAO-preference	Yes	
Assessment type	Comprehensive	
Assessment reason	Self-Referral	
Assessment setting	Hospital	
Assessor	Africa Green	
Triage conducted by	Africa Green	

Client story
 No client story was recorded

Comments

Support plan ● Triage Completed

Comprehensive Assessment ● Triage Completed

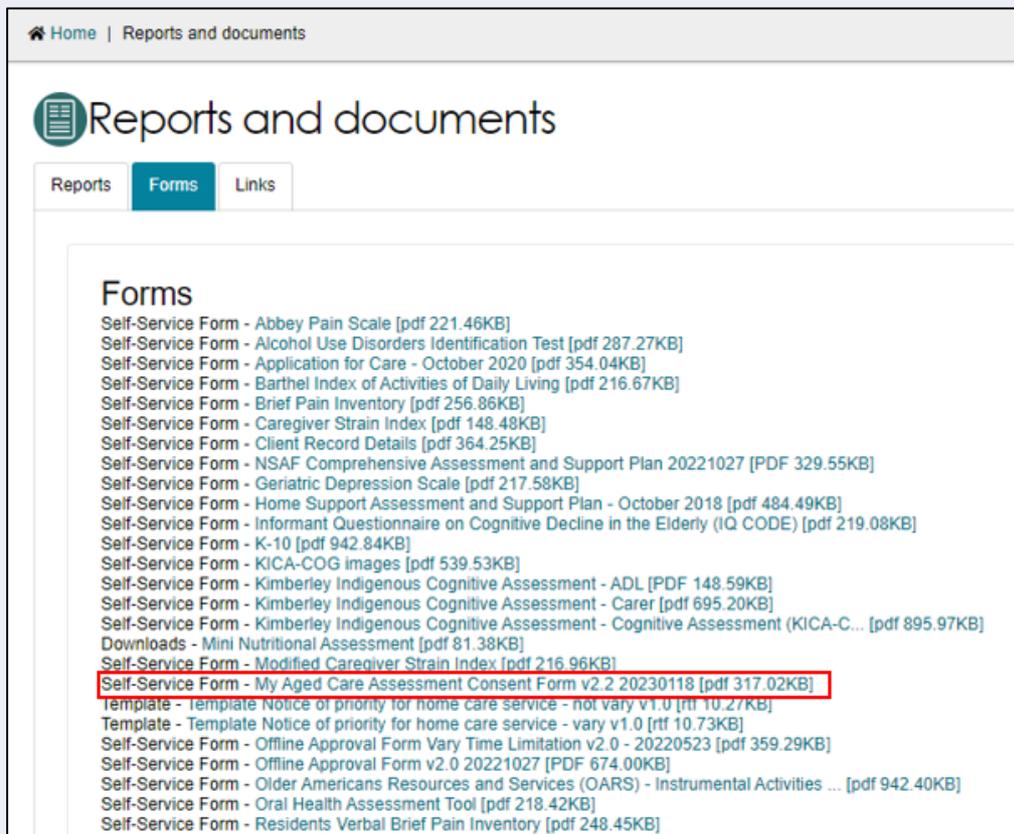
VIEW FULL CLIENT RECORD
VIEW CLIENT REPORT

REFER URGENT SERVICES
START ASSESSMENT

6. You will then be asked to record client consent. To do this, you will be required to read the



relevant consent script, which is in the **My Aged Care Assessment Consent Form**, to the individual and record their response. If there is a suggestion that the client lacks capacity for consent, complete this form with the client's confirmed authorised representative in My Aged Care. The **My Aged Care Assessment Consent Form** is available for download from the **Reports & Documents** tile of the assessor portal.



If consent is given, select the applicable consent options and then click **CONTINUE**. A signed copy of the Aged Care Assessment Consent form should be obtained during this step.



! If a client does not provide consent, a warning message will display advising assessors that the assessment cannot proceed. If this is the case, you must enter a reason as to why the assessment could not be completed. If the response is **'Other, please specify'** you will be required to enter free text. Selecting **SAVE AND CLOSE** will then cancel the assessment.

4. Before you start the assessment, you will be given the option to pre-populate the IAT.

For new clients who have not undertaken screening or have a previous assessment, you will have the option to pre-populate the IAT with their information from triage only. If the client has undergone screening, you can also select to pre-populate the IAT with their previous screening. Similarly, if the client has had a previous assessment you can select to pre-populate the IAT using that information.

Once you have selected the relevant pre-population options, select **CONFIRM SELECTION**.

If you do not wish to pre-populate the IAT select **Blank Assessment**.

! Please note, if you select **Blank Assessment**, you cannot reverse this decision during the assessment.

5. You will then be prompted to review and update information regarding the client's **Demographic details**, including whether this is a remote assessment, the client's personal details and background, if the client would prefer a First Nations Assessment Organisation for their assessment (if available) and any Government ID references such as the client's Medicare card number.

These details will be pre-populated from triage but can be edited if required. After confirming the correct details are entered, select **SAVE AND CONTINUE TO ASSESSMENT**.



Demographic details

All fields marked with an asterisk (*) are required.

Please check the following information for this client before starting the assessment. All fields must be completed before the assessment can begin.

Remote Assessment [?](#)

Personal details & Identification

First name *

Vivan

Middle name

Jayvion

Last name *

Mackey

Address:

Unit 15 656 2 MOWBRAY Road LANE COVE NORTH NSW 2066

Contact details:

0211150356

Medicare number:

41588991161

To change the above details,

[view the full client record.](#)

Background

Please enter the date of birth. If the date of birth is not known, please enter an estimated age in the Age field. This will then be used to automatically determine an approximate date of birth for the Client. *

Date of birth

21/02/1939

or

Estimated age

85

Gender *

Male

Country of birth *

Iran

Ethnicity *

Iranian

SAVE AND CONTINUE TO ASSESSMENT

CANCEL

! It is important to ensure that the client's Aboriginal or Torres Strait Islander identity is accurately captured, as this will trigger the system to display Validated Assessment Tools that are appropriate to use with First Nations people if required.

Does the client identify as an Aboriginal or Torres Strait Islander?

Indigenous origin:

No - Neither

Yes - Aboriginal

Yes - Torres Strait Islander

Yes - Both

Not stated/inadequately desc

! A client's Medicare card number must be correctly entered to ensure that their My Health Record can be successfully linked if they consent to do so.



Marital status *

Unable to determine

Accommodation type *

PR Client Owns/Purchasing

Lives with *

With family

Government ID references

Department of Veterans' Affairs (DVA) card number

Medicare card number

4 digits

5 digits

1 digit

Reference

SAVE AND CONTINUE TO ASSESSMENT

CANCEL



! Remote assessment should be selected when an assessment is conducted in a remote area. This is to help improve reporting and inform future decision making in consideration of this client demographic.

Geographical remoteness is defined using the Modified Monash Model (MMM). Based on this, remote assessments should only be selected where a face-to-face assessment is undertaken in a remote (MM6) or very remote (MM7) area.

You can check the MMM classification of a client's address on the [Health Workforce Locator](#). From the homepage select **Start the locator now** and enter the client's address. The MM will then be displayed in the **Summary** section.

Street Address LEVEL 1 160 ANN STREET, BRISBA

As at 16 May 2024

LEVEL 1 160 ANN STREET, BRISBANE CITY QLD 4000 was classified as:

Summary Classifications

District of Workforce Shortage for Specialists	
Anaesthetics	No
Cardiology	No
Diagnostic Radiology	No
General Surgery	No
Medical Oncology	No
Obstetrics & Gynecology	No
Ophthalmology	No
Psychiatry	No

Catchment: Brisbane Inner (30501)

Distribution Priority Area for GPs

JMGs / FGAMS	No
Bonded doctors	No

Catchment: Brisbane Inner

Modified Monash Model

2015	MM 1
2019	MM 1

ASCS Remoteness Areas

2011	Major Cities of Australia - RA Code 1
2016	Major Cities of Australia - RA Code 1
2021	Major Cities of Australia - RA Code 1

If an assessor needs to update a client's demographic details after they have commenced the assessment, they can do so from the **Client Details** tab of the Client Record.

Client details

Client summary Client details Support network Approvals Plans Attachments Services My Aged Care interactions Notes Tasks and Notifications

REFER THIS CLIENT FOR ASSESSMENT VIEW CLIENT RECORD

NOTIFY MY AGED CARE OF A DEATH

About Jane

Personal information

Born 29 April 1950. Identifies as: Aboriginal
Status: Active
Preference for a First Nations Assessment Organisation to do their assessment: Yes

To contact Jane

Contact details:

Primary Contact

This is who My Aged Care will contact first
Jane SHARPLAND (self)

Notification preferences

Current preferences:
No notification preferences found

Communication requirements

Address details

Home address
Service delivery address
Send any correspondence to

Identify documents (ID)

Aged Care ID: AC12140521

Identity Status

IMI Record status:	Not Attempted
Identity match status:	Not Attempted
Wallet check status:	Not Attempted
Client association status:	Not Attempted

Payment details

Receiving payments
No payments found

Health insurance

Private health insurance
No health insurance found

Service information

The following information is from the Department of Human Services claims system. It may take up to a month to be updated

Consent

Consent to share information with My Health Record: Permit by Jane sharpland (Self)

A record of any previous screenings or assessments will be accessible through the **Plans** tab of the client record under **Assessment history**.



Completing an assessment

! An algorithm is integrated into the IAT to ensure consistent client outcomes based on their needs. The algorithm will draw on assessment responses and the client's current care approvals, and recommend either the Commonwealth Home Support Programme (CHSP) or a Home Care Package (HCP). This will display in the **Support plan and services page** under the **Goals and Recommendations** tab after an assessor finalises the IAT.

Once you have commenced an assessment, the **Assessment Details** page will display. Key client information will be displayed at the top of each page of the assessment.

The screenshot shows the 'Assessment Details' page for Mrs Ezekiel Schwab. The client information at the top includes: 'Mrs Ezekiel SCHWAB', 'Female, 77 years old, 17 January 1947, AC44300275', 'Lot Number 263 9 WILLOUGHBY ROAD NAREMBURN, NSW, 2065', and 'Prefers to Speak Arabic'. The left navigation bar has 'Triage' selected with a checkmark, and 'Assessment Details' is highlighted. The main content area contains the following fields: 'Date of assessment *' with a date picker set to '30/05/2024'; 'Participants consulted prior to the assessment *' with 'Yes' and 'No' radio buttons; 'Mode of assessment *' with 'Face-to-face', 'Over-the-phone', and 'Via tele-health' radio buttons; and 'Assessment setting *' with a dropdown menu set to 'Please select...'. There is also a 'Details' text area at the bottom.

To view information that was collected during triage, you can select **Triage** from the navigation bar. This will open a read-only screen for viewing.

This screenshot is similar to the previous one, but the 'Triage' option in the left navigation bar is highlighted with a red box, indicating it is the selected view.

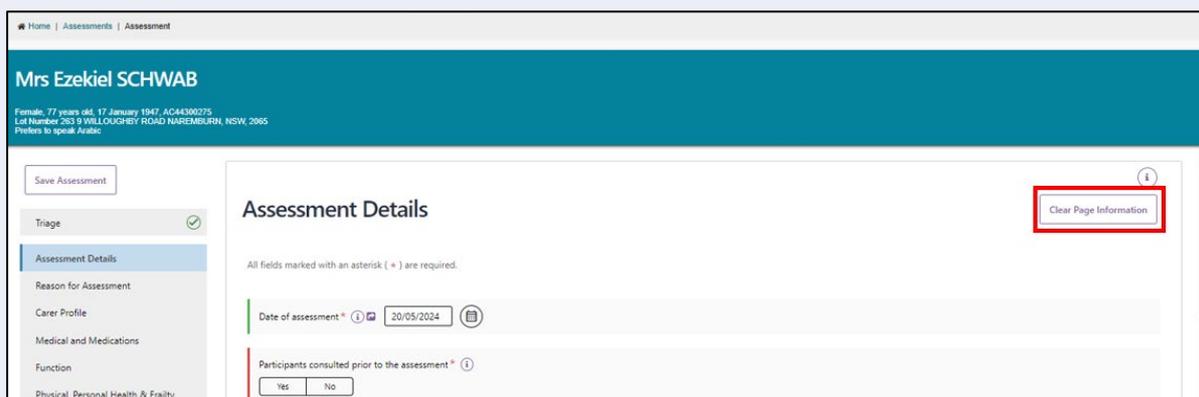
The navigation bar will move up and down the page as you scroll. A tick will display in the navigation bar to confirm completion.

! The system will time out due to inactivity if unused for a period of time to maintain the privacy of the information in the system. A warning banner will display if the session has been left unattended for 25 minutes. If the system remains inactive for a following 5 minutes you will automatically be logged out and will need to log in again to restart the assessment.

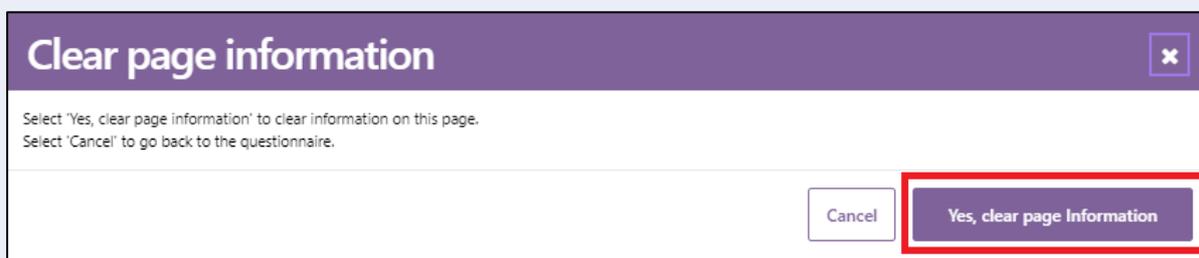
Assessment features



1. On each page of the assessment, you can clear entered information. This can be done by selecting the **Clear Page Information** on the top left-hand side.



A pop-up will then display. Select **Yes, clear page information**.



Please note, pages that do not contain Validated Assessment Tool triggering questions will only have the option to **Yes, clear page** and **cancel**. Whereas pages with Validated Assessment Tools trigger questions, will have a third option to **Clear all**. Clicking **Clear page** will trigger an in-action symbol which demonstrates that the clearing is in progress.

! Selecting **Clear page information** will also remove the check box that triggers the display of Validated Assessment Tools, but not the information entered into the tool.

If an assessor wants to clear the information relating to the Validated Assessment Tools, they can select **Clear all** or navigate to the page the Tool is on and select **Clear page information**.

2. There are visual cues to assist with completing the form. When mandatory questions have not been answered, a red line is displayed on the left of the field. When the mandatory questions are answered, this line turns green.



Some questions will require additional mandatory details depending on the answer. In these cases, an asterisk will appear next to the details section to indicate that it is now mandatory to complete.

Additional questions may also display if triggered by an answer given to a base IAT question. These questions are used to capture additional information about the client's needs as indicated by the answer given within the base questions.

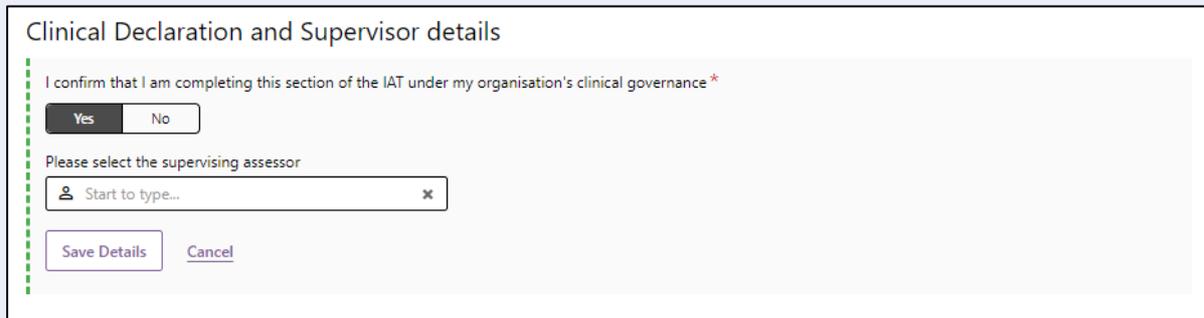
Clinical attendance (non-clinical assessor)

Threshold questions are also used throughout IAT to trigger moving the assessment into clinical/comprehensive areas. These questions are identified by a blue banner.

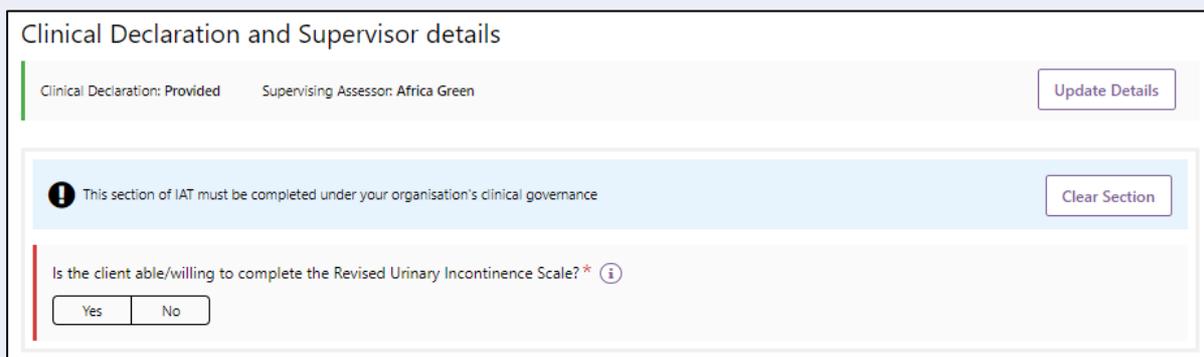
For example, if you answer **No** to the question "*is the client managing urinary incontinence issue?*" then additional questions will be displayed that require clinical attendance to complete.

For non-clinical assessors, these questions can only be completed under the clinical attendance process which is supported by an assessment organisation's clinical governance framework.

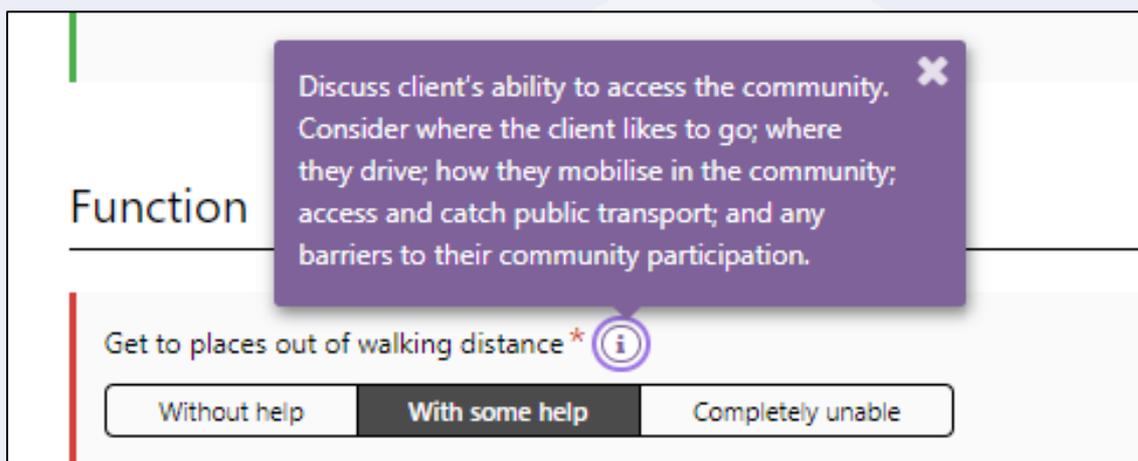
To proceed in answering these questions, the clinical supervisors (clinical assessor) details, who has provided clinical attendance, must be selected from the drop-down menu and **Save Details** selected.



Once the details have been saved, they will display in the IAT and the non-clinical assessor can proceed with clinical supervision.

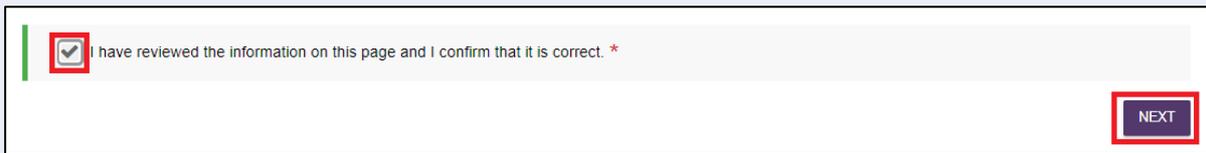


3. View on-screen help text for each question by selecting either the **i** icon next to the question. Help text can be moved around the screen by dragging the text with the cursor and will remain visible until the **X** is selected, or a new help text box is opened.

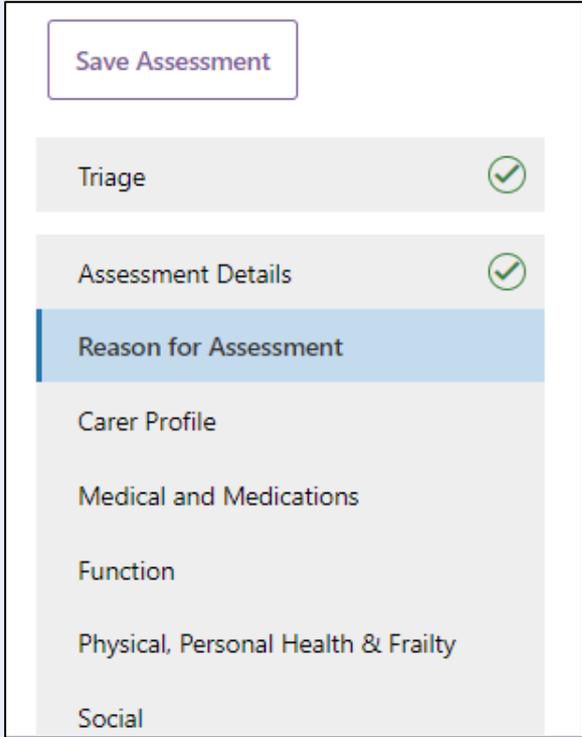


4. A mandatory confirmation box must be completed at the bottom of each section, then you can navigate to the next assessment page by selecting the **Next** button at the bottom right-hand corner or by selecting the relevant section from the navigation bar. Assessment information will also be saved.

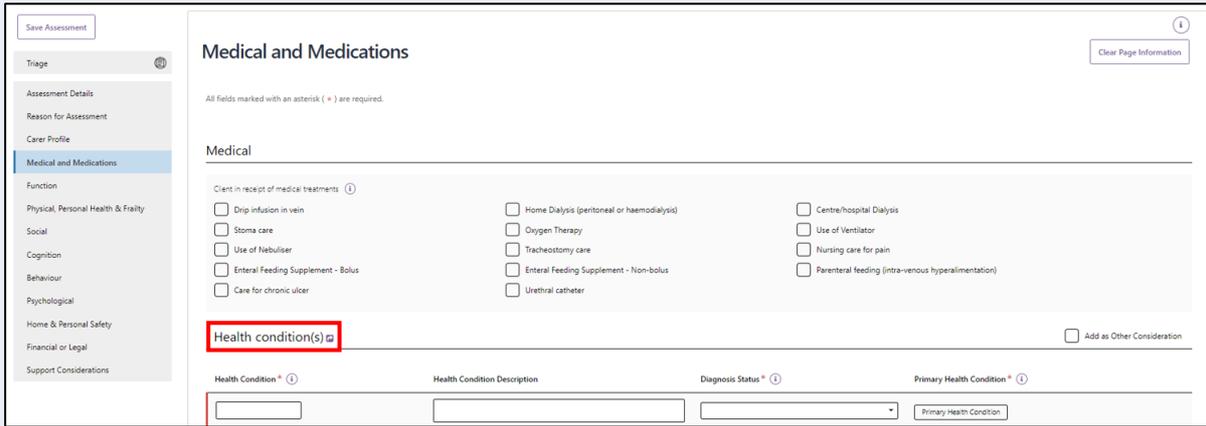




When all mandatory questions (marked with an asterisk and red line) on a page have been completed, a green tick will appear on the navigation bar.



5. From the **Medical and Medications** section you can enter health conditions into the assessment by name or code.



A maximum of ten health conditions can be added for each assessment. Start typing into the free text field to display health condition options.

Health condition(s) Add as Other Consideration

Health Condition * ⁱ	Health Condition Description	Diagnosis Status * ⁱ	Primary Health Condition * ⁱ
1799	Other symptoms & signs n.o.s or n.e.c (includes reflux)		Primary Health Condition
0701	Cataracts		Primary Health Condition
			Primary Health Condition

0101 - Tuberculosis
0102 - Poliomyelitis
0103 - HIV/AIDS
0104 - Diarrhoea & gastroenteritis of presumed infectious origin
0105 - Chronic viral hepatitis

in normal activities *
4
Moderately
Quite a bit

+ Add Health Condition

Once you select a health condition, you are able to edit the description to be specific to the client's health condition and select the appropriate **Diagnosis Status** option.

Health condition(s) Add as Other Consideration

Health Condition * ⁱ	Health Condition Description	Diagnosis Status * ⁱ	Primary Health Condition * ⁱ
1799	Other symptoms & signs n.o.s or n.e.c (includes reflux)		Primary Health Condition
0701	Cataracts		Primary Health Condition
0104		<input type="checkbox"/> Client reported <input type="checkbox"/> GP Confirmed <input type="checkbox"/> Hospital confirmed <input type="checkbox"/> Other health practitioner confirmed	Primary Health Condition

+ Add Health Condition

Additional health conditions can be added by selecting **+ Add Health Condition** or removed by selecting the bin icon. Assessors can also indicate whether the health condition is the **Primary Health Condition**, or whether to as an **Other Consideration** in the client's Support Plan.

Health condition(s) Add as Other Consideration

Health Condition * ⁱ	Health Condition Description	Diagnosis Status * ⁱ	Primary Health Condition * ⁱ
1799	Other symptoms & signs n.o.s or n.e.c (includes reflux)	GP Confirmed	Primary Health Condition
0701	Cataracts	GP Confirmed	Primary Health Condition
0104	Diarrhoea & gastroenteritis of presumed infectious origin	Client reported	Primary Health Condition

+ Add Health Condition

6. When completing the assessment, assessors will be able to select to **Add as Functional Need**, **Add as Complexity Indicator**, **Add as Other Considerations** and **Add as recommendation**.

Function

Get to places out of walking distance * ⁱ

Without help With some help Completely unable

Who helps? *

No one Informal carer(s) Aged care service provider(s)
 Other

How often do you have six or more alcoholic drinks on one occasion? * ⁱ

Please select...

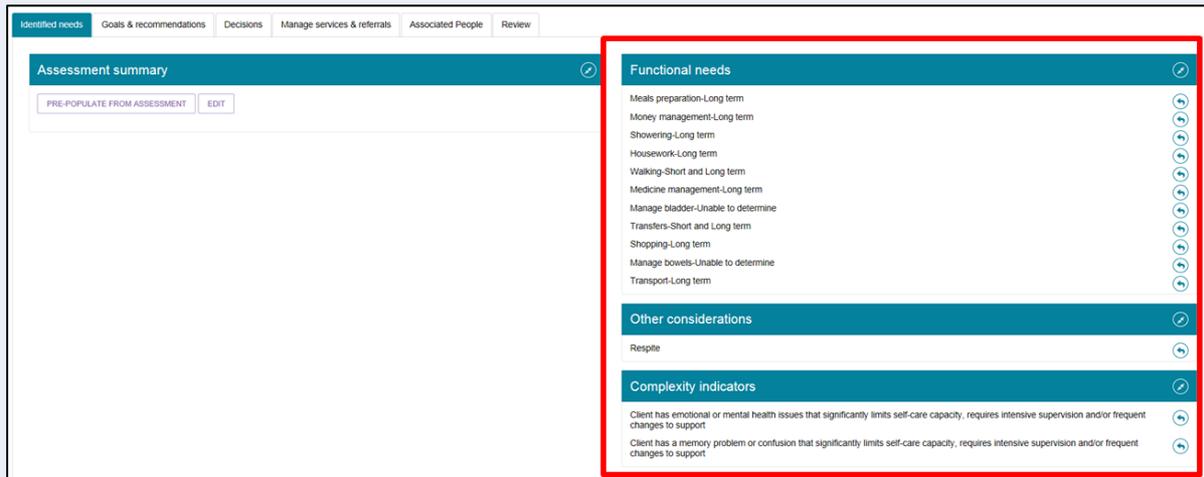
Add as Functional Need

Add as Other Consideration
 Add as Complexity Indicator

Upon selecting the checkbox, the Needs will appear on the **Identified needs** tab of the **Support**



Plan. Recommendations will appear in the **Goals & recommendations** tab.



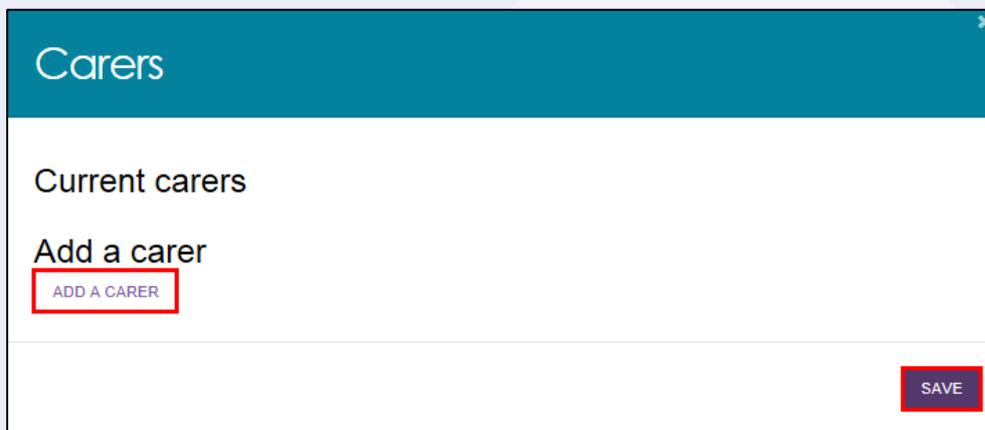
Viewing and adding carers in the assessment

You can view and add information about carers from the assessment, without having to navigate back to the client record.

1. Select the **Carer Profile** section of the assessment from the navigation menu and then select **View/add carers**.



2. A pop-up box will display. Any carers that are already associated with the client will be displayed. If you want to add a new carer select **Add a carer**.



3. Enter the first and last name of the person and select **Search**. You can search with more details by selecting **Show more search fields** and populating the appropriate fields.



If there is already a record for the person, they will be displayed in matching results. By selecting the radio button next to the person, it will open up further fields including both client and carer consent to the relationship, and the relationship of the user to the client. Select **Add**.

4. You will receive a confirmation message on screen, notifying that **You have successfully added a carer**. Select **Save** to save changes.

✕

Carers

✓ You have successfully added a carer.

Current carers

Mavis MATTERS
 Carer, added 21 Jul 2017
 ST THOMAS AQUINAS PRIMARY SCHOOL 25 LHOTSKY Street CHARNWOOD ACT 2615
 Lives with client*
 Yes
 No

Add a carer

ADD A CARER

SAVE

5. If there are no results, or you want to add a different carer, select **Add a carer**.

✕

Find a carer

All fields marked with an asterisk (*) are required.

First name*
 Lesley

Last name*
 Donnelly

Date of birth
 (e.g. dd/mm/yyyy)

SHOW MORE SEARCH FIELDS

No results found

ADD A CARER

SEARCH

CANCEL

Enter mandatory information about the person, including consent for the relationship from both the client and the carer. Select **Save**.



! The consent for registration during this stage is solely to create the client-carer relationship within the My Aged Care system. By creating this relationship, the carer will display in the client's support network and also appear as an option be added to the client's support plan at a later stage. Consent will be sought for any changes to this carer relationship throughout the process.

For information on how to capture a client and carer's consent for call-backs from the [Carer Gateway](#) and/or National Dementia Helpline, go to [Assessor Portal User Guide 2 – Registering support people and adding relationships](#).

Add a person

Last name: *
Donnelly

Date of birth:
(e.g. dd/mm/yyyy)

Gender *
Female

Lives with client*
 Yes
 No

Client Consents to Relationship*
 Yes
 No

Carer Consents to Relationship*
 Yes
 No

What is the relationship of the user to the client?: *
Parent

SAVE CANCEL

6. You will receive a confirmation message on the screen, notifying that **You have successfully added a carer**. Select **Save** to save changes.

Carers

✓ You have successfully added a carer.

Current carers

Mavis MATTERS
Carer, added 21 Jul 2017
ST THOMAS AQUINAS PRIMARY SCHOOL 25 LHOTSKY Street CHARNWOOD ACT 2615
Lives with client*
 Yes
 No

Lesley DONNELLY
Carer, added 21 Jul 2017
Lives with client*
 Yes
 No

Add a carer
ADD A CARER

SAVE

Adding a Sensitive Attachment in the assessment



Assessors can add attachments for client information of a sensitive nature as part of the assessment.

1. To download the Sensitive Attachment form from the assessment, select **Download Sensitive Attachment Form** on the **Support Considerations** page.

Mrs Ezekiel SCHWAB
Female, 77 years old, 17 January 1947, AC44300275
Lot Number 263 9 WILLOUGHBY ROAD NAREMBURN, NSW, 2065
Priority to speak Arabic

Support Considerations

All fields marked with an asterisk (*) are required.

Health and safety

At risk of, or suspected, or confirmed elder abuse? * Add as Complexity Indicator

Client refusing assistance or services when they are clearly needed to maintain safety and wellbeing * Add as Complexity Indicator

Any evidence that the client is self-neglecting of personal care, nutrition or safety? * Add as Complexity Indicator

Risk client may cause harm to themselves or others * Add as Complexity Indicator

2. The **Sensitive Attachment** form can also be downloaded from the **Forms** tab in the **Reports and documents** section of the portal.

Assessor Portal My Dashboard Assessments Reviews Find a client Find a service provider Residential Funding Referrals **Reports and documents**

Home | Reports and documents

Reports and documents

Reports **Forms** Links

Forms

- Self-Service Form - Abbey Pain Scale test [pdf 221.46KB]
- Self-Service Form - Alcohol Use Disorders Identification Test [pdf 287.27KB]
- Self-Service Form - Application for Care - October 2020 [pdf 354.04KB]
- Self-Service Form - Barthel Index of Activities of Daily Living [pdf 216.67KB]
- Self-Service Form - Brief Pain Inventory [pdf 256.86KB]
- Self-Service Form - Caregiver Strain Index [pdf 148.48KB]
- Self-Service Form - Client Record Details [pdf 364.25KB]
- Self-Service Form - Comprehensive Assessment and Support Plan - October 2018 [pdf 442.96KB]
- Self-Service Form - Geriatric Depression Scale [pdf 217.58KB]
- Self-Service Form - Home Support Assessment and Support Plan - October 2018 [pdf 484.48KB]
- Self-Service Form - Informant Questionnaire on Cognitive Decline in the Elderly (IQ CODE) [pdf 219.08KB]
- Self-Service Form - K-10 [pdf 942.84KB]
- Self-Service Form - KICA-COG images [pdf 539.52KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - ADL [PDF 148.59KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Carer [pdf 695.20KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Cognitive Assessment (KICA-C... [pdf 895.96KB]
- Downloads - Mini Nutritional Assessment [pdf 81.38KB]
- Self-Service Form - Modified Caregiver Strain Index [pdf 216.96KB]
- Self-Service Form - My Aged Care Assessment Consent Form v2.0 20220519 [pdf 299.02KB]
- Template - Template Notice of priority for home care service - not vary v1.0 [rtf 10.27KB]
- Template - Template Notice of priority for home care service - vary v1.0 [rtf 10.73KB]
- Self-Service Form - Offline Approval Form Vary Time Limitation v2.0 - 20220523 [pdf 358.31KB]
- Self-Service Form - Offline Approval Form - February 2017 [docx 113.64KB]
- Self-Service Form - Older Americans Resources and Services (OARS) - Instrumental Activities ... [pdf 942.40KB]
- Self-Service Form - Oral Health Assessment Tool [pdf 218.42KB]
- Self-Service Form - Residents Verbal Brief Pain Inventory [pdf 248.45KB]
- Self-Service Form - Revised Faecal Incontinence Scale [pdf 217.63KB]
- Self-Service Form - Revised Urinary Incontinence Scale [pdf 148.13KB]
- Self-Service Form - Rowland Universal Dementia Assessment Scale [pdf 981.66KB]
- Downloads - Sensitive Attachment v1.0 (docx 62.40KB)**
- Self-Service Form - South Australian Oral Health Referral Pad [pdf 217.14KB]
- Self-Service Form - Standardised Mini-Mental State Examination (SMMSE) [pdf 290.84KB]



These can then be uploaded to the client record in the **Attachments** tab by clicking **ADD AN ATTACHMENT**.



3. Once downloaded, the **Sensitive Attachment** form will display.

The screenshot shows the 'SENSITIVE ATTACHMENT' form. It features the Australian Government and myagedcare logos. The form contains the following fields:

Client Name:	
Aged Care ID:	
Concern with financial situation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	
Concern with living arrangements	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	

4. When you have completed the form, select **Upload Sensitive Attachment Form** from the **Support Considerations** page.

The screenshot shows the 'Support Considerations' page for Mrs Ezekiel SCHWAB. The page includes a sidebar with navigation options and a main content area with the following sections:

Support Considerations

All fields marked with an asterisk (*) are required.

Health and safety

- At risk of, or suspected, or confirmed elder abuse? * Yes No Add as Complexity Indicator
- Client refusing assistance or services when they are clearly needed to maintain safety and wellbeing * Yes No Add as Complexity Indicator
- Any evidence that the client is self-neglecting of personal care, nutrition or safety? * Yes No Add as Complexity Indicator
- Risk client may cause harm to themselves or others * Yes No Add as Complexity Indicator



5. You will be prompted to enter information relating to the Sensitive Attachment. Once you have entered this information select **Upload**.

Upload sensitive attachment

Please note: Some attachments will be viewable by other people with authorised access to this client record. Please refer to your portal guide for details.

All fields marked with an asterisk (*) are required.

You can upload files up to 5 MB to this record. The following file types are accepted: .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, .rtf, .txt *

Attachment: *

Name of the attachment: *

Please provide a short description about the contents of the attachment, e.g. assessment date and time

0 / 250

6. Once successfully uploaded, a green banner will display at the bottom of the screen.



The Sensitive Attachment will then appear in **Other Attachments** on the **Attachments** tab of the Client record.

Attachments

Client summary | Client details | Approvals | Plans | **Attachments** | Services | My Aged Care interactions | Notes | Tasks and Notifications

Attachments

Assessment Attachments | **Other Attachments** | Correspondence

Sensitive Attachment

Sensitive Attachment.docx [66.93KB]

Short description



! If you have added a Sensitive Attachment as part of the assessment, you should record this in the **Support Considerations** page.

Sensitive attachments will not display to providers or to clients viewing their information through the My Aged Care online account. The My Aged Care contact centre and assessors will be able to view this attachment.

Service providers who have accepted a client's referral will receive an alert notifying them that sensitive information is available and are advised to contact the client's assessor or My Aged Care contact centre to access this information.

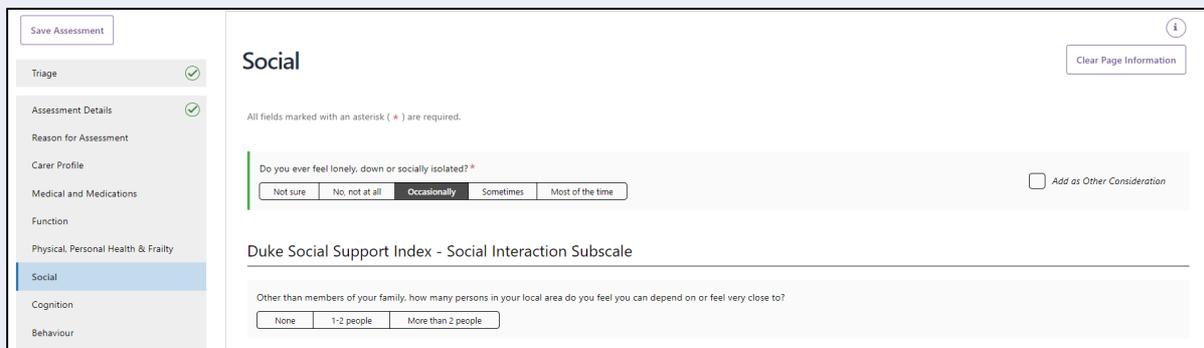


The screenshot shows the 'Support Considerations' page. A red box highlights the 'Attachment *' field, which has a question mark icon and radio buttons for 'Yes' and 'No'. Below this is a checkbox labeled 'I have reviewed the information on this page and I confirm that it is correct *'. The page also shows a character count '0 / 500' in the top right corner.

Navigating the Validated Assessment Tools

There are a range of Validated Assessment Tools (VATs) available for assessors to help support a client assessment. A number of these are either embedded within the IAT itself or are available as prompts to be utilised as needed.

For example, the Duke Social Support Index is incorporated in the IAT under the **Social** section.



The screenshot shows the 'Social' section of the IAT. On the left is a navigation menu with 'Social' selected. The main content area has a 'Social' heading and a 'Clear Page Information' button. Below the heading, it states 'All fields marked with an asterisk (*) are required.' The first question is 'Do you ever feel lonely, down or socially isolated? *' with radio buttons for 'Not sure', 'No, not at all', 'Occasionally', 'Sometimes', and 'Most of the time'. There is also an 'Add as Other Consideration' checkbox. The second question is 'Duke Social Support Index - Social Interaction Subscale' with the prompt 'Other than members of your family, how many persons in your local area do you feel you can depend on or feel very close to?' and radio buttons for 'None', '1-2 people', and 'More than 2 people'.

Other Validated Assessment Tools within the IAT will only display if required and agreed to by the client. For example, the **Step 1 GP Cog** tool is available under the **Cognition** section of IAT assessment.

Save Assessment

Triage

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

Physical, Personal Health & Frailty

Social

Cognition

Behaviour

Psychological

Home & Personal Safety

Financial or Legal

Support Considerations

Cognition

Clear Page Information

All fields marked with an asterisk (*) are required.

Does client have a confirmed dementia diagnosis from a geriatrician or neurologist? *

Yes No

Is it suitable the client complete the Step 1 GP Cog? *

Yes No

Assessor notes on cognition

Add as Other Consideration

0 / 500

I have reviewed the information on this page and I confirm that it is correct. *

Next

If you answer yes to the client being suitable to complete this, the **GP Cog – Step 1** questions will then display below.

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

Physical, Personal Health & Frailty

Social

Cognition

Behaviour

Psychological

Home & Personal Safety

Financial or Legal

Support Considerations

All fields marked with an asterisk (*) are required.

Does client have a confirmed dementia diagnosis from a geriatrician or neurologist? *

Yes No

Is it suitable the client complete the Step 1 GP Cog? *

Yes No

GPCog - Step 1

What is the date? (exact only) *

Correct Incorrect

Name and address for subsequent recall test

I am going to give you a name and address.
After I have said it, I want you to repeat it.

Remember this name and address because I am going to ask you to tell me again in a few minutes:
John Brown, 42 West Street, Kensington
(allow a maximum of four attempts)

Please note, the total score for these validated assessment tools will be auto generated based on the client's answers.

Use of validated assessment tools that are not included in IAT is at the discretion of the assessment organisation. If used, you can upload the completed tools as attachments to the client record. Blank versions of these tools are available in the **Reports and Documents** section in the assessor portal.



The eraser button can be used to clear the responses of Validated Assessment Tools if required.

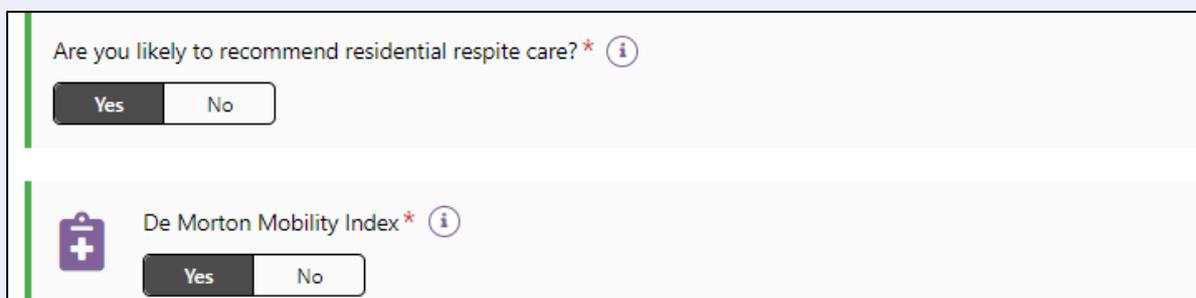


Modified De Morton Mobility Index (DEMMI) and Residential Respite Care (Clinical assessor)

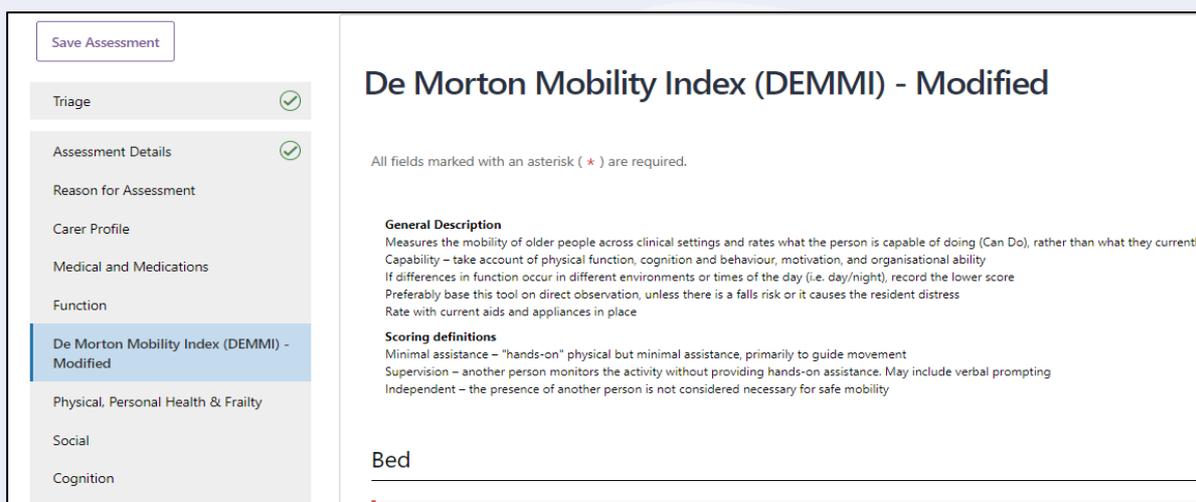
The IAT includes a validated assessment tool called the DEMMI, that may only be used by clinical assessors in a face-to-face setting when assessing individuals' care needs for residential respite services. Non-clinical assessors should **not** complete the DEMMI-Modified tool even with clinical attendance.

The responses captured as part of the Modified de Morton Mobility Index (DEMMI) tool becomes part of the Australian National Aged Care Classification (AN-ACC) initiative.

1. Under the Function section of the IAT, clinical assessors will be asked **Are you likely to recommend residential respite care?**



2. If you answer **Yes** to this question, you will be prompted with a new question: **De Morton Mobility Index?** If you are a clinical assessor and answer **Yes** to this question, you must complete the DEMMI assessment tool. The **De Morton Mobility Index (DEMMI) Modified** will appear in the navigation bar below the **Function** section.



3. Work through the questions associated with the 4 sections of the DEMMI as listed below by selecting the radio box that most reflects the client's mobility:

- Bed;
- Chair;
- Static balance – no gait aid; and
- Walking.

4. Once you have completed the required sections press **Next**.

5. You should then progress with completing the assessment and submitting your recommendation for residential respite care for Delegate approval.

In the event that the Modified DEMMI has not been completed and Residential Respite Care is recommended, you will be prompted that you will need to tick a declaration and to add a reason for not completing the Modified DEMMI.

This screenshot shows the declaration and the text field for not completing the DEMMI in the **Add care type for Delegate decision** pop up

Add care type for delegate decision

All fields marked with an asterisk (*) are required.

Which care type applies? *
Residential Respite Care

If time-limited, when does the approval stop (optional):
(e.g. dd/mm/yyyy)

What is the priority of this care type? * ?
High

Is this emergency care?
 Yes No

Reason or comments
0 / 255

I was unable to undertake a modified DEMMI on this client at this assessment and I am required to enter my 'unable to complete' reason in the text box below. I understand that this means that if this client has not previously received a modified DEMMI assessment they will enter the default respite class and will need to have a modified DEMMI assessment completed at a later date. *

Reason DEMMI not completed *
Modified DEMMI was not completed

SAVE TO PLAN CANCEL

Saving an assessment

If you have not finished completing the assessment and want to complete it at a later time, you can select **Save Assessment**.

Mrs Ezekiel SCHWAB

Female, 77 years old, 17 January 1947, AC44300275
Lot Number 263 9 WILLOUGHBY ROAD NAREMBURN,
Prefers to speak Arabic

Save Assessment

Triage

Assessment Details

Reason for Assessment

Carer Profile



A green banner will then display at the bottom of your screen advising of the successful save.

Mrs Ezekiel SCHWAB
Female, 77 years old, 17 January 1947, AC44300275
Lot Number 263 9 WILLOUGHBY ROAD NAREMBURN, NSW, 2065
Prefers to speak Arabic

Save Assessment

Triage ✓
Assessment Details ✓
Reason for Assessment
Carer Profile
Medical and Medications
Function ✓

Function

All fields marked with an asterisk (*) are required.

General observations of client ⓘ

Assessment successfully saved

You can then continue completing the assessment with the client at another time.

You can also select **SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN** down the bottom of the assessment if you wish to navigate to the support plan but are not yet finished with the assessment.

Mrs Ezekiel SCHWAB
Female, 77 years old, 17 January 1947, AC44300275
Lot Number 263 9 WILLOUGHBY ROAD NAREMBURN, NSW, 2065
Prefers to speak Arabic

DOWNLOAD SENSITIVE ATTACHMENT FORM | UPLOAD SENSITIVE ATTACHMENT FORM

Other Add as Other Consideration

Assessor's notes

0 / 1500

I have reviewed the information on this page and I confirm that it is correct.*

SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN | CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED

The record will appear under **Assessment In progress** in your **Current assessments** tab.

To prevent any potential loss of information captured during the assessment, or when the portal is idle, the assessment will auto-save regularly.



Finalising an assessment

1. Once you have completed the assessment, select **FINALISE IAT AND GO TO SUPPORT PLAN**.

The screenshot shows the 'Assessment' page for 'Mr Ellie INFANTE'. The client's details are: Male, 80 years old, 26 October 1943, AC92629492, 11 2 MONTROSE STREET WARRAGUL, VIC. 3820. There are two buttons at the top right: 'DOWNLOAD SENSITIVE ATTACHMENT FORM' and 'UPLOAD SENSITIVE ATTACHMENT FORM'. Below this, there are four rows of checkboxes with labels and 'Add as Other Consideration' links:

<input type="checkbox"/> a lesbian, gay, bisexual, transgender, or intersex person	<input type="checkbox"/> Add as Other Consideration
<input type="checkbox"/> a person separated from your parents or children by forced adoption or removal	<input type="checkbox"/> Add as Other Consideration
<input type="checkbox"/> a socially isolated individual	<input type="checkbox"/> Add as Other Consideration
<input type="checkbox"/> Other	<input type="checkbox"/> Add as Other Consideration

Below the checkboxes is a text area for 'Assessor's notes' with a character count of '0 / 1500'. At the bottom, there is a confirmation checkbox: I have reviewed the information on this page and I confirm that it is correct. * At the very bottom, there are three buttons: 'FINALISE IAT AND GO TO SUPPORT PLAN' (highlighted with a red box), 'SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN', and 'CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED'.

2. A pop-up will then display asking for consent to share their support plan via their My Health Record. After reading the consent information to the client or their representative, select the applicable consent option based on their consent decision.

! A client can withdraw their consent at any time by calling the My Aged Care Contact Centre on 1800 200 422. A client's consent can also be updated by an assessor via the Client details tab in the client record. For more information regarding this please refer to the [My Aged Care – Assessor Portal User Guide 4 – Navigating and updating the client](#).

If consent is provided select **Yes** and then click **CONTINUE**.

The screenshot shows a pop-up window titled 'Consent to share information with My Health Record'. It contains the following information:

All fields marked with an asterisk (*) are required.

Information

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Division 86 of the Aged Care Act 1997. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

Does the client consent to share their Support Plan with My Health Record (MHR)? *

No Yes

Consent decision by *
Client

Comments:

At the bottom right, there are two buttons: 'CONTINUE' (highlighted with a red box) and 'CANCEL'.

If consent has not been provided, select **No**. You will then be required to select a reason for the decision not to provide consent from the drop-down menu. Next click **CONTINUE**.

Consent to share information with My Health Record

× Please select a valid response from Consent denial reason

All fields marked with an asterisk (*) are required.

Information

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Division 86 of the Aged Care Act 1997. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

Does the client consent to share their Support Plan with My Health Record (MHR)? *

No Yes

Consent decision by *

Client

Consent denial reason *

Please select a reason for not providing the consent

Please select a reason for not providing the consent

Do not wish to disclose

Other

Privacy concerns

CONTINUE CANCEL

Please note if the consent decision has been made by a Representative then the Representative's first name must be entered before clicking **CONTINUE**.

Consent to share information with My Health Record

× First name is mandatory, blanks are not allowed

All fields marked with an asterisk (*) are required.

Information

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Division 86 of the Aged Care Act 1997. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

Does the client consent to share their Support Plan with My Health Record (MHR)? *

No Yes

Consent decision by *

Representative

Representative Details

First name: *

First name is mandatory, blanks are not allowed

Last name:

Comments:

CONTINUE CANCEL



3. Another pop-up will then display. Select **FINALISE IAT** to complete the assessment.

! Once the IAT has been finalised it cannot be edited. Therefore, it is important to ensure all information has been correctly captured before selecting **FINALISE IAT**.

Finalise IAT and go to support plan

Once you select 'Finalise IAT', you cannot make any changes to the responses in this questionnaire, and you will be taken to the Support Plan. Once the IAT is finalised, the system will determine the outcome of the assessment, which will be either a HCP or a CHSP and can be viewed in the Support Plan.

If you wish to continue with the Support Plan, please select 'Finalise IAT' and if you wish to make any changes to the questionnaire, please select 'Take me back to the assessment'.

Note: The IAT recommendations are limited to care needs that can only be met by home support (CHSP) or Home Care (HCP) services. By applying your professional judgement, you can recommend the eligible person to:

- Receive other aged care services if you believe that they are essential. This can be done by adding the other aged care services in the Support Plan which includes:
 - Permanent Residential Care
 - Residential Respite Care
 - Transition Care
 - Short Term services

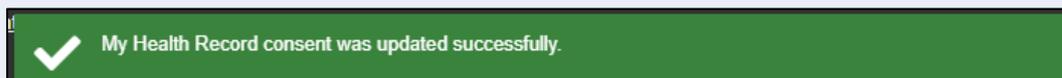
OR

- Not to receive Commonwealth funded aged care services. This can be done by replacing the IAT recommendation with 'No Care type' in the Support Plan.

FINALISE IAT TAKE ME BACK TO THE ASSESSMENT

A banner will appear at the bottom of the screen confirming that the save was successful and you will then be re-directed to the client's **Support plan and services** page to complete the client's support plan.

If the client consented to sharing their support plan via their My Health Record, a green banner will display at the bottom of the **Support plan and services** page if this was successfully linked.



! If the client's My Health Record is not successfully linked an amber error banner will display in place of the green banner.

If the 'Unable to share data as the system could not find an active My Health Record' error message displays the assessor should inform the client that their support plan will not be uploaded to their My Health Record and that they should contact the **My Health Record helpline on 1800 723 471** for assistance if required.



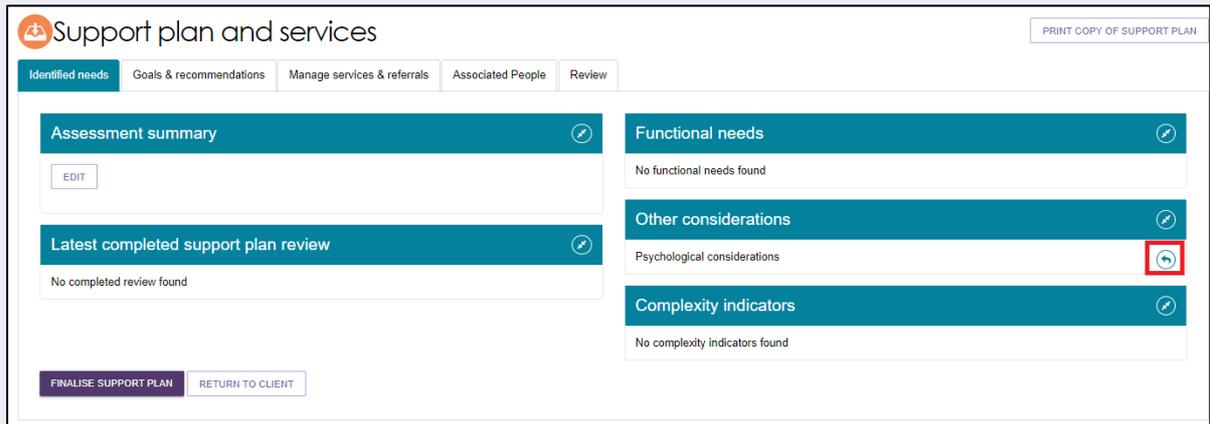
If the 'Unable to retrieve the client's Healthcare Identifier, so we cannot match them with their My Health Record. Their Support Plan cannot be made available in their My Health Record' error message displays the assessor should call the **My Aged Care service provider and**

assessor helpline on 1800 836 799.



In both instances, you will still be able to proceed with the development of the Support Plan, but it will not be uploaded to My Health Record upon finalisation.

From the **Support plan and services** page you can reopen the assessment by selecting **Go to question** (arrow icon) on the **Identified needs** tab.



Support plan and services

PRINT COPY OF SUPPORT PLAN

Identified needs | Goals & recommendations | Manage services & referrals | Associated People | Review

Assessment summary [EDIT] [Go to question]

Latest completed support plan review [Go to question]

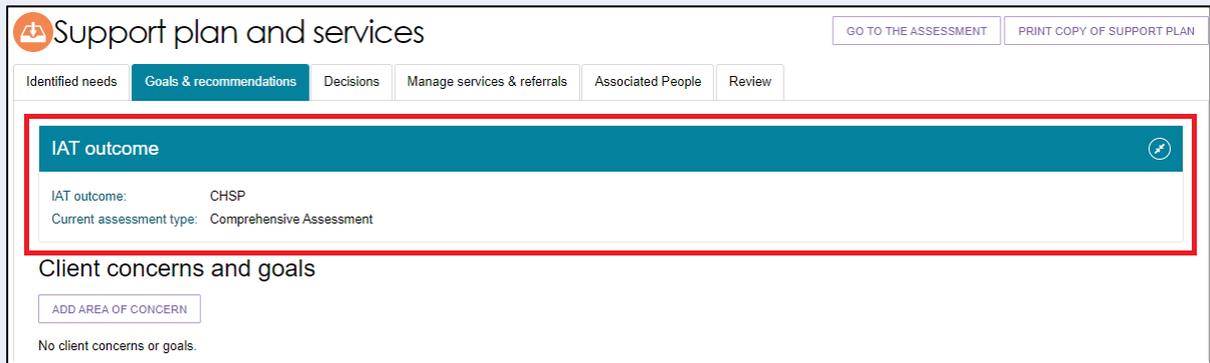
Finalise Support Plan | Return to Client

Functional needs [Go to question]

Other considerations [Go to question]

Complexity indicators [Go to question]

The IAT outcome will be displayed in the Goals & recommendations tab.



Support plan and services

GO TO THE ASSESSMENT | PRINT COPY OF SUPPORT PLAN

Identified needs | Goals & recommendations | Decisions | Manage services & referrals | Associated People | Review

IAT outcome [Go to question]

IAT outcome: CHSP
Current assessment type: Comprehensive Assessment

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.



Cancelling an assessment

If you need to cancel an assessment for a client, you can do so within the assessment. Assessors should add a note or an interaction to the client record explaining the reason for cancelling the assessment.

In order to cancel an assessment, follow the steps outlined below.

1. Select **CANCEL ASSESSMENT- NO FURTHER ACTION REQUIRED** in the assessment.

Mrs Ezekiel SCHWAB
Female, 77 years old, 17 January 1947, AC44300276
Lot Number 263 9 WILLOUGHBY ROAD NAREMBURN, NSW, 2065
Prefers to speak Arabic

Other Add as Other Consideration

Assessor's notes
0 / 1500

I have reviewed the information on this page and I confirm that it is correct.*

SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN **CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED**

2. Record the reason for cancelling the assessment. If you cancel an assessment because a client is deceased, you will need to supply the following:

- Who, when and how you were informed that this person is deceased. For example, "Mrs. Smith rang to inform us that Mr. Smith has passed away on Saturday."
- Date of Death (if known)
- Any Attachments such as Death Certificate, Hospital Discharge documents.

Cancel assessment - no further action required

All fields marked with an asterisk (*) are required.

Reason for ending the assessment *
Client deceased

You are about to notify the department that Noiq Assessment has passed away. Their record will become read only. You will still be able to finalise outstanding assessments and support plan reviews, and add notes and attachments.

Please supply the following information:

Who, when and how were you informed that this person is deceased? *
0 / 500

Date of death (if known)
dd/mm/yyyy

Add Attachments
You can upload files up to 5 MB to this record. The following file types are accepted: jpeg, jpg, bmp, .png, .docx, .xlsx, .pdf, .rtf, .txt (if available)

Choose a file...

Comment *
0 / 200

CANCEL ASSESSMENT TAKE ME BACK TO THE ASSESSMENT

! Cancelling an assessment with the reason of **Client deceased** will change the client's status to **Deceased** and make the client record read-only. Any unaccepted service referrals will be recalled, services in place will be ceased and the client's access to the client portal will be revoked. My Aged Care will not send correspondence to the client or their representatives after the status is changed to **Deceased**.

Where a client is active in the National Priority System or has been assigned a Home Care Package, this will remove the client from the National Priority System and withdraw any assigned Home Care Packages.

3. A confirmation message will be displayed on screen that the assessment has been cancelled. You will then be taken to the Client summary page which will confirm the cancelled status.



After cancelling an assessment, the client information will appear in the assessor's recent assessments tab. Assessors will still be able to search for the client using the **Find a client** functionality.