



Assessor Portal - User Guide 7 - Completing a Support Plan and Support Plan Review

This user guide is intended for aged care needs assessors (assessor) who complete support plan and/or a Support Plan Review, using the My Aged Care assessor portal (assessor portal).

It covers the following topics:

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What is a support plan?

The aged care client's support plan records and identifies the client's:

- areas of concern regarding care
- goals to address these concerns
- any recommendations for services or actions to achieve the identified goals.

The client develops their own support plan with an assessor during the face-to-face assessment.

1. After completing an aged care needs assessment (assessment) in the assessor portal, assessor will be directed to continue to the client's support plan by clicking **FINALISE IAT AND GO TO SUPPORT PLAN**.

Home | Assessments | Assessment

Mr Ellie INFANTE

Male, 80 years old, 26 October 1943, AC92629492
11 2 MONTROSE STREET WARRAGUL, VIC, 3820

DOWNLOAD SENSITIVE ATTACHMENT FORM UPLOAD SENSITIVE ATTACHMENT FORM

- a lesbian, gay, bisexual, transgender, or intersex person Add as Other Consideration
- a person separated from your parents or children by forced adoption or removal Add as Other Consideration
- a socially isolated individual Add as Other Consideration
- 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.*

FINALISE IAT AND GO TO SUPPORT PLAN SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED

2. Once you have selected **FINALISE IAT AND GO TO SUPPORT PLAN** a pop-up box will appear. To continue select **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

- The support plan is also displayed in the **Client Record** in the **Plans** tab or the Assessments section in the assessor portal.

The screenshot shows the 'Plans' tab for Ms Alistair SHARP. The client details are: Female, 109 years old, 31 January 1915, AC75276568, Moana, 269 5 HIGH STREET ASHBURTON, VIC, 3147. There are no support relationships recorded. The 'Plans' tab is active, showing a 'Current Episode' (Episode ID: 1-2QXQ-3759, 15 April 2013 - Present) with a 'SUPPORT PLAN' button. Below this are 'Recommendations' (Residential Respite Low Care, Residential Permanent) and 'Upcoming Review(s)' (No upcoming reviews scheduled). On the right, there are four sections: 'Assessment history' (Comprehensive Assessment 15 April 2013, Comprehensive Assessment 20 January 2011, Screening 20 January 2011), 'Plan history' (No plan history available), 'Review history' (No review history available), and 'Reablement and linking support history' (No linking support items available).

- To add or edit a support plan, the client must have undergone at least one assessment. The following screenshot shows an example of a client's **Support plan and services page**.

The screenshot shows the 'Support plan and services' page for Mr Aditya N BELL (Kiarra). The client details are: Male, 93 years old, 10 January 1930, AC70524012, 15 LIMBURG WAY GREENWAY, ACT, 2900. Primary contact: Aditya Bell (self) - 61 2987 1234. There are no support relationships recorded. The page has tabs for 'Identified needs', 'Goals & recommendations', 'Manage services & referrals', 'Associated People', and 'Review'. The 'Identified needs' tab is active, showing an 'Assessment summary' (with an 'EDIT' button), 'Introduction' (Mr Aditya Bell, age 93, contacted My Aged Care and has been referred for assessment as asdfasdfasd. An assessment occurred Over-the-phone on 18 August 2022 in Carer's home. Assessment information was provided by client's gp.), 'Situation' ([Add comments relating to current social situation]), 'Latest completed support plan review' (No completed review found), 'Functional needs' (No functional needs found), 'Other considerations' (No other considerations found), and 'Complexity indicators' (Client is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, wellbeing and ability to remain living in the community; Client is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support). At the bottom, there are buttons for 'COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER' and 'RETURN TO CLIENT'.

Entering information into the support plan

The support plan is made up of a number of tabs discussed below.

Identified needs

The screenshot shows the navigation tabs for the support plan: 'Identified needs', 'Goals & recommendations', 'Manage services & referrals', 'Associated People', and 'Review'.



The **Identified needs** tab contains a summary of the needs identified as part of the assessment that require addressing in the support plan. This also includes information of the client's latest completed Support Plan Review if applicable.

Adding an assessment summary

When completing a support plan, assessors can add an **Assessment summary** within the **Identified needs** tab.

The screenshot shows the 'Support plan and services' interface for Ms Alistair SHARP. The 'Identified needs' tab is selected, and the 'Assessment summary' field is highlighted with a red box. Other fields include 'Functional needs', 'Latest completed support plan review', 'Other considerations', and 'Complexity indicators'. The interface also shows a navigation menu with options like 'Goals & recommendations', 'Decisions', 'Manage services & referrals', 'Associated People', and 'Review'. There are also buttons for 'COMPREHENSIVE ASSESSMENT 15 APRIL 2013' and 'PRINT COPY OF SUPPORT PLAN'.

This summary appears on the printed support plan provided to the client. It can help conduct further assessments if required. It is visible to service providers who have received a referral for that client.

The assessment summary can be pre-filled based on the information an assessor records in the assessment. An icon (arrow leaving a square pointing right) will display on the fields which automatically pre-fill into the assessment summary.

The screenshot shows the 'Date of assessment' field with the date '11/06/2018' entered. A red box highlights the 'PRE-POPULATE FROM ASSESSMENT' icon (an arrow pointing right from a square). There is also a question mark icon and a calendar icon.

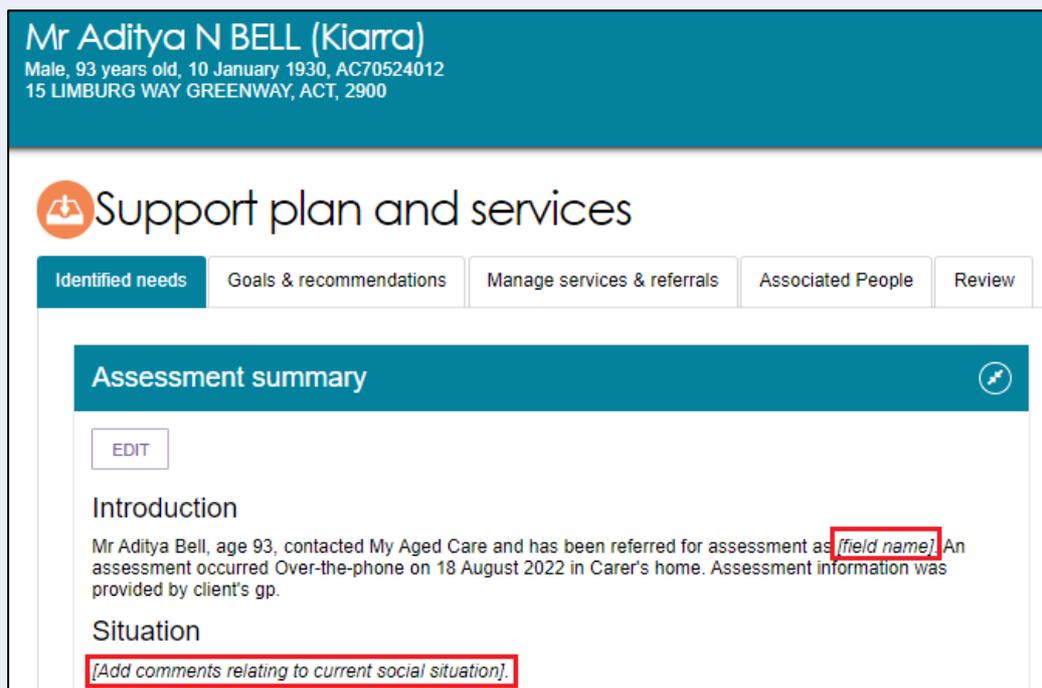
1. To add an assessment summary based on the information captured from the assessment, select **PRE-POPULATE FROM ASSESSMENT**.

The screenshot shows the 'Assessment summary' field with the 'PRE-POPULATE FROM ASSESSMENT' button highlighted with a red box. There is also an 'EDIT' button.

Alternatively, select **EDIT** to edit the assessment summary without any pre-filling. This will open a blank assessment summary. Proceed to Step 4, if you are manually editing the assessment summary without pre-filling.

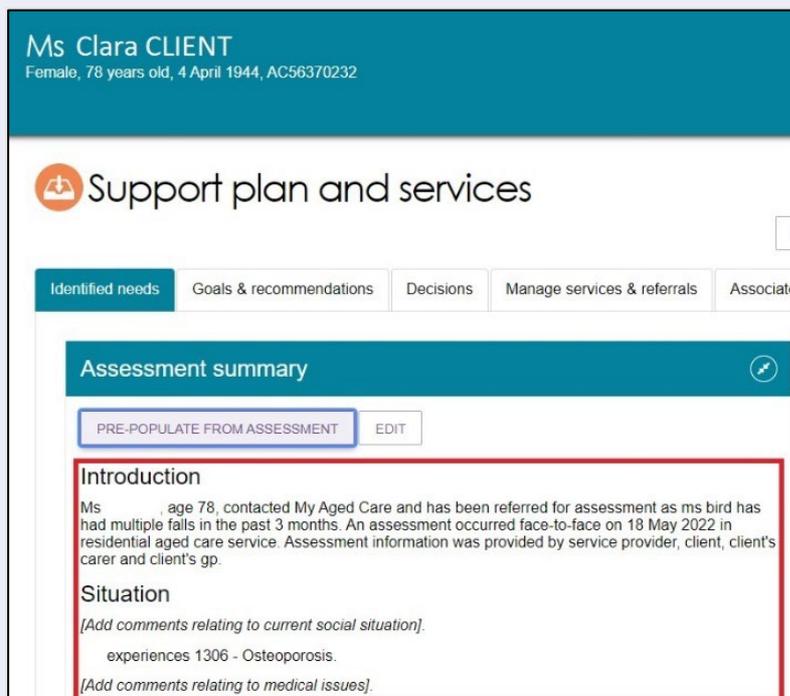
2. A read-only view of the assessment summary will display.

The system will populate information where it exists. If information does not exist in a field, the system will advise which field has not been populated. This will display as *[field name]*.



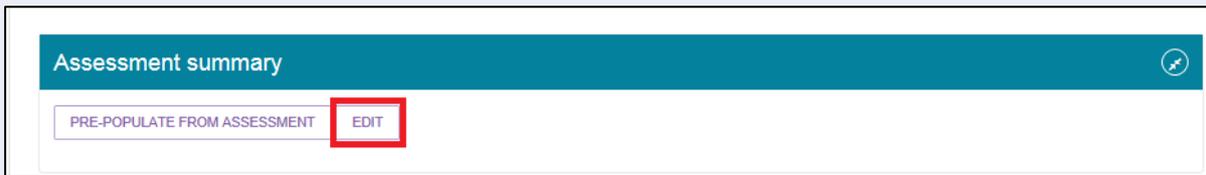
Assessors can choose to enter information in the field in the assessment; add relevant information in the assessment summary; or remove the instruction from the assessment summary.

Assessors will be prompted to enter additional information that could not be populated from the assessment. This will display as *[example instruction]*.

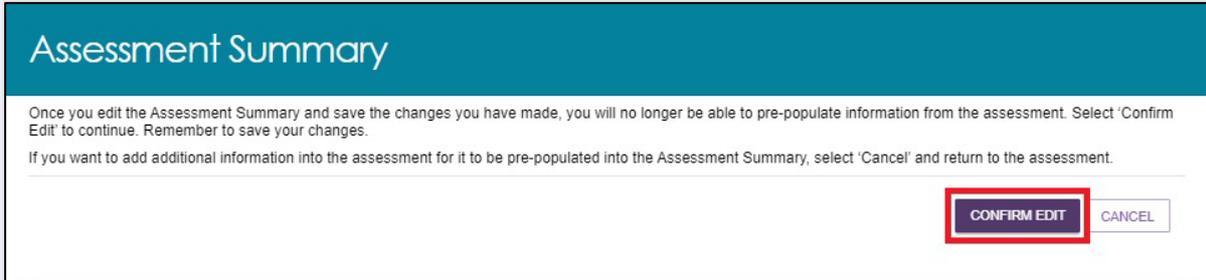


3. Select **EDIT** to start editing information in the assessment summary.





4. Select **CONFIRM EDIT** to open the editable assessment summary.

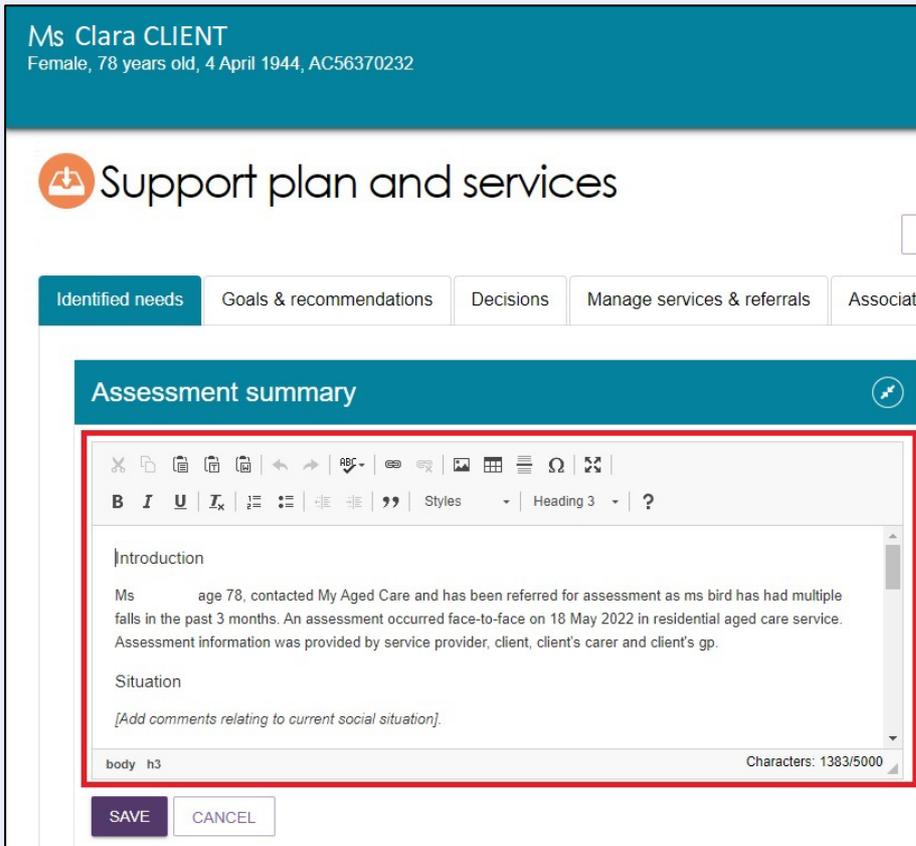


Once **CONFIRM EDIT** has been selected and the changes have been saved, the select **Pre-populate from assessment** option will no longer be available to be selected.

5. Once the assessment summary has been edited/updated, select **SAVE** to save changes.

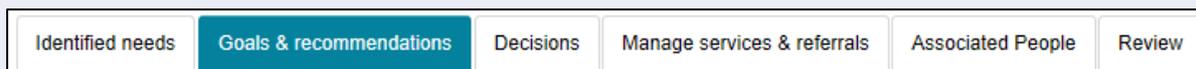
Based on the information pre-populated from the assessment, the assessment summary may exceed the 5,000 character limit. Assessors should reduce the assessment summary by removing or summarise old content.

Assessors can continue to edit the assessment summary after they have saved their changes.



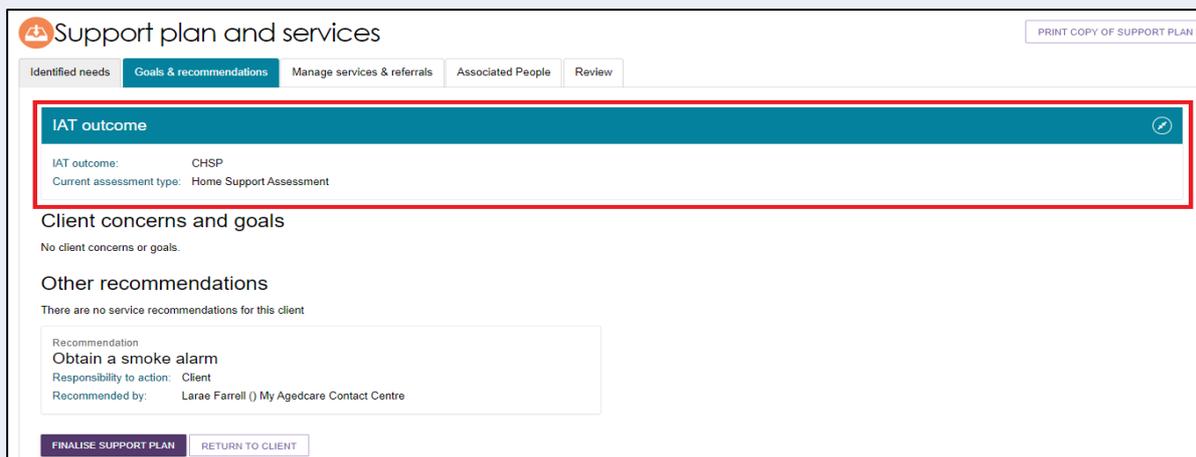
! Ensure changes to the assessment summary are regularly saved, as auto-save does not apply to the assessment summary.

Goals and recommendations



The **Goals & recommendations** tab is where you will record the client's areas of concerns, goals to address their concerns, and any services or general recommendations.

Within the **Goals & recommendations** tab you will also be able to view the IAT outcome recommendation. This recommendation is based on inputs from the assessor on the IAT assessment and the client's current care approvals.



The recommendation displays for guidance only. Assessors will still need to select the service the client requires.

For clinical aged care needs assessors (clinical assessors), this means they should follow current processes for both CHSP and HCP recommendations:

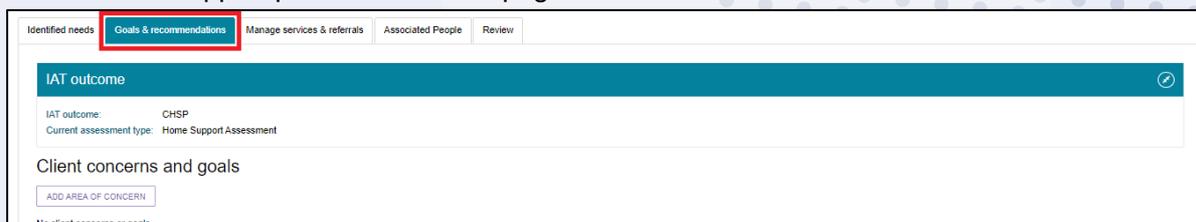
- For a CHSP recommendation – you should consider recommending the client to CHSP services as per current process.
- For an HCP recommendation – you should consider recommending the client for an HCP as per current process.

For non-clinical aged care needs assessors (non-clinical assessors), this means they should consider the following based on the IAT outcome:

- For a CHSP recommendation – you can refer to CHSP services as per current process and continue to finalise the support plan.
- For an HCP recommendation – you should consider converting the assessment to a comprehensive assessment under the supervision of a staff member who holds a clinical assessor role (further information is at [Convert to Comprehensive Assessment](#)).

Adding an area of concern and goals

1. From the support plan and services page select the **Goals & recommendations** tab.



! You can also navigate to a client's support plan via their **Client Summary**. From here you can select the **Plans** tab and then clicking **SUPPORT PLAN**.

Assessor Portal

Home | Assessments | Home Support Assessment | Aditya BELL (Kiarra) support plan and services | Aditya BELL (Kiarra)

Mr Aditya N BELL (Kiarra)
Male, 93 years old, 10 January 1930, AC70524012
15 LIMBURG WAY GREENWAY, ACT, 2900

Primary contact: Aditya Bell (self) - 61 2987 1234
No support relationships recorded

Plans

REFER THIS CLIENT FOR ASSESSMENT | VIEW CLIENT REPORT

Client summary | Client details | Support network | Approvals | **Plans** | Attachments | Services | My Aged Care interactions | Notes

Tasks and Notifications

Current Episode
Episode ID: 1-YA6XGPM
18 August 2022 - Present
SUPPORT PLAN

Upcoming Review(s)
No upcoming reviews scheduled

Assessment history

- Home Support Assessment 18 August 2022
- Screening 13 May 2020

Plan history
No plan history available

Review history
No review history available

Reablement and linking support history
No linking support items available

2. Under the Client concerns and goals section, select **ADD AREA OF CONCERN**.

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other Recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT

Recommend for Comprehensive Assessment

RECOMMEND FOR COMPREHENSIVE ASSESSMENT

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER | RETURN TO CLIENT



- In the pop-up box, record the area of concern, and select **SAVE TO PLAN**. The area of concern will appear under the **Client concerns and goals** section.

- To add a goal to the concern, select **ADD A GOAL**.

- In the pop-up box, enter the goal, record the client's motivation to achieve the goal (with 1 being least motivated to 10 being highly motivated), and the status of the goal, and select **SAVE TO PLAN**.

6. This information will appear under the associated area of concern. You can edit or remove goals and concerns that may no longer be relevant to the client's situation here, by selecting the **Pencil icon** or **Rubbish bin icon** respectively.

Client concerns and goals

ADD AREA OF CONCERN

Concern: Collin's injuries are preventing him from enjoying his usual hobbies, such as gardening.  

ADD A GOAL

 **Goal:** To be mobile enough to enjoy gardening and outdoor activities again.  

7. Continue to add concerns and goals by repeating steps 2-5.

Client concerns and goals

ADD AREA OF CONCERN

Concern: Collin's injuries are preventing him from enjoying his usual hobbies, such as gardening.

ADD A GOAL

 **Goal:** To be mobile enough to enjoy gardening and outdoor activities again.

! Display order of multiple concerns of goals

When multiple concerns or goals have been added, you are able to change the display order by using the drop-down box at the right-hand side of the record.

Client concerns and goals

ADD AREA OF CONCERN

Concern: To be more active in everyday life.   1 

ADD A GOAL

 **Goal:** To go to the gym twice per week.  

Concern: Collin's injuries are preventing him from enjoying his usual hobbies, such as gardening.   2 

ADD A GOAL

 **Goal:** To be mobile enough to enjoy gardening and outdoor activities again.  

Adding recommendations

You may choose to link recommended services to the client's area of concern and goals, or you can recommend services that are not linked to concerns and goals.

There are seven types of recommendations that can be added to a support plan following an assessment:

- **General recommendations** are non-Commonwealth funded supports that are identified by the assessor and the client and will be actioned by the client or the assessor rather than a service provider, for example: that the client sees a health practitioner, or that they join a local support group.
- **Service recommendations** are for adding recommendations for services to a client's support plan, such as Commonwealth Home Support Programme (CHSP) services.
- **Recommended long-term living arrangement** is only applicable to comprehensive assessments. It is the most appropriate long-term living situation identified during a comprehensive assessment that can be selected from a list of accommodation settings after discussing the goals with the client and/or their representative. This can only be recommended after a comprehensive assessment has been completed.
- **Care type for Delegate decision recommendations** are applicable only to comprehensive assessments. These recommendations relate to care types under the [Aged Care Act 1997](#) (the Act) which require approval by a Delegate. This can only be recommended after a comprehensive assessment has been completed.
- **No Care Type Under the Act** is only applicable to circumstances where a client withdraws their application for care or is not applying for care under the Act, and still requires CHSP services and/or general recommendations. This can only be recommended after a comprehensive assessment has been completed.
- **Recommendations for a period of linking support** are for where a client's complex circumstances may be a barrier to accessing aged care services, and providing linking support can assist the client to access various services they require.
- **Recommendations for a period of reablement** are for time-limited interventions that are targeted towards a client's specific goal(s) or desired outcome to adapt to some function loss, or regain confidence and capacity to resume their activities, for example: training in a new skill, modification to a client's home environment or having access to equipment or assistive technology.

Recommendations can be linked to concerns and goals, or they can be added as an **Other Recommendation**.

Further information on linking support and reablement is available in the *My Aged Care Assessment Manual* on the [department's website](#).

Recommendations can be associated to more than one goal. When adding your recommendations you can:

- Select one or more goals to associate a recommendation
- Unlink the recommendation from all goals.

You can select the appropriate recommendation from the **Other Recommendations** section of the **Goals & Recommendations** tab. You can then choose to link this recommendation to a

relevant goal. If you add a recommendation from the **Other Recommendations** section recommendation will be displayed underneath that heading.

Alternatively, you can add a recommendation directly to an area of concern and goal by selecting the arrow next to **Goal** and below **Add to this goal** on the right-hand side of the panel. If you add a recommendation from the **Add to this goal** section, the recommendation will be displayed underneath the goal. Select the arrow to the left of the goal to display the recommendation details.

To add a general recommendation, go to [General Recommendation](#).

To add a service recommendation, go to [Service Recommendation](#).

To add a recommendation for a period of linking support, go to [Period of Linking Support](#).

To add a recommendation for a period of reablement, go to [Period of Reablement](#).

To add a recommendation for a Care type for Delegate decision, go to [Care type for Delegate decision](#).

To add a recommendation of No Care Type Under the Act, go to [No Care Type Under the Act](#).



General Recommendation

Select **Add a general recommendation**.

Examples of general recommendations include:

- Develop Emergency Care Plan
- Connect with GP or other health professional
- Gain assistance with decision making
- Obtain a smoke alarm
- Develop a Personal Emergency Plan
- Investigate getting a Personal Alarm.

When a pop-up box is displayed, enter information about the general recommendation, check the box if you are linking it to a goal and select **SAVE TO PLAN**.

The screenshot shows a pop-up window titled "Add general recommendation". At the top, it states "All fields marked with an asterisk (*) are required." The form contains several sections: "Recommendation: *" with a text input field and a character count of "0 / 255"; "Responsibility to action" with three radio button options: "Assessor", "Client", and "Other"; "Comments:" with a text input field and a character count of "0 / 100"; "Associated goals" with two checkboxes: "To be mobile enough to enjoy gardening and outdoor activities again." (checked) and "To go to the gym twice per week." (unchecked). Below the goals is a button labeled "UNLINK THIS RECOMMENDATION FROM ALL GOALS". At the bottom right, there are two buttons: "SAVE TO PLAN" (highlighted with a red box) and "CANCEL".

As assessors are completing the assessment, they will be able to add general recommendations to the support plan from the assessment.

In the assessment, the assessor can select to **Add as Recommendation** and this will populate in the **Identified needs** and **Goals & recommendations** tabs in the support plan.

The screenshot shows a section of the assessment form. It includes a heading "Emergency care plan * ?" with two radio button options: "Yes" and "No". To the right, there is a checked checkbox labeled "Add as Recommendation". Below this is a "Details ?" label followed by a large text input field. A character count "0 / 500" is visible at the bottom right of the input field.

Service Recommendation

Select **Add a service recommendation**. When a pop-up box is displayed, select the recommended service, complete all mandatory fields and select **SAVE TO PLAN**.

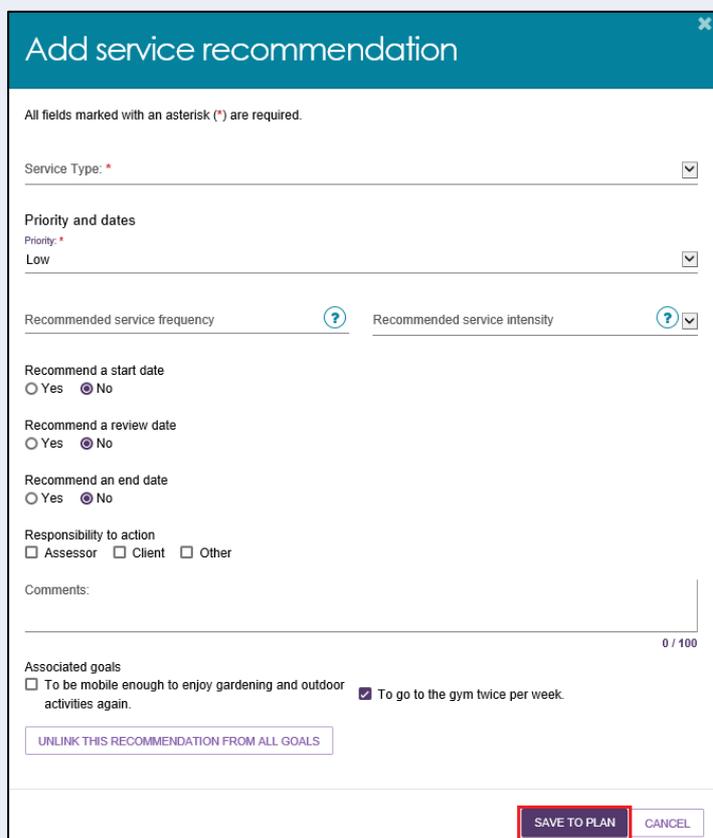
The priority for CHSP service recommendations will default to Low. Assessors should use the comments field to clarify the specific scope of the services that are recommended to be delivered within the CHSP service type. The scope of services should be linked to the identified needs from the assessment and goals referred to in the support plan, for example: unable to get to places beyond walking distance; requires transport to health clinic.

Recording Service Frequency and Intensity:

Assessors can record the recommended service frequency and intensity for each service they recommend. This is **not mandatory**. An assessor can record information that has been discussed with the client or information relating to a client's preference for the intensity of service delivery. This will be provided as a guide to the service provider who will agree the frequency and intensity of services with the client.

Where a client does not wish to access a particular service at that point in time, or only requires infrequent services, you should still create the service recommendation. The client will be able to access these services at a later date by calling the My Aged Care contact centre to facilitate the sending of electronic referrals from recommendations created in their support plan.

Entering specific information about the services required allows the provider and the contact centre to know whether a service is for a specific purpose only or for an ongoing need. The information allows the contact centre to make a decision regarding whether they can make the referral or need to request a Support Plan Review from the assessment organisation.



The screenshot shows a pop-up window titled "Add service recommendation" with a close button (X) in the top right corner. The form contains the following fields and options:

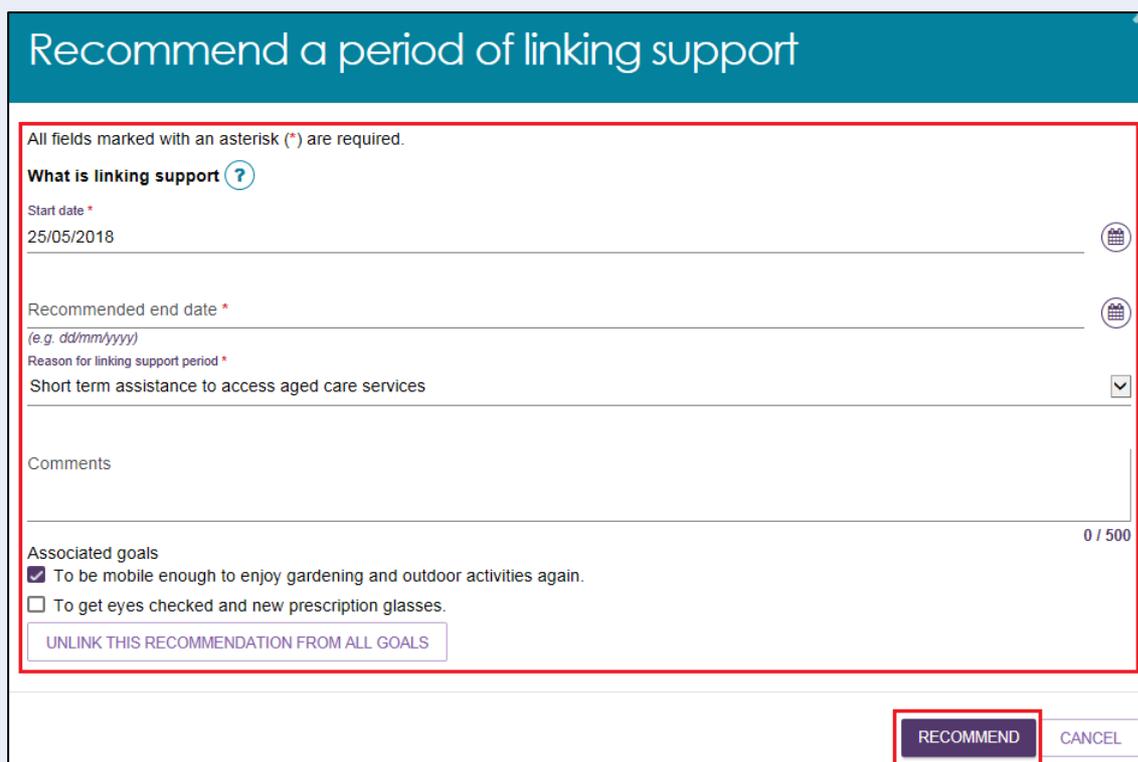
- Service Type:** A dropdown menu with a downward arrow icon.
- Priority and dates:**
 - Priority:** A dropdown menu with "Low" selected and a downward arrow icon.
 - Recommended service frequency:** A text input field with a question mark icon.
 - Recommended service intensity:** A text input field with a question mark icon and a downward arrow icon.
- Recommend a start date:** Radio buttons for "Yes" and "No", with "No" selected.
- Recommend a review date:** Radio buttons for "Yes" and "No", with "No" selected.
- Recommend an end date:** Radio buttons for "Yes" and "No", with "No" selected.
- Responsibility to action:** Checkboxes for "Assessor", "Client", and "Other".
- Comments:** A text area with a character count "0 / 100".
- Associated goals:** Checkboxes for "To be mobile enough to enjoy gardening and outdoor activities again." and "To go to the gym twice per week." The second checkbox is checked.
- Buttons:** A button labeled "UNLINK THIS RECOMMENDATION FROM ALL GOALS" and two buttons at the bottom: "SAVE TO PLAN" (highlighted in red) and "CANCEL".

Period of Linking Support

Select **RECOMMEND A PERIOD OF LINKING SUPPORT**. In the pop-up box that will display, enter the start date for the period of linking support and the recommended end date, and select the reason for recommending linking support from the drop-down menu. Include any relevant comments and linking to any goals where applicable. Select **RECOMMEND** to save to the client's support plan.

Please note that during a period of linking support, extensions requests for Transition Care and Residential Respite Care services can be requested and granted.

Further information regarding linking support is available in the [My Aged Care Assessment Manual](#).



The screenshot shows a pop-up window titled "Recommend a period of linking support". At the top, it states "All fields marked with an asterisk (*) are required." Below this is a section "What is linking support" with a help icon. The form contains the following fields:

- Start date ***: A date input field containing "25/05/2018" and a calendar icon.
- Recommended end date ***: A date input field with a calendar icon and a placeholder "(e.g. dd/mm/yyyy)".
- Reason for linking support period ***: A dropdown menu with "Short term assistance to access aged care services" selected.
- Comments**: A text area with a character count "0 / 500".
- Associated goals**: A list of goals with checkboxes:
 - To be mobile enough to enjoy gardening and outdoor activities again.
 - To get eyes checked and new prescription glasses.

At the bottom of the form, there is a button labeled "UNLINK THIS RECOMMENDATION FROM ALL GOALS". At the bottom right of the pop-up, there are two buttons: "RECOMMEND" and "CANCEL".

Period of Reablement

Select **RECOMMEND A PERIOD OF REABLEMENT**. When a pop-up box is displayed, enter the start date for the period of reablement and the recommended end date, and select the reason for recommending reablement from the drop-down menu. Enter any relevant comments and linking to any goals where applicable. Select **RECOMMEND** to save to the clients support plan.

Please note that during a period of reablement, extensions requests for Transition Care and Residential Respite Care services can be requested and granted.

Further information regarding reablement is available in the [My Aged Care Assessment Manual](#).



Recommend a period of reablement ✕

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

What is reablement ?

Start date*
09/02/2023 📅

RecommendedEndDate:*
28/02/2023 📅

Reason for reablement period*
To supporting independence through assessment for appropriate aids and equipment ▼

Comments
Comments go here

16 / 500

RECOMMEND
CANCEL

Care type for Delegate decision

1. Select **ADD A CARE TYPE FOR DELEGATE DECISION**. This can be done either as part of a goal, or separately.

Adding A Care Type as Part of a Goal

✕

Goal: to walk 30mins 3 times a week

Motivation to achieve: 5

Status: In Progress

🗑️
✎

Recommendations

Recommendation ✎ 🗑️

Find some exercise buddies for bushwalking

Responsibility to action: Client

Recommended by: Joshua Mills74 (Assessor) ACAT Outlet 1

Add to this goal:

ADD A GENERAL RECOMMENDATION

ADD A SERVICE RECOMMENDATION

ADD A CARE TYPE FOR DELEGATE DECISION

LINK TO AN EXISTING RECOMMENDATION

Adding A Care Type Separately

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

Client concerns and goals

No client concerns or goals.

Other recommendations

2. At the pop-up, select which care type applies, enter a reason and comments if necessary, then select **SAVE TO PLAN**. The Care types available are:

- Home Care Package Level 1
- Home Care Package Level 2
- Home Care Package Level 3
- Home Care Package Level 4
- No change to existing care approvals
- Residential permanent
- Residential respite care
- Short-term restorative care
- Transition Care.

Add care type for delegate decision

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

Reason or comments

0 / 255



3. Fill out the next pop-up including all mandatory fields, and then select **SAVE TO PLAN**. The information asked will be different depending on the care type chosen.

The following screenshot is an example of the pop-up for Residential Respite Care.

The screenshot shows a form titled "Add care type for delegate decision" with a close button in the top right corner. A red box highlights the instruction: "All fields marked with an asterisk (*) are required." The form contains the following fields:

- "Which care type applies?*" with a dropdown menu set to "Residential Respite Care".
- "If time-limited, when does the approval stop (optional):" with a date picker icon and a placeholder "(e.g. dd/mm/yyyy)".
- "What is the priority of this care type?*" with a dropdown menu set to "High" and a help icon.
- "Is this emergency care?" with radio buttons for "Yes" (selected) and "No".
- "When did the emergency care start?" with a date picker icon and a placeholder "(e.g. dd/mm/yyyy)".
- "Reason or comments" with a text area and a character count "0 / 255".
- A checkbox: "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.*"
- A text input field: "Reason DEMMI not completed*" with the placeholder "Enter reason here".

At the bottom right, there are two buttons: "SAVE TO PLAN" (highlighted with a red box) and "CANCEL".

! If a client is under the aged of 65, several additional entry fields will appear to document their exceptional circumstances.

Home Care Packages – Priority and Levels

For Home Care Packages, the Priority of this care type determines the Priority for home care service for the purposes of assigning a place in the national priority system.

If it is determined that a client has a high priority for a home care package, you are required to answer all mandatory questions and provide your reason or comments using the available comment field.

! **Please note that interim packages are not being released at this time.** Any decision to reinstate interim packages will be communicated to assessors through the regular bulletins.

Select **SAVE TO PLAN**.

(e.g. dd/mm/yyyy)

What is the priority of this care type? *

High

The priority for home care service is High ?

What is the reason for a high priority home care recommendation ? ? *

Carer is in crisis or no longer able to provide care due to

Personal safety at risk

Immediate risk of the client entering residential care due to

The client's preference for seeking home care services is

Seeking services Not seeking services

What is the agreed minimum interim package level?

Home Care Package Level 1

Is this emergency care?

Yes No

Reason or comments *

0 / 255

SAVE TO PLAN CANCEL

If the client has been marked as Seeking services and/or a Home Care Package has been recommended, assessors will be able to change notifications regarding home care correspondence. To do this, select **REQUEST/CHANGE NOTIFICATION OF HOME CARE CORRESPONDENCE** which will be located at the bottom of the screen.

COMPLETE SUPPORT PLAN REQUEST/CHANGE NOTIFICATION OF HOME CARE CORRESPONDENCE RETURN TO CLIENT

A pop-up will then display. Select the appropriate option and click **SAVE**.

Notify of home care correspondence

i No-one is currently selected to receive notifications when Andy JORGENSEN is sent home care correspondence.

Do not notify anyone

Notify of home care correspondence

Recipient *

Bella BLUETT

SAVE CANCEL



Short-Term Restorative Care (STRC)

! A client is only eligible to receive Short-Term Restorative Care (STRC) under certain conditions. When approving STRC for a client who does not meet the eligibility criteria a warning message will appear asking if you wish to proceed with the approval.



Please ensure this client is eligible for STRC as:

- the client currently has a committed Home Care Package.

Do you wish to proceed?

! Clinical assessors should not recommend a client for approval of STRC where the care recipient has an episode of Transition Care Programme (TCP) within the previous 6 months.

A complete list of the STRC eligibility criteria can be found in the [Short-Term Restorative Care Programme Manual](#).

Add care type for delegate decision



Please ensure this client is eligible for STRC as:

- the client currently has a committed Home Care Package.

Do you wish to proceed?

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

Which care type applies? *

Short-Term Restorative Care

In Home/Community In Home/Community and Residential Facility In Residential Facility

What is the priority of this care type? * 

Low

Is this emergency care?

Yes No

Reason or comments

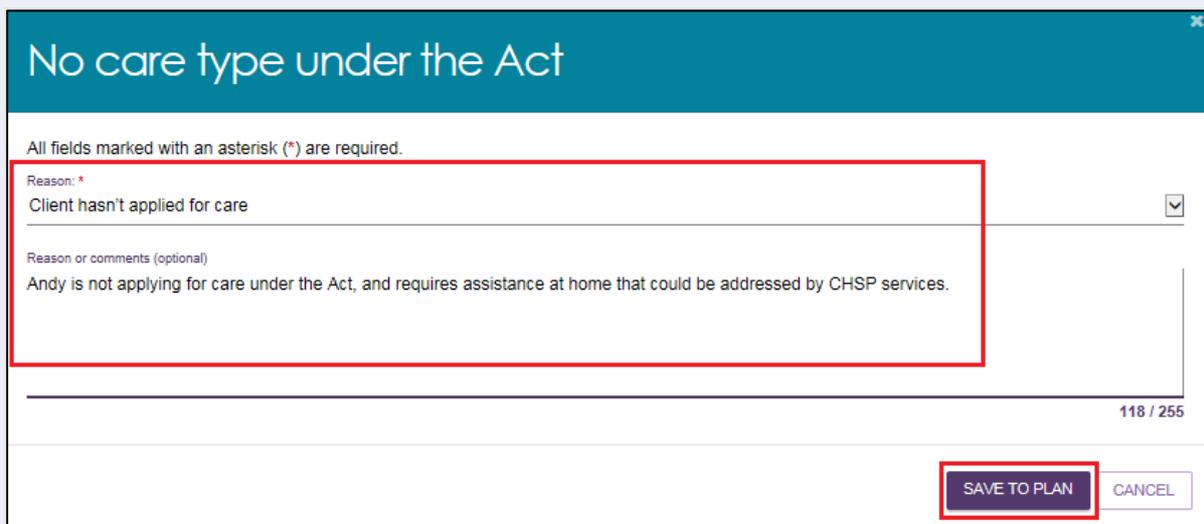
0 / 255

No Care Type Under the Act

Where a person is determined as not meeting the eligibility requirements of any care program under the Act, the assessment will result in **No Care Approved** and the client receives a Non-Approval letter. For assessments where no care under the Act is approved, clinical assessors may recommend other forms of care and support on the support plan, for example CHSP if available and suitable, or local/state-based services.

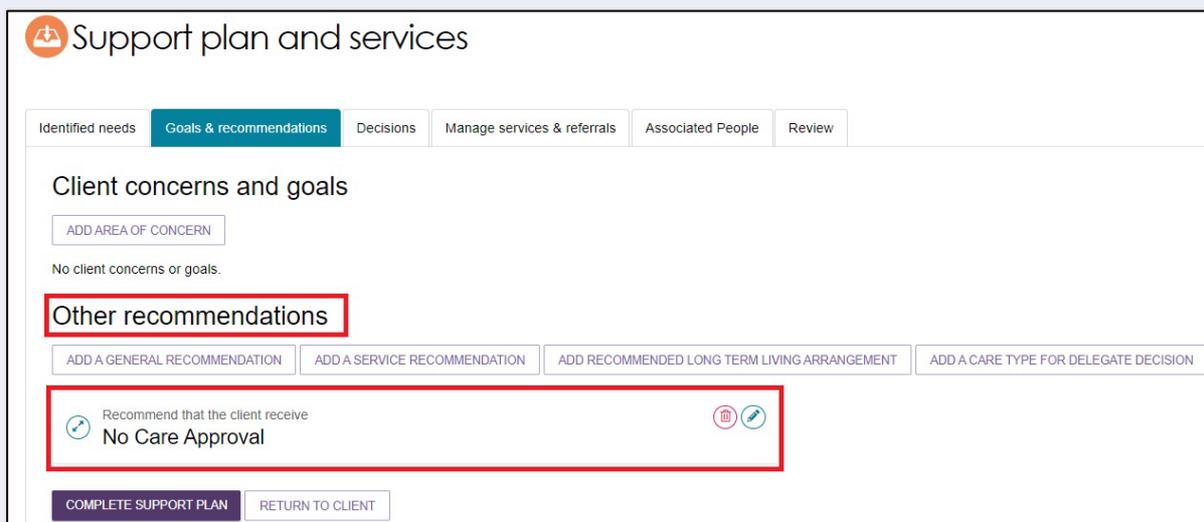
1. Select **No Care Type Under The Act**. When a pop-up box is displayed, select the reason for the recommendation that the client receives No Care Type Under the Act, enter a comment or reason if appropriate and select **SAVE TO PLAN**.

If you recommend **No Care Type Under the Act**, you will be able to match and refer for CHSP services without needing to submit to the Delegate for approval.



The screenshot shows a pop-up window titled "No care type under the Act". At the top, it states "All fields marked with an asterisk (*) are required." Below this, there is a "Reason:" field with a dropdown menu currently showing "Client hasn't applied for care". Underneath is a "Reason or comments (optional)" text area containing the text "Andy is not applying for care under the Act, and requires assistance at home that could be addressed by CHSP services." At the bottom right of the form, there are two buttons: "SAVE TO PLAN" and "CANCEL". A red box highlights the "Reason:" dropdown and the "SAVE TO PLAN" button.

2. Alternatively, if you add a recommendation from the **Other recommendations** section or are adding a **No Care Type Under the Act** recommendation, the recommendation will be displayed underneath that heading. The recommendation will not be linked to a goal.

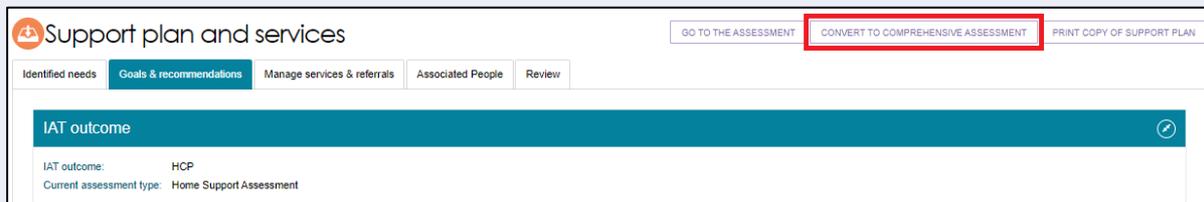


The screenshot shows the "Support plan and services" interface. It has a navigation bar with tabs: "Identified needs", "Goals & recommendations" (selected), "Decisions", "Manage services & referrals", "Associated People", and "Review". Below the navigation bar, there is a section for "Client concerns and goals" with an "ADD AREA OF CONCERN" button and the text "No client concerns or goals." Below that is the "Other recommendations" section, which is highlighted with a red box. It contains four buttons: "ADD A GENERAL RECOMMENDATION", "ADD A SERVICE RECOMMENDATION", "ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT", and "ADD A CARE TYPE FOR DELEGATE DECISION". Below these buttons, there is a recommendation card for "No Care Approval" with a red box around it. At the bottom of the interface, there are two buttons: "COMPLETE SUPPORT PLAN" and "RETURN TO CLIENT".

Convert to Comprehensive Assessment

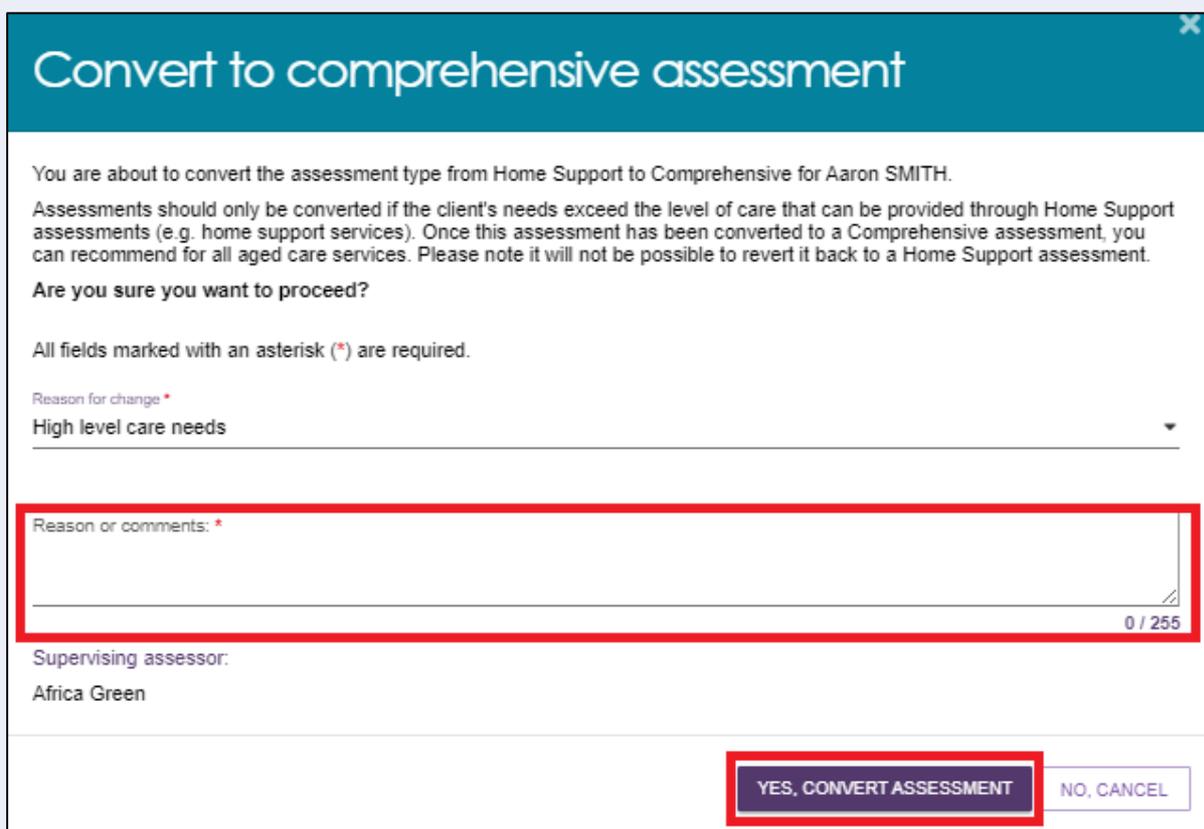
Non-clinical assessors will have the option to change the assessment from Home Support to Comprehensive once the IAT has been finalised and the algorithm has determined an outcome recommendation. This can only be done if the outlet supports both types of assessments.

1. From the **Goals & recommendations** tab select **CONVERT TO COMPREHENSIVE ASSESSMENT** from the top right-hand side.



The screenshot shows the 'Support plan and services' interface. At the top right, there are three buttons: 'GO TO THE ASSESSMENT', 'CONVERT TO COMPREHENSIVE ASSESSMENT' (highlighted with a red box), and 'PRINT COPY OF SUPPORT PLAN'. Below the buttons, there are tabs for 'Identified needs', 'Goals & recommendations' (selected), 'Manage services & referrals', 'Associated People', and 'Review'. The main content area shows 'IAT outcome' with a refresh icon. Below that, it displays 'IAT outcome: HCP' and 'Current assessment type: Home Support Assessment'.

2. The reason for change will be pre-selected to **High level care needs**. Enter in the reason or comments for converting the assessment and then select **YES, CONVERT ASSESSMENT**.



The screenshot shows a dialog box titled 'Convert to comprehensive assessment'. It contains the following text: 'You are about to convert the assessment type from Home Support to Comprehensive for Aaron SMITH. 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.' Below this, there is a dropdown menu for 'Reason for change' with 'High level care needs' selected. A text area for 'Reason or comments' is highlighted with a red box and shows '0 / 255' characters. Below the text area, it says 'Supervising assessor: Africa Green'. At the bottom right, there are two buttons: 'YES, CONVERT ASSESSMENT' (highlighted with a red box) and 'NO, CANCEL'.

3. A green banner will then display at the bottom of the screen confirming the assessment has been successfully changed. The IAT outcome will now also reflect that a Comprehensive Assessment has been completed.

Support plan and services GO TO THE ASSESSMENT PRINT COPY OF SUPPORT PL

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

IAT outcome ✓

IAT outcome: HCP
 Current assessment type: Comprehensive Assessment

Client concerns and goals

ADD AREA OF CONCERN

Concern: And I looked at it, and 9C6341827 ⊕ ✎

ADD A GOAL

Goal: To have access to a home care package ⊕ ✎

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT ADD A CARE TYPE FOR DELEGATE DECISION ADD 'NO CARE TYPE UNDER THE ACT'

RECOMMEND A PERIOD OF LINKING SUPPORT RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive
 Personal Care

Recommend that the client receive
 Residential Permanent

Recommend that the client receive
 Allied Health and Therapy Services

Assessment type has been changed

Manage services and referrals

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

The **Manage services & referrals** tab enables assessors to issue referrals for any recommended CHSP services. It also enables the assessors to actively manage service and waitlist referrals for clients, including reissuing all referrals rejected.

The [My Aged Care – Assessor Portal User Guide 8 – Referring for services](#) contains detailed information on this process.

The below screenshot gives an example of what can appear beneath the Manage Services & Referrals tab.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

Services not yet in place

Help at home ✎

Allied Health and Therapy Services ● Low ● Recalled Referrals

- Dietitian or Nutritionist

No associated goals
 Recommended By: Rose RoseL
 User Type: Assessor

FIND PROVIDERS ISSUE REFERRAL CODE REMOVE THIS SERVICE RECOMMENDATION

Associated People

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

The **Associated People** tab allows non-clinical assessors to record any people that were involved in the development of the support plan, or will assist the client (with the client's consent) with actions within the support plan.

1. Select **ADD PEOPLE**.

People associated with support plan

ADD PEOPLE

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER RETURN TO CLIENT

2. Select **ADD A PERSON**.

Add people to support plan

Which of the following people would you like to associate with the support plan?

Lacey Bloom

ADD A PERSON

SAVE CANCEL

3. Enter required information and select **SAVE** to add the associated person to the clients support plan. You can capture their mailing address in case they wish (with client consent) to receive a copy of the clients support plan.

Add a person to support plan

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

First name: *
Rachael

Last name:
Daniels

Role:
Other

Relationship to client:
Daughter

Organisation:

Phone:

Email:

Mailing address

Unit number or building name and level (if applicable):

Street number, name, street type:

SAVE CANCEL

4. Select the person you want to associate to the clients support plan and select **SAVE**.

Which of the following people would you like to associate with the support plan?

Joseph Franklin

Rachael Daniels

Daughter (Other)

Did this person participate in the planning process? *

Yes No

Has the client consented to providing a copy of this plan to this person? *

Yes No

Provided with a copy of the support plan

ADD A PERSON

SAVE CANCEL

5. The person will now display in the **Associated People** tab in the clients support plan.

People associated with support plan

Rachael Daniels
Daughter (Other)

Did this person participate in the planning process?

Yes No

Has the client consented to providing a copy of this plan to this person?

Yes No

Provided with a copy of the support plan

ADD PEOPLE

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER RETURN TO CLIENT

Review

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

The **Review** tab enables assessors to schedule a date for review of a clients support plan. During a review, assessors can review and, where appropriate, amend a client's support plan. If necessary, a new assessment can be initiated for a client following the review.

1. To schedule a review of a clients support plan, select the **calendar icon** to choose a review date.

All fields marked with an asterisk (*) must be completed before submission

Schedule a review

Schedule a date to review the client's Support plan.

Review Date:
(e.g. dd/mm/yyyy)

SAVE CHANGES

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER RETURN TO CLIENT

2. Once a date has been selected from the drop-down calendar and a reason for review has been entered, select **SAVE CHANGES** to set the review date.

Schedule a review

Schedule a date to review the client's Support plan.

Review Date: *
22/02/2019 

Reason for review *
To ensure care arrangements meet the client's needs. |

SAVE CHANGES

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER RETURN TO CLIENT

3. The review date will be displayed in the **support plan**. Once a review date has been added to the **support plan**, the referral will display in the team lead's **Upcoming reviews** tab. A new ad hoc review request is able to override the scheduled review.

Completing the support plan

A client's support plan must be completed in order to be able to send referrals for any recommended services.

To complete the support plan for a Home Support assessment, follow the steps below.

1. Confirm that you have made all service or general recommendations, and are satisfied with the client's goals and concerns, as the support plan cannot be edited after it has been completed.
2. Select, **COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER** from any tab in the clients support plan.

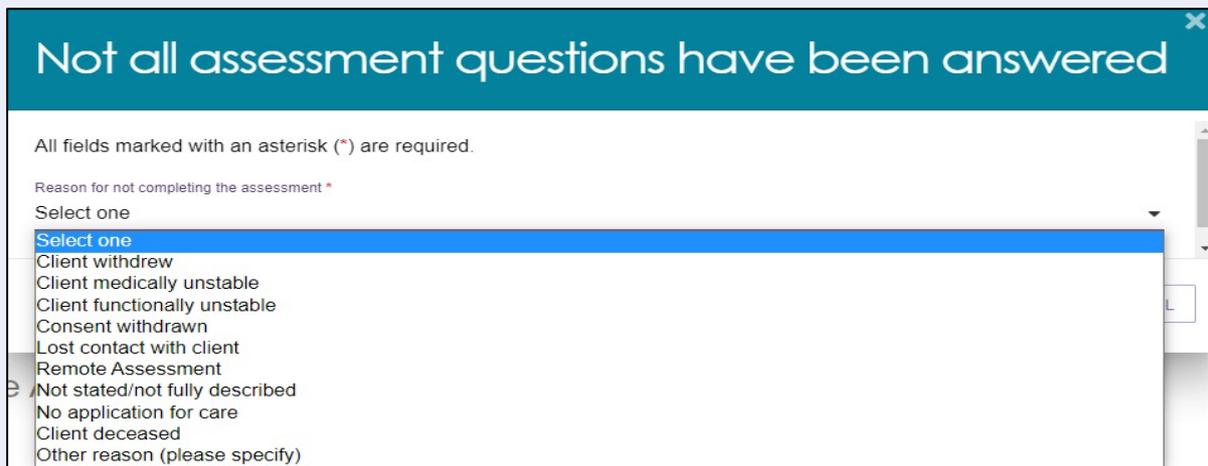
COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER

Review the assessment summary and support plan carefully for consistency and accuracy before completing the support plan. Once you select **COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER**, you will not be able to make any changes to the assessment or support plan.

However, you will still be able to issue referrals, generate referral codes and action rejected referrals, for recommendations after you have finalised support plan, where appropriate.

3. If you have not answered all the mandatory questions in the assessment, a pop-up box will be displayed. You will be required to provide a reason for not completing all the mandatory questions before you can **Complete assessment**.





! If your reason for ending an assessment without answering all mandatory questions is **Client deceased**, this 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, assessments will be cancelled and the client's access to the client portal will be revoked. My Aged Care will not send correspondence to the client or their support network after the status is changed to **Deceased**.

4. You will be taken to the **Manage services & referrals** tab to match and refer for services.

Completing the support plan for a Comprehensive assessment.

To complete the support plan for a Comprehensive assessment, follow the steps below.

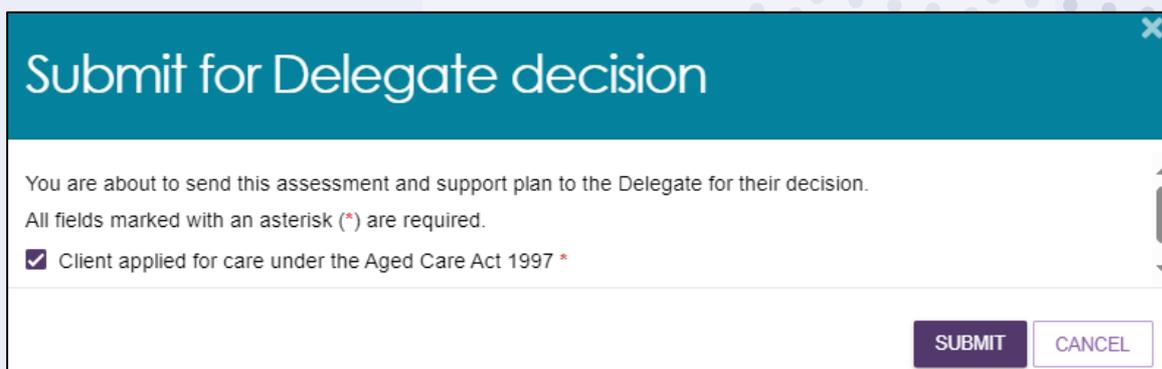
1. Confirm that you have made all service or general recommendations, and are satisfied with the client's goals and concerns, as the support plan cannot be edited after it has been completed.
2. Select, **COMPLETE SUPPORT** from any tab in the clients support plan.



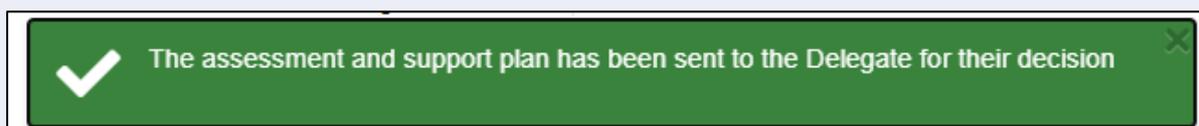
3. You will be taken to the **Decisions** tab to submit for Delegate decision. Scroll to the bottom of the page and select **SAVE AND SUBMIT FOR DELEGATE DECISION**.



4. From the pop-up tick the appropriate box and select **SUBMIT**.



A green banner will then display confirming the assessment and support plan has been sent to the Delegate for their decision.



Finalising the support plan

When you have completed the assessment and the support plan, you will need to arrange referrals for the recommended service(s), before finalising the support plan.

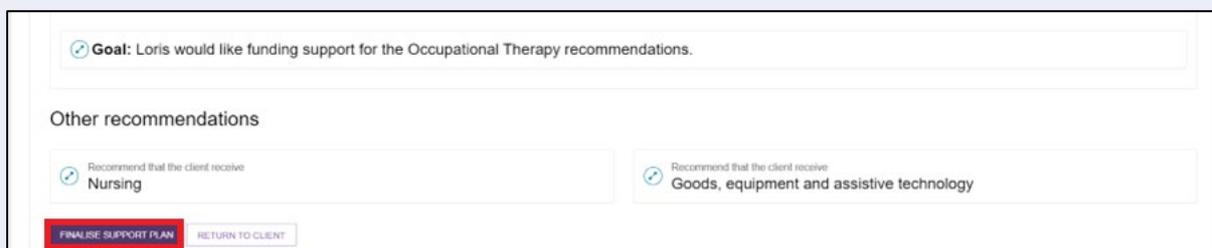
Refer to the [My Aged Care – Assessor Portal User Guide 8 – Referring for services](#) for detailed information on this process.

! The client's support plan should be finalised once an effective referral(s) has been made or where the client chose not to proceed with aged care services or to manage their own referrals. An effective referral is where:

- A referral is accepted by a service provider
- The client has accepted responsibility for managing their own referral
- The outcome of the assessment is that no further action is required by the assessor.

To finalise the support plan, follow the steps below.

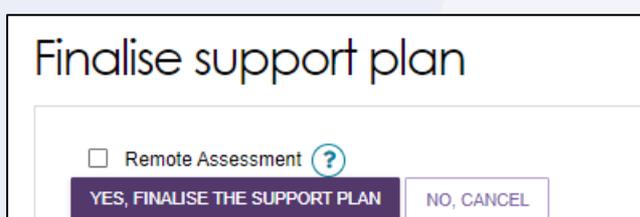
1. From any tab in the clients support plan you will have the option to **FINALISE SUPPORT PLAN** at the bottom of the page.



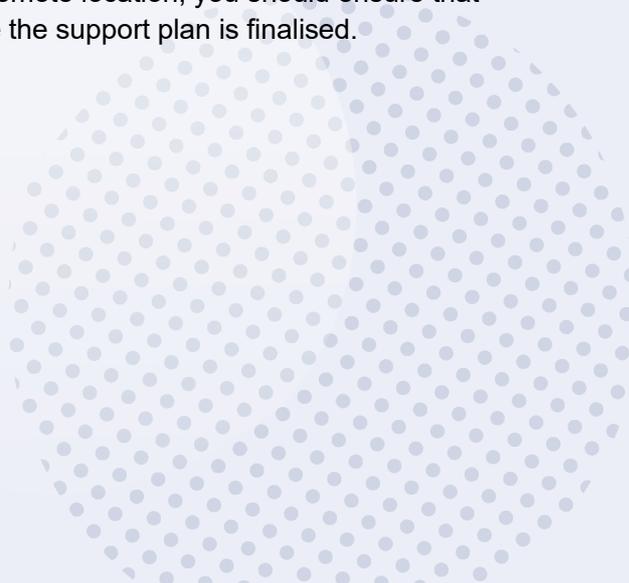
The screenshot shows a user interface for finalising a support plan. At the top, there is a goal statement: "Goal: Loris would like funding support for the Occupational Therapy recommendations." Below this, under the heading "Other recommendations", there are two recommendation cards: "Recommend that the client receive Nursing" and "Recommend that the client receive Goods, equipment and assistive technology". At the bottom of the interface, there are two buttons: "FINALISE SUPPORT PLAN" (highlighted in red) and "RETURN TO CLIENT".

2. A pop-up box will display, and the referral status for each recommended service type will be pre-populated. Where a referral is **Not Actioned** you will need to record a reason.

If the face-to-face assessment was conducted in a remote location, you should ensure that the Remote Assessment indicator is selected before the support plan is finalised.



The screenshot shows a pop-up box titled "Finalise support plan". It contains a checkbox labeled "Remote Assessment" with a question mark icon next to it. Below the checkbox are two buttons: "YES, FINALISE THE SUPPORT PLAN" (highlighted in purple) and "NO, CANCEL".



3. Once you have confirmed these outcomes, select **YES, FINALISE THE SUPPORT PLAN**.

The screenshot shows a web form titled "Finalise support plan". At the top, there is a teal header with the title and a close button. Below the header is a light blue banner with an information icon and the text: "Are you sure you want to finalise this support plan? You will not be able to make any changes to the support plan once finalised." Below this, a note states: "All fields marked with an asterisk (*) are required." There is a checkbox for "Remote Assessment" with a question mark icon. The main section is titled "Service Recommendations" and contains three categories: "Meals", "Domestic Assistance", and "Goods, equipment and assistive technology". Each category has a dropdown menu for "Referral Code Generated" and a "Comments" text area with a character count (0 / 500). At the bottom right, there are two buttons: "YES, FINALISE THE SUPPORT PLAN" and "NO, CANCEL".

! If you are choosing outcomes to support a client located remotely, Community-based care can be selected as an outcome.

Outcome comments are required where not actioned or Community-based care is selected following a remote assessment. Please provide detailed comments to support your outcome reasons.

This screenshot shows the same "Finalise support plan" form, but with a yellow warning box highlighted. The warning message reads: "If you are choosing outcomes to support a remote access client, please supply detailed comments to support your reasoning against the appropriate outcome below." Below the warning, the "Service Recommendations" section is visible, with "Allied Health and Therapy Services" selected. The "Outcome" dropdown is set to "Not actioned". The "Outcome Reason" dropdown is open, showing several options: "Funded services unavailable", "To seek nonfunded services", "Client accepted to waitlist", "Client declined services", "Undergoing support", and "Community-based care". The "Community-based care" option is highlighted with a red box. At the bottom right, the "YES, FINALISE THE SUPPORT PLAN" and "NO, CANCEL" buttons are visible.

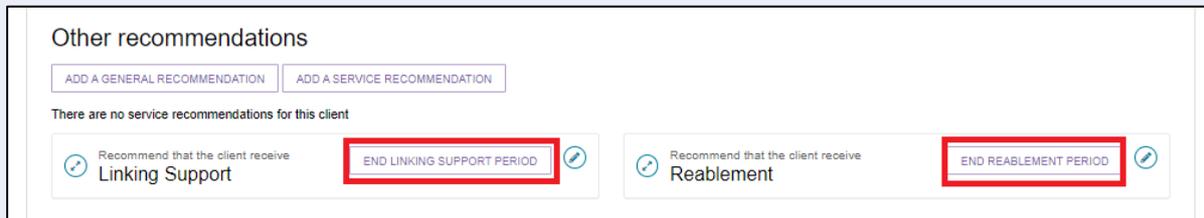
4. You will receive a confirmation message that the support plan has been finalised.



Ending a period of reablement or linking support

Assessors are able to end the period of support, in either one of two ways.

1. End each linking support and/or reablement period individually, by selecting **END LINKING SUPPORT PERIOD** or **END REABLEMENT PERIOD** on the **Goals & recommendations** tab of the clients Support Plan. Assessors are required to enter the end date for the support period and the outcome.



Other recommendations

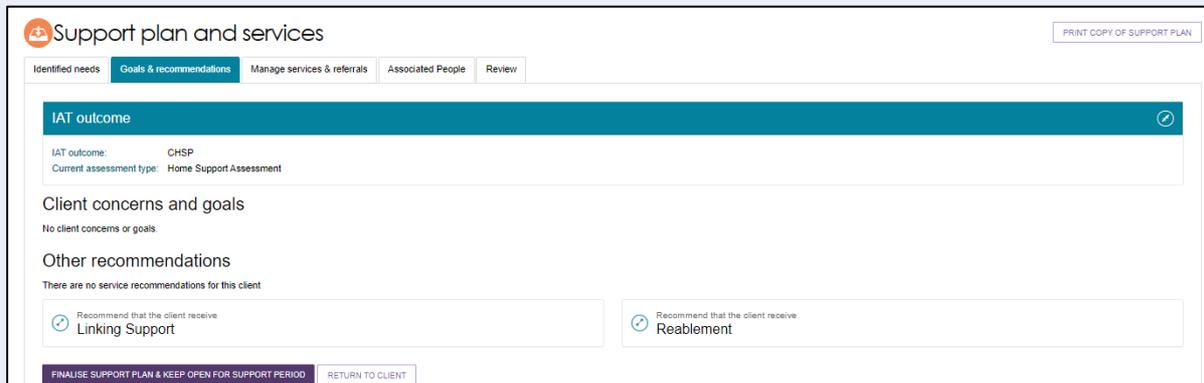
ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

There are no service recommendations for this client

Recommend that the client receive Linking Support **END LINKING SUPPORT PERIOD**

Recommend that the client receive Reablement **END REABLEMENT PERIOD**

2. To finalise the support plan, but keep the support period open, select **FINALISE SUPPORT PLAN & KEEP OPEN FOR SUPPORT PERIOD**.



Support plan and services

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

IAT outcome

IAT outcome: CHSP
Current assessment type: Home Support Assessment

Client concerns and goals

No client concerns or goals

Other recommendations

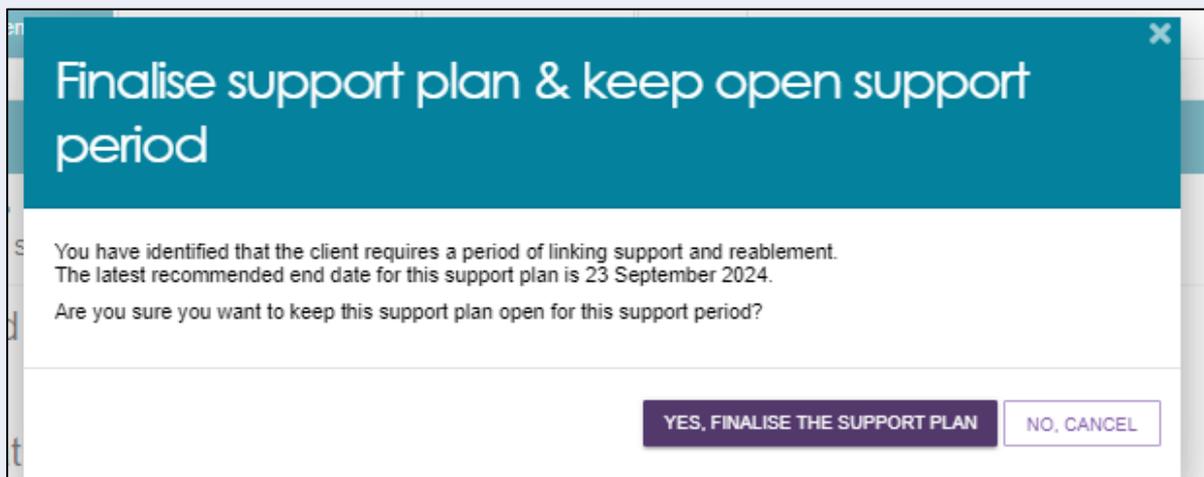
There are no service recommendations for this client

Recommend that the client receive Linking Support

Recommend that the client receive Reablement

FINALISE SUPPORT PLAN & KEEP OPEN FOR SUPPORT PERIOD RETURN TO CLIENT

3. A pop-up box will appear and ask you to finalise the support plan and keep open the support period. To finalise select **YES, FINALISE THE SUPPORT PLAN**.



Finalise support plan & keep open support period

You have identified that the client requires a period of linking support and reablement. The latest recommended end date for this support plan is 23 September 2024.

Are you sure you want to keep this support plan open for this support period?

YES, FINALISE THE SUPPORT PLAN NO, CANCEL

- End all linking support and/or reablement periods at the same time by selecting **SUPPORT PERIOD COMPLETE – FINALISE SUPPORT PLAN** on the **Goals & Recommendations** tab of the clients support plan.

Support plan and services GO TO THE ASSESSMENT PRINT COPY OF SUPPORT PLAN

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

IAT outcome

IAT outcome: CHSP
Current assessment type: Home Support Assessment

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

There are no service recommendations for this client

Recommend that the client receive **Linking Support** END LINKING SUPPORT PERIOD

Recommend that the client receive **Reablement** END REABLEMENT PERIOD

SUPPORT PERIOD COMPLETE - FINALISE SUPPORT PLAN RETURN TO CLIENT

- All periods of linking support and/or reablement that have not ended will be displayed. Assessors are required to enter the end date for each support period and the outcome.

Support period complete - finalise support plan

You are about to end the support period, and finalise the client's support plan.
Where you have not previously provided an end date for each linking support and/or reablement period, it will default to the end date of the support period, as entered below

All fields marked with an asterisk (*) are required.
Are you sure you want to finalise this support plan?
You will not be able to make any changes to the support plan once finalised.

Support Recommendations

The end date for this support period is *
13/09/2024

Linking Support - Access Aged Care services

Outcome of this linking support period *

Comments

Reablement - Mobility

Were the client's goals met? *

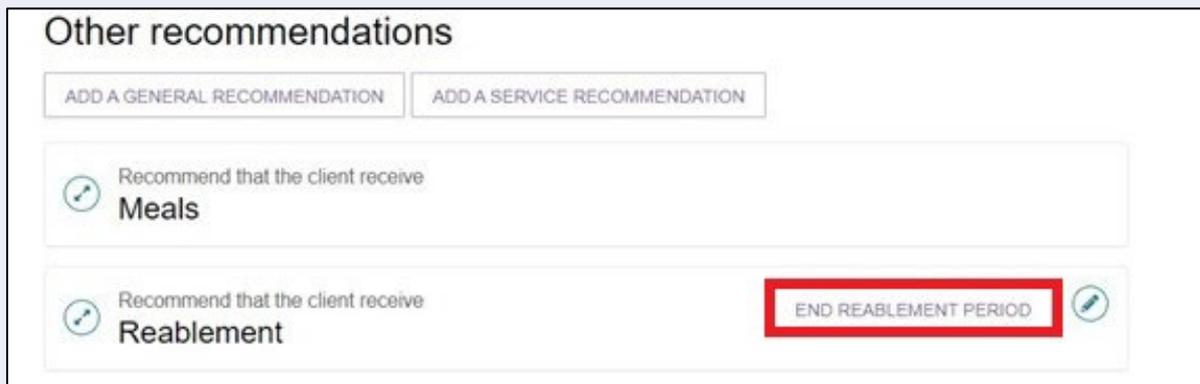
Outcome of this reablement period *

Comments

SUPPORT PERIOD COMPLETE - FINALISE SUPPORT PLAN NO, CANCEL



6. When assessors need to end the period of reablement for client they will be able to access it from the **END REABLEMENT PERIOD** button beside the **Reablement** tile under **Other recommendations**.



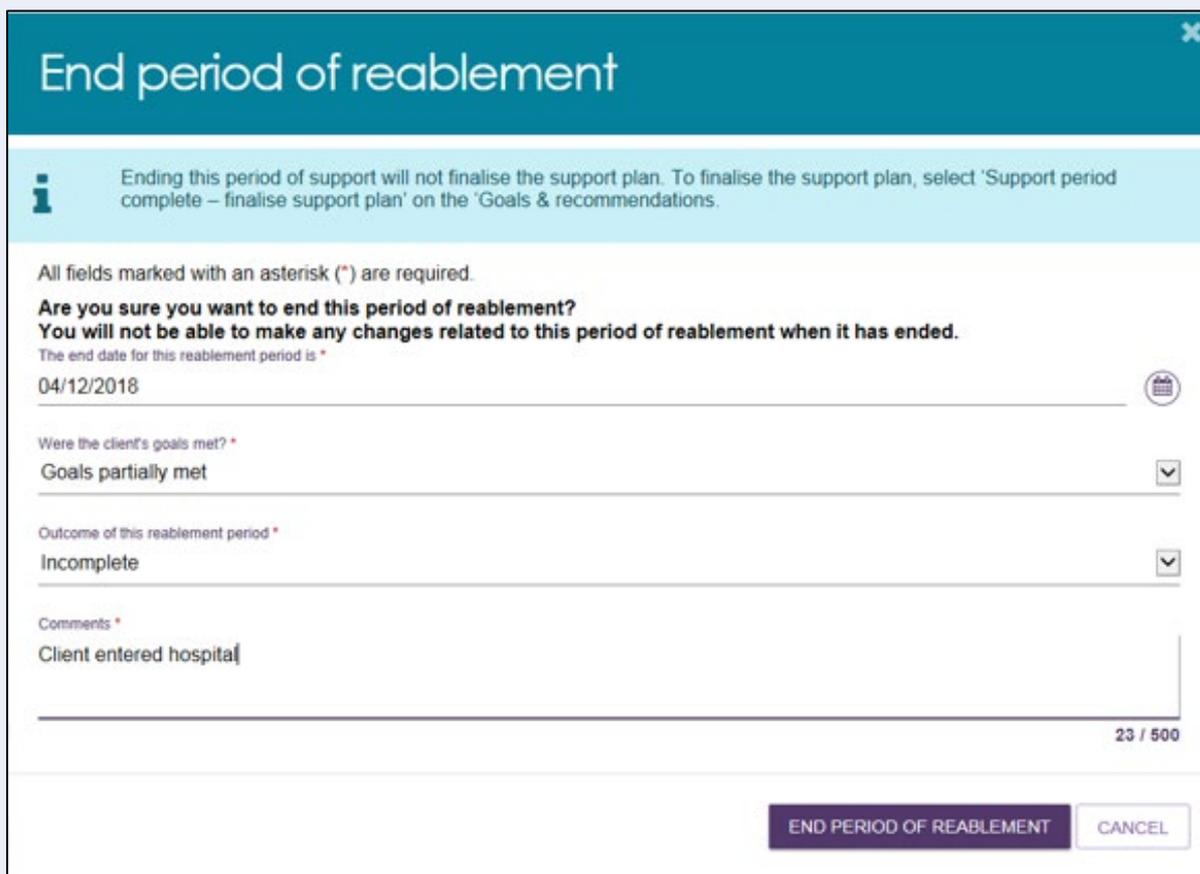
Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

Recommend that the client receive
Meals

Recommend that the client receive
Reablement **END REABLEMENT PERIOD**

7. A pop-up will appear with the title End period of reablement. Assessors will need to answer two mandatory questions in the **End period of reablement** section in the assessor portal. The first question asks whether the client's reablement goals were met. The second question prompts the assessor to detail outcomes by selecting from a drop-down menu. Mandatory questions will be marked with an asterisk. Assessors should provide further information about the end of period of reablement in the comments box.



End period of reablement

i Ending this period of support will not finalise the support plan. To finalise the support plan, select 'Support period complete – finalise support plan' on the 'Goals & recommendations'.

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

Are you sure you want to end this period of reablement?
You will not be able to make any changes related to this period of reablement when it has ended.

The end date for this reablement period is *

04/12/2018

Were the client's goals met? *

Goals partially met

Outcome of this reablement period *

Incomplete

Comments *

Client entered hospital

23 / 500

END PERIOD OF REABLEMENT CANCEL

! If a client is undergoing a period of support (linking support and/or reablement), the team leader may contact the assessor asking them to end the period of support in order to assign a Support Plan Review. Alternatively, the assessor can request that the team leader cancel the review so the assessor can continue the period of support.

Printing a copy of the support plan

A PDF version of a clients support plan is available to print from the assessor portal. The printed version includes the clients: Last completed Support Plan Review (if applicable), Assessment Summary, Goals & Recommendations (including areas of concern), recommended services and strategies and any current care approvals.

To print a copy of the clients support plan, select the **PRINT COPY OF SUPPORT PLAN** link from the client record or support plan.

Support plan and services

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

PRINT COPY OF SUPPORT PLAN

IAT outcome

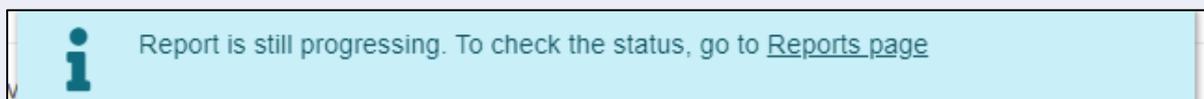
IAT outcome: CHSP
Current assessment type: Home Support Assessment

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

A blue banner will appear at the bottom of the screen whilst the report is in progress. Select **Reports page** to navigate to the Reports and documents page.



From the **Report and documents** page select **View**.

Reports and documents

Reports | Forms | Links

My Reports

Name	Requested Date	Status
Aaron Smith Support Plan 23 September 2024	23 September 2024	Ready View

The printer friendly version of the support plan will download. Select your printer options and select **Print**.

Australian Government | myagedcare

SUPPORT PLAN

Clara CLIENT
Aged Care ID: AC77106631 **Date of Birth: 01/07/1948** **Age: 73 years**

Clara CLIENT

Aged Care ID: AC77106631

DOB: 13/10/1937

Goals & Recommendations

No current concerns, goals or recommendations

General recommendations not associated with any particular goal(s)

No current general recommendations

Service recommendations

Personal Care

Sub-Type N/A Priority Low

Recommended frequency and intensity 2 Days per week

Responsibility to Action

Outcome Referral sent to provider

Service provider (1) Community Options act limited

Contact Details +610243789027 Status Issued

If a client already has a previous Support Plan Review completed the following section named **Support Plan Review (first completed)** would be displayed before the Goals and Recommendations section.

Australian Government | myagedcare | SUPPORT PLAN

Ms Clara CLIENT

Aged Care ID: AC10390094 | Date of Birth: 12/01/1938 | Age: 83 years

Support Plan Review (first completed)

Review Date: 04/03/2021

Conducted by: Ronald Representative

Conducted with: Representative

Outcome of Review: Updates to the existing plan

Outcome Details:

Updated services for CHSP

Assessment Summary

Introduction -

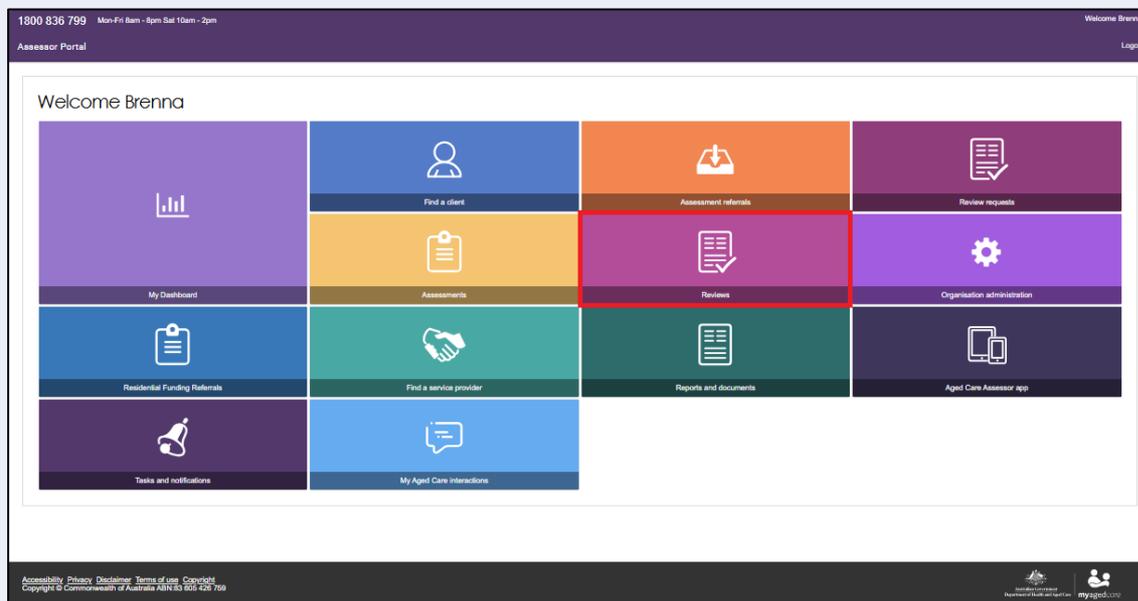
- ▷ Situation
- ▷ Background
- ▷ Assessment
- ▷ Recommendation



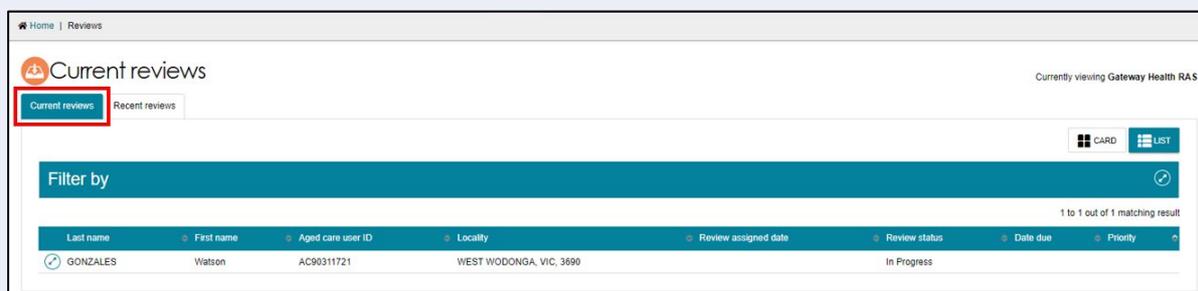
Receiving and starting Support Plan Reviews

How to view Support Plan Reviews

1. An assessor can view all Support Plan Reviews assigned to them by selecting the **Reviews** tile from the homepage.



2. All Support Plan Reviews that have been assigned to them are listed under the **Current reviews** tab. To view assigned Support Plan Reviews, assessors will find their assigned work in the **Current review** section.



Starting a Support Plan Review

You are able to start an ad hoc Support Plan Review for any client who has been assessed by your assessment outlet, without requiring a Support Plan Review to be assigned to you. This can be done from any tab within the client record by selecting **START SUPPORT PLAN REVIEW** or via selecting the client card from the **Current review** page.

An ad hoc review will override a scheduled review. In this instance the team leader should cancel the scheduled review in their upcoming review tab if it is no longer required.

1. To start a Support Plan Review that has been assigned to you, expand the client card in either card or list view. The Client Summary page displays. Select **START SUPPORT PLAN REVIEW**.



1800 836 799 Mon-Fri 8am - 8pm Sat 10am - 2pm Welcome Rose

Assessor Portal Logout

Home | Find a client | Michele JAMISON (Eloy)

Mr Michele N JAMISON (Eloy)
 Male, 93 years old, 10 January 1930, AC75850339
 15 LIMBURG WAY GREENWAY, ACT, 2900

Primary contact: Michele Jamison (self) - 61 2987 1234
 No support relationships recorded

Client summary REFER THIS CLIENT FOR ASSESSMENT VIEW CLIENT REPORT START SUPPORT PLAN REVIEW

Client summary | Client details | Support network | Approvals | Plans | Attachments | Services | My Aged Care interactions | Notes

Tasks and Notifications

Client tracker 🔍 ✎

Client summary 🔍 ✎

Assessments

<p>Home Support Assessment 🔍</p> <p>Finalised on 9 February 2023 Community Options Australia Limited - ACT ☎ 02 8872 4867</p>	<p>Screening 🔍</p> <p>Complete on 12 June 2020</p>
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Alternatively, from the **Current reviews** page you can also expand the client card and select **START SUPPORT PLAN REVIEW**.

Current reviews

Current reviews | Recent reviews

Filter by

Sort by: Urgency in order of Show urgent reviews first

Current sort order is Urgency

Not Started

Melina RAMSEY 🔍

WODONGA, VIC, 3690
 Aged care user ID: AC32746497
 Review assigned date: 7 June 2024

Melina RAMSEY ✕

Female, 84 years old, 30 July 1940

Requested by
 Health Professional/Admin

Contact:
 Brayden Jeanbaptiste

Request submitted by: Denese Mahaffey
 Client last assessed by: Abbey Redman

Request dates
 Date requested: 3 March 2023

Reason for request
 Client's change in circumstances:
 Hospital Discharge

Impact on client's change needs:
 Harley is requesting Domestic Assistance, Meals, Personal Care & Transport for Milena, because increasing functional decline, back pain and falls at home.

VIEW FULL CLIENT RECORD
VIEW ALL CLIENT NOTES
VIEW CLIENT REPORT

START SUPPORT PLAN REVIEW
TRANSFER SUPPORT PLAN REVIEW

Home Support

A banner will be displayed on the request if additional attachments have been added to the clients record as part of the Support Plan Review request.



- From the **Before you start the Support Plan Review** pop-up select either **CONTINUE TO SUPPORT PLAN REVIEW** or **RECOMMEND A NEW ASSESSMENT**.

Before you start the Support Plan Review

If the client's circumstances have changed to any of these scenarios from their initial Support Plan:

- Need Transition care; or
- Need Residential care; or
- Need Residential respite; or
- Client has relocated

you have the option to "Recommend a New Assessment" instead of Support Plan Review.

Otherwise, a Support Plan Review must be undertaken to assess and accommodate changes in the client's current circumstances.

CONTINUE TO SUPPORT PLAN REVIEW **RECOMMEND A NEW ASSESSMENT** CANCEL

Select **CONTINUE TO SUPPORT PLAN REVIEW** to start the Support Plan Review for the client.

If the client's circumstances have changed and it is more appropriate to issue a referral directly for a new assessment rather than completing a Support Plan Review, select **RECOMMEND A NEW ASSESSMENT**.

You will be prompted to enter the outcome of the review and reason for the new assessment referral, then select an organisation of which to issue the referral. This can only be done in circumstances where a client requires Transition Care, Residential Care, Residential Respite or has relocated.

- A pop-up will display asking if the client consents to share their information with My Health Record. Select **No** or **Yes** based on the client's response and select who this decision was made by from the drop-down menu.

Consent to share information with My Health Record

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 *

Comments:

CONTINUE TO SUPPORT PLAN REVIEW CANCEL

Please note if consent is provided by a Representative then their first name must be entered before proceeding.

If the client does not consent to share their support plan with My Health Record you will also be required to enter a consent denial reason before selecting **CONTINUE TO SUPPORT PLAN REVIEW**.

Consent to share information with My Health Record

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

Consent denial reason *

Representative Details

First name: * Last name:

Comments:

CONTINUE TO SUPPORT PLAN REVIEW CANCEL

4. Enter the reason for the Support Plan Review before starting the review.

Start support plan review for Mr Michele N JAMISON (Eloy)

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

What circumstances have changed for the client? *

How has this affected the client's need? *

0 / 1000

START SUPPORT PLAN REVIEW CANCEL



- Once a Support Plan Review has been started, an assessor will be able to make changes to information in the following sections of the clients support plan:
 - Assessment summary
 - Client motivations
 - Goals & recommendations (including recommendations for linking support & reablement)
 - Manage services & referrals
 - Associated People
 - Review

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT outcome

IAT outcome: CHSP
Current assessment type: Home Support Assessment

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

There are no service recommendations for this client

Recommend that the client receive Linking Support END LINKING SUPPORT PERIOD

Recommend that the client receive Reablement END REABLEMENT PERIOD

- Once the Support Plan Review has been completed, select **COMPLETE AND FINALISE SUPPORT PLAN REVIEW** to finalise the Support Plan Review. Please be aware that the outcome details entered above cannot be edited once the Support Plan Review is complete and will appear on the clients support plan.

! If a period of reablement or linking support is added to the clients support plan during a Support Plan Review, the outcome of the review will be automatically set to **Updates to the existing plan**. Once the review is complete, the client's assessment will be open for the assessor to start the support period.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT outcome

IAT outcome: CHSP
Current assessment type: Home Support Assessment

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION RECOMMEND A PERIOD OF LINKING SUPPORT RECOMMEND A PERIOD OF REABLEMENT

There are no service recommendations for this client

COMPLETE & FINALISE SUPPORT PLAN REVIEW RETURN TO CLIENT

7. Enter the outcome of the Support Plan Review from the drop-down menu selection alongside who the plan was conducted with. Select **COMPLETE AND FINALISE SUPPORT PLAN REVIEW** to finalise the Support Plan Review.

Complete & finalise support plan review for Natalie HOLLAND

All fields marked with an asterisk (*) are required.
Reason for this support plan review started on 23 September 2024

Outcome of support plan review *

Details
Please be aware that outcome details entered here cannot be edited once the support plan review is complete and will appear on the client's Support Plan

Support plan conducted with *

COMPLETE & FINALISE SUPPORT PLAN REVIEW CANCEL

If the outcome of the Support Plan Review is that a new assessment is required, please refer to [Issuing an assessment referral as a result of a Support Plan Review](#).

8. The Support Plan Review will be visible under the **Plans** tab in the client record.

Mr Ignatius N WITTING (Annetta)
Male, 90 years old, 15 February 1933, AC46741914
5 CARMICHAEL STREET DEAKIN, ACT, 2600

Primary contact: Ignatius Witting (self) - 61 2987 1234
No support relationships recorded

Plans [VIEW CLIENT REPORT](#)

Client summary Client details Support network Approvals **Plans** Attachments Services My Aged Care interactions Notes

Tasks and Notifications

Current Episode
Episode ID: 1-ZCYPJR4
25 September 2021 - Present

Recommendations
• Domestic Assistance

Upcoming Review(s)
No upcoming reviews scheduled

Assessment history

- Home Support Assessment 25 September 2021
- Screening 25 September 2021

Plan history

Support plan as at 25 September 2021

Review history

- Review 25 September 2022



Transferring a Support Plan Review

Both assessors and team leaders are able to transfer Support Plan Reviews to other assessment organisations.

1. To begin transferring a Support Plan Review, go to **Current reviews** and select the client card you wish to transfer for the Support Plan Review. Select **TRANSFER SUPPORT PLAN REVIEW**.

The screenshot shows the 'Current reviews' page. On the left, there is a 'Filter by' section with 'Sort by: Urgency' and 'Current sort order is Urgency'. Below this is a 'Not Started' section with a card for 'Melina RAMSEY' showing her location (WODONGA, VIC, 3690) and review date (7 June 2024). On the right, a modal window for 'Melina RAMSEY' is open, displaying client details: 'Female, 84 years old, 30 July 1940', 'Requested by: Health Professional/Admin', 'Contact: Brayden Jeanbaptiste', 'Request submitted by: Denese Mahaffey', 'Client last assessed by: Abbey Redman', 'Request dates: Date requested: 3 March 2023', and 'Reason for request: Client's change in circumstances: Hospital Discharge'. It also lists 'Impact on client's change needs: Harley is requesting Domestic Assistance, Meals, Personal Care & Transport for Milena, because Increasing functional decline, back pain and falls at home.' At the bottom of the modal, there are buttons for 'VIEW FULL CLIENT RECORD', 'VIEW ALL CLIENT NOTES', 'VIEW CLIENT REPORT', 'START SUPPORT PLAN REVIEW', and 'TRANSFER SUPPORT PLAN REVIEW', with the latter highlighted by a red box.

2. You will need to enter **What is the reason for the transfer** and search and select the Assessment Organisation which the Support Plan Review will be transferred to. Once the reason for transfer and organisation have been selected, click **TRANSFER** to finalise.

Please note, a banner will display at the bottom advising you to call the assessment organisation you are referring the client to. This banner also highlights the need for client consent prior to transferring.

The screenshot shows the 'Transfer this support plan review for Melina Ramsey' form. It includes a note: 'All fields marked with an asterisk (*) are required.' There is a dropdown menu for 'What is the reason for transfer? *', a 'Comments:' text area, and a search for 'Assessment Organisation: *' with a '0 / 250' character count. Under the search, there are two radio button options: 'Use the client's address' (selected) and 'Enter an alternative assessment address'. The 'Use the client's address' option shows 'Client address' as '11 7 NICOLE Crescent WODONGA VIC 3690'. At the bottom, there are 'SEARCH', 'TRANSFER', and 'CANCEL' buttons, with 'TRANSFER' highlighted by a red box. A light blue banner at the bottom contains an information icon and the text: 'Before making the transfer, please contact the Assessment Organisation you want to refer the client to and provide as much information as possible in the comments box to assist the receiving organisation. Please note, a review can only be transferred once. Please ensure that you have client consent before transferring.' The footer includes 'Accessibility Privacy Disclaimer Terms', 'Copyright © Commonwealth of Australia', 'Australian Government Department of Health', and 'myagedcare' logos.

! Support Plan Reviews can only be transferred once.



Issuing an assessment referral as a result of a Support Plan Review

When completing a Support Plan Review, an assessor is able to refer the client for a new assessment. This is completed during the **Complete & finalise Support Plan Review** page.

1. In the **Complete and Finalise Support Plan Review** section of the client's support plan, select **A new assessment required**.

Complete & finalise support plan review for Lilly Field

All fields marked with an asterisk (*) must be completed before submission

Reason for this support plan review started on 5 March 2021

Change in medical condition

Outcome of support plan review *

A new assessment required

Not selected

No changes to support plan

Updates to the existing plan

A new assessment required

SPR cancelled

Other

2. You will be required to issue a new assessment referral before completing the review. You are able to send the assessment referral to yourself, your organisation or to another organisation. Select the appropriate option.

Assign this referral to:*

Myself

My Organisation

Another Organisation

If you choose **Myself** or **My Organisation**, you will be prompted to select the assessment type, outlet for referral, assessment setting (if you've selected a Comprehensive Assessment) and indicate the priority of the referral.

Support plan conducted with *

Client

Assign this referral to:*

Myself

My Organisation

Another Organisation

Please select the assessment type: *

Comprehensive Assessment

Please select outlet for this referral *

GRAZIER AGED CARE Outlet ACAT-RAS

Assessment setting: * ?

Hospital

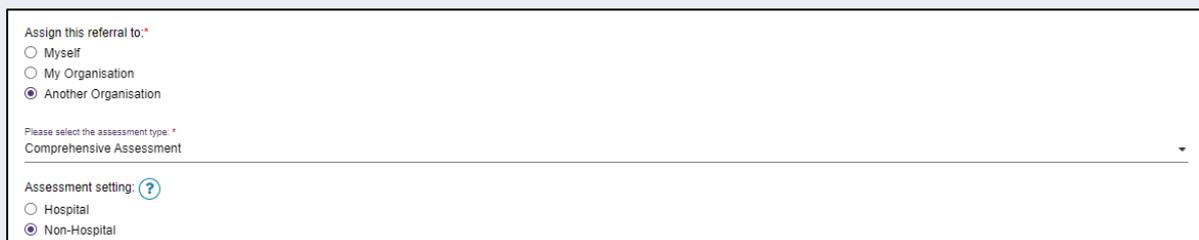
Non-Hospital

Priority * ?

Comments:

COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT CANCEL

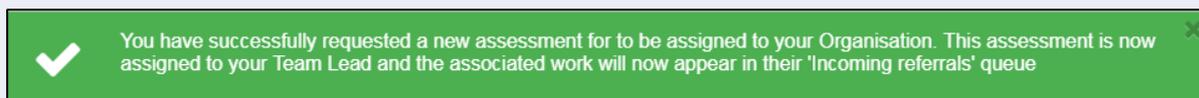
If you choose **Another Organisation**, you will be required to indicate the type of assessment required and the assessment setting (if Comprehensive Assessment has been selected) .



You can then search for the organisation to which the referral will be sent by client address or alternative assessment address. Once you have selected an assessment organisation you will be asked to enter the priority of the assessment. Click **COMPLETE AND FINALISE SUPPORT PLAN AND REFER FOR ASSESSMENT**.



3. Upon completing the Support Plan Review, a green banner will display to confirm the referral has been issued.



The new assessment will appear under the Current assessments tab if you have assigned it to yourself or appear in the Incoming referrals queue for a team leader if assigned to My Organisation or Another Organisation.

! All assessments, including those generated from Support Plan Reviews are required to undergo triage.