My Aged Care Assessment Manual

For Aged Care Needs Assessment Teams

Version 7.3

June 2025

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PART A – INTRODUCTION

1 Overview of Manual

My Aged Care assessors provide a valuable and trusted public role in the delivery of aged care assessment services on behalf of the Federal Minister for Health and Aged Care and the Australian Government Department of Health, Disability and Aged Care (the department). To achieve the delivery of quality assessment services, assessment organisations are required to comply with the guidance in this My Aged Care Assessment Manual (the Manual) which specifies good practices in the assessment of older Australian's support needs and eligibility for Commonwealth subsidised aged care services under the Commonwealth Home Support Programme (CHSP), and/or types of care under the Aged Care Act 1997 (Cth) (the Act).

The department intends to regularly review and update the Manual as required to ensure it remains up to date in the context of future system changes and enhancements to the My Aged Care operating model. Assessment organisations are welcome to provide feedback to the department at any time, including suggestions on how the Manual can continue to be improved to drive good assessment practice and support quality outcomes for aged care clients.

In addition to the Manual, assessors must use the [Aged Care Assessment Quality Framework](#) to maintain a high quality assessment experience and service for every client. Additionally, all assessors are required to complete the mandatory training outlined in the My Aged Care Workforce Learning Strategy 2024 (and subsequent versions) (see section **23** Training).

Assessors must also be aware of the following resources:

- The [My Aged Care assessor guidance and portal resources](#) available on the department's website
- The [Principles and guidelines for a younger person's access to Commonwealth funded aged care services](#)

To keep the Manual concise, text boxes with links to further information appear throughout the document. The document is also designed to be accessible for people using assistive technology.

2 Overview of My Aged Care Assessment Services

2.1 My Aged Care

My Aged Care aims to make it easier for older Australians, their families, and carers to access information on aged care, have their needs assessed, and be supported to locate and access services.

The key elements of My Aged Care include:

- Older Australians, their families or carers can access My Aged Care by:
    - Calling the contact centre on 1800 200 422 (FreeCall*)
    - Visiting the My Aged Care website (www.myagedcare.gov.au)
    - Booking a face-to-face appointment with an Aged Care Specialist Officer (ACSO), located in some Services Australia service centres by calling 1800 227 475.
- a My Aged Care Service Provider and Assessor Helpline (1800 836 799)
- an assessment to identify client needs using the Integrated Assessment Tool (IAT).

My Aged Care is supported by a customer relationship management system that includes:

- a central client record that will include each client's current aged care requirements and associated history and services provided through My Aged Care
- a capability to create and confirm support network relationships
- a referral capability that enables the contact centre and assessors to find appropriate assessment, home support, residential and community support services or resources for clients
- web-based portals for clients (My Aged Care Online Account), assessors, service providers and support organisations.

Staff within an assessment organisation can use the My Aged Care assessor portal to:

- manage their assessment organisation contact details and set up individual staff members with access to the My Aged Care assessor portal
- manage referrals for assessment
- create or confirm agent and representative relationships
- complete triage questions
- conduct assessments using the IAT and develop the Support Plan
- make delegate approvals (assessment delegates)
- conduct Support Plan Reviews (SPRs)
- refer clients for service

- recommend a period of reablement or for linking support to the Support Plan
- share client's contact details with the National Dementia Helpline or Carer Gateway
- review and update client records consistent with the assessment and Support Plan outcomes.

> **Note:** My Aged Care assessor portal users are reminded that they are subject to a number of obligations with respect to the handling of information in the Portals. This includes obligations under the *Privacy Act 1988* (Cth) and where relevant the *Aged Care Act 1997* (Cth).

Further information

Department of Health, Disability and Aged Care website: [About My Aged Care](#)

My Aged Care website: [Your right to quality care](#)

2.2 Single Assessment System program

The Single Assessment System provides a single aged care assessment pathway for older people to access aged care services. The system has been established in response to Recommendation 28 of the Royal Commission into Aged Care Quality and Safety to make it easier for older people to access aged care and adapt services as their needs change.

The Commonwealth delivers aged care assessments through the Single Assessment System workforce, which came into effect in late 2024. The workforce comprises a mix of public (state and territory governments) and private sector providers.

Under the Single Assessment System, assessment organisations will have a mix of clinical and non-clinical assessment staff and will conduct both home support and comprehensive assessments. Some assessment organisations may also deliver residential aged care funding assessments using the Australian National Aged Care Classification (AN-ACC) assessment tool.

Assessment organisations are responsible for the day-to-day operation of the Single Assessment System Program, including the timely delivery of assessments for home support services and care types under the Act, as well as the management, training, and performance of individual assessors and delegates. Each assessment organisation is required to manage workloads to ensure that priority is given to those in greatest need and that access to aged care services is not delayed unnecessarily due to delays in the assessment process.

Each assessment organisation is multidisciplinary and includes a range of health-related disciplines such as medical practitioners, registered nurses, social workers,

physiotherapists, occupational therapists, and psychologists. The department has oversight responsibility for the Single Assessment System Program, including providing advice on Australian Government policy, the monitoring and reporting of performance against agreed service levels, and the management of regulatory and other administrative processes relating to the *Aged Care Act 1997.*

The department and assessment organisations are jointly responsible for training assessment organisation staff, establishing communication protocols, working cooperatively to develop nationally consistent approaches to Single Assessment System Program operations, and participating in regular forums to support the national administration of the Single Assessment System Program.

With assessment organisations having a mixed clinical and non-clinical workforce, it is a requirement that all assessment organisations have effective clinical governance operationalised through a clinical governance framework. The department has provided guidance in Appendix 2 which aims to help assessment organisations to implement effective clinical governance. The guidance describes the importance of good clinical governance, details the elements of an effective clinical governance framework in an aged care needs assessment context and outlines the minimum supports that must be in place to support clinical and non-clinical staff.

Within the Single Assessment System, the Aboriginal and Torres Strait Islander assessment pathway will commence the phased rollout from July 2025, initially with a small number of Aboriginal and Torres Strait Islander organisations. These organisations will provide the choice of a culturally safe pathway for older Aboriginal and/or Torres Strait Islander people.

Further information
Department of Health, Disability and Aged Care website: Single Assessment System for Aged Care   Aboriginal and Torres Strait Islander Assessment Organisations   Supporting clients with the rollout of Aboriginal and Torres Strait Islander assessment organisations | Fact Sheet

2.3 The single assessment pathway

On entry into My Aged Care, screening will determine the allocation of an older person's assessment referral to an assessment organisation. Following an assessment referral being accepted by an assessment organisation, triage will determine eligibility for an assessment and the assessment pathway. Clients with entry level needs are assigned for a home support assessment and those with more complex needs are assigned for a comprehensive assessment.

There may be occasions where, during a home support assessment, questions will be triggered in the IAT that will require clinical judgement. To reduce the need for an assessment to be reassigned to a clinical aged care needs assessor (clinical assessor), the non-clinical aged care needs assessor (non-clinical assessor) will be required to seek the attendance of a clinical assessor to be involved in asking the clinical questions at the time of the assessment via video or phone, or at a later time via phone (see Section **5.5**).

Assessment organisations including Aboriginal and Torres Strait Islander Assessment Organisations may deliver assessments through subcontracting arrangements subject to approval from the department.

2.4 Home support assessments

Assessment organisations are responsible for the provision of home support assessment services in their service area/s, including the assessment of service eligibility for the CHSP.

A home support assessment is an assessment of aged care needs for older Australians, typically undertaken by non-clinical assessors, who use the IAT to enable nationally consistent assessment services. Home support assessments are appropriate for older Australians who have registered with My Aged Care, been screened by contact centre staff or Aged Care Specialist Officers (ACSOs) (or GPs/health professionals via web referral processes) and identified as having entry level needs that can be accommodated by Commonwealth Home Support Services (i.e., less than $10,588 per annum).

Prior to commencing a home assessment, a triage delegate will use the IAT to conduct triage to help verify the information collected at screening, ensure the client has low needs and does not require a comprehensive assessment, and that the priority assigned to the client is appropriate.

A home support assessment builds on the information collected during registration, screening, and at triage to determine a client's eligibility to receive CHSP services. Home support assessments are generally conducted face-to-face when safe to do so in the client's usual accommodation setting. After the assessment, the assessor develops a Support Plan that summarises the assessment findings, goals, and recommendations.

During the assessment, questions may be triggered in the IAT by the non-clinical assessor that require clinical judgement. These questions (referred to as clinical questions) will need to be asked in accordance with the assessment organisation's clinical governance framework (see section 5.5 and Appendix 2).

At the end of the assessment, the assessor may determine that the older person requires more complex, Act-based services. In these circumstances the assessment must be converted to a comprehensive assessment in the IAT before it can be finalised

(see section 5.7). If this conversion is initiated by a non-clinical assessor, they will need to seek the supervision of a clinical assessor.

2.5 Comprehensive assessments

A comprehensive assessment is an assessment of aged care needs for older Australians, undertaken by clinical assessors, who use the IAT to enable nationally consistent assessment services. Clients receiving comprehensive assessments have registered with My Aged Care, have been screened by contact centre staff or ACSOs and identified at triage as having complex needs that cannot be accommodated only by the CHSP (i.e., less than $10,588 per annum).

A comprehensive assessment builds on the information collected during registration, screening and at triage, to determine a client's eligibility to receive aged care services. A comprehensive assessment is usually conducted in a suitable face-to-face context (preferably in the client's usual accommodation setting) when safe to do so, to determine a client's eligibility for care types under the Act. After completion of the IAT the assessor develops a Support Plan that summarises the assessment findings, goals, and recommendations.

2.6 Other assessment activities

2.6.1 Support Plan Reviews (SPR)

After the assessment is finalised, assessors conduct SPRs for clients where the client's needs and circumstances have changed or when finalising a period of reablement and the Support Plan is updated. Where there is a significant change, or for any assessment delegate eligibility decision under the Act, a new assessment is undertaken (see section **5.13** Support Plan Review (SPR) and New Assessment').

2.6.2 Wellness and Reablement

The provision of wellness and reablement approaches are embedded in the home support assessment. These approaches build on people's strengths and goals to promote greater independence and autonomy in daily living tasks. It avoids 'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves (or with less assistance). Clinical assessors undertaking a comprehensive assessment should also adopt wellness and reablement approaches during the assessment and consider whether a recommendation for time-limited reablement under the CHSP is appropriate.

2.6.3 Linking support and care coordination

An assessment includes the provision of linking support activities to vulnerable clients where areas of vulnerability pose barriers to receiving mainstream aged care supports or care. Issues leading to vulnerability could include experiencing homelessness, mental health concerns, drug and alcohol issues, elder and systems abuse, neglect,

financial disadvantage, cognitive decline and/or living in a remote locality, and previous traumatic events. The provision of linking support will assist in linking the client to one or more services they require to live with dignity, and independence.

2.6.4 Assessment delegation

The Secretary of the department or the assessment delegate (previously known as an ACAT delegate) of the Secretary has the power to make decisions of the client's eligibility for care under the Act. As a result of a comprehensive assessment, the assessment delegate may approve a client for a Home Care Package, Residential Care, Residential Respite Care or Flexible Care Transition Care Programme (TCP) or Short-Term Restorative Care (STRC).

An assessment delegate has the power to grant residential respite and TCP extensions to increase the number of days of care allowable under the Act and its Principles.

2.7 Multi-disciplinary approach

Assessors undertaking a comprehensive assessment may be required to participate in a multi-disciplinary approach, particularly for complex or difficult assessments. This may include activities within or outside of the team such as multi-disciplinary case conferencing, joint assessments with other health professionals where necessary or multi-disciplinary consultation.

2.8 Aims and key features of assessment

The Single Assessment System Program aims to deliver consistent, high-quality assessments. The aims and key features of a My Aged Care assessment are to:

- Deliver timely, safe, and nationally consistent assessments of a high quality guided by the Aged Care Assessment Quality Framework, facilitating access to Commonwealth subsidised and non-subsidised aged care services which best meet the current needs of the client.
- Be conducted in accordance with privacy obligations, and with the consent of the client (or their authorised representative) in a face-to-face setting when safe to do so.
- Value and support a client's identity, culture, and diversity.
- Involve clients and their carers, support network and other service providers (where appropriate) as appropriate in assessment and care support planning processes.
- Ensure assessments of older Australians are independent, holistic, and client-focused, incorporating assessment of physical, medical, psychological, cultural, social, environmental and wellness dimensions which are separate from service provision.
- Deliver tailored Support Plans incorporating client choice which improves the health and wellbeing of older people, are based on a client's goals and current

care needs, embedding wellness and reablement approaches where appropriate (see section **5.7**. Developing the Support Plan).

- Ensure older Australians from special needs groups have equitable access to assessment services.

- Consider both formal and informal services to assist clients to remain in the setting most appropriate to their needs (such as their own home) to prevent premature or inappropriate admission to residential care.

- Build and maintain effective and respectful working relationships with all My Aged Care assessors, service providers and other support agencies.

- Provide short-term case management/linking support or care coordination to vulnerable clients (and clients with special needs) to address barriers affecting their access to aged care services, including extending connections with services and organisations in local communities (including those not listed on My Aged Care); and

- Use the My Aged Care assessor portal, including the IAT and its built-in validated assessment tools and associated guidance materials to record assessment information accurately, prevent duplication, and re-use (pre-populate) information to deliver assessments of a high quality and standard.

- During the assessment and Support Plan processes, assessors should uphold the Charter of Aged Care Rights (see Table 1 and section **22**. Aged Care Resources for Consumers) which applies to all aged care consumers receiving Australian Government subsidised care and services, to ensure clients are provided with the following rights.

Table 1. Charter of Aged Care Rights

Safe and high-quality care and services	Be treated with dignity and respect
Live without abuse and neglect	Their independence
Have their identity, culture and diversity valued and supported	Be listened to and understood
Have control over, and make decisions about, the personal aspects of their daily life, financial affairs, and possessions	Have a person of their choice, including an aged care advocate, support them or speak on their behalf (including access to an interpreter)
Be informed about their care and services in a way they understand	Complain free from reprisal, and to have their complaints dealt with fairly and promptly

Safe and high-quality care and services	Be treated with dignity and respect
Access all information about themselves, including information about their rights, care, and services	Personal privacy and to have their personal information protected[1]
Have control over and make choice about their care and personal and social life, including where the choices involve personal risk	Exercise their rights without it adversely affecting the way they are treated.

Further information
Aged Care Quality and Safety Commission website: Charter of Aged Care Rights   Department of Health, Disability and Aged Care website: Aged Care Assessment Programs and Aged Care Assessment Quality Framework   My Aged Care website: Right to Quality Care

2.9 Integrated Assessment Tool (IAT)

The IAT has replaced the National Screening and Assessment Form (NSAF).

The IAT was developed in response to aged care reforms which are focused on the Support at Home Program and a Single Assessment System workforce. These reforms form part of the Australian Government's response to recommendations from the Royal Commission into Aged Care Quality and Safety.

The IAT is an assessment tool that has been designed to support skilled assessors to determine a client's aged care needs. It comprises questions across the social, physical, medical, cognitive, and psychological domains as well as home and personal safety, risk of vulnerability and support considerations.

The IAT's triage and assessment components feature specific questions that trigger additional questions, allowing for more in-depth exploration of flagged concerns.

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[1] Note: Assessors are required to comply with the legislative requirements under the Privacy Act 1988 (the Privacy Act), including the Australian Privacy Principles (APP) (see section 17.1. Privacy Act).

2.10 Overview of assessment organisation roles and responsibilities

Contract and operational managers lead and manage the assessment organisation's outputs and performance according to their agreements with the Commonwealth. Assessment organisations cover geographical assessment regions across Australia. In the My Aged Care assessor portal the staff roles comprise administrators, the team leader, clinical and non-clinical assessors and delegates.

The following table explains at a high level the different assessment organisational roles. The role type describes business roles which are part of the delivery of the program through the agreement and system roles, conducted on the My Aged Care system.

Table 2. Assessment organisational roles and responsibilities

Role	Role type	Description
Contract manager	Business	Manage and report the assessment services and performance specified in the organisation's agreement with the Commonwealth. Contact point for the department for contract management.
Assessment Organisation Operational Manager	Business and System	Manage and deliver the assessment services specified in the organisation's agreement with the Commonwealth at an operational level. Operational managers may also hold organisational or outlet administration roles in the My Aged Care assessor portal. Can initiate and submit delegate applications for others in their organisation.
Organisational and/or outlet administrator	Business and System	Administrators are assessment organisation personnel who are responsible for coordinating the operations of assessment organisations and their outlets. The administrator at an organisation level can view and manage information for the entire organisation in the portal. They are also responsible for updating service information as required.

Role	Role type	Description
Team leader (clinically qualified)	Business and System	Assessment organisation personnel who will manage and oversee the activities of aged care assessors and undertake a regular review of quality management processes to support continuous improvement of assessment related services. The assessment organisation must ensure that a sufficient number of Team Leaders are provided to adequately support and oversee the activities of aged care needs assessors. Team leaders regularly engage with delegates, assessment delegates and assessors in peer review processes. They provide ongoing support for assessors in the field through various communication channels via the assessment organisation's clinical governance framework and standard operating procedures. Team leaders have the ability to manage and assign, un-assign and reassign referrals or transfer referrals for triage and assessment(s) and assign SPRs to the assessor. While accepting the referral, team leaders can change the priority of assessment referrals.
Triage delegate (clinically qualified)	Business and System	Triage delegates will be the initial contact with an older person and their support people by performing an initial needs assessment as part of the triage process. The triage delegate will utilise their clinical judgement to determine the assessment type and the priority/urgency in which care can be provided. Undertake the triage process to confirm: • eligibility for an assessment • directing the assessment pathway by determining the assessment type and

Role	Role type	Description
		• assigning a clinical or non-clinical assessor • assessment priority – including whether the client urgently requires aged care services.
Clinical assessor	Business and System	Deliver assessment services according to their agreement with the Commonwealth. Clinical assessors can deliver comprehensive and home support assessments. A clinical assessor undertakes assessments using the Integrated Assessment Tool (IAT) with older people that requires clinical judgement. A clinical assessor may include an Aboriginal Health Practitioner working within their scope of practice.
Non-clinical assessor	Business and System	A non-clinical assessor undertakes assessments using the Integrated Assessment Tool (IAT) of older people which do not require clinical judgement. A non-clinical assessor may include an Aboriginal Health Worker or an Aboriginal Health Practitioner working within their scope of practice.
Assessment Delegate (clinical)	Business and System	A clinical delegate can approve a person as eligible to receive different types of aged care. While the clinical delegates are exercising the powers of the Secretary, they are accountable in their own right for decisions they make under the Act. Determine eligibility for care under the Act. Perform and record delegate functions and decisions in the My Aged Care assessor portal.
Workplace trainer	Business	Provides and coordinates the mandatory training that is required to be undertaken by staff within the assessment organisation.

Role	Role type	Description
		Provide training to assessment staff through a train-the-trainer model.
Administration officer	Business	Provides support to the Team Leader and delegates, by performing the day-to-day work of phoning and booking appointments, assigning the booking to assessors, rescheduling and reassigning an assessment should any changes need to occur (assessor on unplanned leave, client needs to change the appointment) and assigning SPRs. Administration officers may hold the team leader system role to manage and assign, un-assign and reassign referrals or transfer referrals for triage and assessment(s) and assign SPRs to an assessor.
Delegate support	Business and System	Supports the assessment delegate with administrative tasks associated with delegation such as printing and sending client letters.

Further information
See Part B Team Leader, Assessor and Delegate Activities and Part H. Operational Procedures. Department of Health, Disability and Aged Care website: My Aged Care Assessor Portal - Organisational Administrator User Guide

3 Client Entry into My Aged Care

My Aged Care is the entry point to access Australian Government-funded aged care services. My Aged Care consists of three access channels: telephone (the My Aged Care Contact Centre), digital (website and GP e-referral) and face-to-face with ACSOs (through selected Services Australia service centres).

My Aged Care Contact Centre staff receive inbound calls and referrals, create records for clients and representative/agent relationships, raise SPR requests, screen for eligibility and needs and refer to assessment organisations and service providers and/or provide information to clients, including in the instance where no further assessment or service provision is required.

3.1 Modes of entry into My Aged Care

3.1.1 Request via Phone

People can call the My Aged Care Contact Centre on 1800 200 422 (freeCall*).

3.1.2 Apply for an Assessment Online

The Apply for an Assessment Online process can be used as an alternative to contacting the My Aged Care Contact Centre or seeing an ACSO. The online form enables consumers to register with My Aged Care and apply for their first assessment online or on behalf of a family member or friend. The My Aged Care system automatically processes the online form and registers the client and any nominated agents or representatives.

Where the form successfully processes, a referral for assessment will be automatically issued to the appropriate assessment organisation. In instances where clients have an existing client record, or are missing key identifying information, or there is an error in the automated processing, they will be directed to call the My Aged Care Contact Centre. For existing clients, the My Aged Care Contact Centre will issue a SPR request to the assessment organisation.

3.1.3 Web referrals (Make a Referral form)

For a client's first contact with My Aged Care, GPs and health professionals can make a referral directly to an assessment organisation using the 'Make a Referral' through the My Aged Care website.

Web referrals contain decision support to guide the home support or comprehensive assessment pathway, however, the incoming referrer can accept the recommended assessment pathway or recommend (with justification) an alternative pathway.

Where the referral is submitted by a GP or health professional, for the first assessment referral (e.g., where no previous assessment exists), the system will automatically

process the referral. Where automated processing is successful, a referral for assessment will be automatically issued to the appropriate assessment organisation.

If the GP or health professional recommends a comprehensive assessment and the client has previously been assessed for a home support assessment, the web referral will be intercepted by the My Aged Care Contact Centre and follow the SPR pathway rules to the assessment organisation that undertook the most recent assessment, regardless of the recommendation (unless the request qualifies for a direct comprehensive assessment referral, such as for TCP (see direct comprehensive assessment referral under section **4.2**).

3.1.4 GP e-Referral

GPs may also choose to use GP e-Referrals which can be accessed from their practice management system. The form will pre-populate the patient's information with the GP then adding any additional information and attachments as required. It is then submitted safely and securely to My Aged Care for processing and will follow a similar process to that outlined for the Make a Referral form.

3.1.5 Face to Face access through Services Australia

People seeking access to aged care can alternatively book a face-to-face appointment with an ACSO who are located in some Services Australia service centres. Bookings for the free service can be made by calling 1800 227 475 on weekdays from 8am to 5pm.

Customer service officers in all Service Australia service centres can provide general information about aged care services. They can help connect people to My Aged Care's online or phone service and/or connect the client to more intensive support if required.

Further information
Services Australia website: Aged Care Specialist Officer

3.2 My Aged Care Online Account

3.2.1 Create Account and Registration

Once registered with My Aged Care, a client, representative or agent can set up access to their My Aged Care Online Account by linking it to their myGov account. Confirmation of the type of account, identification and contact details are required. The Online Account contains important information about the client, representative or agent's details (registration), aged care assessments, services, and interactions. Further information about accessing and using a My Aged Care Online Account is available on the My Aged Care [website](#).

3.2.2 Setting up a Support Network for clients

Where a client is registered, there may be a support network of agents, regular representatives and/or authorised representatives nominated on the client record.

3.2.3 Agents and Representatives

Agents

An agent can assist a client with My Aged Care but is not permitted to make or convey decisions for the client. The assessor must obtain consent from both the client and agent to create the relationship. An agent can:

- provide information to My Aged Care about the client, including talking to and being involved in discussions with assessors, the contact centre and service providers;
- receive copies of the client's correspondence (including Home Care Package letters);
- see and update some client information through the contact centre or via the My Aged Care Online Account;
- receive My Aged Care information about the client; and
- be listed as the client's primary contact so they can be the first contact point for My Aged Care.

Agents can be the following:

- A professional support person in the community (who must have or consent to having a My Aged Care record, such as a community advocate, language support or cultural support person)
- An organisation outlet (must be formally approved by the department to provide support in My Aged Care, such as an advocacy organisation). Staff associated to this outlet will be able to support the client.
- A specific staff member of an approved organisation outlet. Only this staff member can provide support to the client.

Representatives (Regular and Authorised)

Note: The *Aged Care Act 2024*, which comes into effect on 1 November 2025, introduces a new supported decision-making framework. On the commencement of the *Aged Care Act 2024*, the framework will replace regular and authorised representative relationships in My Aged Care. The framework introduces the role of a registered supporter. Transition arrangements for existing representative relationships to become supporter relationships are being developed. The assessment workforce will receive training on this transition. Until the commencement of the *Aged Care Act 2024*, assessors should continue to assist clients to register their representatives. Clients and representatives will have the opportunity to opt out of the transition to the *Aged Care Act 2024*. An updated registration form is available here: [Appointment of a representative form (PDF) | My Aged Care](#)

A representative for a client in My Aged Care can speak and act on behalf of the client. There are two types of representatives. Regular and authorised.

A representative can:

- provide information to My Aged Care about the client including talking to and being involved in discussion with assessors, the My Aged Care Contact Centre and service providers
- make decisions about aged care assessment and referrals for aged care services
- see and update client information through the My Aged Care Contact Centre or via the My Aged Online Account
- receive Home Care Package letters, and
- be listed as the client's primary contact so they can be the first contact point for My Aged Care.

Representatives can be the following:

- A trusted person (who must have or consent to having a My Aged Care record, such as a family member/s, friend, neighbour)
- An organisation outlet (must be formally approved by the department to provide support in My Aged Care, such as an Office of the Public Guardian or State Trustee). Staff associated to this outlet will be able to support the client
- A specific staff member of an approved organisation outlet. Only this staff member can provide support to the client.

The person or organisation/staff details stored in My Aged Care are used to authenticate the agent/representative and ensure My Aged Care is speaking to the right person.

Assessors should be aware that My Aged Care clients and their agents and representatives (regular and authorised) can also receive email and/or SMS notifications when a client reaches the following key stages: completed registration,

finalised assessment, approval for care under the Act, assigned Home Care Package and SPR request submitted. Notifications will also be sent about support relationship statuses and actioning of documents submitted to My Aged Care. Agent and Representative Organisations cannot opt out of receiving emails about clients they support.

Regular representative

If the client is able and wishes to provide consent for someone else to speak and act on their behalf, they may nominate a regular representative. This could be a family member, neighbour, or friend.

A regular representative can speak and act on behalf of the client, however must:

- seek the client's permission before discussing their My Aged Care information with anyone
- consult the client on all decisions and actions they make on the client's behalf ensuring decisions made on behalf of the client are in their interests, and
- work and consult with other representatives (if applicable).

A client, who has a regular representative or agent, can still communicate with My Aged Care and the assessor directly and can convey decisions, if they wish.

Regular representatives will automatically be opted in to receive Home Care Package letters for a client and can choose to opt out by calling the My Aged Care Contact Centre.

Authorised representative

An authorised representative is needed if the client is not capable of providing consent for someone else to speak on their behalf, such as a client with cognitive impairment or mental health conditions. Where clients have lost the capacity to make decisions about personal, lifestyle and/or health-related matters, they will require an authorised representative to be established in My Aged Care.

When assessors are creating or confirming an authorised representative for a client, they must ensure supporting documents, including medical evidence (if required), are uploaded to the client's record in My Aged Care. The documents required depend on the rules in each state or territory. The Appointment of Support Person form or Appointment of a Support Organisation form and other accepted legal documents can be attached in the My Aged Care assessor portal. An authorised representative is the primary contact for all communication with My Aged Care and will receive all client correspondence. Authorised representatives can opt the client out from receiving Home Care Package letters but they themselves cannot opt out.

Potential representatives can be referred to the 'Arranging someone to support you' section of the My Aged Care website for more information on setting up their

representative relationship and attaching legal documents through their My Aged Care Online Account.

Further information
Department of Health, Disability and Aged Care website: My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships My Aged Care website: Arranging someone to support you Legal documents to become an authorised representative

3.3 Screening

Methods

My Aged Care Contact Centre staff and ACSOs complete screening after a person registers with My Aged Care and has a My Aged Care client record and identification number assigned. Alternatively, screening is built into the online inbound referral, such as when a health professional conducts a web-referral and applies for a client's assessment online.

Eligibility for Assessment

The screening component of the assessment, is an initial needs identification of clients which asks a series of questions with a conversational approach over the phone or through the web-referral.

To be eligible for an aged care assessment, the client must meet age criteria (in most circumstances) *and* have aged care needs. The My Aged Care Contact Centre and ACSOs use the screening decision support tool where responses to the screening questions confirm the client's eligibility for an aged care assessment. Screening considers

Table 3. Screening eligibility for assessment

Aged Criteria	Aged care needs
General age criteria - 65 and over - 50 and over and Aboriginal and Torres Strait Islander	Home and health concerns associated with functional ability: - Walking - Travelling by car or bus

Aged Criteria	Aged care needs
Special circumstances age criteria (see section 7.3 Younger People seeking Aged Care Services) Prematurely aged people 50 and over (45 and over for Aboriginal and Torres Strait Islander people) and on a low income and homeless or at risk of homelessness, or living with hoarding behaviour or in a squalid environment A younger person applying for care under the Act	• Shopping for groceries • Preparing meals • Eating meals • Managing medications • Doing housework • Managing money • Taking a shower or having a bath • Getting dressed • Going to the toilet • Getting out of chairs or bed Health concerns impacting on independence • Recent falls or fear of falling • Pain impacting on daily living • Weight loss or nutritional concerns • Feeling lonely, down, or socially isolated • Risks, hazards, or safety concerns in their home, including environmental concerns • Vision, hearing or communication (currently labelled special needs) • Memory loss or confusion

3.3.1 Outcomes of screening

On completion of the screening, outcomes include:

- Assign referral priority to indicate the timing of the assessment and the urgency in which services are delivered to a client, which is based on a client's level of function, the level of risk in relation to the care situation and any other relevant concerns.

- Send the referral to the appropriate assessment organisation with client consent.

> **Note**: Where a referral is issued to the organisation inappropriately but is not at the status of accepted, rejected or transferred, the contact centre can recall the referral (see 4.2 Managing Referrals).

- For urgent referrals to a CHSP provider, send the urgent referrals to a CHSP service provider with client consent and develop an Action Plan with the client that includes the screening information and identifies the assessment pathway a client will take.

- Client not eligible for assessment, information provision as appropriate.

3.3.2 Urgent CHSP referrals

A client can be referred by My Aged Care directly to a CHSP service provider only if the client has a need for an immediate health or safety intervention that is not available through other means.

The My Aged Care Contact Centre or ACSO can issue urgent referrals directly to a CHSP service provider for time-limited support at the point of entry/registration, before the client has received an assessment.

Examples of urgent services under the CHSP that may be referred directly to a service provider are:

- nursing for wound care
- transport to a specialist medical appointment or the delivery of meals
- personal care
- other support services due to the absence of a carer

Urgent services, unless otherwise specified by the department, will initially be delivered for a maximum period of eight weeks. An assessment may be required for ongoing services and will depend on the client's needs.

When issuing an urgent referral, the My Aged Care Contact Centre or ACSO will place a high priority on the referral to an assessment organisation. For an existing client, the contact centre or ACSO will issue a SPR request (unless the client meets the requirements for a direct assessment referral).

An assessor must contact the client as soon as possible to follow up the client, within two weeks of the urgent service being put in place to ensure that:

- appropriate services are in place and the urgent need is being addressed
- the assessor provides a more thorough analysis of the needs
- services can be confirmed or adjusted as required.

If required and envisaging that ongoing support will be required past eight weeks, to ensure continuity of services, the assessor must complete the assessment (or support plan review as appropriate) **before** the CHSP service/s is due to cease. See Direct assessment referral under section **4.2** and section **10.3.** Urgent referrals to home support services (time-limited).

If a service provider is approached directly before the client has contacted My Aged Care, the CHSP provider can assist the client with the My Aged Care Registration process. CHSP service providers must support their clients to register with My Aged Care during the period of care provision and support them to arrange for a formal assessment of their care needs if it is likely their care will be ongoing or long term (i.e., longer than eight weeks). The provider will need to monitor the services delivered. For existing clients, the provider should submit a SPR request if services are required beyond 8 weeks.

GPs and hospitals should use their existing processes and networks to refer patients who need urgent CHSP services. My Aged Care should not be used for referrals for services that should be provided to older Australians through the health system.

PART B –Team Leader, Assessor and Delegate Activities

4 Referral activities

Through the My Aged Care assessor portal, the team leader can review, assign, un-assign, and re-assign referrals and SPR requests to assessors in their team. The team leader can be supported by administration officers to support day-to-day referral activities. Before accepting the referral, team leaders can change the priority of assessment referrals. Referrals can be transferred under certain conditions. Team leaders and assessors can notify My Aged Care of a deceased client. The portal allows assessors (and team leaders who have the assessor role type) to manage self-referrals.

4.1 Referral priority

A referral for assessment will include a priority rating that relates to the timing of the assessment and the urgency in which services are delivered to a client. The allocation of a priority category for a referral is based on a client's level of function, the level of risk in relation to the care situation and any other relevant concerns. While accepting the referral, the team leader can change a priority allocation set by the My Aged Care Contact Centre or ACSO if their professional view is that it does not align with the guidance on priority for home support and comprehensive assessments (hospital and community setting) below. Timeframes associated with priority categories are specified in assessment organisation funding agreements with the department. A priority category is also assigned when a client is referred to services. Note: the timeframe is calculated from the date the referral was issued, not the date the priority was changed.

In the assessor portal, there are visual indicators for referrals and assessments to facilitate timely responses of priority timeframes. For web referrals, the priority is automatically set to medium. Direct comprehensive assessment referrals and urgent CHSP referrals are set to high.

Assessment referrals to assessment organisations must be actioned (accepted, rejected or transferred) within three calendar days from issue. Following acceptance of the referral, other timeframes are applied for managing referrals, as highlighted in Tables 4, 5 and 6 below.

4.1.1 Home support priority categories

Based upon the client's needs, a referral for a home support assessment may be classified as one of three priority categories, as outlined in the table below.

Table 4. Home support assessment priority categories

Priority Level	Definition	Timeframes (from day of referral acceptance)
High	Requires an urgent assessment based on the information collected during the referral process indicating the person would need to be hospitalised or leave their current residence without support because they are unable to care for themselves, or their carer is unavailable and/or has serious risks or safety hazards in their home. This may be due to a crisis in the home involving either the client or the carer, or a sudden change in the client or carer's medical, physical, cognitive, or psychological status. High priority referrals may also be accompanied by a parallel direct referral to short-term CHSP services (e.g., nursing, transport, personal care, or meals), consistent with the urgent pathway process.	10 calendar days
Medium	Information available at referral indicates that the client is not at immediate risk of harm, however there is a progressive deterioration in the client's current status (physical, mental, cognitive, situational, functional), and/or the level of care that is currently available does not meet the client's needs and is not sustainable long term.	14 calendar days

Priority Level	Definition	Timeframes (from day of referral acceptance)
Low	Refers to cases where the referral information indicates that the client has sufficient support at present and does not need immediate assistance but requires an assessment in anticipation of their upcoming care requirements. Examples include the carer planning a holiday which will result in the care recipient requiring the provision of substitute care, or recognition that the person is having increased difficulty living independently and options for care need to be discussed with the client and their carer or family. Low priority cases would also indicate that a client can manage with their current living arrangements, can complete most functional tasks without help, and/or there are no immediate aged care related health and safety risks apparent.	21 calendar days

4.1.2 Comprehensive assessment priority categories- community setting

The community setting includes the client or carer's home, a community centre, private residence, a clinic, a residential aged care service, or where the setting is not specified.

Table 5. Comprehensive assessment priority categories – community setting

Priority Level	Definition	Timeframes (from day of referral acceptance)
High	Requires an immediate response (e.g., response within 48 hours) based on the information collected during the referral process. An urgent assessment is required if the person's safety is at risk (e.g., high risk of falls or abuse), or there is a high likelihood that the person will be hospitalised or required to leave their current residence because they are unable to care for themselves, or their carer is unavailable. This may be due to a crisis in the home	10 calendar days

Priority Level	Definition	Timeframes (from day of referral acceptance)
	involving either the client or the carer, or a sudden change in the client or carer's medical, physical, cognitive, or psychological status.	
Medium	Information available at referral indicates that the client is not at immediate risk of harm. Referrals should be allocated to this priority category if they indicate progressive deterioration in the client's physical, mental, or functional status, or that the level of care currently available to the client does not meet their needs or is not sustainable in the long-term.	20 calendar days
Low	Refers to cases where the referral information indicates that the client has sufficient support available at present, but that they require an assessment in anticipation of their upcoming care requirements. Examples include the carer planning a holiday, which will result in the care recipient requiring the provision of substitute care or recognition that the person is having increased difficulty living independently and options for care need to be discussed with the client and their carer or family.	40 calendar days

4.1.3 Hospital assessment priority categories

The hospital setting includes aged care assessments in an acute setting, a public or private hospital, or other hospital inpatient setting.

Table 6. Hospital assessment priority categories

Priority Level	Definition	Timeframes (from day of referral acceptance)
High	Requires an immediate response based on the information collected during the referral process (e.g., response within 2 calendar days and completion within 5 calendar days of referral acceptance).	5 calendar days
Medium	Information available at referral indicates that the client is not at immediate risk of harm. Referrals indicate progressive deterioration in the client's physical, mental, or functioning status, or that the level of care currently available to the client does not meet their needs or is not sustainable in the long-term (e.g., response within 5 calendar days and completion within 10 calendar days of referral acceptance).	10 calendar days
Low	Information available at referral indicates an appropriate response within 10 calendar days and completion within 15 calendar days of referral acceptance).	15 calendar days

For all priorities in the hospital setting, the expectation is that at the time the assessment is undertaken:

- The person is anticipated to be medically stable, unless they have a rapidly deteriorating condition that cannot be stabilised.
- The full range of clinical and rehabilitation support (to be provided by the hospital) are explored to ascertain the best care options for the client on discharge from hospital. This may include:
    - multidisciplinary case conferencing with the carer and family
    - consultation with the hospital geriatric rehabilitation service or equivalent

- o   consultation with members of the treating multidisciplinary team; and
- o   liaison with hospital discharge planners.

Adverse effects on the client of prolonged hospitalisation, or where a delay may disadvantage the client from accessing the care option they need, are other factors that influence the decision on the priority.

4.2 Managing Referrals

Once a referral for assessment is issued, team leaders can action by accepting, rejecting or transferring the referral. After allocating to an assessor, it is only the team leader who can reject or transfer a referral. A referral can only be transferred once. The system also allows 'bulk' acceptance of referrals. If this functionality is used, the department expects that the referral has been appropriately reviewed prior to the team leader's decision to accept a referral. Referrals cannot be recalled or cancelled by the My Aged Care Contact Centre once the referral has been accepted.

> **Note:** Business allocation counts all referrals issued to the assessment organisation, regardless of the action (accept, reject or transfer).

> **Note: From February 2025** new My Aged Care system functionality will be available to record if Aboriginal and/or Torres Strait Islander clients would prefer to have their assessment completed by an Aboriginal and Torres Strait Islander Assessment Organisation (displays as First Nations Assessment Organisation or FNAO in the assessor portal). This should be recorded when registering a client in the My Aged Care system and confirmed when completing a client's demographic details during triage. It may also be recorded by an assessor during an assessment. The preference will then display in the client details as well as on the client's card.
>
> In some regions while services are being established, an older Aboriginal and/or Torres Strait Islander person will not be able to be referred to an Aboriginal and Torres Strait Islander Assessment Organisation. Information about an older person's preference will be used to collect data on the demand for these services. Once Aboriginal and Torres Strait Islander Assessment Organisations become available, this preference information will be used to refer older people to these services if they are needed for a reassessment or Support Plan Review. See Appendix 6 for further information.

Table 7. Referral Management Flowchart

REFERRAL MANAGEMENT FLOWCHART

ASSESSMENT REFERRALISSUED AND RECEIVED

↓

REFERRAL REVIEWED

- Team leaders should review information on the referral card and supporting information in the client's record.

- Team leaders should also review the priority assigned to the assessment, and change priority if required.

- If the referral appears to be inappropriate, contact the referrer to discuss (i.e. GP, health professional). If the team leader wishes to transfer/reject the referral, the client/primary contact should be informed of the decision. A client note should be made in the assessor portal accordingly.

Self-referrals

Assessment Organisations can only self-refer if the client is: in selected remote and very remote regions; an older Aboriginal and Torres Strait Islander person; or homeless or at risk of homelessness; or is in hospital; or vulnerable.

↓

REFERRAL ACTIONED

ACCEPT	**TRANSFER**	**REJECT**	**RECALL**
Following review of referral card and client record, team leaders can accept the referral, and assign for triage. Team leaders can change the priority if required. Depending on the client circumstances and referral priority, contact the client (or representative) within three calendar days to undertake triage and schedule the assessment*. If assessor commences assessment and must discontinue, they will need to cancel the assessment. *SPRs to be completed within 15 days	Transfers can occur between assessment organisations when there is agreement between team leaders that a different assessment organisation would be geographically more appropriate, or the client has relocated. A referral can only be transferred once, otherwise it must be rejected.	Rejected referrals should be well justified such as: outside region, assessment no longer required, client does not consent, client deceased, duplicate client, duplicate referral, unable to contact client or client unavailable for assessment. The decision to reject a client's referral should be communicated with the client/primary contact as well as information about how to request an assessment in the future.	If a referral has been issued in error, team leaders can call the MAC Contact Centre and request that the issued referral is recalled, provided the referral has not been accepted by the assessment organisation.

POSSIBLE

OUTCOMES OF ASSESSMENT REFERRAL MANAGEMENT

4.2.1 Accept a referral

When a team leader receives a referral, they should view the client information to gain a preliminary understanding of the client's situation, to determine whether the referral is accepted, transferred or rejected and to begin the assessment process responsive to the person's individual situation.

Best Practice Steps/Activities

Review the referral information and determine whether the referral is appropriate to be accepted, transferred or rejected.

Determine whether the referral has been made to the right organisation or outlet (e.g. the client is in the same geographical location).

Note any concerns for the triage delegate's consideration relating to eligibility for aged care (CHSP and care types under the Act) including checking age requirements for various aged care programs (see section **7.3**. Younger People seeking Aged Care Services, and Part E – Types of Commonwealth-Subsidised Aged Care).

- On receiving an assessment referral, any relevant information relating to the client's referral should be reviewed. Information can be sourced from the client record, including:
    - previous screening/assessment details
    - previous Support Plans
    - previous approvals
    - attachments (e.g., hospital discharge summary)
    - notes
    - interactions; and
    - primary contact/support person/representative/agent for the client.
- Check that the client's contact details are accurate and up to date in My Aged Care and amend as necessary. For clients who are approved and seeking Home Care Package services, the assessor must ensure the accuracy of client and support network contact information as this will make sure correspondence is received.
- Check whether a representative or agent for the client has been established (either an 'Appointment of a support person' or 'Appointment of support organisation' form was included in the referral or appointed in the 'Apply for an Assessment Online' form).
- Review the priority assigned by the referrer and change it if it does not align with the guidance on priority for assessment referral. Once a referral is received, it is important that clients are contacted and seen in a timely manner, especially those with urgent needs. **Note:** The referral priority is unable to be changed after triage.

- As web referrals (including referrals submitted by GPs, health professionals and clients using the 'Apply for an Assessment Online' form) are automated to a *medium* priority, it is important to review the referral information and reassign the priority (if applicable) according to the client's needs. This will prevent urgent cases from being overlooked.

- Clients or their representatives should be contacted and eligibility determined through triage within three calendar days of accepting the referral , noting that assessors must balance the completion of new assessments with SPRs (see section **5.13** Support Plan Review (SPR) and New Assessment) to ensure priority is given to clients with the greatest need.

4.2.2 Transfer of referrals

Team leaders can transfer incoming and accepted referrals (that have not been commenced) between assessment organisations. Transfers can occur between assessment organisations when there is agreement between those organisations' team leaders that this is necessary (e.g. due to the location or organisational capacity issues). A referral can only be transferred once, otherwise it must be rejected.

Where a referral has been transferred the assessment organisation must ensure that:

- The client understands why their referral is being transferred and consents to the transfer of the referral to the new assessment organisation.

- They have contacted the assessment organisation that will be receiving the client referral to confirm that they will accept the referral. A referral should not be transferred before confirmation has been obtained that it will be accepted by the receiving assessment organisation. This ensures that the client does not experience any delay in receiving an assessment.

> For guidance on how to manage referrals and SPRs to Aboriginal and Torres Strait Islander assessment organisations, see Appendix 6.

4.2.3 Reject a referral

Team leaders can reject a referral when first managing the referral or reject or transfer a referral after acceptance. Once an assessor starts the assessment, they will need to cancel it if they are not proceeding with the assessment. Note: if the assessment is going ahead, but needs to be reassigned to another assessor, it should not be cancelled.

Table 8. Referral rejection - List of values

Client/family/rep unavailable	Client age – alternate options
Duplicate client record	Client does not consent

Client/family/rep unavailable	Client age – alternate options
Interpreter not available	Client deceased
Unable to contact client	Clinical staff not available
Outside assessment region	Client prefers a FNAO
Assessment no longer required	Hospital assessment required
Care approval meets needs (the older person is receiving aged care services and they are sufficient)	Client prefer later assessment
Client medically unstable	Other

Note: The department monitors the rejected referral rates and rejection reasons.

Referral rejection decisions need to align with good practice and place the client's interests as paramount. Referrals should only be rejected after careful consideration and for valid reasons. For example, a referral may be rejected if it is outside the assessment region, or the client does not consent to the assessment. An incorrect referral priority is not a valid reason to reject a referral. If rejecting a referral, a rejection reason from the list of values needs to be selected and relevant comments added on the reason for the rejection where further explanation is required.

Best Practice Steps/Activities

If, upon accepting a referral, more information about the client is received or there is a change in the client's circumstances, there may be a need to reject the referral or cancel the assessment.

The following types of situations are examples where rejecting a referral or cancelling the assessment may be required:

- The assessor is unable to transfer the referral to another assessment organisation
- The client has been admitted to hospital so the assessment is no longer required, or the client is medically unstable
- The client does not consent, withdraws their consent, is no longer seeking services and/or withdraws the request
- The client is deceased
- There is a duplicate client entry or a duplicate referral
- There is insufficient information to proceed with the referral, or the client is unable to be contacted after many attempts.

In circumstances where the older person and/or their representative or primary contact is unable to be contacted after a number of attempts, assessment organisations should have a procedure in place to manage the referral request. For example, this may cover:

- the expected number of contact attempts (and documentation of attempts)
- who should be contacted
- ensuring special needs (e.g., identified hearing impairment) have been considered
- whether, after a number of unsuccessful contact attempts, a letter is provided advising the client/representative how to reactivate their assessment referral request, or informing the client and/or their representative if they are rejecting, transferring or cancelling their referral (including an explanation of the reason/s).

The decision to reject a referral should be communicated to the client/primary contact with information about how to request an assessment in the future. Effective communication with the client/representative on a decision to reject the referral, and effective communication between assessors, assists with managing expectations and reducing complaints.

From February 2025 a new rejection reason '*Client prefers a FNAO',* will be available in the IT system. An older Aboriginal and/or Torres Strait Islander person should not be rejected based on a client's preference unless it is a last resort. A transfer prior to the assessment is preferable to a rejection.

In instances where an Aboriginal and/or Torres Strait Islander client is already booked for an assessment with an assessment organisation, but an Aboriginal and Torres Strait Islander service has recently become available, it is recommended that the assessor continue the assessment as planned with the agreement of the client. The client's condition needs to be taken into consideration; that their health condition and care needs would not be adversely impacted by a delay in assessment if they were to be referred to another organisation.

Any preferences should be identified during the assessor's pre-assessment planning, allowing the assessor time to organise the transfer of the client to another organisation prior to the assessment. If the referral is cancelled by the assessor at the point of assessment, this may slow down the assessment process for the client, which is not the desired outcome.

A conversation to discuss this with the client prior to the assessment is recommended, to ensure that they have choice and control and the ability to make decisions regarding their care.

See Appendix 6 for further information.

4.2.4 Recall a referral

Where a referral is issued to the organisation inappropriately but is not at the status of accepted, rejected or transferred, the team leader may request that the My Aged Care Contact Centre recall the referral. Once a referral has been accepted by the assessment organisation, it cannot be recalled or cancelled by the My Aged Care Contact Centre.

The decision to approve the recall will be assessed on a case-by-case basis by the My Aged Care Service Provider and Assessor Helpline (1800 836 799). In this scenario, the team leader of the outlet will receive a system notification if a referral has been recalled.

4.2.5 Direct assessment referral

The Support Plan Review (SPR) process (See section 4.3 Managing Support Plan Review (SPR) requests) is the usual pathway for clients with a previous finalised assessment to access a review of their Support Plan or a reassessment.

In scope

If the client's circumstances have changed, it may be more appropriate to issue a referral directly for a new assessment rather than completing a SPR.

A client **is** eligible for a direct new assessment if they meet the following criteria:

1. Client needing Residential Care and/or Residential Respite Care for a new approval or change in respite level and:

   - A health professional is requesting an assessment to consider eligibility for residential care or residential respite care; and/or

   - The client has significant care needs, is unable to care for themselves and the information received indicates a carer no longer provides care; and/or

   - The client has increased frailty, deteriorating health or a cognitive condition causing rapid health decline; and/or

   - The client or representative has identified residential care facility and has bed booked.

2. Client admitted to a hospital, needing TCP approval.

The assessment referral can be self-referred to an assessment organisation if it meets the self-referral criteria (see section 4.4 Self Referrals). If it does not meet the self-referral criteria, the referral will be assigned through My Aged Care.

Out of scope

The client **is not** eligible for a direct assessment referral if they do not meet the above criteria at 1) and 2). All other requests (including requests relating to home care and STRC) follow the usual SPR pathway to the most recent assessment organisation. The rationale is:

- the assessor is best to determine if their client can continue to be supported under CHSP services or the needs and circumstances warrant a reassessment.
- For existing home care clients, the assessor is best to determine whether an SPR or reassessment is required for a change in Home Care Package (HCP) level or priority.

4.3 Managing Support Plan Review (SPR) requests

Unless a client meets the direct assessment referral criteria, following a finalised assessment, where a client has changed needs and circumstances requiring potential changes to the client's Support Plan, a SPR can be requested. Following a continuity of care principle, a SPR request will be referred to the assessment organisation that undertook the most recent assessment.

4.3.1 Review request process

A client may require a SPR in the following circumstances:

- informal care arrangements have changed/ceased; or
- there is a change to the client's needs, goals, additional services, or a time-limited service is requested to be extended.

A SPR may be requested by:

- the client/representative (through the My Aged Care Contact Centre or ACSO)
- a service provider (through the My Aged Care Service and Support portal)
- a GP, hospital, or community health professional through the contact centre or a My Aged Care web referral. **Note**: If a web referral is received by the My Aged Care Contact Centre, they will create a SPR request (unless client meets direct comprehensive assessment referral criteria in section **4.2**). For clients in receipt of a home care package, requests for increases to home care package level will be directed to the home care package provider for further review.
- If a reablement or linking support period is open, the team leader will ask the assessor to finalise the support period so the SPR request can be issued
- the assessor may initiate a SPR without requiring a request or scheduled SPR.

A SPR may be requested when a client is undergoing reablement and/or linking support. If the client is undergoing reablement or linking support, the team leader will not be able to assign the SPR until the support period is completed. To allow continuity of the support period, the assessor can re-add the support period during the SPR.

The My Aged Care Contact Centre, ACSO and service providers should include the following information when requesting a SPR or new assessment:

- why the request has been made (e.g., client's circumstance)
- what is the request for (e.g., service type) and why it is needed (e.g., client's change in needs or goals)
- if the request is urgent and why it is urgent
  - o identify what services the client is currently receiving
  - o identify options explored with the client to increase their current support
  - o attach supporting documentation about the client's care arrangements (optional, unless it is a HCP client)
  - o for HCP clients, providers requesting a reassessment for changes to the HCP level or a referral for adjustments to the interim CHSP service should include information confirming their review of the client's current care plan and provide details to indicate that the client's changed care needs can no longer fit within the existing budget. The Individualised Budget and Care Plan should be attached for assessors to confirm that the home care budget is fully allocated for care and services.

4.3.2 Receiving the SPR request

Upon receiving a SPR request, the team leader should consider the most appropriate action:

- conduct the SPR (see section **5.13** SPR and New Assessment)
- transfer the SPR
- bypass the SPR, or
- cancel the SPR

Assessment organisations should make contact with the client's primary contact (who may be the client, representative or agent) about a non-urgent SPR request within **two** to **four** weeks. SPRs should be completed within 15 days from the date of the SPR referral is accepted, with priority given to clients with the greatest need (as specified within the request indicated by providers or by the My Aged Care contact centre/ACSO).

Assessment organisations should consider the urgency of a SPR request relating to the client's situation and determine if the client has a rapidly deteriorating condition that

requires a direct comprehensive assessment referral. This ensures clients who require higher level of care and services due to their condition are afforded an appropriate assessment with minimal delays. The assessor may, as appropriate, also recommend interim CHSP services for the client.

Transfer the SPR

In some instances, assessment organisations may need to transfer the SPR to another assessment organisation or return the request to the My Aged Care contact centre. If the former, it is recommended that the assessment organisation contact the other assessment organisation to confirm the transfer before actioning in the system.

Bypass the SPR

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 SPR, select 'Request Assessment'. This can only be done in circumstances where a client requires transition care, residential care or residential respite that was not identified through the direct assessment referral process, or where the client has relocated.

Cancel the SPR

Actions if considering cancelling the SPR:

- If there is insufficient information on the SPR request, however clarification is required on certain aspects, the assessor should contact the client or service provider where possible to clarify the request, prior to progressing a decision to cancel the SPR. This will manage the risk to clients to ensure the client is not disadvantaged where they require changes to their aged care support.

- The review request may be cancelled by an assessor and a SPR not undertaken if it is inappropriate or if insufficient information is provided to warrant the SPR, or the assessor (after a number of attempts) has not been able to contact the client's primary contact (who may be the client and/or representative/agent).

- As a minimum requirement, where the assessor cancels the SPR, they must include the cancellation reason and provide clear explanation justifying the cancellation in the cancellation details field.

After the SPR is cancelled, a notification is sent from the My Aged Care assessor portal to the service provider or My Aged Care Contact Centre/ACSO.

- The inclusion of clear cancellation reason and details from the assessor allows the person making the request to receive the reason for the cancellation and, if necessary, amend and resubmit the request or follow up with the assessor as necessary.

Where possible, it is good practice to contact the client or their authorised representative to notify them of the cancellation as this ensures clients/representatives remain informed at each step of the process.

Note: If a client is requesting a reassessment, an SPR should be undertaken in the first instance. Doing so will allow the assessor to decide whether there has been a significant change in aged care needs to determine whether a new assessment is warranted (See Section 5.13 SPR and New Assessment).

In most circumstances, the cancellation of the SPR should only occur where the client and/or their authorised representative understands and agrees to the cancellation of the SPR. This is also applicable where the assessor decides to cancel an SPR due to the client having been recently provided with an SPR and there has been no change in the client's care needs or situation since the SPR was conducted.

Further information
Department of Health, Disability and Aged Care website: My Aged Care Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews My Aged Care Assessor Portal User Guide 7 – Completing a Support Plan and Support Plan Review YouTube video: My Aged Care Assessor Portal - How to manage a support plan review (SPR) request

4.4 Self-referrals

The circumstances in which a self-referral can be made by an assessor (and team leaders with a system assessor role) are limited to assessment referrals:

- in a hospital setting
- in remote regions – (Monash Modified Model 6-7)
- for those who identify as Aboriginal or Torres Strait Islander
- for older people at risk of or are experiencing homelessness
- vulnerable groups (e.g. experiencing or at risk of domestic or family violence or elder abuse, at risk of hospitalisation, primary carer is absent or non-existent)

In these circumstances, an assessor can only self-refer clients to themselves through the My Aged Care assessor portal and app.

Where the assessor identifies a potential client with aged care needs that is cohabitating with the current client at the time of the assessment, the assessor may wish to encourage that person to contact My Aged Care to request screening, which will determine eligibility for an assessment referral. Note: assessors should not self-refer a younger person and should follow younger people pathways guidance, see section 7.3 Younger People seeking Aged Care Services.

When creating the self-referral, assessors are encouraged:

- to upload any additional documentation pertinent to the client's situation (for example, a hospital discharge notice),
- Provide any reasoning relating to the person's vulnerability under the 'Notes' tab in the assessor portal. With the client's consent, sensitive information should be recorded in sensitive notes and attachments (see section **5.6.** Recording Assessment Information).

Prevention of duplicate records

Prevention of duplicate records is of particular importance to assessors who can undertake self-referrals to themselves and in doing so are required to register a client.

Duplicate client records occur when a client is already registered in My Aged Care and a new client record is created for the same client.

Duplicate client records can have a significant impact on a client's experience with the My Aged Care process including:

- care approvals across multiple records
- referral for assessment where an assessment has already taken place
- delaying access to services
- providers unable to claim subsidies.

Best Practice Steps/Activities

When registering a client on My Aged Care, the assessor must always first search for a client record to see if they exist. If no existing client record is found using the search function, assessors should view any potential matches that are returned by the system when creating the new client record.

If the assessor observes a duplicate record already exists, report the duplicate to the My Aged Care Service Provider and Assessor Helpline (1800 836 799).

Legal Name vs Preferred Name

- When searching for a client to determine if they already have a My Aged Care client record, the assessor must ask if the client prefers to go by a name other than their legal name.
- Conducting searches under each name can help to identify if a previously created record exists.
- Use the wallet check process to verify individual's legal name (see section **5.4.** Commencing the Assessment, Wallet check).
- When a record does not exist and you are creating the record, use the legal name in the first name field.
- Once the record is created, add a preferred name in the field provided in the personal details section of the client record.

Additional information in name field

- Do not add any additional information in the name fields – putting the relationship of a person to a client in the name field, for example Mary (Daughter), will prevent the system from matching that record in future searches and may cause the creation of a duplicate record.

- Any additional information that does not have a predetermined field can be entered into the 'Notes' section of the client record.

- Where possible, you should enter the client's date of birth as opposed to entering the client's age.

Special Characters

When completing the name fields for a client record only use the following characters:

- alphas (letters)
- hyphens
- apostrophes; and
- blank spaces

Any other characters (such as brackets, commas, and full stops) are considered invalid characters and can prevent other users from being able to find the records. This can lead to the creation of duplicate records.

4.4.1 Deceased clients

Team leaders and assessors can notify My Aged Care of a deceased client or representative/agent through the assessor portal to change the client record status to inactive. If assessors are aware of this information during the assessment process, they should complete the notification from the client details tab by selecting the 'Notify My Aged Care of a death' button.

Alternatively, the assessor can complete the notification process by selecting 'Client deceased' from the drop-down list when:

- rejecting a referral for assessment; or
- cancelling a support plan review.

See section **9.8** Urgent Circumstances for clients who urgently enter residential care without an approval and deceases before receiving a comprehensive assessment.

Further information
Department of Health, Disability and Aged Care website:
My Aged Care – Assessor Portal User Guide 1 – Registering and referring clients

Further information
[My Aged Care Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews](#)
[My Aged Care – Assessor Portal User Guide 4 – Navigating and updating the client record](#)

5 Assessment activities

5.1 Consent

Assessors must obtain consent, written or verbal, from the client prior to undertaking triage and assessment.

When obtaining the client's consent to the assessment or before disclosing a client's personal or protected information to other parties, the department requires that assessment organisations establish policies and protocols that include the following considerations:

- The assessor should use the My Aged Care Assessment Consent Form. The Consent Form includes the consent scripts and fields to record the consent for assessment and service referrals. It is located via the Reports and documents tile within the My Aged Care assessor portal. For triage, the team leader will use the consent script within the My Aged Care portal's triage component (or in the app in the case of self-referrals).

- The assessor should read out the consent script/s to ensure the client understands and is informed of the purpose for collecting the information and how it will be used and stored, and who the personal or sensitive information will be collected from (such as contacting a person's GP, other health professionals, disability service coordinator or service provider, family members or carers).

- A regular representative can speak on behalf of the client if they have consulted with the client and the client has agreed to the decision. If the client is not able to give consent, the consent should be obtained from a person who has the role of an authorised representative in My Aged Care. If an authorised representative relationship is required but is not yet in place, the family member/loved one can check the [My Aged Care website](#) for further information on how to become an authorised representative in this circumstance. Where there is no representative to assist with consent, the person will need to be referred to an organisation in their state or territory that is responsible for appointing a guardian (see Note below).

- The assessor must take adequate steps to determine that the client has capacity to provide informed consent and be aware of matters that may suggest a lack of capacity. This may include further assessment of a client's mental capacity to make decisions. Noting where a client lacks capacity, the assessor should consider who can act on the individual's behalf.

- The client must be able to make an informed decision about whether they want personal information disclosed to others. When the client consents to an assessment, they must be made aware that they are agreeing to their personal information being collected for the purposes of the assessment and, where appropriate, disclosed to or used by other parties for the purposes of providing aged care or other community, health, or social services to the client. **Note:** The assessor should discuss the implications of approving a Disability Support for Older Australians (DSOA) client for aged care, ensuring DSOA clients are informed of the considerations relating to their DSOA funding and supports when they consent to proceed with the home support or comprehensive aged care assessment DSOA clients should confirm they understand if they are deemed eligible for a HCP and/or permanent residential care will mean their DSOA funding is capped (see section **14.5** DSOA and aged care).

- A client's right to confidentiality must always be respected. If an assessor considers that maintaining confidentiality will interfere with or compromise their role in relation to a client, the matter should be discussed with the client or their authorised representative.

- When sharing client information with other parties, assessors should ensure the information is shared securely and is received by individuals who are authorised to receive the information and on a 'need to know' basis.

- Ensure that third parties who receive client information are aware of privacy requirements and have procedures in place to ensure that the client's information is not misused.

- For triage, the team leader must use the My Aged Care portal prompts to indicate that consent was provided. If the client does not wish to give consent, the team leader will be required to select a reason for not providing consent.

- For assessment, the assessor must record the informed consent in the My Aged Care Assessment Consent Form and upload it in the client record through the 'Attachments' function. The assessor can then use the 'Notes' section in the client's record to:
    - indicate the signed form has been uploaded and consent given
    - record any detail the circumstances regarding any disclosure of a client's personal information) and
    - record any instructions relating to the assessor's conversation with the client (or authorised representative) on informed consent.

- If a carer is identified for the first time during the assessment under the 'Carer profile' section of the IAT, the assessor may wish to remind the client that the client has the carer's consent to provide the carer's telephone number and related personal information.

- Clients must be made aware that once consent for assessment is gained for the use and disclosure of personal information as authorised by the Privacy Act 1988 (Cth) (Privacy Act), and when the Application for Care approval is finalised, these records need to be retained in accordance with the Archives Act 1983.

- When seeking consent to make the client's Support Plan available in their My Health Record (MHR), the assessor should ensure the client understands that their GP, along with other authorised health professionals, will also be able to view their Support Plan on MHR. The assessor can note that the client can also withdraw their consent at any time by calling the MAC Contact Centre and requesting removal of their Support Plan from MHR.
- If consent cannot be given by the client or their authorised representative, the triage or assessment cannot proceed, and the referral is rejected.

> **Note**: There may be situations where a comprehensive assessment has been requested and there are concerns about a person's capacity. In some instances, it may be appropriate for another person to sign the Application for Care Form and proceed with the assessment (see sections 9.7 Application for Care Form and 9.8 Urgent Circumstances for more information).

Further information:

Federal Register of Legislation website:

Aged Care Act 1997 (Cth) (Part 6.2 Protection of Information)

The Privacy Act 1988 (Cth)

Healthdirect website: Healthdirect Privacy policy

My Aged Care website: Arranging someone to support you

Office of the Australian Information Commissioner website:

Australian Privacy Principles

5.2 Triage

Triage is performed after the acceptance of a referral and prior to conducting a home support or comprehensive assessment. Triage is conducted for every accepted referral, generally over the telephone and should occur within three calendar days of accepting a referral.

> From February 2025 new IT system functionality allows for triage delegates to be assigned to a triage delegate role in the My Aged Care Assessor portal.
>
> Triage delegates must hold certain qualifications and certifications (See section 8.4). Full delegations for triage delegates will come into effect with the commencement of the new Aged Care Act.

Triage helps ensure that older people with low needs are not over-assessed and that those with complex needs have access to a comprehensive assessment. Triage also aims to validate the outcomes produced at screening, including the priority allocated to the assessment and whether urgent services are required. In addition, the triage process includes scheduling the assessment, work health and safety screening, arrangements for communication needs and confirming support people ahead of the assessment.

Depending on the client circumstances and referral priority, triage delegates should undertake triage with the client and/or the nominated contact within three calendar days. Clients will require faster response times based on level of risk and need.

Prior to calling the client to conduct triage, triage delegates should:

- review the client's My Aged Care account
- note the client's preferences, choices, any additional needs and communication preferences that will need to be accommodated during the assessment process (e.g. when a hearing impairment is identified or an interpreter is required).
- where the client has a nominated contact, note if the nominated contact is an agent or a representative.

If the nominated contact is an agent (i.e. advocate, care finder or elder care support) or a regular representative, then the client will need to be present for the phone call. Triage delegates may wish to contact the agent/representative in the first instance to confirm a time to conduct triage so the agent can be present with the client, or make an outbound call to the client with the agent/representative present on the same phone call. Alternatively, the agent/representative may confirm that the client is comfortable undertaking triage without the agent/representative's support, and the team leader can proceed to contact the client directly (the agent/representative may give prior warning to the client to expect a call, to help ensure the client feels comfortable to receive the phone call).

If the nominated contact is an authorised representative, then triage can be undertaken without the client being present for the phone call. However, triage delegates should mention to the representative that it is preferred, where possible, that the client is present on the call.

Triage delegates may consider a referral to care finder for a vulnerable client who does not have anybody who can support them. Information on care finder services is available at My Aged Care.

5.2.1 Initial discussion

When contacting the client and/or nominated contact, triage delegates should:

- Identify who you are and the organisation you are from and confirm that they have 15 to 20 minutes to discuss their assessment request.
- Advise you have received the referral, who it is from and the role your organisation plays (e.g., home support/comprehensive assessment).
- Advise you will be asking a few questions relating to their general health and wellbeing to help inform assessment needs.
- Confirm consent (consistent with section 5.1) and ensure the client understands why they are having the assessment, why the assessor needs to come to their home (if applicable) and allay any concerns or fears that they may have about the assessment. Should the client or their representative choose not to give consent, the triage process is to end and the assessment referral is rejected.
- If applicable, identify who are the pending representatives/agents and obtain the appropriate consent and check to see if a referrer and/or representatives/agents need to be contacted.
- Check client, and if appropriate, representative/agent or care finder contact information (including address for receiving correspondence) to ensure it is complete, correct and validated.
- Gather any additional information required, including whether the client would like a support person/representative/agent present for the triage questions asked using the Integrated Assessment Tool (5.2.2) or at the assessment. If a client lacks capacity, a representative or support person should be involved in the assessment to ensure the client is accurately assessed. The assessor can create or confirm a new representative/agent if required (see Setting up a Support Network for clients under section 3.2).
- 'Confirm' means a representative/agent relationship is recorded in the system as needing to 'confirm a pending relationship'. Pending regular representatives/agents can be confirmed over the phone, however, authorised representatives must be confirmed following sighting and uploading of verified authority documents.
- Organise an interpreter if required (e.g., for interpreting services or Auslan) and ensure other necessary supports are in place for the assessment. Note: you may

need to pre-book an interpreter, so early action on interpreter arrangements will assist meeting timeliness measures.

- Consider asking the client if they have a My Health Record to help ensure their Support Plan can be linked to it (subject to their consent, as per section 5.7)

Preferences for Aboriginal and Torres Strait Islander assessment organisations will need to be confirmed or captured at the triage stage. A client's preference for an Aboriginal and Torres Strait Islander assessment organisation should usually be captured at the point of registration, though during the transition phase some may come through to triage and assessment with a blank preference, in which case the preference will need to be captured. Suggested scripts in Appendix 6.

5.2.2 Asking triage questions using the Integrated Assessment Tool

The triage component of the IAT helps validate the appropriateness of an assessment referral and to collect information to support the assessment process. Triage delegates must refer to the IAT User Guide to ensure competency in the use of the IAT and in the delivery of high-quality triage. Triage delegates are also required to complete all mandatory training before undertaking the triage component of the IAT.

Triage delegates will be able to choose whether information gathered at screening is pre-populated into the triage component of the IAT. Pre-populating information will help reduce the client's need to repeat their story.

The triage component of the IAT comprises questions relating to the reason for their assessment, current access to services, function, general health and general wellbeing and safety.

At the conclusion of the triage component of the IAT, triage delegates will confirm eligibility for an assessment, the assessment type, priority and whether urgent services and/or linking supports are required, in instances where these services were not provided at screening (as per section 5.2.5).

If the triage delegate disagrees with the assessment type and/or priority recommendations made at the screening stage, the triage delegate will have the ability to change the recommendations.

After triage, the team leader may also transfer the client to another assessment organisation if appropriate. The team leader should ensure the client understands why they are being transferred, and that the receiving assessment organisation is aware that they will receive the referral.

Note: If the client is deemed to be ineligible for assessment services, the team leader should communicate the decision and inform them how to request an assessment in the future (this can occur at a separate time to the initial phone call, if necessary). Effective communication with the client/representative on a decision to not recommend an assessment, and effective communication between assessors, assists with managing expectations and reducing complaints.

Within the IAT, the triage delegate will be able to consider the type of assessor recommended for client assessment, having regard to:

- relevant cultural background or understanding
- who has the expertise to address the diverse needs of the client
- who is geographically closest to the client, which helps to ensure the client is assessed in the most efficient, effective and timely manner.

Further information
IAT User Guide
Department of Health, Disability and Aged Care website:
My Aged Care – Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews

5.2.3 Preparing for assessment

Triage delegates should outline to the client what will happen at the assessment, discuss their availability for the assessment and then make the appointment. Where possible, the triage delegate should give the name of the assessor that will be undertaking the assessment.

Additionally, triage delegates should:

- Complete the Work, Health and Safety (WHS)/Home Safety Risk screen and check for alerts and notes in the referral information on the My Aged Care record. Ask relevant questions to identify work, health and safety concerns which could affect the assessment for example: "Are there any risks or hazards the Assessor needs to be aware of before attending the assessment in your home?". If the team leader has knowledge of a client's criminal history that may be relevant to assessment services and assessor safety, they may choose to ask an additional question such as "Have you been convicted for a crime of a sexual or violent nature?" Note: Not all criminal convictions would be relevant to an assessor's safety, therefore this question is discretionary. (See also section 7.6 Prisoners.)
- Note special WHS requirements (such as the necessary presence of the client's guide dog) at the assessment. Arrange other responses (such as the need for

two assessors to attend the assessment due to safety concerns). (See also **7.6** Prisoners.)

- Upload any additional client information to the client record (e.g., WHS screen) and use 'Notes' to record assessment booking details. Include if relevant, with client's consent, sensitive information in sensitive notes and attachments (see section **5.6.** Recording Assessment Information).

- Check to see if there are cohabitating clients in the house who may also require an assessment, as appropriate.

Once triage is finalised and assessment assigned to an assessor, the answers to triage questions cannot be altered by an assessor. Assessors and team leaders will be able to access historical triage information on a client's record, which includes details such as the dates of previous triage, the organisation and individual who conducted it, and the outcomes of the triage. Assessors should:

- After the referral has been assigned to the assessor, the assessor must review all information in the client record prior to attending the assessment.

- With the client's consent, consider the collection of information on the client's situation and medical conditions diagnosed by suitably qualified medical personnel that may be required prior to the assessment. Contact the referrer or health professional if indicated prior to the assessment.

- Note and manage WHS risks.

- Note the timeliness measure for completion of the assessment process.

- Gather any anticipated forms or resources, including providing copies of relevant My Aged Care booklets and/or brochures depending on the type of assessment to be conducted and likely outcome i.e., providing a copy of the *Your guide to Commonwealth Home Support Programme Services* if the person is likely to be recommended for CHSP services. For comprehensive assessments, access the Application for Care form (see section **9.7**. Application for Care Form)

- Download assessment (if using Aged Care Assessor App).

> For guidance on how to manage preferences for Aboriginal and Torres Strait Islander assessment organisations when preparing for an assessment see Appendix 6.

5.2.4 In-hospital triage and self-referrals

For hospital assessments, in the first instance an assessor, once obtaining the client's consent, will complete the triage questionnaire using clinical records and information that is available, in liaison with the hospital discharge team. Following triage, the assessor may recommend a high or medium priority assessment.

Where an assessment is self-referred, and the assessor is with the client, assessors will be able to conduct triage with the client at the same time as the assessment. For assessors who are not triage delegates, triage can be conducted with triage delegate oversight. Assessment will not be able to be completed until triage delegate oversight is secured.

5.2.5 Urgent and other services following triage

Triage delegates may determine the need for urgent referral for services at triage, if not recommended at the screening stage. Referral for urgent services can occur during triage if:

- the client urgently requires aged care services, and there is a significant risk of harm if services are not provided,
- an assessor's availability to complete the assessment is expected to be significantly delayed, and this potential delay to the client in receiving aged care services will result in a significant risk of harm to the person. For example, the assessment recommendation may indicate that a high priority assessment is required, but the assessment timeframe cannot be met due to the client's location and the assessor's travel requirements.

The triage delegate may also identify and recommend linking supports for the client following triage, or for consideration by the assessor at assessment.

Further information
Department of Health, Disability and Aged Care website:
Deaf Connect (free face-to-face sign-language and Remote Video Interpreting Service)
Fact sheet for Assessors on care finders
My Aged Care website: Support for Hearing and Vision Impairment;
Help from a care finder
Department of Home Affairs website: Translating and Interpreting Service

5.3 Assessment Settings

Usual accommodation setting

If possible, the initial assessment should be face-to-face in the client's usual accommodation setting. This will assist with the environmental, physical, and social components of the assessment by observing the client's level of independence, functioning, and existing support arrangements in familiar surroundings (see section

5.5.2). Due to the nature of transition care services, some assessments will occur in the hospital setting (see section 13.1. Transition Care Programme).

Telehealth

Where face-to-face contact between the assessor and client is not possible (e.g., when assessing a client in a remote area or the client is inaccessible due to exceptional circumstances such as a seasonal weather event or pandemic), a teleconference, video conference or telehealth assessment may be undertaken. The assessor must make additional efforts to ensure the quality of assessment is not compromised when conducting a telehealth assessment and that assessment decisions remain evidence based.

Another suitably qualified person (such as a local health worker) and/or the client's agent or representative may attend the assessment with the client to assist the assessment process.

Remote

Assessors should use the remote assessment indicator in the My Aged Care assessor portal to indicate if an assessment has been or will be conducted in a remote area. This indicator can be checked before starting an assessment, when uploading from the Aged Care Assessor App or on finalisation of a client's Support Plan.

The Department uses the Modified Monash Model (MMM) as the classification system to define geographical remoteness. The remote assessment flag 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 by entering their address in the department's Health Workforce Locator.

Further information
Department of Health, Disability and Aged Care website: My Aged Care – Assessor Portal User Guide 6 – Completing an assessment

Hospital Setting

Assessments in a hospital setting are typically conducted by a clinical assessor.

For those clients in hospital requiring an assessment, they should be assessed in the same way as those assessed at home, utilising the IAT to ensure a nationally consistent approach to assessment of aged care needs, including consideration of the home environment and social issues. A client needs to be in a stable condition for a hospital based assessment to take place (unless a rapidly deteriorating condition makes this impossible). Being medically stable ensures that the care needs of the client outside of the hospital can be accurately assessed and the most appropriate care services recommended.

In hospital assessments, the assessor must ensure that a carer or other advocate is advised of the assessment in all circumstances and should be present during an assessment where possible.

Approvals for all types of care can be made following an assessment in a hospital environment (e.g. an assessor can recommend CHSP, time-limited reablement, etc.). There should be no presumption that older Australians will progress from hospital to residential care, as they may be able to return to their previous living arrangements. This is especially appropriate following an acute incident where the individual may benefit from a reablement approach or reassessment in the home environment after the acute phase.

Assessors need to be aware that for a client to be approved for TCP, the assessment must be conducted while the person is in hospital. Assessors should also consider arranging an assessment for home care when the client is discharged from a hospital and returns to their usual accommodation setting. This allows a more accurate picture of care needs in the home setting and ensures the client's current needs and goals are being assessed.

5.4 Commencing the Assessment

Before starting the collection of the assessment information into the IAT, the assessor must: inform the client of the assessment process and potential outcomes, ensure a wallet check is attempted and confirm consent and representative/agent relationships.

Wallet check

A wallet check assists to verify the client's identity and reduce the risk of duplicate records. Whoever has the first face-to-face contact with the client following the creation of the client record (e.g., an assessor or service provider) is expected to sight two types of valid client identification and record this information on the client record. The My Aged Care assessor portal provides a list of types of identification that can be used for the wallet check. Note the wallet check can be conducted at any stage of the registration or assessment process and through the Aged Care Assessor App. The wallet check only needs to occur once.

Best Practice Steps/Activities

- Preparing to commence the assessment with a conversational, respectful, and empathetic approach will allow you (the assessor) to develop rapport with the client and their support network (see Table 9. Best practice communication tips for conducting the assessment).

- Ensure you have reviewed notes entered at Triage, to help familiarise yourself with the client and their needs and limit the need for the client to repeat their story.

- Be clear to the client who you are and the organisation you are from and outline your role as an assessor on behalf of My Aged Care.

- Wear the My Aged Care badge or ID according to assessor branding protocols and style guide (see section **21**. Branding)*.*
- Confirm that the client understands the role of the assessor and the assessment process and obtain client (or authorised representative) consent before commencing the assessment. Explain to the client that the assessment has now commenced as they have provided consent.

> **Note:** The client can withdraw their consent at any time. In this case the assessment is discontinued. See sections **17.1**. Privacy Act, and 5.1. Consent.

- Create or confirm representatives/agents as required and when practical, ensure the supporting documentation is uploaded, including medical evidence if required. If necessary, the Aged Care Assessor App camera can take a photo of the document to upload as an attachment (see Setting up a Support Network for clients under section **3.2** and section **5.8** Assessment Wrap-Up) as long as the document photographs are clear and readable. Alternatively, the pending representative can mail a copy of the documents to the My Aged Care contact centre and the assessor can write a note in the client record of this undertaking (see Appendix 4. Contact Details).
- Conduct wallet check:
  - explain to the client why you need to do this
  - sight two valid identity documents
  - if the wallet check has been attempted but the client is unable to produce two valid identity documents or has indicated they will provide documents at a later point, enter this information as a note in the client record as evidence of attempting the wallet check
  - record the results on the client record.

5.5 Conducting the Assessment

The assessment is started with consent, using the IAT.

The assessment component of the IAT is divided into twelve sections. Some sections of the IAT contain nested questions to tailor assessments, only diving deeper into areas where needed. This means that some question sets or validated tools in the IAT will only display to the assessor if certain answers are selected to the question directly proceeding it (See the IAT User Guide for more information)

The IAT integrates eleven validated tools directly into the assessment process, enhancing the depth and clinical relevance of the assessment compared to the NSAF, where such tools were treated as supplementary. The use of supplementary validated tools is at the discretion of the assessor (see below).

Assessors must refer to the IAT User Guide to ensure competency in the use of the IAT and in the delivery of high quality assessments.

Table 9. Best practice communication tips for conducting assessments

Best practice	Communication tips
Use the Aged Care Assessment Quality Framework	• use the four quality goals, personal, effective, and connected in your assessment practice
Use a conversational approach when interacting with the client	• use a conversational approach when asking questions, rather than simply running through the assessment questions and ticking boxes ensure your conversation is undertaken in a manner that is respectful, non-judgmental, and non-confrontational. • know when and how to best use closed, open, direct, and indirect questioning • use motivational interviewing techniques such as expressing empathy and eliciting self-motivational statements. • use active listening skills • make eye contact with the client to ensure client is engaged with the process (unless culturally inappropriate to do so – e.g., Aboriginal and/or Torres Strait Islanders) • if using a computer at the client's home, ensure you are not focused on just the computer • gauge the client's level of engagement in the assessment. Look for signs of fatigue or discomfort and adjust approach accordingly
Use appropriate language when speaking with the client	• use needs-focused language, explaining what could be short-term vs. long-term options to meet their needs • use language that is positive and not dismissive. If necessary, potentially sensitive topics (such as lack of service availability or client fees) can be introduced at the appropriate place during the assessment process after the client's areas of concern and goals have been identified, and when support options are being explored in the Support Plan stage • use language that focuses on the client's strengths, abilities and what they want to achieve and how these could be further supported – a focus on independence • reflect the conversation back to the client to ensure you have understood what was said and agreed on
Interpreters or support person	• where the client prefers to communicate in a language other than English or has indicated in their record that a support person is required, an interpreter or support

Best practice	Communication tips
	person must attend the assessment (either in-person or via phone)

5.5.1 Clinical attendance

All sections of the IAT will be visible to both clinical and non-clinical assessors.

Where an assessment is initiated as a home support assessment by a non-clinical assessor and questions are triggered that require clinical judgement (referred to as clinical questions), the non-clinical assessor must arrange for the attendance of a clinical assessor to be involved in asking the clinical questions in the IAT. This process is known as clinical attendance and is supported by an assessment organisation's clinical governance framework (see Appendix 2 for guidance) and standard operating procedures. This process helps to make it easier for an older person to have their needs fully assessed without delaying their assessment or having to be transferred between assessors. The clinical attendance process is outlined in detail below.

Clinical attendance in practice

When a non-clinical assessor triggers clinical questions in the IAT, a warning message in the Assessor Portal or Aged Care Assessor App will prompt the assessor to complete the section in accordance with their organisation's clinical governance framework. If the assessor is using the IAT offline form, the clinical questions are colour coded in light pink.

Where clinical questions are triggered, the assessor will need to seek clinical attendance to ask the clinical questions (listed at Appendix 3). Clinical attendance will need to be sought from a staff member who is assigned a clinical assessor role in the My Aged Care Assessor Portal. The ways in which clinical attendance can occur are detailed in Table 10 and presented as tiers. Tier 1 is considered best practice; it is expected that an assessment organisation will adopt Tier 1 clinical attendance in the majority of cases.

For case studies of how clinical attendance will work in practice please see Appendix 3.

Table 10. Clinical attendance procedure

Tier no.	Clinical attendance procedure
Tier 1	A clinical assessor who holds a clinical assessor role in the My Aged Care Assessor Portal is available by video or phone call at the time the assessment is taking place to be involved in asking the clinical questions with the non-clinical assessor to the older person being assessed. A video call is preferable, but not essential.

Tier no.	Clinical attendance procedure
	The assessor can receive a call back when a clinical assessor becomes available. The assessment should continue while waiting for the callback. In this instance, if the assessor is using the IAT in the Assessor Portal or the Aged Care Assessor App, it is advised the assessor selects 'no' to the declaration. The assessor can revisit the question/s once a clinical assessor is in attendance. As the assessor continues through the IAT, they will need to make note of any other clinical questions (see appendix 3) and ensure that these questions are answered with a clinical assessor in attendance. There may be situations where it is not appropriate for the assessor to continue with the assessment, even with virtual, clinical attendance. This will be determined using the following criteria: It is not physically or psychologically safe for the older person to continue the assessment, It is not physically or psychologically safe for the assessor to continue the assessment, The older person's condition requires a clinical assessor to undertake an end-to-end assessment, Where it is considered inappropriate to continue, the assessment will end and a team leader will reassign it to a clinical assessor to undertake.
Tier 2	There may be circumstances where real-time clinical attendance is not possible. If a clinical assessor cannot be contacted at the time the assessment is taking place, the assessor will complete the questions that do not require clinical judgement. All other clinical questions are noted and cannot be asked. In this instance, if the assessor is using the IAT in the Assessor Portal or the Aged Care Assessor App, it is advised the assessor selects 'no' to the declaration. The assessor can revisit the question/s once a clinical assessor is in attendance. As the assessor continues through the IAT, they will need to make note of the clinical questions

Tier no.	Clinical attendance procedure
	prompted (see appendix 2) and ensure that these questions are answered with a clinical assessor in attendance.
	The assessment will end once the assessor has completed the non-clinical questions in the IAT (noting the IAT itself will remain incomplete). The assessor will need to speak with a clinical assessor in their organisation about the assessment and the clinical questions.
	If it is appropriate for the clinical questions to be asked by a clinical assessor over the phone, arrangements will be made with the older person and relevant support people for this to take place. It is preferable the original, non-clinical assessor is also on the call. If the clinical components are completed over the phone by a clinical assessor, the assessment does not need to be reassigned to this assessor.
	It may be determined that the assessment should be reassigned to a clinical assessor to complete the assessment, either in person or over the phone. This may be required because:
	multiple clinical questions are triggered in the IAT,
	the needs of the older person are best assessed in person to ensure a high-quality assessment,
	Where an in-person assessment with a clinical assessor is required, a team leader will reassign the assessment to a clinical assessor.

Best Practice Steps/Activities

- Prior to calling the clinical assessor, ensure the client understands that there are questions in the assessment tool that need to be asked with a clinically qualified assessor so that they can apply clinical knowledge and judgment to ensure that the client's needs are assessed in full and with their safety and wellbeing in mind.

- Where a clinical assessor is called into the assessment, it is important for the client be a part of the initial discussion when the clinical assessor is being briefed on the client's situation. The client and/or their support person should be given the opportunity to describe their circumstances if they feel comfortable to do so.

- If the clinical assessor is called in on a video enabled device, ensure the camera is on at both ends so that client can see the clinical assessor.

- If the clinical assessor is called on a phone without video functionality, ensure the call is on speaker phone so that the client and clinical assessor can speak directly to one another.

- If real-time clinical attendance is not possible, it is important that the non-clinical assessor explains that a follow-up phone call will be necessary to complete their assessment.

- If a follow-up call is necessary, the original non-clinical assessor should be present on the phone call to ensure there is continuity of contact with the original assessor.

- If a follow-up call is necessary, it is important that the non-clinical assessor keeps the client, their primary contact and/or support person up to date on when the follow up phone call will take place.

5.5.2 Tools and Techniques for assessing a client's needs

Assessors must observe the client's activities to gain insight beyond information that is conveyed just verbally by the client or the representative. Therefore, collect information through additional means:

- ask the client to **show you** how tasks are completed in the home and **observe** the client undertaking those tasks (this is an 'active' assessment) and

- advise the client **what** you have observed/seen during the task.

Assessors may wish to use assessment tools not included in the Validated Assessment tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). However, this is at the discretion of the assessment organisation.

The IAT includes decision support rules to assist assessors to make recommendations for the type of support a client requires based on the client's responses to relevant questions.

The role of an assessor, when developing the Support Plan (see section 5.7) with a client, is to consider IAT findings and the client's needs holistically to recommend support most appropriate to their needs and circumstances.

Where these assessment tools have been used, the assessor should reference their use, the reason for use, the outcome and the actions taken from the outcome in the support plan.

Where a recommendation for residential respite care is foreseeable, a clinical assessor (when trained to do so) will be required to complete the de Morton Mobility Index (DEMMI Modified) (see section **12.3.** Residential Respite Care.) A non-clinical assessor cannot complete the DEMMI Modified, even with clinical attendance.

In completing the IAT, the assessment information should include:

- evidence that the assessor has explored the client's own supports and/or non-funded services (e.g., state and local government programs, private services) as options to help maintain the client's independence.

- evidence of supporting a client's communication or support person needs.

- a completed 'Support Considerations' section to demonstrate an understanding of what is important for the client in regard to how support is provided, such as:
    - any cultural and/or religious values and beliefs
    - gender identity or sexual orientation/sexuality or experience of discrimination
    - history of childhood experiences
    - Life experiences including traumatic events and associated triggers
    - other relevant information relating to parole conditions or other information that should be sensitively discussed with the client when developing the Support Plan and that providers should be aware of (see 7.6. Prisoners).

5.6 Recording Assessment Information

Assessors should make sure all important assessment information is recorded before leaving the client's home. The assessment information in the IAT should be transparent, objective, accurate, complete and in plain language.

Before an assessment is finalised, assessors should perform a quality check on the assessment information, expanding on information and assessment evidence where required. Accurate recording assessment information prevents unnecessary follow-up queries and makes it more easily readable and usable for people who need to access it in the future. Once the IAT is finalised, it will become read-only and cannot be edited.

The accurate recording of assessment information (see the Aged Care Assessment Quality Framework):

- lays the foundation for creating the Support Plan for the client and is reflective of what the client actually said, showed or was observed doing
- minimises duplication between the assessment and Support Plan
- provides sufficient evidence for assessment delegate decision (comprehensive assessments only)
- is required for audit purposes
- helps to inform a client's provision of care and highlights important information or risks about the client's situation that needs to be managed by the provider or other parties.

Depending on the risk and issues highlighted in the assessment, the assessor must decide where to record the information in the client record, e.g., in the IAT, the Support Plan, in Notes, as attachments or as sensitive notes or sensitive attachments.

The assessor must include any specific requirements for that care type in the collation of evidence for the assessment delegate to consider. If making a recommendation for Act-based services, ensure that a Home Care Package and/or a younger person's assessment recommendation has appropriate justification recorded in the dedicated "Reason" field on the client record.

5.6.1 Recording sensitive information

If the person shares (or the assessor is in receipt of) sensitive information, with the client's consent this can be recorded by adding a sensitive note and/or a sensitive attachment on the client's record. This information will not display to providers or to client's viewing their information through the My Aged Care Online Account and will be visible only to assessors and contact centre/ACSO staff.

Sensitive notes should be used to record information that is of importance. This may include information about:

- financial issues
- safety concerns
- health issues
- legal situations
- Past experiences of trauma

For example, a sensitive note could be used to record a personal safety issue such as conflict between family members causing the client to be anxious.

> **Note**: Assessors must follow their reporting obligation specified in relevant legislation and protocols in their state or territory where they identify a client is at risk of abuse.

Sensitive notes and attachments are not visible through the My Aged Care Service and Support portal. Instead, a message will display on the client's record stating "the client has a sensitive note/attachment on their record".

If a provider sees this message on the client's record, they are advised to call the My Aged Care Service Provider and Assessor Helpline (1800 836 799). Given the assessor may be best placed to discuss the sensitive issues with the provider/s, the helpline may direct the provider to contact the assessor for enquiries on notes and/or attachments. The provider may also contact the assessor directly if they have a question concerning sensitive attachments. Sensitive information may be disclosed to the provider if it is relevant to their particular service. For example, where it is recorded that a client has a sensitive health issue, an assessor may be contacted by a garden maintenance provider and the assessor may consider it inappropriate to disclose the information; whereas if the assessor is contacted by a personal care provider, the assessor may have a duty of care to disclose the information as it has implications for the service being delivered.

Where an existing client currently receiving services has received a reassessment, and has disclosed new information that is categorised and recorded as a 'sensitive' note (that may impact the safety and welfare of the client, staff or other clients), the assessor should contact the provider/s to make them aware of the sensitive information and enable them to make a risk-determination of how best to support the client for the safe delivery of services (see section **7.6** Prisoners).

5.6.2 Sensitive client flag

The My Aged Care system also enables a registered client or representative/agent to be flagged as a 'sensitive person' if the client or representative requests to limit access to their information, AND the client or representative:

- works for My Aged Care or the department
- has a conflict of interest with My Aged Care staff
- has provided reasonable justification to support that their identity and contact information is to be protected.

A client or their representative/agent may request that they are made a 'sensitive client' through the contact centre. The request will be assessed by contact centre team leaders and if appropriate the client or representative's record will be flagged as 'sensitive'.

Sensitive client details will remain available to assessors and service providers who are working with the client. Clients or representatives/agents who are flagged as a 'sensitive client' will need to disclose this status to the contact centre at the time of their interaction, as the information is restricted and will require a team leader to access and edit the record.

5.7 Developing the Support Plan

The Support Plan is a plain language summary of the client's situation, strengths, goals, aged care needs and recommendations, based on information obtained during the completion of the IAT.

The Support Plan sections include:

- assessment summary
- concerns, goals, recommendations (general and service recommendations) and care approvals
- recommendations for periods of reablement and/or linking support
- associated people (where identified).

The Support Plan is a key document provided to the client and other key stakeholders (i.e., service providers), summarising the assessment findings and outcomes. The Support Plan formally becomes part of the My Aged Care client record.

The service provider's Care Plan (or equivalent) is expected to be consistent with the service recommendations in the Support Plan, including implementation of wellness and reablement approach.

The Support Plan can be updated as the client's needs change.

5.7.1 Linking the client's Support Plan with My Health Record

The Support Plan can be linked to the client's My Health Record (MHR). Before doing so, assessors must seek consent from the client or the authorised representative to link their Support Plan with MHR (this is required for new Support Plans and Support Plan Reviews). The assessor should also inform them that any health professionals who they have authorised to view their MHR will be able to access their Support Plan. Assessors should note that the client can also withdraw their consent at any time if they change their mind by calling the My Aged Care Contact Centre and requesting that their Support Plan not be linked to MHR.

Best Practice Steps/Activities

- Ensure that there is consistent information across assessment and Support Plan documentation.

- The client is central to the development of their Support Plan and should participate, agree to, and understand the content and decisions (including all recommendations).

- Provide the client (and/or representative if allowed by the client) the opportunity to review the draft Support Plan and confirm they agree that the assessment information has been recorded appropriately. This is particularly important in relation to any sensitive information provided about family members/carers and/or the client.

- Clients (and/or their representative, if appropriate), must consent to any service recommendations on their Support Plan and be aware and consent to their assessment information being shared with the service provider for purposes of providing their aged care services (See Section **5.1** Consent).

- If the client (and/or their representative, if appropriate) does not consent to information included in the Support Plan, the assessor should further discuss with the client and/or representative and amend accordingly.

- The Support Plan should consider:
  - non-funded supports options to help maintain the client's independence (e.g., the client's own informal supports, state and local government programs, private services)
  - if the client would benefit from short-term reablement support (see Delivering reablement under section **5.7**).

- Linking support or short-term case management or connection with a care finder (see section **14.10** Care finders) for a vulnerable client and ensuring clients with special needs are provided with recommendations appropriate to their circumstances and background.

- Safety/environmental issues are recorded using objective language that outlines the specific, observed issue (e.g., "some floorboards in the main access corridor found to be rotting and unsafe").

- If sensitive information relevant to client, assessor or service provider safety is recorded as a 'sensitive note', ensure the 'sensitive note' is not referenced in the Support Plan. This prevents enquiries about the nature of the note where disclosure of this information needs to be limited to certain individuals.

5.7.2 Assessment Summary

The assessment summary section of the Support Plan is a succinct overview of the assessment that appears on the printed Support Plan for the client.

Once the assessment has been finalised, based on the information entered into the IAT, the Assessor Portal or Aged Care Assessor App will indicate whether the client requires CHSP or Act based services.

When completing the assessment summary, the My Aged Care system allows the assessor to pre-populate a summary of the client's functional ability, support

considerations and complexity indicators that were identified during the assessment. The pre-populated information will be displayed in the ISBAR format, which is the recommended template for recording information in the assessment summary.

Using a standard template (example – Table 10. ISBAR approach below) to complete the assessment summary can help to ensure information is recorded in a consistent manner across assessment types. It is simple to adopt and helps make information easier to read while better supporting the delegation process and assisting the service provider to develop the care plan.

There are several principles that should be adhered to when completing the assessment summary. The assessment summary should be:

- Written in a succinct manner (using the ISBAR approach), focusing on relevant/essential information.
- Presented in a structured way that makes the information easy to interpret.
- Grammatically correct and free from acronyms, abbreviations, jargon, and unnecessary headings.

Relevant. Only include information that is relevant to the client's current situation. This may mean updating previous information.

Best Practice Steps/Activities

- Use the 'pre-populate' function in My Aged Care to enable the ISBAR template to tailor the pre-populated assessment information in consultation with the client. See template in Table 10 below.

Review and edit information populated from the assessment – such as functional needs, health conditions, support considerations, and complexity indicators. For a SPR or reassessment, the assessor (in updating previous information) may need to remove content that is no longer current to remain within the 5000 character system limit. All past versions of the Support Plan are retained as a record of any deleted content.

As time-limited-service recommendations and comments entered in the My Aged Care assessor portal do not appear on the Support Plan, assessors are encouraged to record additional information on time-limited services in the assessment summary so it is visible to the client. (E.g., 'client needs time-limited transport services until 28 February 2025 to purchase groceries/attend medical appointments, as they are unable to drive while recovering from acute episode/surgery').

- If the CHSP episode is ongoing, the recommendation should explain why ongoing services are needed for the client (e.g., 'due to an ongoing health condition'). Ensure the explanation is justified, well-evidenced and consistent with the CHSP Manual.
- If clinical attendance occurred during the assessment process, the assessor should make a note of this in the Support Plan.

Table 11. Assessment summary template using the ISBAR approach

*indicates items that are not pre-populated

ISBAR topic	Assessment information
Introduction	• Client's name and age • Reason for assessment, including referral details (who made the referral and why, if appropriate) • Assessment details – type (home support or comprehensive), date, location, mode, attendees, assessor name
Situation	Current social situation* • Key health conditions that impact functional limitations • Medical issues (clinical assessors to include diagnosis status)*
Background	• Living arrangements* • Social history* • Current support • Carer support (including details of Power of Attorney in place) • Other informal supports* Current services including aged care, mental health,
Assessment	• Carer profile • Function • Medical and medications • Physical and personal health and frailty • Social • Cognition • Behaviour • Psychological • Home and personal safety • Financial or legal • Support considerations • Whether clinical attendance was sought by a non-clinical assessor • 'Reference the use of any validated assessment tool (including those conducted through use of clinical attendance), the outcome of the tool and how that outcome was incorporated into the assessment.
Recommendations	Previous approvals Current recommendations*

ISBAR topic	Assessment information
	• Reason for the recommendation (the client benefit from X) • Comments relating to the priority/urgency of service • Who is to action the recommendation – client, assessor • Recommendations associated with the carer or associated people support • Referrals* • Status of referral (e.g., referral made with consent, client declined referral) • Who is responsible for contacting services • Time-limited/end date or review date, or a rationale for ongoing services. Contact details (if not client)* Who has been sent a copy of the Support Plan, including whether it has been linked to the client's My Health Record*

5.7.3 Goals, Concerns, Recommendations and Associated People

After completing all relevant domains and categories in the IAT (noting that, once the IAT is finalised, answers in the IAT become read-only), the assessor and client identify the goals the client wants to achieve that are associated with the areas of concern that the client wishes to address.

The goals note the client's strengths and abilities, the domain the goal(s) relate to, their area of difficulty and level of motivation to achieve the goal. The recommendations represent the agreed strategies and supports to achieve goals.

There are two types of recommendations that can be made on the Support Plan:

- **Service recommendations** represent referrals that can be made through the Assessor Portal to Commonwealth-subsidised aged care services.

- **General recommendations** relate to a type of support that is non-Commonwealth funded or where a referral is made outside of the Assessor Portal.

Best Practice Steps/Activities

- Ensure the Support Plan concerns and goals are clear, actionable, realistic and written from the client's perspective (e.g., Mr Arnold finds showering can be painful (concern). He would like to learn ways to undertake his shower without undue pain and achieve a reduction in his pain rating from moderate (6/10) to mild to (3/10) (goal).

- Ensure the client's concern/need can be associated with the relevant assessment domain in the IAT (e.g., Physical and Medical domains of the IAT provide details

of Mr Arnold's functional limitations with showering and the pain he is experiencing).

- Reference the use of any validated assessment tool (including those conducted through use of clinical attendance), the outcome of the tool and how that outcome was incorporated into the assessment.

- Consider whether the client will benefit from a reablement approach, and the client's capability, motivation, and strengths to contribute to their goals.

- Consider all care options, ensuring general and service recommendations are evidence-based, defensible and:
  - are clearly drawn from and linked to the client's goals and needs/area of concern. For example: a recommendation for respite, links to information on the client/carer relationship, dementia support, and any difficulties or concerns that are experienced to reduce carer stress and support the care relationship.
  - relate to the client's current unmet needs and are supported by the assessment.
  - take into account their identified support considerations when recommending options for support.

- Consider availability and capability of services and supports to meet the client's care needs including:
  - services in and outside of aged care
  - non-funded services.
  - informal supports, what family, friends and neighbours contribute (including the sustainability of these)

- General recommendations include responsibility to action (client/other).

- Recommendations for Act based services are appropriately evidenced and aligned to a client's immediate needs.

- Clearly articulate the service recommendation details – service type and sub-type (if applicable), start, end and review dates (if applicable), frequency, intensity, priority, and outcome:

- The frequency and intensity of the services may be recorded if indicated, however may be decided at a later point by the service provider with the development of the Care Plan. Example: Two times weekly.

- The priority for the service recommendations is based on the client's needs and urgency for services. The determination of urgency for services is based on the client's circumstances, such that there is an urgent need for services which, if not met immediately, may place the client's health and safety at risk.

- Include CHSP service episode (time-limited or ongoing) information in the assessment summary (see previous sub-section: Assessment Summary).

- A review date can be entered on the client's Support Plan and reason for the review such as for "12-month review for CHSP ongoing service recommendation". Linking support and reablement start and end dates and review dates are displayed on the Support Plan. The 'Associated People' section of the Support Plan helps assessors identify the people who will be helping the client meet their goals, or who may be providing support. It also assists in checking whether the client consents to the associated person receiving their Support Plan.

5.7.4 Converting a home support assessment to a comprehensive assessment

If an assessment is triaged as a home support assessment and Home Care Package services, residential care, residential respite or short-term restorative care are recommended, the assessment will need to be converted to a comprehensive assessment under the supervision of a staff member who holds a clinical assessor role in the My Aged Care Assessor Portal.

In the expanded view of the Goals and Recommendations tab, the assessor will have the option to convert to a comprehensive assessment if the current assessment type is Home Support. An assessor will only be allowed to convert to a comprehensive assessment from a home support assessment.

In assessments where comprehensive services are recommended, but clinical questions are not triggered in the IAT during the assessment, an assessor will need to seek the supervision of a staff member who holds a clinical assessor role in the My Aged Care Assessor Portal. The supervising assessor will need to be nominated before the assessment will be converted.

- If a clinical assessor has already provided clinical attendance during the assessment and nominated as the supervising assessor, the details saved when the IAT was finalised will display as read-only.

- When the assessment is finalised, a system notification 'Notification of Supervised Assessment' will be sent out to the outlet associated with the nominated supervising assessor. This notification will be visible on the Assessor portal as per existing notifications functionality.

5.7.5 Delivering Reablement

The provision of wellness and reablement approaches should be embedded in the assessment and support planning processes. Wellness and reablement underpins all assessment and service provision, drawing on the wellness philosophy to inform a way of working with people. It involves assessment, planning and delivery of supports that build on the strengths, capacity, and goals of individuals. Additionally, it builds on people's strengths and goals to promote greater independence and autonomy in daily living tasks, as well as reducing risks affecting the ability to live safely at home. It avoids 'doing for' when a 'doing with' approach can assist individuals to undertake a task or

activity themselves (or with less assistance), and to increase satisfaction with any gains made.

Reablement approaches involve time-limited services and always include a specific goal. Time-limited support aims to address a specific barrier to independence and to support the client getting back to doing things for themselves. This involves a targeted timeframe, developed with the client, to achieve their goals.

It should be noted that wellness and reablement approaches should be adopted by all assessors, including clinical assessors. For clinical assessors who are undertaking a comprehensive assessment, the option is available to recommend a client to receive a reablement service if it is appropriate to do so.

Understanding what a good day looks like for a client and how it relates to their individual goals and outcomes is important to determine short-term support needs during an assessment. This could be maintaining a level of activity or independence or working towards regaining it. Time-limited reablement is usually delivered within a 12-week period with the aim to wrap up and cease the services when the client has met their goal or specific outcome.

Time-limited reablement that assessors may refer clients for can include:

- learning a new skill, or actively working to regain or maintain an existing skill
- modification to a person's home environment
- providing access to equipment or assistive technology to help live more independently and safely in the home.

For example, learning a new skill could require referral for support on how to prepare simple meals for themselves, rather than referring for meals delivery. Regaining or maintaining existing skills could require referral for Allied Health and Therapy Services to ensure the client can continue to transfer around the home and reduce the risk of falls.

As part of the assessment process, the assessor will need to work with the client to identify whether they would benefit from a reablement approach to home support services, based on their needs and goals.

If the client agrees short-term reablement support is appropriate and/or beneficial to them, the assessor should include service solutions within the Support Plan to promote their independence. The assessor can record the reason for reablement period within the Support Plan such as:

- rebuild confidence and independence in mobility
- rebuild confidence and independence in cognitive abilities
- adaptation to functional limitation
- support the development/relearning of daily activities
- task simplification and energy conservation for managing housework

- promote social contact, community access and participation
- skills development in using public transport to supporting independence through assessment for appropriate aids and equipment
- training in the use of assistive technology

The Support Plan may include recommendations to assist the client to maintain and strengthen their capacity to continue to undertake daily activities and maintain social and community connections. Due to the nature of reablement supports, it is possible there will be several items in the Support Plan that need to be delivered in a coordinated way across a number of service types over a limited time period. In these circumstances, the assessor could refer a client to a lead provider – the organisation or individual provider who will deliver the key services as identified in the Support Plan.

The assessor may also need to take on a coordination role to ensure that all services in the Support Plan are linked to a provider, and that they will all be delivered within the timeframe of the overall reablement service. For clients receiving reablement support, assessors must include review dates on the client's Support Plan for the purposes of reviewing the client's progress towards their goals and desired outcomes, requirement for ongoing services, or whether to adjust the services required.

The reablement function on My Aged Care is designed so that the Support Plan can be finalised but also kept open for the support period to allow additional edits to be made (by the assessor who completed the assessment)). The timeliness Key Performance Indicator (KPI) will not be impacted. The timeliness KPI ends at the "finalise Support Plan & keep open for support period". For a smaller sub-set of older Australians, restorative care may also be appropriate, where assessment indicates that the client has potential to make a functional gain. Restorative care involves evidence-based interventions led by an allied health worker or professional that allows a person to make a functional gain or improvement after a setback, or to avoid a preventable injury (see section **10.4** CHSP Wellness and Reablement).

The department's expected proportion is that assessment organisations recommend a period of reablement to a minimum of 10% of clients.

Best Practice Steps/Activities for Facilitating Reablement

- Consider if the client would benefit from short-term reablement support, particularly if the client has experienced some functional loss and expresses the desire to improve independence and/or regain confidence and capacity to resume activities, including connecting with their community.
- If reablement is provided by the assessor, recommend a period of reablement on the client's Support Plan. This function allows assessors to identify clients who would benefit from reablement and allow assessors to make changes to the client's Support Plan during the reablement period. Users accessing the client's record (such as clients and service providers) will be informed that the client is undergoing a period of linking support and/or reablement.

- Focus on elements of functional tasks that a client can complete, and discuss what specific assistance they would benefit from in order to complete the task by themselves (to maintain and continue the independence to live at home)

- Discuss strategies a client can employ to more easily manage day-to-day tasks (e.g., transport planning to meet goals around the use of public transport to maintain usual activities)

- It is important to ask what goals the client wants to achieve. This can be as simple as making a cup of tea without help, or to understand their bus timetable. A goal could be walking to the local bus stop to go shopping, or to get to regular senior's events. Even small goals go a long way towards building self-confidence and regaining (or maintaining) skills to get back to doing things for oneself, to be more independent; and

- When looking at what goals the client could achieve, start by asking what a good day looks like for them? Then work out with the client what goals they need to achieve to have more of those good days.

- Consider the client's need for a mix of short-term, episodic, or ongoing services across service types (e.g., short-term personal care, episodic allied health, ongoing transport). Review this approach regularly to ensure the intensity of services matches the client's needs.

- Maintain regular contact with the client and providers and during the period of reablement.

In consultation, determine when the reablement period should be finalised and what ongoing support (if any) may be required for the client.

Develop local knowledge of reablement-type services in the region. Discuss with local providers their capacity and willingness to take on short-term clients as part of a reablement episode.

An expanded in-depth description of Supporting Independence: Reablement including client scenarios is at Appendix 4.

Further information
Department of Health, Disability and Aged Care website:
Guidance on Priority for Home Care Services
Commonwealth Home Support Programme Manual – Chapter Two: Supporting Independence
Living Well at Home – CHSP Good Practice Guide

5.7.6 Delivering Linking Support/Care Coordination to Vulnerable Clients

Most clients will be able to be assisted by assessors through the referral management process offered through My Aged Care. However, facilitating linking support can greatly benefit some clients. Where an older person's issues or circumstances may impede their access to aged care services, provision of linking support will assist in linking the client to one or more services they require to live with dignity, safety, and independence. These may be formal or informal services. Linking support may also be seen as short-term case management or care coordination to the point of effective referral (see section **5.10** Generating referrals / recommendations following the assessment). Assessors may consider connecting a vulnerable client with a care finder instead of providing linking support if they are in the target population for this program (See **14.10** Care Finders).

Linking support activities are aimed at working with the client to address areas of vulnerability preventing access to receiving mainstream aged care supports or care, to the extent that the client is willing or able to access aged care services. Issues leading to vulnerability could include homelessness, mental health concerns, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage, cognitive decline and/or living in a remote locality.

Assessment organisations are expected to provide short-term case management services for vulnerable clients who require linking services.

Identifying a vulnerable person for linking support

The IAT is designed to assist the assessor in identifying the complexity of a client who may require linking support, however, assessor judgment also plays a significant role, noting the presence of the same risk in different people may signify varying degrees of vulnerability. If applicable, the assessor selects from the following complexity indicators:

   a) 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
   b) There is risk of, or suspected or confirmed abuse
   c) Client has emotional or mental health issues which significantly limits self-care capability, requires intensive supervision and/or frequent changes to support
   d) Client is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support
   e) Client has experienced adverse effects of institutionalisation and/or systems abuse (e.g., spending time in institutions, prisons, foster care, residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and wellbeing
   f) Client is exposed to risks due to drug and/or alcohol related issues and is likely to cause harm to themselves or others

g) Client is exposed to risks or is self-neglecting of personal care and/or safety and is likely to cause harm to themselves or others

h) Client has a memory problem or confusion that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support.

Although not built into the IAT, the assessor may also need to consider challenges faced for people living in remote or very remote regions.

The assessor then selects, if applicable, the Risk of Vulnerability Cohort from the following:

a) Aboriginal or Torres Strait Islander
b) Veteran
c) Change in family/carer support arrangements
d) Refugees, asylum seekers or recent migrants without support
e) Lesbian, Gay, Bisexual, Transgender, Intersex, or other gender diverse
f) individuals
g) Culturally and linguistically or ethnically diverse individual; and/or
h) Socially isolated individual.

Following this, the assessor will decide whether the person would benefit from Linking Support by considering and selecting (if applicable):

a) whether complexity indicators impact the client's ability to live independently in the community
b) whether urgent intervention is required and
c) whether the client has indicators that impede access to delivery of aged care services.

Where the access to delivery of aged care services might be impeded, the assessor is to recommend Linking Support and short-term case management.

Linking support and short-term case management activities

The level of linking service support offered by assessors is time-limited and is not designed to provide ongoing support services. The activities that an assessor chooses to undertake when providing linking support will be dependent on the needs, circumstances, and preferences of the client, and may include one or more of the following:

- **Information provision and tailored advice** – provision of clear, reliable, up-to-date, and relevant information and advice to clients regarding service options and pathways.

- **Guided referral** – facilitation and management of the process of linking a vulnerable client to appropriate service pathways within or outside the aged care system. This includes monitoring the success of the referral process and ensuring that linking to the appropriate services is achieved.

- **Service coordination** – where a client's needs are complex and require a range of services spanning multiple sectors, the assessment organisation oversees the coordination of these services.

- **Advocacy activities** – for the vulnerable client to gain access to the identified support services, the assessment organisation may be required to speak, act, and write to the identified service providers on behalf of the vulnerable client.

- **Case conferencing/multidisciplinary service coordination** – provision of comprehensive, integrated service coordination for clients with high-level needs. This involves using a case conferencing/multidisciplinary service coordination approach which brings together a number of team members and a suite of services across sectors in order to meet the client's needs at different levels.

- **Establish local knowledge and networks** – the assessment organisation establishes local connections with service providers which support vulnerable people in their region.

- **Administrative tasks** – establish and undertake the administrative functions necessary to support the smooth and seamless progression of vulnerable clients through the required services. Some examples are:
  - Contact the relevant service providers on behalf of the client (e.g., legal services, health services, housing services etc.)
  - Obtaining the necessary client information from various sources and organisations
  - Compiling and completing the necessary forms on the client's behalf
  - Organising relocation services for the client, if required (e.g., removalist and utility services)
  - Organising cleaning services for the client's place of residence, if required
  - Documenting the client's progress.

Assessors may work closely with the Assistance with Care and Housing – Hoarding and Squalor Sub-Program (ACH) of the CHSP service providers in the management of vulnerable clients on a low income who are living with hoarding behaviour or in a squalid environment and at risk of homelessness or unable to receive the aged care services they need. Where there is no ACH coverage, the assessor will need to provide linking support to these clients and if applicable to the client, the eligible ACH client can be referred to CHSP services such as social work and other services targeted at avoiding or reducing the impact of hoarding and squalor situations (see section **10.6** Assistance with Care and Housing – Hoarding and Squalor Sub-Program).

People receiving assistance through the Care Finder program or Elder Care Support program may be eligible to access CHSP services targeted at avoiding homelessness or reducing the impact of homelessness. Any entry level CHSP services made available to a care finder or Elder Care Support Program client between the age of 50 and 65 (or between 45 and 50 for Aboriginal and Torres Strait Islander people) must be targeted at avoiding homelessness or reducing the impact of homelessness. All care finder and

Elder Care Support Program clients must be assessed by My Aged Care via the assessment services to determine eligibility and need to receive additional CHSP services.

Refer to Part C People with Special Needs for more information on support for a vulnerable person.

My Aged Care system function – linking support

The linking support function on My Aged Care provides assessors with the opportunity to record activities for clients identified as benefiting from linking support. The function allows assessors to make changes to the client's Support Plan during the linking support period. Users accessing the client's record, such as clients, contact centre and service providers, will be informed that the client is undergoing a period of linking support. The department's expected proportion is that assessment organisations deliver linking support to a minimum of 2.5% of clients.

The function is designed so that the Support Plan can be finalised and kept open for the support period and the timeliness KPI will not be impacted. The timeliness KPI ends at the 'Finalise Support Plan & keep open for support period'.

Vulnerable clients relating to Home Care Packages

Where the assessor wishes to monitor the client's access to a Home Care Package more closely, the assessors can elect (or at the client or representative's request) to be notified of home care correspondence sent to the client. This particularly applies to vulnerable clients who need assistance with the process of finding a suitable provider, and do not have support to assist them. Only one person from an outlet can be selected to receive this notification. This person's contact details will also appear on all client correspondence relating to their Home Care Package assignment.

This notification can be enabled from any tab in the client's Support Plan or on the 'Approvals' tab in the client record. The notification link will only be enabled if the client has been marked as 'seeking services', or a Home Care Package recommendation has been made (see section 11 Home Care).

Where an assessor is receiving home care notifications for a vulnerable client who has been assigned a Home Care Package, the assessor is able to extend the client's take-up deadline beyond the 56 day entry period, and extend the client's time to select a provider for an additional 28 days through the extension process on My Aged Care (see section 11. Home Care).

Best Practice Steps/Activities

- Consider if linking support is likely to be required – particularly if the client presents with two or more complexities (and/or risk of vulnerability) – and may have been further confirmed through the support considerations process. If identified as 'vulnerable', with the client's agreement, the client will be provided

with linking support. If not applicable, check an appropriate plan is in place. Therefore, the IAT and/or the Support Plan evidences the complexity or risk of vulnerability support has been considered and documented. If linking support is applicable, develop the Support Plan to include linking support, recommending the period of linking support and the planned activities. Action the recommended activities, monitor progress and record the outcomes (using the linking support function).

- Consider all available care and support options appropriate to the needs of the client and facilitate the provision of services to the point of effective referral.

- Liaise, consult, and work collaboratively with all stakeholders and service providers in a multidisciplinary approach across service sectors to support individual client needs. For example:

  o Contact relevant experts and service providers to discuss the client's current situation and Support Plan moving forward, and to assist with the co-ordination of the client's care whilst receiving linking support (e.g., care finders, ACH – Hoarding and Squalor providers, health, housing and legal services, community Geriatric Evaluation and Management teams, advocates, social, case management and/or mental health workers and local councils).

  o With client's consent, obtain the necessary client information from various sources and organisations.

  o Maintain regular contact with the client, providers, and those co-ordinating services during the period of linking support.

  o Assist clients with issues relating to transition to alternate service options.

  o In consultation, determine when the linking support period should be finalised, and what ongoing support (if any) may be required for the client

  o If no aged care support is required, consider referral to a support service outside of aged care and if relevant a support service which provides a coordination or case management function.

  o Offer the information in a variety of formats to promote equitable access (e.g., paper-based, electronic, face-to-face, over the phone, etc.) and where appropriate, include information to self-refer to the identified services and supports and information on rights, responsibilities, and mechanisms for complaints.

5.8 Assessment Wrap-Up

At the end of the assessment, an assessor should inform the client of the next steps so they have a realistic expectation of what will occur following the assessment. This will help the client to feel more assured and increase their satisfaction in the overall assessment experience.

There are a variety of [resources](#) an assessor might leave with a client at the conclusion of an assessment that are also available in many languages other than English (see section **22**. Aged Care Resources for Consumers).

Best Practice Steps/Activities

- Inform the client on the next steps, such as:
    - who to contact and in what instance (e.g., if the client has chosen to be referred to service/s, they will be contacted by service providers to discuss details of the service being requested; if the client has chosen to receive a referral code, they will need to take the code to the provider of their choice to access the service)
    - the actions they, or others identified in the Support Plan, are responsible for (e.g., visiting providers, organising a check-up with a GP/specialist)
    - identify the client's preferred referral method to action service referrals to providers and specialist assessment (e.g., allied health, occupational therapy assessment or vision services)
- Consider client information preferences (e.g., hardcopy or electronic copy) and their communication needs.
- Provide contact details to the client on who they should contact in the future [e.g., the My Aged Care Contact Centre, the assessment organisation (name and contact details of the assessor), and one or more service providers].

For care under the Act explain that the assessor recommendations will be submitted to the assessment delegate for approval and the client will be contacted about the outcome of the application.

If a non-clinical assessor is recommending Act based services, they must seek the supervision of a clinical assessor to assist with providing recommendations for Act based services. If clinical attendance occurred during the assessment, this supervision should be given by the clinical assessor who provided this attendance. If Act based services are recommended and clinical questions were not triggered in the IAT, the non-clinical assessor will need to seek the supervision of a clinical assessor upon converting the assessment to a comprehensive assessment.

If a copy of the authority documents cannot be obtained, advise the pending authorised representative to return the relevant documents to My Aged Care. The contact centre will process the documents and if validated, activate the relationship.

5.9 Finalising Delegation (Act based services)

Assessment delegates should review all assessment information carefully to ensure their decision results in the approval of the most appropriate care type/s to address the client's needs.

Best Practice Steps/Activities

- Delegates must review:
    - the full comprehensive assessment to ensure all pertinent assessment information is considered
    - the 'Reason' field to ensure that any recommendations for High priority Home Care Package approvals are appropriately evidenced.
- For a younger person, evidence of options explored to establish that there are no other care facilities or care services more appropriate to meet their needs.
- Gather further information from the assessor who conducted the assessment (if needed) and clinical assessor who provided attendance for a non-clinical assessor (if relevant).
- The assessment information, Support Plan and approvals on the client record must contain clear evidence of decisions made by the assessment delegate.
- Reasons for all approval decisions under the Act must be clearly recorded in the client record. Statement of reasons in client notifications (Approval or non-Approval Letter), must justify the rationale for aged care approval/s and reviewable decisions.
- See section **7.3.** Younger People Seeking Aged Care Services; Part D - Delegation and Approvals; Part E - Types of Commonwealth-Subsidised Care; and section 15.5 The Right of Review / Reconsideration Process.

5.10 Generating referrals/recommendations following the assessment

An assessor must ensure that clients are referred to service providers according to service availability and the client's needs and preferences.

Assessors may send referrals electronically to one or more Commonwealth-funded service providers of the client's choice or provide the client with a referral code for the client to self-manage the referral.

Prior to sending the referral, the assessor must ensure that the client (or their authorised representative):

- consents to the My Aged Care referral method (broadcast, preference, or referral code)
- consents to the department providing information from the client's My Aged Care online account to the provider for the purposes of the provider actioning the referral (including to provide the agreed service recommendation on the Support Plan (See Section **5.1** Consent).

Where the Support Plan is recommending more than one service sub-type from the same service type category (e.g., both physiotherapy and podiatry service sub-types under the CHSP allied health and therapy service type), the assessor generates a separate referral or referral code for each sub-type recommended. If the service aligns

with the client's assessed needs and goals, assessors can issue more than one referral code for the same service recommendation sub-type so the client can access the service from two different providers (as long as no duplication of a service occurs). For example, if a client is approved to receive two different Social Support Individual sub-types, the assessor should issue two referral codes. **Note:** If an assessor has provided multiple referral codes for the same service sub-type, include the sub-type for each of those referral codes.

For residential and CHSP services, the assessor can issue a referral code following the assessment and approval of services to enable the client to take time to look for a suitable facility or provider.

When selecting a residential aged care service provider to issue a referral to, assessors can use Star Ratings to help compare the quality of aged care homes. Star Ratings are available via the 'Find a provider' tool on the My Aged Care website. All aged care homes receive an overall Star Rating and ratings against Compliance, Residents' Experience, Staffing and Quality Measures). For Home Care, the assessor does not generate a referral code, it is included in the client's Home Care Package assignment letter on assignment of a Home Care Package from the National Priority System. The client can present the referral code directly to their preferred provider or alternatively they can request assistance from the contact centre or the assessor for assistance in issuing a referral to a provider(s).

If a client prefers a particular service provider who does not have availability, the client can elect to be referred to that service provider's waitlist on the system (if a waitlist is available). Clients may be on a number of waitlists at any one time.

Where a service is not available to meet the needs of the client and the client does not want to be put on a waitlist, the assessor should have a further conversation with the client to consider other alternative options for support. Other options may include:

- a different Commonwealth-funded service that could meet the need (on an interim or ongoing basis)
- non-Commonwealth-funded services; or
- the client and/or their carer/representative being able to address part of their need.

Where required, the assessor is to provide short-term assistance to the client for the purpose of implementing the Support Plan. This may include monitoring referrals or discussing options with service providers for the provision of alternative services if necessary, or in cases of providing for vulnerable clients, linking support or care coordination.

Best Practice Steps/Activities

- Check availability of service providers in the client's region. Assessors can access Commonwealth funded service provider contact details in the My Aged Care Service Finder. Service providers will find the name of a client's assessing outlet in the 'Plans' tab of the client record.

- If required (e.g., for vulnerable clients) contact providers on behalf of clients when referring.

- Add additional documentation in the 'Notes' to ensure all pertinent information is available to service providers.

- Consider all referral options (through portal by broadcast, preference, direct referral, or issue referral code) and the service priority (excluding home care).

- Consider referrals/recommendations to services not listed in My Aged Care.

- Where service availability is limited, work with the client to explore alternative options of support to meet their areas of concern and goals.

- Discuss and record carer information and advise clients and/or their carers of carer support options available including requesting a call back from a local Carer Gateway service provider or the National Dementia Helpline.

Options for Care

Assessors must know that the care options within and outside Commonwealth funded aged care include local supports, health and community services and private services.

To offer a broad range of strategies to assist the client to achieve their goal, the assessor builds and maintains effective working relationships with service providers and extends connections with services and organisations in their local community, including those not listed in My Aged Care.

5.11 Providing the Client with Assessment Outcomes

Providing the client with adequate information relating to their assessment outcomes will ensure the client has a clear understanding of what will happen following the assessment, including who will contact them or who they will need to contact.

Best Practice Steps/Activities

- Advise the client that their Support Plan and information can be accessed via the My Aged Care Online Account and My Health Record (if the client has consented). The client can also be sent a copy of their Support Plan and relevant letters, taking into account the client's communication needs.

> **Note**: While it is considered good practice to offer a client a hard copy of their Support Plan and relevant information, where this is not feasible for an assessment organisation, the minimum requirement is that the client/representative:

- is clear on what is in their finalised Support Plan and are agreeable to this and which Associate People it will be shared with.
- agrees to be provided a soft copy of the finalised Support Plan and if appropriate the referral code letter (noting that Home Care Package clients will receive a letter once they have been assigned a package); and/or
- is aware of how to obtain a copy of the Support Plan and relevant information via their My Aged Care Online Account.

Advise the initial referral source of the assessment outcome, the delegation (if relevant) and referral outcome - if requested by the referrer and with client consent.

Client information includes:

- the finalised Support Plan
- the client satisfaction survey as part of the organisation's performance requirements
- a copy of the approval or non-approval letter or other associated notification documents, for clients who had a comprehensive assessment
- any relevant aged care consumer information not provided at the time of the assessment

5.12 Finalising the Assessment

The home support assessment is finalised when:

- the Assessment and Support Plan is completed; and
- when an effective referral has been made and/or the client decides to manage their own referral code/s; or
- where the client has made a choice not to proceed with aged care services.

The comprehensive assessment is finalised when:

- the Assessment and Support Plan is completed; and
- relevant delegation activities are finalised;
- when an effective referral has been made and/or where the client decides to manage their own referral code/s; or
- where the client has made a choice not to proceed with aged care services.

An effective referral is where:

- a referral is accepted by a service provider who can deliver a service response consistent with the service recommendations on the client's Support Plan

- the client has accepted responsibility for managing their own referral through a referral code
- the outcome of the assessment is that no further action is required by the assessor; or
- the assessor has made all available and reasonable efforts to connect the client with a service provider appropriate to their assessed care needs.

When the Support Plan is finalised to the point of effective referral, the assessor should inform the client to contact their provider or the contact centre if they have a change in needs, goals, or preference. If within their remit, the contact centre will assist the client with their enquiry. This could include re-issuing a referral code or if a referral is rejected, sending a referral to another provider. The contact centre or the provider can send an unplanned/ad hoc SPR request to the assessment organisation if it is an appropriate request.

Where appropriate, assessors are encouraged to follow up vulnerable or at-risk clients post-assessment who:

- have referrals that have been rejected/not actioned. This may include the monitoring of referrals to services or negotiating with service providers for the provision of alternative services if necessary.
- are working on short-term reablement goal(s) – in line with the length of time stipulated in the Support Plan; and/or
- are vulnerable clients, as determined by complexity indicators or need for linking support and required short-term linking assistance purpose of implementing the Support Plan.

Following finalisation of the assessment, where the department becomes aware that a client is having difficulty with accessing services, an assessment organisation may be required to follow-up with the client or service provider and provide advice on any follow-up action/s taken.

5.13 Support Plan Review (SPR) and New Assessment

A SPR by an assessor relates to the effectiveness and ongoing appropriateness of the client's Support Plan. The aim of the review is to ensure clients receive a smooth, consistent experience in a timely manner, and to avoid unnecessary assessment. An assessor may set a review date on the Support Plan at the time of the assessment or initiate the review on an ad-hoc basis. Unplanned/ad hoc reviews may be requested by the service provider or through the contact centre or ACSOs (see section **4.3** Managing SPR requests).

Key Principles

- The SPR may be completed over the phone with the client or representative.

- Assessors are best placed to make the decision as to whether a client requires a new assessment following a review. This decision is supported by the information provided by the client, the contact centre, service providers and health professionals.

- The My Aged Care contact centre has ability to issue a direct referral to the assessment organisation for an urgent comprehensive assessment for residential care, residential respite care or transition care.

- For other services such as a request for Home Care Package, if appropriate to the client's aged care needs, a non-clinical assessor can create an assessment referral after starting the SPR.

- If a client is admitted to hospital, it is best practice for an SPR to be conducted once the client is discharged from hospital and there is a clear picture of the care needs and type and level of support that will be required. If an urgent referral is required before discharge, the SPR can be conducted in the hospital setting. This may mean that the referral needs to be transferred to an assessment organisation that is contracted to conduct assessments in a hospital setting (limited to State and Territory Governments). If the request does not meet bypass circumstances to be directly referred for a comprehensive assessment, the SPR process will need to be followed to refer the client for a new assessment. Alternatively, the assessor may contact the state or territory assessment organisation to self-refer directly.

- Where there is a significant change in a client's needs or circumstances which affect the objectives or scope of the existing Support Plan, a new assessment may be undertaken. A new assessment can be the outcome of a SPR.

- If not already scheduled earlier, a SPR may be routinely scheduled 12 months from the last assessment for clients with ongoing CHSP services in place. A new assessment is only required for significant changes in care needs or circumstances since the last assessment. Note: The service provider also has responsibilities and processes to monitor and review the services at least every 12 months.

- When conducting an assessment, assessors should be considering the current needs of the client, and not recommending services that aren't supported by the assessment.

- An unplanned SPR will replace the schedule review in the system, which if necessary, can be re-scheduled at the completion of the unplanned review.

- A client can have multiple reviews of their Support Plan linked to the same assessment.

- If new WHS information is recorded on the Support Plan following a SPR for an existing client, the assessor should advise the provider of the new information so the provider can make the appropriate risk-based determination of how best to support the client's service delivery.

Support Plan Review (SPR) process

A review by an assessor will look at the following aspects:

- The reason a review has been requested and its impact on the client's existing assessment information and Support Plan.

- The appropriateness of the services in meeting the client's goals.

- Any new goals for the client and associated referral(s) for service.

- Agree (or change) priority for existing service recommendations (excepting home care priority, which requires a reassessment).

- Option to add a period of linking support or reablement during the SPR and to keep open the support period after finalising the SPR.

- The appropriateness of setting another SPR date or an end date for service delivery.

- The assessor may determine that no changes to the Support Plan are required as the existing Support Plan meets the clients' needs.

- Alternatively, the assessor may determine that the existing Support Plan needs to be updated to recommend additional services.

- Where changes are made, assessors will be prompted to seek the client's (or authorised representative) consent to link their Support Plan with MHR, as detailed under 5.7.

Once a support plan review has been commenced, an assessor will be able to

make changes to information in the following sections of the client's Support

Plan:

- Assessment summary
- Client motivations
- Goals & recommendations, including recommendations for linking support & reablement
- Manage services & referrals
- Associated People
- Review

Outcome of the SPR

After conducting the SPR, the assessor should consider possible outcomes, including: determining that no changes to the Support Plan are required (as it meets the clients' needs), updating the current plan, or conducting a new assessment.

The assessor can record the outcome to 'complete' the SPR and 'finalise' the SPR when it has been completed. If the SPR outcome is a new assessment, then the assessor is prompted to issue the assessment referral. The SPR referral will appear above the Assessment Summary Information in the client's Support Plan.

> **Note**: A SPR should accurately reflect the review details, including date, attendees, mode, assessor name, reason for SPR and the outcome of the review (up to 1000 characters). Assessors must ensure the client or representative agree to the details entered in the outcomes field as these comments will automatically appear on the client's Support Plan.
>
> The Assessment Summary section of the Support Plan has a 5000-character limit which can also be updated with the SPR. All past versions of the Support Plan are retained on the My Aged Care system and are a record of any deleted content.

After selecting 'complete & finalise Support Plan review' no further changes can be made to the Support Plan as part of the review.

Assessors should consider whether the client requires a new copy of the Support Plan as a result of the SPR.

The assessor may determine that the clients' needs or circumstances have changed significantly since their original assessment and a new assessment is required.

New assessment

A client may require a new assessment following a SPR in the following instances:

- client has multiple new needs or significantly increased needs
- client requires Act-based services for the first time (refer for comprehensive assessment)
- client requires further Act-based services in addition to their existing approvals requiring assessment delegate approval (e.g., client needs another episode of STRC or a review of level of Home Care priority).

The My Aged Care assessor portal allows a new assessment referral where:

- SPR request meets one of the four defined scenarios only (transition care, residential care, residential respite care and client relocation) or
- if the request does not meet the defined scenarios and the SPR clearly needs to be converted to a new assessment, the assessor can issue a new assessment referral where they select 'A new assessment required' as the outcome of the SPR or
- after the full SPR is completed and finalised, the assessor has the option to start a new assessment referral if this is appropriate.

Where the SPR outcome does not indicate the reassessment is necessary, but the person (or representative) continues to request a comprehensive reassessment to receive additional care under the Act:

- assessment organisations should be aware that making a decision not to proceed with a reassessment process under the Act prevents the client from receiving an assessment delegate decision regarding their eligibility to be a care

recipient, a formal notification of the assessment outcome, and a right of review process should the person disagree with the assessment decision.

- If the triage delegate's clinical opinion (based on guidance materials and evidence) is that a comprehensive assessment is not required, the assessment organisation must ensure the client:

- is aware of, understands and accepts this decision.is provided with the updated support plan which details the outcome of the SPR and if applicable, references the reason/s to the client why the requested reassessment is not required at this stage; and

- is provided with information on how to request a further SPR should the client's care needs or circumstances change.

- If the client does not accept the decision, then the assessment should proceed.

Further information
Department of Health, Disability and Aged Care website: [My Aged Care – Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews](#) [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#) [Commonwealth Home Support Programme Manual](#) [Home Care Packages Program Operational Manual: A Guide for Home Care Providers](#) [Star Ratings for residential aged care](#) My Aged Care website: [Help from a care finder](#) You Tube video: [How to manage a Support Plan Review request](#)

PART C - People with Special Needs (for Assessors and delegates)

All assessors and delegates need to be informed and aware of the needs and experiences of people with special needs under the Act and the complexity indicators and risk of vulnerability cohorts that are integrated within the IAT and support plan processes. This knowledge assists the assessor to identify 'vulnerable' clients and ensure the assessment provides a safe and inclusive environment, provides appropriate linking support, and individual support considerations are actively explored (see Delivering Linking Support/Care Coordination to Vulnerable Clients under section **5.7** and section **14** Other).

Assessors also need to consider groups noted under the Act including care recipients with Dementia and other forms of cognitive impairment, disability, mental health and hearing impaired, deaf, and blind.

Assessors should also consider, if appropriate, referring a vulnerable person with special needs to a care finder. Care finders can provide assistance to vulnerable people who do not have anybody who can support them and need intensive support to understand and access aged care services and other relevant community services. A care finder can help someone at any time including before they have any services in place and when they need help with new or different supports.

There is likely to be a significant cross-over between people who are within the target population for care finders and the special needs groups. However, not everyone from a special needs group will be supported by a care finder and not everyone who is supported by a care finder will be from one of the special needs groups (See **14.100** Care finders).

Assessors are required to complete training on working with people with special needs (see section **23** Training).

6 People with Special Needs under the Aged Care Act 1997 (Cth)

Section 11-3 of the Act identifies the following special needs groups:

   a) people from Aboriginal and Torres Strait Islander communities;
   b) people from culturally and linguistically diverse backgrounds;
   c) people who live in rural or remote areas;
   d) people who are financially or socially disadvantaged;
   e) veterans;
   f) people who are homeless or at risk of becoming homeless
   g) care-leavers;
   h) ga) parents separated from their children by forced adoption or removal;
   i) lesbian, gay, bisexual, transgender and intersex people (LGBTI); and
   j) people of a kind (if any) specified in the *Allocation Principles 2014*.[2]

The needs of these groups are described in more detail in this section. It is important to note that each group is not one single homogenous group; individuals may identify across more than one group and may have a variety of special and diverse needs that will need to be recognised and taken into consideration. This includes consideration of groups not noted under the Act.

During the assessment process, the assessor should create a safe environment for all people and ensure clients are aware they may have a trusted support person present. This may be a carer, partner, friend or perhaps a member from their 'family of choice' (who may or may not include biological family). This will encourage a person who is Aboriginal and/or Torres Strait Islander, comes from a diverse background and identifies with one or more diverse groups to share this information which will assist the assessor to develop an appropriate and tailored Support Plan with the person that considers their diverse needs.

> **Note**: It is important assessors recognise that many older Australians with diverse needs, characteristics and life experiences may have experienced exclusion, discrimination and stigma during their lives and may not feel safe to reveal such potentially sensitive information at this early stage.

Assessors should also be aware of the [Aged Care Diversity Framework](#). The Aged Care Diversity Framework is an overarching set of principles designed to ensure an accessible aged care system where people (regardless of their individual social, cultural, linguistic, religious, spiritual, psychological, medical and care needs) are able

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[2] As at 01 April 2021, there were no changes or additions to these special needs groups specified in the *Allocation Principles 2014* – this may be amended in future and if so, the Manual will be updated.

to access respectful and inclusive aged care services. A number of action plans have been developed under the Aged Care Diversity Framework to address the aged care barriers and challenges faced by particular groups, including:

- Aboriginal and Torres Strait Islander people
- people from culturally and linguistically diverse (CALD) backgrounds
- lesbian, gay, bisexual, trans and gender diverse and Intersex (LGBTI) peoples
- the shared action plan which outlines actions to support all diverse people.

Further information
Department of Health, Disability and Aged Care website: [Aged Care Diversity Framework](#)

6.1 Aboriginal and Torres Strait Islander People

An assessment of an Aboriginal and/or Torres Strait Islander person should be carried out in a culturally safe, sensitive, and appropriate manner. It is recommended to match the client to an assessor of the same cultural background, an assessor who has knowledge of the local region and culture, or an assessor who can best meet their needs. Assessors should observe local protocols and create a culturally safe environment for the assessment process. This may include involving a trusted person nominated by the client in the assessment process to support the client or facilitate assessment (e.g., family, friend, Aboriginal health worker or carer or an Elder Care Support worker)

Assessors should develop a good understanding of the communities in which they operate, as this ensures the advice and assistance provided to clients is appropriate for their needs and takes into account any local sensitivities. Assessors should establish links with Aboriginal and Torres Strait Islander community and health services, Elder Care Support workers and consider engaging with health workers whom the client knows, as they may be able to assist with the assessment. Interpreting services are available for some First Nations Languages (See **14.9** Interpreting services for Aboriginal and Torres Strait Islander people).

Assessors should also be aware that Aboriginal and Torres Strait Islander people may be distrustful of government processes including aged care assessments and be unwilling or uncomfortable when discussing personal or sensitive information with people they are unfamiliar with, particularly if they are also of the opposite gender or concern topics that involve a feeling of shame.

In 2019, Action Plans to Support Older Aboriginal and Torres Strait Islander people were developed under the Aged Care Diversity Framework to address the specific needs and challenges faced by Aboriginal and Torres Strait Islander people:

- The provider action plan sets out what aged care providers can do to deliver inclusive care that is appropriate and sensitive to the needs of older Aboriginal and Torres Strait Islander people.

- The consumer guide helps older Aboriginal and Torres Strait Islander people to express their needs when speaking with aged care providers. It can also help people working in aged care to better understand the needs of Aboriginal and Torres Strait Islander people.

Assessors are required to complete an introduction cultural safety training (see section **23**.Training). It is also recommended that assessors seek additional cultural safety and trauma aware, healing informed training relevant to the customs and protocols local to the area in which they are working.

As a part of the Single Assessment System, Aboriginal and Torres Strait Islander assessment organisations will be rolled out from 1 July 2025. These organisations will provide the choice of a culturally safe pathway for older Aboriginal and Torres Strait Islander people. Further information on the rollout of Aboriginal and Torres Strait Islander Organisations is in Appendix 6.

Eligibility considerations

The assessment process for Aboriginal and/or Torres Strait Islander people between 50-64 years of age is the same process for assessing non-Aboriginal and Torres Strait Islander people aged 65 years or older. Aboriginal and/or Torres Strait Islander people between 50-64 years of age can seek access to aged care or test their eligibility with the NDIS. If a person is approved and is required to enter aged care on an urgent basis, the assessor should also make the Aboriginal and/or Torres Strait Islander person aware that all people under 65 years of age can test their eligibility with the NDIS to ensure access to the most appropriate program on an ongoing basis (see Part C, section **7.3** Younger People seeking Aged Care Services).

A person does not need to provide proof that they are Aboriginal and/or Torres Strait Islander. Self-identification, or identification by a person or organisation they trust is sufficient for aged care purposes. Note that older Aboriginal and Torres Strait Islander people may be members of the Stolen Generations and/or be impacted by displacement and social disruption and therefore may be traumatised by having to demonstrate their Indigeneity. If a person identifies as Aboriginal and/or Torres Strait Islander it is important for this to be documented during the assessment for service and data collection purposes.

Further information

Department of Health, Disability and Aged Care website:

Further information
[Aboriginal and Torres Strait Islander Assessment Organisations](#)
[Actions to Support Older Aboriginal and Torres Strait Islander People: A Guide for Consumers](#)
[Actions to Support Older Aboriginal and Torres Strait Islander People: A Guide for Aged Care Providers](#)
[Principles and guidelines for a younger person's access to Commonwealth funded aged care services](#)
[Working with Diverse Groups in Aged Care](#)
[Elder Care Support Program](#)
Aboriginal Ageing Well Research website: [Good Spirit Good Life guide](#)

6.2 People from Culturally and Linguistically Diverse (CALD) Backgrounds

Assessors in areas with culturally diverse populations must engage workers from relevant backgrounds where the client agrees, and such workers are available. To ensure an accurate exchange of information during the assessment, independent and qualified interpreters should be used to assist people who do not use English as their main language. Client or carer consent regarding the use of an interpreter must be sought in all cases.

An assessment of culturally diverse persons should be carried out in a culturally sensitive and appropriate manner. Assessors need be aware there are a number of potential etiquettes, social and religious customs which may affect an assessment interview. There is no 'one-size-fits-all' approach to appropriately engaging CALD clients in a culturally safe, supportive environment which enables them to participate as active partners and articulate their individual needs.

In 2019, Actions Plans to Support Older CALD People were developed under the Aged Care Diversity Framework to address the specific needs and challenges faced by people from CALD backgrounds:

- The provider action plan sets out what aged care providers can do to deliver inclusive care that is appropriate and sensitive to the needs of older CALD people.
- The consumer guide, available in a variety of languages, helps older Australians from CALD backgrounds to express their needs when speaking with aged care providers. It can also help people working in aged care to better understand CALD needs.

Assessors should be aware of (and extend connection with) culturally appropriate aged care services for these clients in their region. Assessors may also use the services of specialised workers for older people from culturally diverse backgrounds. Organisations such as local migrant resource centres, the Federation of Ethnic Communities' Councils of Australia (FECCA) and Partners in Culturally Appropriate Care (PICAC) can provide more information.

Assessors are required to complete working with cultural and linguistically diverse clients training (see section **23**. Training).

Further information
Department of Health, Disability and Aged Care website:
[Actions to Support Older CALD People: A Guide for Consumers](#)
[Actions to Support Older CALD People: A Guide for Aged Care Providers](#)
[Partners in Culturally Appropriate Care (PICAC)](#)
Federation of Ethnic Communities' Councils of Australia ([FECCA](#)) website: [Working with Diverse Groups in Aged Care](#)

6.3 People who live in Remote and Very Remote areas

A small number of clients live in isolated areas. Whilst recognising face-to-face assessment is good practice and should be the first option, this mode of assessment is not always possible. In these circumstances, assessments may be conducted using non-face-to-face technologies such as by telephone or telehealth. Where this occurs, a suitably qualified person from within the local health service or community care provider should be present to support the client and to facilitate the assessment.

Assessors should develop and maintain good working relationships with health and community workers in rural and remote communities who may be called upon to assist with assessments and provide information and community needs and local services.

6.4 People who are Financially or Socially Disadvantaged

Financial or social disadvantage can often create a significant barrier for people to access a wide range of services in the community. Assessors should ensure that they develop and promote links with organisations in their area which attempt to overcome these barriers and provide assessments to people who may benefit from services regardless of their financial or social circumstances.

People who are financially or socially disadvantaged may also experience difficulties in accessing services after their approval. Assessors should be prepared to engage in a wider range of care coordination activities on behalf of these clients to ensure that they receive the care which they need and to which they are entitled.

A person's access to aged care must not be affected by their ability to pay consumer fees, but should be based on the need for care, and the capacity of the provider to meet that need. See section 16.5 Financial Hardship.

6.5 Veterans

The Australian Government recognises the aged care needs of the veteran community, in particular, mental health issues including post-traumatic stress. This is creating demand for a wider range of health care and support services in residential and home care services.

Assessors should establish links with relevant veterans' organisations in their communities and develop links between veterans and home care and residential care services. They should aim to facilitate an understanding of veterans' particular needs and to improve integrated care and access.

Assessors should have a good understanding of services provided by the Department of Veterans' Affairs (DVA) including the Veterans' Home Care (VHC) Program, the Coordinated Veterans' Care (CVC) Program and other mental health and rehabilitation programs (see section **14.3**. Department of Veterans' Affairs).

Assessors should advise veterans that if they are an Australian former prisoner of war or Victoria Cross recipient, DVA will pay their basic fee and means tested care fee for Home Care Packages, CHSP, Transition Care and STRC.

Further information
Department of Veterans' Affairs website

6.6 People who are Homeless or at Risk of Becoming Homeless

Assessors have a responsibility to recognise clients who are experiencing, or are at risk of becoming homeless, and to ensure that they can access an assessment and any aged care services approved for them. Liaisons between assessors and support services for homeless people are particularly important for this cohort because of their extreme vulnerability.

Under the CHSP, the Assistance with Care and Housing (ACH) - Hoarding and Squalor Sub-Programme supports older people or prematurely aged people aged 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) who are on a low income and who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need

People receiving assistance through the care finder program or Elder Care Support Program may be eligible to access CHSP services targeted at avoiding homelessness or reducing the impact of homelessness. Frail older people or prematurely aged people 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander

people) who are on a low income and receiving care finder or Elder Care Support Program services and are homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation, can access CHSP services targeted at avoiding homelessness or reducing the impact of homelessness (see section **10.6** ACH – Hoarding and Squalor Sub-Program and **14.100** Care Finders).

Assessors should take particular care to understand the client's usual living arrangements and their particular circumstances when arranging an assessment and assessing the person for care.

Assessors should also be aware that homelessness alone is not grounds to approve a client as eligible for residential or other forms of aged care. The person should meet the eligibility criteria set out in the Act and *Approval of Care Recipients Principles 2014* (Approval of Care Recipients Principles).

Where housing assistance services are not available, assessors should be prepared to make appropriate referrals and work with their state and territory government housing and homeless services.

Homeless means people who are:

- without any acceptable roof over their head e.g., living on the streets, under bridges, in deserted buildings etc. (absolute homelessness or 'sleeping rough')
  a) moving between various forms of temporary or medium-term shelter such as hostels, refuges, boarding houses, or friends
  b) constrained to living permanently in single rooms in private boarding houses; or
  c) housed without conditions of home e.g., security, safety, or adequate standards (includes squatting).

6.7 Care Leavers

The department's website provides information on care leavers, including a description of the term 'care-leaver'.

This term refers to children who were in institutional and other out-of-home care prior to the year 2000, including:

- Forgotten Australians - people who spent a period of time as children in children's homes, orphanages, and other forms of out-of-home care prior to the year 2000.
- Former Child Migrants - children who arrived in Australia through historical child migration schemes and were subsequently placed in homes and orphanages.
- Stolen Generations - children of Aboriginal and Torres Strait Islander descent who were removed from their families and communities by federal and state government agencies from the late 1800s to the 1970s.

Assessors should be particularly sensitive to the effects of care-leavers' childhood experiences with government officials, authorities and institutional care. These individuals may have experienced complex trauma and have general distrust of institutions and Government departments. Assessors should consider how to best support clients in the most sensitive and respectful way with an awareness and understanding of how childhood experiences may influence their concerns, preferences and decisions in relation to aged care, and emphasise that clients can have a support person at the assessment and that they are not obliged to take up any approved care (see section **12.1.** Permanent Residential Care).

In December 2016, the 'Caring for Forgotten Australians, Former Child Migrants and Stolen Generations' resource was launched. This package is designed to enhance aged care services and ensure residential and home care providers provide the best possible care to the care leaver groups. Additionally, the Real Care the Second Time Around Project has developed practical tips to assist aged care providers and staff to engage with Forgotten Australians/Care Leavers.

Further information
Department of Health, Disability and Aged Care website: Caring for Forgotten Australians, Former Child Migrants and Stolen Generations Information Package   Helping Hands website: Real Care the Second Time Around – Practical Tips

6.8 Parents Separated from their Children by Forced Adoption or Removal

'Parents separated from their children by forced adoption or removal' are recognised as people with special needs under the Act.

This term refers to the policies and practices that resulted in forced adoptions and the removal of children throughout Australia, particularly during the mid-twentieth century.

Forced adoption practices impacted a large number of Australians and caused significant ongoing effects for many people, particularly mothers, fathers, and adoptees.

Assessors need to be particularly sensitive to those clients who have been adopted or impacted by past forced adoption practices, including interactions with government officials, authorities, and institutional care, as these experiences can have significant personal and psychological impacts. Assessors should emphasise that clients' wishes are taken into account, they can have a support person at the assessment, and they are not obliged to take up any approved care.

6.9 Lesbian, Gay, Bisexual, Trans and Gender diverse, and Intersex people (LGBTI)

Assessors should ensure they conduct a non-judgmental assessment and the choice to disclose sexual orientation, sex/gender identity or variations of sex characteristics is entirely the client's decision. Where a client does disclose this information, the Assessor should emphasise that the information is protected information under the Act. In the case of transgender and intersex clients, where specific medical history may need to be communicated to service providers, it is important to discuss the way this information will be provided to the providers.

Assessors should also be aware of service providers who provide LGBTI-specific services and those that are LGBTI inclusive and be prepared to advocate for LGBTI clients with other service providers as necessary as part of their care coordination activities.

In 2019, Actions Plans to Support LGBTI elders were developed under the Aged Care Diversity Framework to address the specific needs and challenges faced by LGBTI people. The provider action plan sets out what aged care providers can do to deliver inclusive care that is appropriate and sensitive to the needs of LGBTI elders. The consumer guide helps older LGBTI peoples to express their needs when speaking with aged care providers. It can also help people working in aged care to better understand the needs of LGBTI peoples.

Assessors are required to complete working with LGBTI training (see section **23. Training**).

Further information

Department of Health, Disability and Aged Care website:

[Actions to Support LGBTI Elders: A Guide for Consumers](#)

[Actions to Support LGBTI Elders: A Guide for Aged Care Providers](#)

[Working with Diverse Groups in Aged Care](#)

Federal Register of Legislation website: [Aged Care Act 1997](#) (Cth) (see Special Needs Groups, Part 2-2, Division 11, Section 11-3)

7 Other Groups

7.1 Carers

Assessors are to recognise the valuable contribution and informal support that carers provide in the care of older Australians.

Where possible, with the client's consent, the assessor should involve the client's carer, family or other nominated representative/agent in the assessment and support planning process. In assessing the client's care needs where family and carers are involved, assessors may find there is a need to balance the client's concerns and preferences with those of their family and/or carers. Assuming the client has capacity to make their own decisions, only the goals and preferences of the client are reflected on the Support Plan. The assessor may need to meet with the client separately to ascertain the client's preferences.

Assessors should (with the client's consent) gain an understanding of the carer's support preferences for the client and their capacity to continue in the caring role. Assessors need to consider the carer's circumstances and assess if there are any factors that may affect the sustainability of the caring role. A client may agree to service recommendations that also benefit the carer, for example a type of respite service where there is an identified area of concern regarding strain in the client/carer relationship and a goal to relieve stress on the carer.

Assessors should provide information to carers regarding specific support services that are available for carers to access in their own right and inform carers how to link with these support services such as Carer Gateway, the National Dementia Helpline and other carer-focused dementia supports delivered by Dementia Australia, and consumer support and advocacy. Assessors can directly refer carers (with their consent) to Carer Gateway and the National Dementia Helpline through the Assessor Portal and Aged Care Assessor App. (See section **14.6**. Carer Support).

Further information
Carer Gateway website.
Department of Health, Disability and Aged Care website:
My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships
Dementia Australia website.
Dementia Support Australia website.

7.2 People with Mental Illness

Older Australians with a mental illness may seek entry to aged care services. Assessors are encouraged to liaise with mental health services to assist their understanding of the needs of older Australians with mental illness. Assessors can also assist by facilitating links between clients, providers, and appropriate mental health services.

Aged care services usually do not have the capacity to adequately meet the needs of people with a serious uncontrolled mental illness without the support of, and treatment by, mental health services. People who are a danger to themselves or others may not be suitable for entry to an approved aged care service.

Assessment and approval for entry to aged care is only appropriate if the intensity, type, and model of care is the most appropriate to meet the person's care needs. This includes the following considerations:

- The person meets the eligibility criteria set out in the Act and Approval of Care Recipients Principles or CHSP assessment criteria.
- The person's mental health is stable. If they have recently received treatment, their mental health should be stable prior to being assessed although it is understood they may still have significant symptoms.
- Community mental health services will continue to provide collaborative care for those elderly people who have significant or unstable psychiatric symptoms.

The assessor must, prior to commencing an assessment, obtain informed consent for the assessment either from the person (if they have the capacity to do so), or a decision maker consistent with state guardianship legislation who is able to make decisions regarding health, accommodation, and daily living care.

Involuntary mental health care is governed by separate mental health legislation in each state and territory. People who are placed under some form of an involuntary order (e.g., to manage their medicines when living in the community) may be eligible for aged care services. Assessors should consider each referral on a case-by-case basis.

In some jurisdictions, under certain circumstances, mental health legislation empowers the treating psychiatrist to make accommodation decisions in the best interests of a person receiving treatment under an involuntary order. This power is only exercised when a particular accommodation setting is required to facilitate the treatment of a person's mental illness. It does not replace the need for guardianship when mental illness is incidental to that person's need for placement in residential care.

A comprehensive assessment is also required to access residential aged care facilities in jurisdictions where residential aged care facilities are part of the aged mental health service system.

All assessment organisations should develop assessment protocols that reflect relevant state or territory legislation and regulations, to ensure that older Australians with a

mental illness are directed to the responsible agency to assess and recommend services most appropriate to meet their care and support needs.

7.3 Younger People seeking Aged Care Services

To be eligible for aged care services, younger people must meet the eligibility requirements of the *Aged Care Act 1997*, including the Approval of Care Recipients Principles 2014 (Approval of Care Recipient Principles). The Approval of Care Recipient Principles require that all options for age-appropriate accommodation and supports have been actively explored. Aged care services should only be used as a last resort for younger people.

A younger person is generally considered to be under the age of 65, or under 50 for Aboriginal and Torres Strait Islander people (see section **6.1.** Aboriginal and Torres Strait Islander People), or under 50 for a person who is homeless or at risk of becoming homeless.

Prematurely aged people aged 50 years and over (or 45 and over for Aboriginal and Torres Strait Islander people) on a low income who are homeless or at risk of becoming homeless, or living with hoarding behaviour or in a squalid environment, may be eligible for CHSP (see section **10.6** for further information about eligibility under CHSP).

My Aged Care is the entry point for younger people seeking access to aged care services (by phone, face-to-face or web referral). The My Aged Care contact centre arranges a comprehensive screening assessment for a younger person who meets the criteria for a comprehensive assessment. Prior to undertaking an aged care assessment by a clinical assessor, younger people should ensure that they have explored all other options, or they are unlikely to meet this eligibility requirement.

The My Aged Care contact centre will advise the younger person (and/or their representative /authorised representative) that prior to being referred to an assessment organisation for consideration of their eligibility for HCP support, they will need to have available for the assessment organisation evidence that they have explored and exhausted all other support options as listed above.

Clinical assessors are responsible for determining whether or not a younger person is eligible to receive aged care services under the Act. For a person to be eligible to receive aged care services under the Act, aged care legislation requires that there are no other care facilities or care services more appropriate to meet the person's needs.

When assessing younger people for services under the Act, the assessor is expected to check and document evidence during the assessment and delegation process demonstrating careful consideration of the above requirements in the Approval of Care Recipients Principles and where relevant, aged care program policy and guidance for the care type. These additional requirements are part of the self-auditing requirements for assessment organisations (see section **19** Aged Care Assessment Quality Framework).

If the younger person is at risk of entering residential care (including non-urgent residential respite care or permanent residential care) the My Aged Care contact centre will refer the younger person to the following agencies to actively explore all alternative aged care appropriate accommodation and supports:

- The National Disability Insurance Agency (NDIA) (for NDIS participants) or
- Ability First Australia (AFA) (for non-NDIS participants, or individuals who are yet to test their NDIS eligibility).

Either the NDIA Younger People in Residential Aged Care (YPIAC) Team or AFA will provide the younger person with specified documentary evidence (see section 11A of the *Approval of Care Recipients Principles 2014*) confirming that exploration of all age-appropriate accommodation and supports has been undertaken – with the results included. Evidence **must** include:

- an 'Exploration of Home & Living Supports for NDIS Participants Form' completed in collaboration with the person **only** by the NDIA YPIRAC Team; or
- a 'Summary Report: Younger People at Risk of Entering Residential Aged Care' completed in collaboration with the person by AFA.

To improve and support more effective data collection and reporting mechanism within the Department of Health, Disability and Aged Care , new fields have been introduced into the My Aged Care Assessor Portal for completion when assessing the needs of the younger person who is seeking residential aged care. Three new attachment types can be added to a client's profile in the attachments tab if the client is under the age of 65 years, including *NDIA YPIRAC Report*, *AFA YPIRAC Summary Report* and *Other YPIRAC Supporting Doc*.

This documentary evidence is not required for:

- A person from an Aboriginal or Torres Strait Islander community who is at least 50 years of age
- A person who is homeless or at risk of becoming homeless and at least 50 years of age
- A person who urgently needed residential respite and it was not practical to apply for approval beforehand.

Urgent residential respite care means the person urgently needed the care when the care started, and it was not practicable to apply for approval beforehand under Section 22-5 (2) the Aged Care Act (See Section 9.8 Urgent Circumstances).

See section 6.1 Aboriginal and Torres Strait Islander People for eligibility considerations.

Further information
Department of Health, Disability and Aged Care website: [Principles and guidelines for a younger person's access to Commonwealth funded aged care services](#) [Younger People in Aged Care](#) Fact Sheet – Assessing a Younger Person for Aged Care Services [National Disability Insurance Scheme](#) website

7.4 People with Dementia

The Australian Government recognises the special needs of people with dementia and their care partners. Assessors should foster links with dementia specific services, including with Dementia Australia and Dementia Support Australia (DSA), and where relevant, include this expertise in the assessment process. This will facilitate an understanding of how best to communicate with older Australians with dementia or other cognitive impairment. It will also assist assessors to better understand the needs of people living with dementia and their care partners, and assist to improve linkages, integrated care, and access.

Assessors should be particularly alert to concerns about cognitive impairment or people who indicate a previous diagnosis of dementia. Referrals to the National Dementia Helpline or a GP should be considered where concerns about cognitive impairment are raised or where there is a diagnosis of dementia but the person or their care partner are not receiving the dementia-specific support they need. Assessors can request a call back for people or their carers who have concerns about dementia (with their consent) from the National Dementia Helpline through the Assessor Portal and the Aged Care Assessor App. A trained professional from Dementia Australia would then call the client and speak to them about dementia specific services and supports that might be of assistance.

> **Note:** A person does not need to have a formal dementia diagnosis to be referred to the National Dementia Helpline.

Assessors must use their professional judgment if a client has dementia or is confused. In these cases, the input of carer partners and/or advocates is particularly important. Note that assessors should be aware that applying professional judgement might be especially difficult when dealing with Aboriginal and Torres Strait Islander people and clients from CALD backgrounds living with dementia or cognitive impairment. Factors such as language barriers, different concepts around ageing and dementia, a lack of awareness of dementia among family members and the additional stigma attached to

dementia in some cultures can all make assessment more complex. Some culturally appropriate dementia resources are included under further information below.

Assessors may find the National Health and Medical Research Council (NHMRC) approved Clinical Practice Guidelines and Principles of Care for People with Dementia (the Guidelines) useful. The Guidelines provide recommendations for the diagnosis and management of dementia and are intended for use by staff working with people living with dementia in the health and aged care sectors, including GPs.

A companion document to the Guidelines for people living with dementia and their carer partners is titled 'Diagnosis, treatment and care for people with dementia: A consumer companion guide'.

Further information
Dementia Australia website:
[Resources for Aboriginal and Torres Strait Islander communities](#)
Department of Health, Disability and Aged Care website:
[My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships](#)
University of Sydney (Cognitive Decline Partnership Centre) website:
[Clinical Guidelines for Dementia](#)

7.4.1 Training and tools for health professionals

- Accredited education, upskilling and continuing professional development for the workforce providing dementia care in the primary, acute, and aged care sectors is available through [Dementia Training Australia](#).

- The Wicking Dementia Research and Education Centre at the University of Tasmania offer two online courses known as MOOCs (Massive Open Online Courses): Understanding Dementia and Preventing Dementia.

- Dementia Outcomes Measurement Suite (DOMS) provides tools for the assessment of various aspects of dementia.

- Services and supports for people living with dementia, their carers, and health and aged care workforces

See 14.2 for a list of programs which provide support for people living with dementia, their carers and families, and health and aged care workforces.

Further information
Australian Dementia Network (ADNeT) website: [ADNeT Memory and Cognition Clinic Guidelines](#) Dementia Australia website: [Culturally Appropriate Dementia Assessment Tools](#) [Dementia Training Australia](#) website: Dementia care training and resources for health and aged care professionals University of Sydney (Cognitive Decline Partnership Centre) website: [Assessment process diagram for dementia diagnosis](#) [Cognitive Decline Partnership Centre](#) [Clinical Practice Guidelines and Principles of Care for People with Dementia](#) Dementia Centre for Research Collaboration (DCRC) website: [Dementia Outcomes Measurement Suite (DOMS)](#) - Tools for the assessment of various aspects of dementia University of Tasmania website: [Understanding and Preventing Dementia](#), Massive Open Online Course

7.5 People with Palliative Care Needs

Palliative care may be beneficial to any person with a life-limiting illness, regardless of their age.

The Aged Care Quality Standards (as specified by the *Quality of Care Principles 2014*) stipulate that care recipients are entitled to receive personal and/or clinical care that is appropriate and recognises their needs, goals, and preferences. This is particularly important for care recipients nearing the end of their lives whose preference may be to remain in their home for as long as possible.

The aim of palliative care is to improve the quality of life for a person with a life-limiting illness, and to help them live well for as long as possible. While people who have chronic or terminal health conditions may be supported via state and territory health palliative care specific services and housing systems, they may also be supported for their additional care via the aged care system, depending on their needs.

Where the aged care system is identified as part of the care requirements for a person over the age of 65 years (or over 50 years for Aboriginal and/or Torres Strait Islander people) with a life-limiting illness, it is important the aged care assessment is holistic and considers all of the person's needs. An important part of the aged care assessment will be the identification of palliative care needs and in particular, end of life care requirements. The timely provision of care will support and enable a person to be cared

for in their home for as long as possible. This is therefore important to consider as part of the assessment and when recommending care options.

Supporting Information

Palliative care seeks to prevent and relieve suffering through early identification and correct assessment and treatment of pain and other symptoms, associated with a life-limiting illness, whether physical, psychosocial, or spiritual. The types of supports that may be needed by an individual, their families and carers will vary and may include a range of formal and informal supports.

Palliative care can occur in almost all settings where health and aged care is provided. It may be provided by a variety of professionals, including general practitioners, allied health workers, aged care workers, counsellors, and pastoral carers. The assistance of specialist palliative medicine physicians and nurses may be required when a person's symptoms are complex or difficult to manage.

Palliative care is different to 'end-of-life care'. While palliative care may be provided from the point of diagnosis of a life-limiting illness, end-of-life care is care for a person who is likely to die within the next 12 months, including for those whose death is imminent (within weeks or days). The needs of patients are higher at this time and timely access to services is vital. Timely access to aged care services however may depend on the services being sought and whether a person is already engaged with an Aged Care Program. It is therefore important to explore all options for a client.

The provision of both palliative care and end-of-life care cuts across systems – care should be integrated to facilitate seamless transition, building upon state-based palliative care services and housing systems with other health services, such as those offered through the aged care system.

For example, where a state or territory provide palliative care services in the home, palliative care clients may also require assistance with basic daily living support and care to ensure they are able to remain at home for as long as possible. These care needs range from assistance with daily chores to personal care, providing meals, transport assistance, respite care, home modifications and social support.

Further information
Department of Health, Disability and Aged Care website: AN-ACC Class 1 – admit for palliative care National Palliative Care Strategy

7.6 Prisoners

Usually, My Aged Care assessments will be conducted when the person is released from prison into the community by referral through My Aged Care. Assessments of ex-prisoners in a community setting will depend on the person's needs and the screening and triage outcome. However, in a prison setting, only clinical assessors can undertake such assessments. A triage delegate can only arrange an assessment by a non-clinical assessor to take place after the person is released.

If it is imperative that an assessment occurs in prison, the clinical assessor can conduct an in-prison assessment, provided the prisoner has a release date and the prison is agreeable to the arrangement. By exception, a client may be assessed in a prison setting by a clinical assessor prior to them securing a release date. This can only occur in cases where a release date is dependent on a needs assessment being undertaken.

In recognition that prisoners can have very complex health and care needs, it is appropriate for a clinical assessor to be supported by another assessor. This is a decision for the assessment organisation to make keeping in mind the health and safety of its assessors. For additional considerations for WHS screen prior to assessment see section **5.2** Triage).

Regardless of whether the assessment occurs in a community or prison setting, Commonwealth subsidised aged care services can only commence after the prisoner is released. It is the responsibility of the relevant state or territory government to provide the appropriate care and services while the person is incarcerated. If the client is found eligible for a Home Care Package, the assessor should update the client's status to 'not seeking services' at the time of assessment. Upon receiving a prison release date, the client or representative will need to contact My Aged Care to indicate they are actively seeking care to be placed on the National Priority System (see section 11.5 Consumers seeking or not seeking services).

If the person shares (or the assessor is in receipt of) sensitive information, with the client's consent this can be recorded by adding a sensitive note and/or a sensitive attachment. Providers will be presented with a banner message on My Aged Care where a sensitive note exists prompting them to contact the assessor. The assessor should disclose information where it is applicable to the provider in their provision of care or services to the client (see Recording sensitive information under section **5.6**). Where it is recorded the client has challenging behaviours that may impact the safety and welfare of the client or staff, the assessor should contact the provider to help ensure they can appropriately manage these behaviours once services commence.

The Support Considerations section of the IAT gives assessors the opportunity to ask the client if there is any further information providers should be aware of in the delivery of care and services. This will allow (although this is up to the client to agree to) the client to advise of parole conditions or any implications of their incarceration that relate to effective and safe aged care provision that have not previously been raised during the assessment. The assessor can record this information as a sensitive note and/or

sensitive attachment and should add a note in the Support Considerations section of the IAT (and only if appropriate, the Support Plan) indicating that there is a sensitive note and/or sensitive attachment to view.

Assessors should be mindful that there is an increased likelihood that prisoners or ex-prisoners are at risk of vulnerability and complexity and requiring additional linking support (see Delivering Linking Support / Care Coordination to Vulnerable Clients under section 5.7).

PART D – DELEGATION AND APPROVAL PROCESSES UNDER THE AGED CARE ACT 1997 (Cth)

The primary audience for this section is assessors and assessment delegates.

8 Delegations

Under Part 2.3 of the Act, the Secretary has the power to approve a person as a recipient of Commonwealth-subsidised aged care. Subsection 96-2(14) of the Act permits the Secretary to delegate their powers and functions under Part 2.3 of the Act to a person making an assessment for the purposes of section 22-4 of the Act.

The current Instrument of Delegation relevantly delegates the Secretary's powers, functions, and duties under section 22-4 of the Act to those holding a position and performing the duties of a delegate for Act based services in an Aged Care Assessment Organisation. The Instrument of Delegation under the Act attaches a Schedule that includes each state and territory, the names of the Aged Care Assessment Organisations and the core disciplines (known as positions) to which the functions under the Act and Principles are being delegated. The occupants of these positions are known as 'assessment delegates'. Once powers and functions have been delegated to positions, assessment organisations are able to nominate individuals to occupy those positions.

The Secretary also delegates their powers and functions under different sections of the Act to various departmental delegates.

Delegation to assessment organisations is subject to the continued operation of the Single Assessment System program according to Commonwealth guidelines, funding conditions and any directions issued by the Secretary to the Secretary's delegates.

> **Note**: the introduction of the Integrated Assessment Tool from 1 July 2024 and Single Assessment System workforce in late 2024 does not change Delegations.

8.1 Assessment Delegates

An assessment delegate can approve a person as eligible to receive different types of aged care under the Act. While the assessment delegates are exercising the powers of the Secretary, assessment delegates are accountable in their own right for decisions they make under the Act. The approval of a person as a recipient of Australian Government subsidised aged care is not a simple matter of agreeing to a recommendation by an assessor. Although other parties contribute to the evidence to make a decision, the delegate is ultimately responsible for the decision.

When an assessment delegate makes an eligibility decision, they operate as primary decision makers in a legal system which has well-established processes, standards, and requirements. Assessment delegates need to understand what is involved in making a legal decision, and how a legal decision must be supported by evidence, facts, and reasons.

Delegate decisions can be subject to review in a number of different contexts, such as a reconsideration of a decision or be required to justify their decisions before bodies such as the Administrative Review Tribunal (ART).

The following principles underpin the delegation framework:

- assessment delegates must comply with all applicable Australian Government and state or territory laws which include, but are not limited to:

  o the Act and associated Principles; and

  o the Privacy Act.

- An assessment organisation's delegated responsibilities must also be consistent with the Aged Care Assessment Quality Framework (see section **19** Aged Care Quality Framework, for quality management).

- The assessment delegate is accountable for the quality and accuracy of the assessment, so must ensure that the comprehensive assessment has been completed without errors, contradictions, or omissions before approving the care.

- If the assessment delegate is not satisfied with the quality and accuracy of the assessment, they may request additional information from the assessor (and any clinical assessor who has provided clinical attendance at an assessment if applicable). They may request that the assessor seek further information from the client.

- The assessment delegate must ensure that assessments that have been undertaken by a non-clinical assessor and converted to a comprehensive assessment under the supervision of a clinical assessor, have been undertaken in accordance with the assessment organisation's clinical governance framework and standard operating procedures.

- Assessment delegates must approve a person as a care recipient if the care recipient's care needs have been assessed and they are satisfied the person is eligible for that type and level of care.

- The composition of assessment delegates within any one team should reflect the multidisciplinary approach and should include a mix of disciplines drawn from the core assessment professions.

- The approving assessment delegate should not perform the role of assessor, unless there are extenuating reasons such as in rural and remote locations, where this separation is not possible.

- The assessment delegate must notify the person of the decision in writing, including a statement of reasons for the decision outcome and ensure the person is aware of their right of review process.

- Assessment delegates must ensure reasons for their decisions are recorded in the client record and that the client is notified of these reasons in any correspondence relating to the outcomes of the assessment.

- The assessment delegate is able to discuss decisions with clients and family should there be any concerns.

- The assessment delegate should be able, if asked, to provide further information to the departmental delegate when there is a right of review application. If required, the assessment organisation or department delegate is available to appear before the ART to give evidence in support of a decision, in the event that an appeal is made.

- Assessment delegates should disclose and take reasonable steps to avoid any conflict of interest (real or apparent). Types of interest and relationships that may need to be disclosed include shareholdings, gifts, employment, voluntary work, company directorships or partnerships that could or could be perceived to impact upon the delegate's decision-making powers.

8.2 Triage Delegates

The triage delegate performs triage for an assessment organisation (see section 5.2). The Triage Delegate job position was introduced on the My Aged Care assessor portal in February 2025 to prepare for the changes that will take effect with the introduction of the *Aged Care Act 2024* on 1 November 2025. Existing team leaders will be automatically moved to the triage delegate position. Full delegations for triage delegates will come into effect with the commencement of the *Aged Care Act 2024*.

8.3 Occupants of Delegate Positions and Nomination Process

Individual assessment staff members in aged care assessment organisations who meet the delegate criteria (at section 8.4) can be nominated to occupy delegate positions by their team leader or operational manager.

To hold a delegate position individuals must go through an application process which will be received and approved by the Department using the online Delegate on/off form. The online form allows applicants to add users to delegate positions, cease existing delegates from delegate positions and replace existing delegates.

The department will discuss and clarify any issues with the assessment organisation as required. If the department accepts the nomination, the delegate's information will be established to allow access to the My Aged Care assessor portal with delegate role access.

The department and operational managers will liaise on particular circumstances where for the effective operation of a team (such as small or rural remote teams) some flexibility in the application of the criteria is required.

8.4   Delegate Criteria

The department has set minimum qualification criteria to ensure that assessment organisation staff members have appropriate levels of experience, knowledge and skills to competently undertake delegate roles.

Assessment Delegates (clinical)

Nominees will need to meet the below criteria to be considered and occupy assessment delegate positions:

- Must have tertiary qualifications in a health-related discipline directly related to health, aged care or related specialist area. For example:
  - Medical officers
  - Registered Nurses
  - Social Workers
  - Occupational Therapists
  - Physiotherapists
- At least one years' aged care needs assessment experience is preferred
- Current unrestricted registration with the Australian Health Practitioners Regulation Agency (AHPRA) or part of, or eligible to be part of, a relevant professional association.
- Completion of recognised assessor training (either pre-1 March 2023 or in MAClearning)
- Completion of training requirements as specified under the My Aged Care Workforce Learning Strategy 2023 (or subsequent versions). (See section **23**.Training)

Triage delegates (clinical)

Triage delegates will need to meet the below criteria to be considered and occupy triage delegate positions:

- Must have tertiary qualifications in a health-related discipline directly related to health, aged care or related specialist area. For example:
  - Medical officers
  - Registered Nurses
  - Social Workers
  - Occupational Therapists
  - Physiotherapists

- Current unrestricted registration with the Australian Health Practitioners Regulation Agency (AHPRA) or part of or eligible to be part of a relevant professional association.
- At least one years' aged care needs assessment experience is preferred
- Completion of training requirements as specified under the My Aged Care Workforce Learning Strategy 2025 (or subsequent versions). (See section **23**.Training)

> **Note** Full delegations for triage delegates will come into effect with the commencement of the *Aged Care Act 2024*.

8.5 Delegate IDs

There are different delegate IDs for delegate positions in the My Aged Care system which are derived from the initials of the delegate role, delegate team ID, profession code and position number.

8.5.1 Initials of delegate role

Delegate Role	Initials of Delegate Role
Triage Delegate	TD
Clinical Assessment Delegate	blank (no value)
Non-Clinical Assessment Delegate	NCAD

8.5.2 Delegate Team ID

The Delegate Team ID is unique to an outlet

8.5.3 Profession Code

Profession	Profession Code
No Profession	0
Medical Practitioner	1
Registered Nurse	2
Social Worker	3
Occupational Therapist	4

Profession	Profession Code
Physiotherapist	5
Other Health Professional	6
Psychologist	7

8.5.4 Position number

The position number is a 2-digit counter till it reaches 99 and then changes to 3-digit and this is automatically incremented.

For example, a Triage Delegate role for an outlet with Delegate Team ID as '7YC', Profession as 'Social Worker' with a profession code of '3' and Position number as 00, will have a position name (Delegate Position) as **TD7YC300**.

> **Note** the non-clinical delegate role will start on 1 November 2025 with the introduction of the new *Aged Care Act 2024*. Further information about how non-clinical assessors will access the non-clinical delegate role will be provided by the department closer to the implementation date.

9 Eligibility and Approval Process

9.1 Eligibility and Approval as a Care Recipient

A person is eligible for approval for care if the person meets the eligibility requirements under Division 21 of the Act and Part 2 of the Approval of Care Recipients Principles.

Under section 22-1(2) the Act, to be eligible for a type of care, an assessment delegate must approve a client for a particular type (or types) of care (see Part E – Types of Commonwealth-Subsidised Aged Care) if:

- the person has made an application in writing to be approved as a recipient under section 22-3 of the Act (see section **9.7.** Application for Care Form); and
- they are satisfied through the assessment information collected that the person meets the eligibility criteria for that type (or types) of care (see Division 21 of the Act*)*; and
- the type (or types) of care being approved are the most appropriate to meet the person's care needs.

The specific eligibility requirements for the different types of care and the limitations that can be placed on approvals are set out in the Act and in the Approval of Care Recipients Principles.

9.2 Review of assessment care needs before approval decisions

Subsection 22-4(1) of the Act states that "before deciding whether to approve a person, the Secretary must ensure the care needs of the person have been assessed."

The assessment and approval processes are separate functions and there can be no assumption that assessment automatically leads to a person's approval as a care recipient.

Therefore, before making any approval decisions, the assessment delegate must review the assessment process and evidence be satisfied that the assessor has:

- conducted a holistic assessment, including assessment of the person's usual living arrangements in accordance with relevant legislation and guidelines, such as assessor training, and good practice principles
- ensured that a multidisciplinary approach was taken and involved the disciplines required to assess different aspects of a person's care needs
- recommended the care types and services for which the person is eligible and that is most suitable to meet their current care needs and wishes (see Part E - Types of Commonwealth-Subsidised Aged Care)
- involved the client (carer, representative/agent and/or advocate as appropriate) in the assessment process, and kept the client informed at key decision points
- collected adequate verbal or written assessment information, sufficient to address any queries the assessment delegate may have
- conducted a quality check of the information captured prior to submitting their recommendation to the assessment delegate for approval, and
- Sought advice and supervision from a clinical assessor for assessments that have been converted from a home support assessment to a comprehensive assessment.

The assessment delegate must review the evidence, facts, and recommendations within the client's record to ensure that all necessary information to make a decision has been collected and make a good practice decision based on the evidence/facts and to ensure that it is of a standard to withstand external scrutiny. This information may include:

- Referral information
- Consent
- Application for Care form
- IAT and built-in validated tools as appropriate to the client's specific circumstances and needs
- Support Plan and recommendations
- For a younger person, accurate completion of the Check Form
- For home care recommendations, evidence consistent with the Guidance Framework for Home Care Package Level and Priority for Home Care Service.

Where a high priority is being approved, the reason field contains a justification of the priority.

- Any other evidence - e.g., provided by medical practitioners, health professionals or other agencies.

9.3 Types of approved care

The 'types' of Commonwealth subsidised aged care services under section 22-1 of the Act that a person can be approved as a recipient of are:

- Home care
- Residential care, including respite and permanent care
- Flexible care

In accordance with section 22-3(1) of the Act a person can apply to be approved as a recipient for one or more types of aged care. If the person applies for one or more types of care in their application, it is open to the assessment delegate to approve one or more other types of aged care under section 22-3(2) of the Act care if the person is eligible for that type of care.

Flexible care can be approved in the form of transition care or STRC. Clinical assessors will need to consider legislative exclusions for certain types of care that may have a number of criteria that need to be met. For example, a person is not eligible for STRC if they are currently receiving a Home Care Package or they have received transition care within the last six months. Clinical assessors can refer the person to a variety of other flexible aged care services that do not require approval, such as those provided by a Multi-Purpose Service (MPS) or a service funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC).

The assessment delegate is responsible for determining whether a younger person is eligible to receive aged care services under the Act. For a person to be eligible to receive aged care services under the Act, aged care legislation requires that there are no other care facilities or care services more appropriate to meet the person's needs (see the relevant sections of the *Approval of Care Recipients Principles 2014:* section 6(1)(b) for residential care, sections 7(1)(e), 7(2)(e), 7(3)(e) and 7(4)(e) for home care; and section 8 for transition care). Additionally, the decision must be consistent with the relevant aged care program requirements for that care type in relation to a younger person. Further requirements for younger people at risk of entering residential aged care is at section 7.3 Younger People seeking Aged Care Services and eligibility considerations for Aboriginal and Torres Strait Islander people is at 6.1 Aboriginal and Torres Strait Islander People.

Where a person is determined as not meeting the eligibility requirements of any care program under the Act, the assessment would result in 'No Care Approved' and the client receives a Non-Approval letter. For assessments where no care under the Act is

approved, 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.

Assessors and assessment delegates should refer to Part E of this Manual for further information on assessment and eligibility for Commonwealth subsidised aged care.

9.4 Limitations and varying limitations

Section 22-2 of the Act and Part 3 of the Approval of Care Recipients Principles deals with the limitation of approvals. Decisions in relation to limitations of approvals, limitations of approvals to one or more levels of care, and variations of limitations on a person's approval for a type of care are reviewable decisions under Part 6.1 of the Act.

An assessment delegate is permitted to limit an approval to one or more of the following:

- care provided by an aged care service of a particular kind (e.g., flexible care in the form of transition care)
- the provision of respite care for the period specified in the limitation
- to a particular level of care (e.g., home care level 1, 2, 3 or 4); and/or
- care provided during a specified period (e.g., to time limit the approval).

For a person approved as a recipient of care, the assessment delegate may time-limit the approval for a specified period. If a time-limited approval is granted, the decision must be well-evidenced and must be consistent with the care needs of the person to whom the approval relates. For example, time limiting an approval may be considered where the assessment delegate foresees an improvement to the client's condition meaning the person is not likely to require that level or type of care. This should be considered, with a view to:

- likely recovery from hospitalisation or acute medical condition/s
- improvements from other supports or interventions; or
- more appropriate care options will be available at a future point.

The assessment delegate may also, at any time, vary any limitation. Limitations and variations to the limitation of an approval should be clearly documented where appropriate in the My Aged Care system and specified in the client's approval letter (see section **9.9**. Outcome of Decisions). Assessment organisations have been issued a Fact Sheet on 'Managing Time-limited Approvals' relating and a 'Vary a Time-limitation' form to be used for home care variations through their state or territory manager.

9.5 Priority of home care service

The assessment delegate can determine and vary a person's level of home care, or priority of home care services (sections 22-2(3), and 22-2A of the Act). These are reviewable decisions under Part 6.1 of the Act. (See 11.3 Decisions on home care levels and priority).

9.6 Date of Effect of Approval

Under section 22-5(1) of the Act, an approval takes effect on the day on which the Secretary approves the person as a care recipient.

Under the Act, an approval cannot be backdated. There is one provision that allows a person urgently needing care to be provided with that care if it was not possible to gain an approval beforehand (see section 22-5 (2) of the Act, and Manual section **9.8**. Urgent Circumstances).

Where a system issue prevents the assessment delegate from recording their approval decisions on My Aged Care, the assessment delegate is required to use the Offline Approval form (accessed through the My Aged Care assessor portal) to manually record their decision/s. The approval takes effect on the day on which the assessment delegate signs and dates this form. If the client needs to enter care, and the system issue is outstanding, this form provides evidence to the provider of the approval. When possible, the completed and signed form must be uploaded to the client's record via the My Aged Care assessor portal. When the system is operating, the assessment delegate must record the approval including the actual date of delegation in My Aged Care. This information is transmitted to Services Australia. Completing the assessment online when system functionality resumes will allow the system to generate service referrals and referral codes and the client can receive their support plan and approval/non approval letters. Refer to the FAQs for Assessors - Business Continuity available from your assessment organisation's operational manager.

9.7 Application for Care Form

The Application for Care form is the Secretary's approved form that must be used by a person (or by another person) to request approval for one or more types of care (see section 22-3 of the Act). For a person to be approved by the assessment delegate under section 22-1 of the Act, a valid Application for Care form must be completed.

The Application for Care form has three components:

- a privacy statement for the use and disclosure of information collected during the assessment
- the Application for Approval section
- the emergency case application section (see section **9.8**. Urgent Circumstances).

The Application for Care form is available through the My Aged Care assessor and Service and Support portals, or at [Application for Care form](#). When completed, the

Application for Care form is uploaded as an attachment to the My Aged Care client record by the assessor prior to seeking delegation.

Signing the Application for Approval

The Application for Approval section of the form should be physically signed by the applicant. Subject to the person's capacity to give or demonstrate consent to the assessor, the Act provides that an application to be approved as a recipient of aged care may be made on a person's behalf by another person.

The legislation does not limit who the other person is and the interpretation of 'other' should not be prohibitive. In exceptional circumstances, if the client does not have a legal representative or guardian, or such a person cannot be present, another person acting in the interests of the client can do this. For example, a guardian, person with Power of Attorney, spouse, GP, or solicitor.

There may also be exceptional circumstances where it is appropriate for an assessment organisation or an approved provider to sign an Application for Care form. For example, in circumstances where it is not possible to obtain a client's physical signature.

An electronic version of the form can be accessed through the My Aged Care assessor portal. This form contains a 'Signature' field that includes the following options:

- Electronic signing
- Typing name
- Inserting saved signature from file

These options allow the person or their representative to sign the form electronically or the assessor to sign on behalf of the client (with their consent) - see '*Signing the Form*' below, and Manual section 9.9. Outcome of Decisions (Using electronic signatures).

> Note: in instances where a non-clinical assessor has been able to secure clinical attendance and complete a clinical assessment, and there is agreement that Act-based services are required, they will need to ensure that the Application for Care form is completed, consistent with the above.

When to complete the form

A new Application for Care form is to be completed in the following circumstances:

- for a client's first comprehensive assessment; or
- for a client who has been recommended Act based services through a home support assessment which has subsequently been converted to comprehensive assessment; or
- for a client whose prior approval for a type of care under the Act has expired and they are wanting to apply for that type of care again; or

- for a client who has a valid approval for a care type and is seeking to apply for a different care type under the Act than that previously approved.

A new Application for Care form is not mandatory for a client who has a valid prior approval for a particular type of aged care and is seeking a variation or change to the approval within that type of care.

Examples are:

- low to high residential respite care
- a change to level or priority for home care
- Short-Term Restorative Care to Transition Care.

The Application for Care process is finalised at the assessment delegate decision stage or, if applicable, following a reconsideration process (see section 15.5. Right of Review).

9.8 Urgent Circumstances

The Act (s22-5(2)(b)) allows the assessment delegate to make a reviewable decision when a person urgently needs residential care or residential respite care, and it is not possible for the person to apply or be assessed for relevant approval before entering aged care. If the assessment delegate agrees to the urgent circumstances, the legislation allows them to record the date of effect of the approval from the date that the urgent care started.

Urgent circumstances do not apply to home care. A home care provider is not eligible to receive a home care subsidy until a person has been assigned a Home Care Package through My Aged Care and entered into a home care agreement with the provider (under Part 3.2 section 46-1 of the Act).

Application Process

To be considered for a Commonwealth subsidy in urgent circumstances, the approved provider must complete and submit a valid Application for Care Form. That is:

- fully complete the Application for Approval section and the emergency case section
- submit the form and include information to support a referral for an assessment to their local assessment organisation within five business days after the day on which care commenced, unless an extension period to submit the Application for Care form has been granted by the assessment delegate

Signing the form – urgent circumstances

Providers and care recipients (and/or their families) should be made aware that the Application for Care form should be completed in full at the time of entering care. If the family is not available to sign the form, then the approved provider can sign the Application for Care form. The Application for Care form is still a valid form when it is signed by the provider. It is unnecessary for the provider to wait until a family member is

available to sign the Application for Approval section as this may cause further delay in organising an assessment for the person.

There could be a concern from the provider filling out the Application for Care form in case the family does not want the person to enter aged care. However, the Application for Approval form is an application for an assessment only and does not mean that at this stage the person is entering residential aged care permanently. In emergency cases, the person is already in care, however, this does not mean that the person has permanently entered aged care, or even that the person will stay in that facility (e.g., the person might stay in residential care and might move to a different facility).

If the provider does want the client's family to be involved in signing the Application for Care form, they may use the extension process. The Act states that if the application is not able to be made within five business days, there must be an application for extension of time under section 22-5(3) (see Application for Extension Process below).

Intake and Assessment Process

When the assessment organisation receives the Application for Care form:

- Ensure the Application for Approval is signed by the client, or other person, and that the 'emergency case' box is completed correctly by the approved provider.
- Confirm the date of receipt of the Application for Care form. If the form is received outside the 5 business days after the care started, the clinical assessor can only proceed with the assessment when they confirm that the provider has been granted the extension from the assessment delegate.
- Register and self-refer the client via the My Aged Care assessor portal (if required and requirements for self-referrals are met).
- Assign the priority on intake. Although the person is now receiving care, the Team Leader needs to take into account the urgent circumstances of the individual case when determining priority. If the person has a rapidly deteriorating condition, they may need to conduct the assessment as soon as possible.
- Upload the checked and receipted Application for Care form on the client's record.
- Schedule a comprehensive assessment with the client with a clinical assessor. This face-to-face assessment (if possible) should collect information:
  o on the client's eligibility as a recipient of aged care and type of care required; and
  o that supports the circumstances that an emergency existed at the time the client entered care and that it was not practicable to obtain prior approval.

The clinical assessor must gather as much information as possible about the urgent situation from the client, the carer (if available), the service provider and any other professional who was involved at the time.

Delegate Process for Urgent Circumstances

In order to consider approval for a client who started receiving care prior to applying for approval, the assessment delegate must determine the following:

- the application process meets requirements
- the client is eligible for the type of care being provided and the client urgently needed the care at the time the care started; and it was not practicable to obtain approval beforehand.

The care needs of the client must form the basis for all urgent admission decisions. If emergency care is approved, the clinical assessor will need to action the following:

- Check the emergency care flag and enter the date of admission to care on My Aged Care – this will ensure the approved provider receives subsidy from the date of entering care.
- Send the referral to the provider via the My Aged Care assessor portal. This enables the provider to access the client record and see all the approval details.

> **Note:** This process can also be applied to the scenario where the clinical assessor has completed an assessment and the client dies after the assessment but before the assessment delegate has made their decision (see section 9.8 Urgent Circumstances, Client dies prior to comprehensive assessment).

There are some situations that are not considered urgent and therefore should not be approved as urgent admissions. For example, this may include a bed becoming available in a residential aged care facility or moving from an acute care setting to another care setting. If an assessment delegate determines the person did not urgently need care before the date of decision (because an emergency did not exist), but the client is still eligible for approval as a care recipient, the date of effect of the approval will be the date that approval was granted.

A decision about whether a person urgently needed care is reviewable under Part 6.1 of the Act (see section **15.5.** Right of Review).

Application for Extension Process

While the department considers it good practice that the provider submits the Application for Care form (with completed 'emergency case' section) within five business days, the Act states that if the application is unable to be made within five business days, an application may be made for extension of time under section 22-5(3).

If the Application for Care form is not signed and submitted within the five business days, the form is considered incomplete, and the provider may first make an application to the assessment delegate to extend the period. The assessment delegate has the power to grant or reject the extension application. An extension application can be made by the provider by:

- making a written application to the assessment organisation (e.g., mail, fax, or email)
- stating the date the person entered care without an approval; and
- including the reason for the extension and any evidence to support the application

It is the assessment delegate's decision whether to accept or reject the extension application on a case by case basis (see Application for Extension Process, below).

If the extension is rejected, the service provider can seek a review of the decision under Item 24, Part 6.1 of the Act (see section **15.5**. Right of Review).

The assessment delegate notifies the provider in writing (by mail, fax, or email) of the outcome and includes the reason/s for the decision to accept or reject the application. If accepting the application, the notification will include the timeframe the provider has to submit the Application for Care form/completed 'emergency case' section. On timely receipt of the form, the assessment organisation can proceed with the decision on whether an emergency existed at the time the client entered care. All documentation for the extension application is uploaded on the client record.

Note: The extension process requiring the provider to a) submit an application for the extension, and then if approved b) submit the form, reflects the legislation. The provider may also provide the form at the same time as their application. If this is the case, the assessment delegate is still required to notify the provider that their application has been accepted within the extended timeframe or rejected.

If the clinical assessor considers that the person urgently needed the care when it started but the approval relating to this care event is already recorded on My Aged Care, the clinical assessor will need follow the corrections process to backdate the approval to the date the person entered care. If beyond the 42 days from the date of approval, the assessment delegate can contact the My Aged Care Service Provider and Assessor Helpline (1800 836 799) for advice (see section **9.11**. Corrections Process).

Note: Assessment organisations can seek advice from the department on a particular application. For example, where a significant amount of time has lapsed between the person entering care without an approval and the date the application is made, an accurate comprehensive assessment can no longer take place because the person's circumstances and/or care needs have changed since entering care.

Client dies prior to comprehensive assessment

When a client has entered into residential care as an emergency and dies before the clinical assessor conducts the comprehensive assessment, the assessment delegate is open to using additional powers under Section 22-4(3) to make a decision without a person's care needs being assessed, where justified by exceptional circumstances.

As well as all the considerations for an urgent circumstances case outlined in this section 9.8 Urgent Circumstances, clinical assessors should use the Client Deceased Before Assessment online process on My Aged Care. The benefit of the online process is that the approval is recorded on My Aged Care and is automatically submitted to Services Australia.

If there are complicated circumstances inhibiting the online process, discuss with the team leader.

Note: Cancelling the assessment in My Aged Care with the reason 'client deceased' will change the client status to deceased, making the client record 'read-only'. This will prevent the assessment delegate from being able to make a decision regarding the comprehensive assessment outcome of the client's entry into emergency care. Therefore, the assessor will need to contact the My Aged Care Service Provider and Assessor Helpline (1800 836 799) to request the client status be temporarily reverted to reactivate the client record, to enable the assessor to record the assessment outcome once a decision has been made. Ensure to change the client status back to 'client deceased' once the process is completed.

9.9 Outcome of Decisions

The assessment delegate has a legal obligation under the Act to notify a client, who applied for the approval to be a recipient of Commonwealth-subsidised aged care, about the outcome of their application or of any changes to their approval (section 22-6 of the Act). Section 85-3 requires that the Secretary (or delegate) must give reasons for reviewable decisions. The preparation of a statement of reasons is permitted disclosure of 'protected information' under Division 86 of the Act.

The notification includes:

- the delegate's decision/s as to whether to approve a person as a care recipient under section 22-1 of the Act and any limitations or variations to the approval decision/s
- a statement of reasons
- reference to supporting evidence to justify the decision/s and
- the client's review rights

The approval/non-approval or vary/not vary priority for home care service template letters are produced after the assessment and delegation process is finalised. The

templates can be edited by the assessment delegate to tailor the notification to the client's specific assessment.

Assessment delegates must ensure reasons for their decisions are clearly evident in the IAT including the Support Plan and any associated client correspondence.

Using an electronic signature

Section 10 of the *Electronic Transactions Act 1999* specifies the requirements in relation to using electronic signatures in circumstances where a law of the Commonwealth requires the signature of a person. In relation to notifications under the Act, the Assessment delegate is permitted to use an electronic signature in lieu of a written signature (for instance, where the Assessment delegate may not be physically on site). However, before authorising the use of an electronic signature, the assessment delegate must be satisfied that the legislative elements required to satisfy the approval have all been met.

As a matter of practice:

- appropriate procedures should be in place to monitor the use of the electronic signature, so that the assessment delegate will know when their signature has been applied.

- while the assessment delegate's responsibility to notify the client may be discharged with assistance from administrative staff who will attach the electronic signature, the administrative staff are not themselves delegated with the power to undertake this function.

- consent of the recipient to receive such approvals by electronic communication must first be sought.

Communicating the assessment outcome

Taking the client's communication preferences into account, the client must be provided with a copy of the Support Plan with the notification letter and other relevant letters. These documents can be:

- a printed/hard copy; and/or
- an electronic (soft) copy (such as a Word file) if the client consents to receive in this format.

In addition, the client and representatives can be advised how the client can access the document via the My Aged Care Online Account) (see sections **15** Complaints and **15.5.** Right of Review).

Once approved, a client is eligible to receive Commonwealth-subsidised care from an approved provider if they choose to do so. Clients should be advised that a person is not compelled to enter residential aged care or accept a Home Care Package or any other service recommended by a clinical assessor once eligibility has been determined.

Similarly, clients should be made aware that being approved for an aged care service does not ensure the availability of that service and be informed how the National Priority System for a Home Care Package works (see sections 11. Home Care and 22. Aged Care Resources for Consumers).

9.10 Approvals that Cease to Have Effect

Approvals that expire

A subsidy cannot be paid to an approved provider for providing care to a person unless the person is approved under the Act as a care recipient and has a valid approval. If an approval has expired, the person is no longer approved for care and, if receiving care, is no longer eligible to receive that care.

Approved providers must check that the care recipient has a current approval for the care type and level they will be providing when a care recipient:

- moves from one service to another
- changes their care type
- needs a higher-level of care
- has a time-limit on their approval; and/or
- has a break in care.

Assessors who are recommending residential care (including non-clinical assessors who are recommending residential care under the supervision of a clinical assessor) should be aware that a provider cannot receive subsidy for a day where a resident does not have valid approval for the care type received. The assessor needs to take reasonable steps to ensure clients and providers are aware of any limitations on the approval. Providers are advised to access Services Australia's payment systems to check if an approval has expired.

Clinical assessors should refer to the Reassessment Table at Appendix 2 as a guide to check to whether an approval is valid or the person requires a reassessment.

For difficult cases, clinical assessors should seek further advice from the department through their assessment organisation's operational manager. Administrative errors made by assessment organisations around approvals may result in Act of Grace claims which are managed by the Australian Government Department of Finance.

Approvals that lapse

Approvals for certain types of care can lapse under certain conditions, such as if care is not provided within the entry period timeframe. This applies to TCP and STRC. For more information on lapsing conditions, see sections **13.1**. Transition Care and **13.2.** Short-Term Restorative Care.

Approvals for the following types of care do not lapse **unless they are time-limited**:

- residential care (permanent and/or respite care); and
- home care.

Approvals that are revoked

A client's approval can be revoked if, after ensuring that the client's care needs have been assessed, the Secretary is satisfied that the client has ceased to be eligible to receive a type of aged care for which they are approved. This power is delegated to departmental delegates (not assessment delegates). On the rare occasions that revocation is being considered, the departmental delegate will liaise with the assessment delegate to ensure that the necessary assessment is made.

Section 23-4 of the Act sets out the process for revocation of an approval. A new approval for care does not revoke previous approvals.

9.11 Corrections Process

The assessment delegate is responsible for ensuring their decisions are recorded correctly on My Aged Care (e.g. correct dates, including the date of approval, type of care, level of care, any limitations on the approval). These quality checks minimise the need to make correction changes on the system.

However, if an administrative/typographical error does occur, My Aged Care has a correction process. As an example, typographical errors could include an error in recording an approval for home care level two on My Aged Care when the decision was to approve home care level three; or the date of approval on My Aged Care does not reflect the correct date the decision was made.

Where an assessment delegate has incorrectly recorded their decision on a client's record, they must request a 'correction'. Corrections are requested via the My Aged Care assessor portal **within 42 days of the original decision** and are work-flowed to the department for consideration (decision).

The reason for the correction must be recorded when lodging the request. For example, "*Home Care Package Level 2 omitted from online approval process, evidence of a Level 2 recommendation in Support Plan*". For the department to agree to the correction, the assessment delegate's intention (as at the time the decision was made) should be clearly evident though assessment documentation and/or other supporting documents on My Aged Care.

If the assessment information is not consistent with the correction request, the department will reject the request. In instances where a client's needs change after the original decision, it is required that a new assessment is undertaken.

In situations where the assessment delegate has reconsidered their decision and changed their mind after recording the approval (based on additional information they have received), a correction request is not appropriate and a new assessment is

required. Any correction requests received by the department for this reason will be rejected.

A correction cannot be requested where service referrals have been issued for Act-based services. Where a correction is required for an assessment and service referrals have been issued, the assessment organisation must recall all services in an 'issued' state before they can request a correction.

If the assessment delegate requires a correction on an assessment where referrals have been accepted or commenced, the assessment delegate must raise a case through to the My Aged Care Service Provider and Assessor Helpline (1800 836 799). Assessment organisations must provide details justifying why the correction should be undertaken despite a provider having already commenced service provision. These cases will be escalated to the department for consideration, noting that the outcome of such a correction may trigger Act of Grace claims.

Corrections to residential respite extension dates are only required where the respite extension request has been **incorrectly applied for a financial year** e.g., date of extension request was entered as 1 July 2022 when it should have been for 1 June 2022. In this instance, contact the My Aged Care Service Provider and Assessor Helpline on 1800 836 799 and raise a request for this to be corrected.

Further information
Department of Finance website:
[Act of grace payments, waiver of debts to the Commonwealth, Compensation for Detriment caused by Defective Administration](#) –
Department of Health, Disability and Aged Care website:
[Guidance Framework for Home Care Package Level](#)
[My Aged Care – Assessor Portal User Guide 10 – Assessment Delegate processes](#)
[Application for Care Form](#)
Federal Register of Legislation website:
[Aged Care Act 1997](#) (Cth) (see Part 2.3, Division 21 – Who is eligible for approval as a care recipient?; Section 22-2 – Limitation of approvals; Section 22-2A – Priority for home care services; Section 22-3 – Applications for approval; Section 22-5 – Date of effect of approval; Section 22-5(2)(b) – Urgent circumstances; and Section 23-4 – Revocation of Approvals; Part 3.2, Division 46 – Who is eligible for home care subsidy?; Section 46-1 – Eligibility for home care subsidy)
[Approval of Care Recipients Principles 2014](#) (see Part 4, Section 13 – Limitations of approvals)

PART E – TYPES OF COMMONWEALTH-SUBSIDISED AGED CARE (for Assessors and Delegates).

Part E contains important information for all assessors and assessment delegates, in order to be able to determine eligibility for Commonwealth subsidised aged care (see section **9.1.** Eligibility and Approval as a Care Recipient).

10 Commonwealth Home Support Programme (CHSP)

The CHSP provides funding for a broad range of entry-level support services to assist frail older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and who have functional limitations, including cognitive, to remain living independently at home and in their community.

The CHSP deliver services and support with a strong focus on wellness and reablement and restorative care on a short-term, intermittent, or of an ongoing nature, or across a small number of time-limited interventions, to maximise a client's independence and social connectedness, taking into account each person's individual goals, preferences, and choices.

CHSP providers must deliver services consistent with the goals and recommendations contained in the client's Support Plan as agreed with the My Aged Care assessor.

The CHSP is designed to provide small amounts of support services in a timely manner to older people who have difficulty performing activities of daily living without help due to functional limitations. Examples of services funded under the CHSP include domestic assistance, transport, meals, personal care, home maintenance and modifications, social support, nursing, and allied health.

In recognition of the vital role that carers play, the CHSP also supports care relationships through providing planned respite care services for frail older people, which allows regular carers to take a break from their usual caring responsibilities.

10.1 CHSP Target Groups

All new CHSP clients will access services through My Aged Care. Target groups for the CHSP are:

- Frail older people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need assistance with daily living to remain living independently at home and in the community.

- Frail older Commonwealth Home Support clients aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need

planned respite services, to provide their regular carers with a break from their usual caring duties.

- Frail older people or prematurely aged people 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) on a low income who are:

- homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation; or

- living with hoarding behaviour or in a squalid environment and at risk of homelessness or unable to receive the aged care services they need.

Prematurely aged people are those aged 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) whose life course such as active military service, homelessness, or substance abuse, has seen them age prematurely.

Note: Before undertaking an assessment for Commonwealth Home Support Program services, assessors should confirm whether a person is currently receiving services through the Disability Support for Older Australians (DSOA) program. Access to DSOA is impacted by the outcome of aged care assessments (see 14.5 DSOA)

10.2 Definition of 'Entry-level' Support

As an 'entry-level' program, the CHSP is designed to provide relatively low intensity services to a large number of frail older people who need only a small amount of assistance or support to enable them to maintain their independence, continue living safely in their homes and participating in their communities.

A higher intensity of episodic or short-term services may also be provided under the CHSP where improvements in function or capacity can be made, or further deterioration avoided. For example, where a client experiences a temporary setback such as a fall and requires a period of more intensive support to regain their independence.

The Home Support Assessor may recommend different CHSP service types over time or remove service recommendations as the client's needs and goals change provided that the recommendations are consistent with entry level requirements.

The CHSP is complemented by the Home Care Package Program which provides the second tier of support in the aged care system. CHSP services delivered to a client are generally expected to be, in total, lower than the cost or volume of services provided under a Level 1 Home Care Package (e.g., less than $10,588 per annum).

10.3 Urgent referrals to home support services (time-limited)

Older Australians seeking access to Commonwealth-subsidised aged care services for the first time must contact My Aged Care to have a client record created and arrange for an assessment of their care needs.

Clients should have their care needs assessed before accessing CHSP services. A client may, however, be referred by My Aged Care to a CHSP service provider

without an assessment if they require an immediate health or safety intervention that is not available through other means. The services should be:

- for a one-off or short-term intervention (e.g., such as nursing for wound care, transport to a specialist medical appointment or the delivery of meals and other support services due to the absence of a carer) lasting no more than eight weeks.
- for a direct health or safety intervention that needs to occur before a face-to-face or telehealth assessment can take place.
- monitored by the CHSP service provider and if the client requires long term or ongoing access to services, then the CHSP service provider must support the client to arrange an assessment.

See Urgent CHSP referrals (new client) in section 3.3. Screening for further information.

10.4 CHSP Wellness and Reablement

CHSP service providers are required to work with frail older people to maximise their independence and enable them to remain living safely in their own homes and communities. Providers must structure services with a focus on client strengths and goals to support independence. This means that service providers should generally not undertake tasks that the client can do safely for themselves. The longer a client avoids reliance on ongoing services, the longer they are likely to maintain their functional independence, giving them more good days doing the things that matter to them most. The reablement approach involves the delivery of time-limited services and always includes a specific goal.

This approach known as wellness and reablement builds on people's strengths and goals to promote greater independence and autonomy. Offering care that focuses on individual client goals and recognises the importance of client participation is fundamental to the CHSP.

Where a client is undergoing a period of reablement support, CHSP service providers have a role in progressing the agreed reablement support service interventions identified in the client's Support Plan. See Chapter 2, 2024-2025 CHSP Program Manual, Appendix 4 Supporting Independence (Reablement) and Delivering Linking Support/Care Coordination to Vulnerable Clients under section **5.7**.

10.5 CHSP Restorative Care Services

Time-limited reablement may involve restorative care services where the client has the potential to make a functional gain or improvement after a setback, or in order to avoid a preventable injury. Restorative care involves the delivery of evidence-based interventions led by an allied health worker or health professional that allows a person to make a functional gain or improvement after a setback, or in order to avoid a preventable injury.

Providers may deliver these interventions as one-to-one or group services and may involve a multi-disciplinary approach that goes beyond CHSP services, for example, involving primary health care providers. These services are coordinated by providers of allied health and therapy services based on clinical assessments of the clients. As with other kinds of reablement, providers and assessors work together in an integrated way to help clients set functional goals and review their progress during and after a defined period.

Client scenario – Entry-level support

JOYCE

Joyce's son comes to visit her and notices that she is not eating well and seems low in spirits. When they talk about it, Joyce reveals that her closest friend has moved interstate to live with family. Joyce misses her friend's company and is feeling lonely. Since she no longer drives, she has not been to see her other friends at the local seniors' centre.

Joyce and her son call the contact centre. She consents to register as a client and create a client record. The contact centre organises for Joyce to receive a face-to-face assessment.

The team leader contacts Joyce via telephone within two weeks of accepting the contact centre referral, to confirm the information gathered at screening and to ask some additional questions (triage). The team leader assigns Joyce to an assessor and schedules an appointment.

The assessor meets Joyce in person and talks about her needs and goals, and establishes a Support Plan that includes:

* appointments with a CHSP funded accredited dietician on a short-term basis (to address nutrition issues); and

* community transport to the local seniors' centre where Joyce will see her friends again.

This entry-level support helps Joyce to re-connect with her community, improve her physical and emotional health and continue living in her own home.

10.6 Assistance with Care and Housing – Hoarding and Squalor Sub-Program

ACH navigation services are delivered and funded through the care finder program.

The CHSP ACH Sub-Program supports frail or prematurely aged people who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to access the supports they need.

Clients who are eligible to access ACH – Hoarding and Squalor services, remain eligible for this service indefinitely and do not require a re-assessment for ACH – Hoarding and

Squalor services. These clients are also eligible to access other CHSP services targeted at avoiding or reducing the impact of hoarding and squalor situations.

Assessment organisations are required to work collaboratively with ACH – Hoarding and Squalor service providers in supporting clients to access aged care due to their particular circumstances. ACH – Hoarding and Squalor service providers link clients to the most appropriate range of housing and care services in order to meet their immediate and ongoing needs. The range of ACH - Hoarding and Squalor services may include:

- developing a client plan
- one-off clean-ups
- review care plans
- linking clients to specialist support services.

A specialised approach is required for ACH – Hoarding and Squalor clients due to their particular circumstances. For these clients, care finders may be a point of entry in addition to My Aged Care.

Care finders can help clients contact My Aged Care and work with assessors, to understand what services are available and to find and choose services. It is also appropriate for the assessor to refer suitable clients identified during the assessment process to care finders for further support.

To connect a person to support, because they are homeless or at risk of homelessness (and there are no concerns regarding hoarding behaviour or squalor), contact the care finder program or the Elder Care Support program by phone. Assessors will no longer be able to refer for people who are homeless or at risk of homelessness to ACH Advocacy- Financial, Legal or Assessment – Referrals through the My Aged Care assessor portal. (See section **14.100** Care finders)

It is appropriate for the assessor to refer suitable clients identified during the assessment process to ACH -Hoarding and Squalor for further support after an assessment. In areas where ACH is not available, the assessment organisation may be required to provide linking support and referrals to CHSP services such as social work and other services targeted at avoiding or reducing the impact of hoarding and squalor situations (see Delivering Linking Support/Care Coordination to Vulnerable Clients under section **5.7**).

10.7 Transition from CHSP to higher levels of support

The CHSP is not designed for older people with multiple or complex needs who require higher intensity levels of ongoing care and case management, nor is it intended to replace or fund support services provided for under other systems (such as the health care system). These higher needs are generally supported through other aged care programs including the Home Care Packages Program, residential aged care, and the health care system, including through early intervention, rehabilitation, subacute and transition programs.

As care needs change over time, the client may need to transition from the CHSP to higher levels of aged care support. If the client has ongoing needs for multiple services, a coordinated package of care or a higher intensity and/or more frequent provision aged care support (that is anticipated to be over the $10,588 per annum), the non-clinical assessor should refer the client for a re-assessment.

When deciding whether a person remains supported by the CHSP, assessors are to make evidence-based recommendations on the client's level of assessed needs. Concerns with income/finances are not sufficient reasons to remain at entry level where care needs indicate higher tiers of aged care support are more appropriate. If a client's needs no longer meet the entry level definition, they (and their representatives) need to be encouraged and informed about the comprehensive assessment pathway. If there are financial concerns the client should be provided with further advice (see section 16.5. Financial Hardship). While clients with multiple and complex care needs cannot be forced to transition from the CHSP to a Home Care Package or other support services, clients who choose to remain on the CHSP can only expect to receive entry level support.

The Guidance Framework for Home Care Package Level is useful for assessors to guide whether someone should be referred for a re-assessment (see section 11 Home Care, for links to resources).

10.8 CHSP Interaction with Home Care Packages

Home Care Package client's access to CHSP

The care needs of a person receiving Home Care Package should be addressed through their Home Care Package. CHSP service types (e.g., meals, transport, nursing) would generally be paid for on a full cost-recovery basis from the Home Care Package client's individualised budget. Full cost recovery means that the CHSP provider would charge the Home Care Package client the full cost of the service provision.

Given Home Care Package clients already receive an individualised budget that they control, with which they can purchase the types of services offered under the CHSP, Home Care Package client access to CHSP services is limited. Where a new client has been assessed and approved as eligible for a Home Care Package but is waiting to receive that package, the client may be eligible to receive some services under the

CHSP as an interim arrangement, but only to entry-level support consistent with the CHSP; not at the level of support of the package they are eligible for.

There are six defined circumstances in which a Home Care Package client may be able to access some specific CHSP-subsidised services in addition to the services they receive from their Home Care Package budget. These additional CHSP services will not be charged to the client's individualised Home Care Package budget; however, the client will be expected to contribute to the cost of these services in line with the CHSP provider's client contribution policy. The client contribution must be paid for privately and not from the client's package funds.

In all the following circumstances the additional CHSP services must only be provided on a short-term, time-limited basis, which should be monitored and reviewed by the client's most recent assessment service. The circumstances include:

- For clients on a Level 1 or 2 Home Care Package: where the Home Care Package client's budget is already fully allocated, the client can access additional, short-term, or episodic allied health and therapy services or nursing services from the CHSP, where these specific services may assist the client to get back on their feet after a setback (such as a fall).

- For clients on a Level 1 to 4 Home Care Package: where the client's budget is already fully allocated and a carer requires it, a Home Care Package client can access additional planned respite services under the CHSP (on a short-term basis).

- For clients on a Level 1 to 4 Home Care Package: in an emergency (such as when a carer is not able to maintain their caring role), where the client's budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short-term basis (see circumstance 6 for urgent goods, equipment and assistive technology). These instances must be time-limited, monitored and reviewed.

- For clients on an interim Level 1 or 2 package who are waiting for a Level 3 or 4 Home Care Package: where the client's Home Care Package budget is already fully allocated, a client can access additional home modifications from the CHSP.

- For clients on a Level 1 to 4 package who have transitioned from the CHSP: clients may continue to access their existing CHSP Social Support Group on an ongoing basis to allow the continuity of social relationships. This only applies to clients attending a pre-existing CHSP Social Support Group service on or after 1 July 2020.

- Clients on Level 1 to 4 package or awaiting their package: where there is urgent need, and the care recipient has insufficient funds in their package budget for goods, equipment and assistive technology (GEAT), they may be assessed to access GEAT in the short term.

If recommended for CHSP services, the assessor will refer the client to an appropriate CHSP provider in line with standard My Aged Care referral processes and is advised to set a SPR date to monitor the services.

If recommended for HCP Levels 1-4 and it is determined by the clinical assessor that a care recipient's health and safety may be at risk if they do not receive the necessary assistive equipment, they can make a High Priority referral directly to national CHSP goods, equipment and assistive technology provider geat2GO for low-risk items. Clients with cognitive impairment or complex needs should be referred for an assessment by an allied health professional to ensure equipment is prescribed appropriately. The allied health professional will make the request for urgent equipment with geat2GO.

Assessors should send referrals for geat2GO through the outlet Australian geat2GO HCP Emergency Funding for their relevant State or Territory as referrals will only be accepted with a direct referral to the outlet. Once a referral is received, geat2GO will look for a request in the geat2GO portal so where an assessor is making the request for urgent equipment for the client, the assessor should use the geat2GO portal to submit a request by selecting the funding type *HCP emergency funding*.

Further information:
Department of Health, Disability and Aged Care website:
Guidance Framework for Home Care Package Level
Commonwealth Home Support Programme
Commonwealth Home Support Programme – access to GEAT for HCP recipients
Commonwealth Home Support Programme Manual
Commonwealth Home Support Programme Resources
Living Well at Home – CHSP Good Practice Guide

11 Home Care

The intent of the Home Care Packages Program (the Program) is to support senior Australians to optimise health and wellbeing in accordance with their assessed needs, goals, and preferences, and to help them to live safely and independently at home. Home Care Packages ('packages')[3] deliver co-ordinated packages of care and services to meet people's assessed care needs within the limits of their individual home care budget and the scope of the Program. How care and services are identified and delivered should reflect and respect the individual, their care needs, personal situation, and preferences.

All packages are delivered using a Consumer Directed Care model. The aim of this approach to planning and managing care and services is to give consumers choice and flexibility in the supports they access, based on need, and how they are delivered.

Consumers should be actively involved in deciding how their package funds are spent. A package, however, is not a source of income that people can use completely at their own discretion.

Under the Act, the Australian Government provides a subsidy to an approved provider of home care to coordinate a package of care, services, and case management to meet the individual assessed needs of older Australians. Funding is paid in arrears to providers after services are rendered. Funding for a package follows the consumer to provide them with greater choice in selecting an approved provider and allow for flexibility to change providers, including if they move to another area to live. The structure of a consumer's[4] package will be developed by the approved provider working in partnership with the consumer to co-design the package based on the assessed care needs as determined by the clinical assessor, an individualised budget and the scope of the program. This provides greater transparency to the consumer about what funding is available under their package and how funds are spent, which ensures greater accountability for the way approved providers manage their packages.

11.1 National Priority System

The National Priority System is the system that assigns packages. Once a consumer is assessed and approved as eligible, they will be placed in the National Priority System, where they will wait for the assignment of a package. They will not be able to access Australian Government subsidised home care services under the Program until they have been assigned a package.

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[3] In this Home Care section, a Home Care Package/s is referred to as a 'package/s'.

[4] In this Home Care section, clients are referred to as 'consumers' due to the consumer directed focus of the Home Care Packages Program.

The National Priority System ensures the equitable assignment of packages based on a consumer's assessed care needs and circumstances; not where they live.

A person's position in the National Priority System is determined by their priority for home care services and the date of approval for care as decided by the assessment delegate. When a consumer reaches the top of the National Priority System, they will be assigned a package when one becomes available (see section 11.5 Consumers Seeking or Not Seeking Services for more information).

11.2 Eligibility and Approvals

Clinical assessors and delegate decisions must comply with all requirements under the legislation, apply clinical judgement and consider all information collected in the assessment concerning the person's care needs.

A person must be assessed as meeting all the eligibility criteria in order to be approved by an assessment delegate as eligible to receive home care. Eligibility requirements for Home Care are stated in Part 2.3, section 21-3 of the Act and Part 2, section 7 of the Approval of Care Recipients Principles.

Part of consideration for home care eligibility is that the person's needs can only be met by a coordinated package of care services (see Definition of Coordinated Package of Care Services, below).

A person who is eligible for home care must be:

- approved for a package level – either 1, 2, 3, or 4 with the package level indicating the current care needs of the client; and
- assigned a priority for home care services – either medium or high priority.

Definition of Coordinated Package of Care Services

A coordinated package of care services may occur where a person is assessed as having care needs that can only be met by a number of different support services working together with an arranged plan to assist with and support. A client's eligibility for a coordinated package of services is based on their need for multiple services to meet their care needs rather than their capacity, or otherwise, to coordinate those services. Eligibility for a package is determined by some ongoing basic support that can only be met by coordination of a number of services, and does not necessarily mean that these services need to be coordinated by a third party (e.g. case manager, care coordinator). This is consistent with Australian Government policy which advocates Consumer Directed Care, greater flexibility, greater choice and control, and self-management for clients interacting with the aged care sector.

Decisions on eligibility for a package and any limitations on the level of package should consider the informal care provided by family/friends and the sustainability of these arrangements.

If a person chooses or is financially able to pay for formal care and services, this care should be excluded from the considerations of the assessor in determining an appropriate level of package.

Any ongoing services a person receives through informal caring arrangements or self-funds should be excluded from an individual's support plan and package (i.e. their package should only address remaining care needs and reflect the level of package they require).

> **Note:** Income/finances are taken into account for Home Care Package recipients via the income assessment and should not be a consideration for entry into the Program (see section **16.2** Fees for Home Care Consumers).

Should care needs be higher than a package can accommodate and these needs are not able to be supplemented by other service or informal care arrangements, the assessment delegate should consider all the relevant evidence of whether the eligibility criteria for home care is met, and make the approval or non-approval decision accordingly. For example, careful consideration of an eligibility decision concerning a person in permanent residential care who wishes to return to the community and is seeking approval of a package to facilitate this (see section **12.1.** Permanent Residential Care).

11.3 Decisions on home care levels and priority

The assessment delegate must determine the home care level and priority for home care service (see 9.4 and 9.5). Level and priority are not necessarily linked – a level 4 consumer will not always have a 'high' priority for home care service – they may need a high level of care, but not be at immediate risk for a range of reasons.

A change in priority or level will require a new assessment with an associated assessment delegate approval. Assessors and assessment delegates should be aware that in making assessment recommendations on package levels that under the Act, there is no provision to allow a package to be 'downgraded' once a person has been assigned a higher-level package. In deciding home care level recommendations, assessors should also consider a reablement focus and the likelihood of improvement (see section **11.5**. Consumers Seeking or Not Seeking Services for more information).

Assessors and assessment delegates should also make recommendations on services and programs appropriate to the consumer's needs and consider all program interfaces such as CHSP and residential care.

Interim packages are not being released at this time. Any decision to reinstate interim packages will be communicated to assessment organisations through the regular bulletins.

Significant changes in care needs and circumstances requiring higher-level of care or different types of care (and/or changes to priority) will require a reassessment. For

example, a consumer approved for home care at a lower-level (e.g. Level 1) who requires a higher level of package (e.g. Level 2) due to increased care needs or a change in priority for home care service must first be reassessed by an assessor and approved by an assessment delegate.

11.4 Recording of recommendations, decisions and notifications

Assessment decisions must be defensible and able to withstand scrutiny. Assessors and assessment delegates (if applicable) must include robust assessment documentation in the IAT and the client record that clearly sets out evidence concerning their recommendations and approvals for all aged care services and programs.

The default priority for home care is advised to be medium with only a small percentage of clients who are at immediate risk being approved as high priority. Where home care high priority is recommended by a clinical assessor or added by an assessment delegate through the approval process, reasons or comments providing appropriate justification must be added before the recommendation or approval is saved on the My Aged Care portal.

If eligible for home care, the assessment delegate will notify the client of their eligibility outcome, level and priority for the package in their approval letter, which also includes their right of review. If, having applied for home care, the client is not eligible, they will be advised in the non-approval letter. Template letters are available on the My Aged Care assessor portal to notify a client of a reassessment to vary or not to vary the priority for home care service (see 9.9. Outcome of decisions).

Should a person who is approved for home care be identified as vulnerable, the assessors can elect to be notified of home care correspondence sent to the consumer through the My Aged Care assessor portal. The assessor's contact details will appear on all consumer correspondence relating to their package assignment and if necessary, provide assistance with the process of finding a suitable provider (see sections **5.10.** Generating referrals/recommendations following the assessment and Delivering Linking Support/Care Coordination to Vulnerable Clients under section **5.7**).

To ensure the correct dispatch of home care correspondence, the assessor should check, and if not already done so validate the address details of the client, and if appropriate, representative/s.

11.5 Consumers seeking or not seeking services

The decision to 'seek' or 'not seek' services is an important discussion to have with an older person as part of the assessment to support their current needs and ensure timely access to services. Consumers not actively seeking packages who are on the National Priority System may delay clients who are actively seeking packages. Assessors must ensure that only those clients who are currently seeking services are included in the National Priority System. This will allow the National Priority System to operate more efficiently and ensure that packages will be offered earlier to clients.

At the time of assessment, the assessor should discuss if it is the consumer's immediate intention to seek services. Consumers who were actively seeking care at the time of their approval will be automatically placed in the National Priority System and set as 'seeking services'. They will receive a package as soon as one is available based only on the priority for home care and the date of approval.

If the client is not seeking services (e.g. their private or family care situation is adequate at this point in time, the assessor must update their status to 'not seeking services' at the time of assessment when adding a care type for an assessment delegate decision.

The consumer should be assured that they will not lose their place in the National Priority System as their position is determined by the date of their original home care approval and priority for service.

If someone who was not seeking services wishes to be assigned a package, they will need to indicate to the contact centre that they are actively seeking care to be placed on the National Priority System. The assessor and consumers also have this functionality through the My Aged Care portals. Following this, they will be assigned a package as soon as one is available.

If a client initially seeking services decides to change to not seeking services, they are encouraged to advise My Aged Care as soon as possible so that someone else who is in need can be assigned the package more quickly.

While seeking services and waiting for a Home Care Package to be assigned, a person may need to access short-term CHSP or consider paying for care and services in the interim (see **10.8** CHSP Interaction with Home Care Packages).

11.6 Guidance and legislation

The Guidance Framework for Home Care Package Level provides guidance on identifying the client's current needs and determining if those needs are being met before a recommendation is made.

Further information
Department of Health, Disability and Aged Care website: My Aged Care – Assessor Portal User Guide 10 – Assessment Delegate processes My Aged Care – Assessor Portal User Guide 13 – Management of Home Care Packages Guidance for Home Care Package High Priority Guidance Framework for Home Care Package Level Guidance Framework for Home Care Package Level User Guide Guidance on Priority for Home Care Services Home Care Packages Program Home Care Packages Program Operational Manual: A Guide for Home Care Providers Federal Register of Legislation website: Aged Care Act 1997 (Cth) (see Part 2.3, Section 21-3 – Eligibility to receive home care; Part 3.2, Division 45-3 – Meaning of home care) Aged Care Legislation Amendment (Increasing Consumer Choice) Act 2016 Approval of Care Recipients Principles 2014 (see Part 2, Section 7 – Home care) My Aged Care website: Home Care Packages Manual – for care recipients

12 Residential Care

Residential care can take the form of permanent residential care and residential respite care.

12.1 Permanent Residential Care

Permanent residential care is personal care, nursing care, or both, that is provided to a client in a residential facility in which they are also provided with accommodation.

A person must meet all the eligibility criteria in the Act to be approved as eligible to receive residential care. Eligibility requirements are stated in section 21-2 of the Act and Part 2, section 6 of the Approval of Care Recipients Principles.

A person who is eligible for residential care may require daily assistance with:

- meals (including special diets)
- bathing, showering, dressing and personal hygiene
- toileting and continence management
- general nursing care (e.g. wound management)
- organising and taking medication
- communication (including fitting sensory or communication aids)
- transfers and mobility
- assessment and referral for appropriate support; and/or
- emotional support

Application and approval for residential care means the person meets the eligibility criteria and the care type is appropriate for their care needs.

On 1 October 2022, the Australian National Aged Care Classification (AN-ACC) residential care funding model replaced the Aged Care Funding Instrument.

Following a client's admission to residential care a residential aged care funding assessor (funding assessor) will conduct an appraisal using the AN-ACC assessment tool to assess the level of care needed by the client, relative to the needs of other care recipients.

Assessor considerations on entering permanent residential care

A permanent residential care approval does not compel a client to enter residential care. Matters relating to residential care must be decided with the consent of the client, and if they do not have capacity, their authorised representative.

Where possible, assessors aim to support people to live in the community as long as possible. The comprehensive assessment may, however, identify residential care as a suitable option for a client who is no longer able to be adequately cared for by carers or

family, and is incapable of living in the community without support. Considerations for entering permanent residential care could include:

- Informed discussion with the client, family and other relevant people such as the aged care provider and the GP; or if in the hospital context, the hospital discharge planner and other health professionals.

- Ascertaining the preferences and choice of the client and/or authorised representative. This could involve provision of targeted information, such as through use of the Star Ratings, to help compare the quality of aged care homes. Some clients may have special needs that may be best met by residential aged care homes, which offer particular kinds of care, such as dementia specific facilities (see section **22.** Aged Care Resources for Consumers).

- Determining whether the client is able to live safely at home, including identifying any potential risks to a person's well-being, health and safety, or whether a residential care setting would better meet the client's current needs and preferences. For example, such discussions may occur where multiple residential respite extension requests have been made in one financial year, indicating that there may be concerns with the client returning home (see section **12.4.** Residential Respite Care Extensions).

- Identifying whether or not there are appropriate supports available to the client to meet their care needs safely in the community (informal supports and the sustainability of the care arrangements in the community, formal services including those the person chooses or is financially able to pay and if applicable, aids and equipment).

- Documenting the current care needs, goals and agreed general and service recommendations in the record of assessment and the Support Plan.

When a client is approved for residential care, issuing a referral code is usually the appropriate referral method on My Aged Care. This allows the client, their carers and/or family to identify a residential care home that meets their needs when they are ready to do so.

Assessor considerations on leaving permanent residential care and Home Care Packages

There is nothing in the Act that precludes a person from leaving their place in residential care to access a Home Care Package.

If the person has a prior home care approval, they can elect to seek services to be placed on the National Priority System. If the person does not have a home care approval, they will need an assessment of eligibility for home care under the Act. When a person is assigned a package, they will be able to leave residential care.

A decision for a client to leave residential care should be an informed decision. The assessor can perform an important role in ensuring the client and their family understand the purpose of residential care compared to a Home Care Package, and that they are making an informed choice based on the care needs of the client and the

client's choice. This will include whether there is an appropriate Support Plan that shows that the necessary and sustainable supports (and if applicable, aids and equipment) will be in place for the person to return home safely from residential care.

12.2 Security of Tenure

A comprehensive assessment is requested by a service provider who can no longer provide accommodation and care suitable for a resident whose care needs have changed.

Part 2, sections 6 and 7 of the *User Right Principles 2014* identifies the legal responsibilities of residential aged care providers to care recipients. These responsibilities include security of tenure and relate to when residential aged care providers may ask or require a recipient to leave residential care service:

- The circumstances in which a care recipient may be asked to leave a residence must be specified in a resident agreement. Circumstances include:
    - the residential care service is closing
    - the residential care service no longer provides accommodation and care suitable for the care recipient
    - the care recipient no longer needs the care provided, as assessed by an assessment organisation
    - the care recipient has been receiving care under a specialist dementia care agreement and a clinical advisory committee constituted in accordance with the agreement has determined that the care recipient is not suitable to continue receiving that care
    - the care recipient has not paid agreed fees within 42 days
    - the care recipient has intentionally caused serious damage or serious injury; or the care recipient is away from the residential care service for at least 7 days for a reason other than as permitted by the Act or due to an emergency.
- Suitable accommodation must be available before the care recipient can be required to leave.
- It is the provider's responsibility to ensure that suitable alternative accommodation is available which is affordable to the resident and suitable for their long-term assessed care needs.
- The care recipient's long-term needs must be assessed by a clinical assessor or at least two medical or other health practitioners specified in the *User Rights Principles 2014*, Part 2, Division 2, section 6(4).
- Written notice must be given to care recipients at least 14 days before asked to leave residential care service. The notice must meet certain requirements under section 7(1) of the *User Rights Principles 2014*.

Where an assessment organisation is requested to provide an assessment for security of tenure circumstances the assessment can be performed on My Aged Care through a self-referral. The Application for Care form must be completed to allow the assessment delegate the option to make any eligibility decisions for new care types that may result following the reassessment. If the form is not completed, the assessment delegate is limited to varying an approval within the residential care type. If the existing approvals are valid the assessor and assessment delegate may make a recommendation of no change to existing care.

Further information:
Department of Health, Disability and Aged Care website:
Star Ratings for residential aged care and Residential aged care
Department of Veterans' Affairs website: Respite Care
Federal Register of Legislation website:
Aged Care Act 1997 (see Part 2.3, Section 21-2 – Eligibility to receive residential care and Part 3.1, Section 41-3 – Meaning of residential care)
Approval of Care Recipients Principles 2014 (see Part 2, Section 6 – Residential care)
Quality of Care Principles 2014 (see Part 2, Division 1, Section 7 – Care and services that must be provided)

12.3 Residential Respite Care

A new residential respite funding model came into effect on 1 October 2022 which aligns respite funding with the AN-ACC funding model that commenced at the same time.

Respite care is provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement. Residential respite is not intended as an alternative to aged care rehabilitation services or restorative care.

To be eligible for respite care, a person must meet the eligibility criteria for residential care.

An approval for residential respite care must be approved by the assessment delegate. When recommending a client for residential respite, it is best practice for a clinical assessor to complete the modified de Morton Mobility Index (DEMMI modified) assessment which determines the respite funding class (Classes 101,102 and 103) based on a person's mobility. The DEMMI-modified is part of the IAT and can only be

undertaken by clinical assessors. A non-clinical assessor cannot complete the DEMMI-modified even with clinical attendance.

The question, '*Are you likely to recommend residential respite care*' in the IAT is only available in comprehensive assessments. Assessors who are completing a home support assessment and likely to recommend residential respite must convert the assessment to a comprehensive assessment.

If the DEMMI-modified cannot be undertaken at the time that residential respite is approved, a default class (class 100) is allocated to the client. The DEMMI-Modified can be undertaken in the residential aged care setting by a Residential Aged Care Funding assessor to determine the respite funding class. If this does not occur, a client can be transferred back to an assessment organisation for the DEMMI-modified to be undertaken in the home at a later date.

A person may have a reassessment of their DEMMI-modified if their care needs increase.

A person may be approved for respite care and permanent residential care simultaneously. For example, this might be necessary where the carer has a current need for residential respite and at assessment it is foreseen that the client needs permanent residential care, but there are factors that prevent the client from entering ongoing residential care at that point in time.

A respite care approval entitles the client to a maximum of 63 days of respite care in a financial year, however, extensions of up to 21 days may be granted (see section **12.4** Residential Respite Care Extensions). The respite days are not required to be taken consecutively. Usage can span across the financial year.

Subsidised respite care cannot be taken in a residential aged care facility if a care recipient is already receiving permanent residential care in an aged care facility.

Further information
Department of Health, Disability and Aged Care website: My Aged Care Assessor Portal User Guides Managing residential respite care | Australian Government Department of Health, Disability and Aged Care

12.4 Residential Respite Care Extensions

An assessment delegate has the power to grant an extension up to 21 days. The 21 day extension is added to the maximum number of days and there is no limit on the number of extensions that may be granted.

A 21day extension that is current on 30 June in any year will cease on that day, as the person automatically becomes eligible for their annual allocation of another 63 days of respite from 1 July each year.

The provider should submit a respite extension request through the My Aged Care Service and Support portal to the assessment organisation on, or before, 63 days has ended if the person requires additional respite care. The assessment organisation will receive the request through the My Aged Care assessor portal to action. **Note**: Providers can submit extension requests via the My Aged Care Service and Support portal if there is an accepted or commenced referral.

An assessment delegate in any outlet can generate a residential respite care extension request for a person who requires additional respite. This is an important feature where the request is unable to be sent through the My Aged Care Service and Support portal (e.g. the person is living in the community but is seeking to access further residential respite care). If the extension request in My Aged Care is made by an assessment organisation outlet other than the original outlet, the system will always return the request to the original outlet for assessment delegate approval.

The assessment delegate also has the power to reject the request. There is no right of review on a decision to reject the extension request. The assessment delegate is open to grant the request if it is due to factors specified in subsection 23(2) of the Subsidy Principles, such as: carer stress or absence of the client's carer, severity of the client's condition or any other relevant matter.

Where multiple extensions are being requested in one financial year, the assessor should review the Support Plan in consultation with the client, family and provider, to confirm the appropriateness of the residential respite care with the possibility of considering other care options. This will include whether there is an appropriate Support Plan in place to safely support the person to return home following the residential respite care episode (see section **12.1.** Permanent Residential Care).

If the extension request is submitted on or before the end of the respite period (the 63 days or the extension period), the assessment organisation is still able to approve the request after the respite period has ended and the extension dates will reflect the start date requested in the form.

The extension, if granted, will be at the approved level of care. If a higher level of care is required, the client must be reassessed and approved by the assessment organisation for the higher level of care.

If the request is granted, the provider will be able to claim payment for the respite supplement for the further care provided by up to 21 days. The system will not end date a residential respite extension, to reflect the legislation that the days are not required to be taken consecutively.

On making the decision, the provider will receive a notification advising of the decision in their 'Tasks and Notifications'. It is also good practice for the assessment delegate to record a note in the client record of their decision.

Further information
Department of Health, Disability and Aged Care website: [My Aged Care – Assessor Portal User Guide 10 – Assessment Delegate processes](#)

13 Flexible Care

Flexible care acknowledges that the needs of aged care recipients may require a different care approach than that provided through mainstream residential or home care. Flexible care can take the form of:

- Transition Care
- Short-Term Restorative Care
- Innovative Care Services
- Multi-Purpose Services

13.1 Transition Care Programme (TCP)

TCP provides short-term care and services that are therapeutic, goal oriented, and time limited. TCP is for clients at the conclusion of a hospital stay who require more time and support in a non-hospital environment to complete their recovery and optimise their functional capacity, while assisting them and their family (or carer) to make long term care arrangements. TCP provides therapeutic care so that clients can maintain and improve their physical, cognitive and psycho-social functioning, thereby improving their capacity for independent living.

TCP provides a package of services that includes low intensity therapy (such as physiotherapy, occupational therapy and social work) and either nursing support or personal care. TCP also provides medical support such as GP oversight, case management (including establishing community supports), and where required, identification of residential care options.

Transition care can be delivered in either:

- a facility-based residential setting (e.g, a residential aged care home or a multi-purpose service)
- a community setting (e.g., a person's own home)
- a mixture of both

Duration of care

The maximum number of days for a transition care period is 12 weeks (84 days). This may be extended to 18 weeks (126 days) if the client has been approved for an extension.

Lapsing

A transition care approval will lapse:

- if the client does not enter care within the entry period – that is four weeks (28 days) beginning on the day after the date of the delegate's approval.
- if the client ceases their transition care episode and seeks to enter a new transition care episode after a further hospital stay, after the entry period for the person's approval has ended.

Transition Care Eligibility and Assessment

A person must meet all the eligibility criteria in order to be approved by an assessment delegate as eligible to receive transition care. Eligibility requirements are stated in Part 2.3, Section 21-4 of the Act and Part 2 Section 8 *Approval of Care Recipients Principles 2014*.

In addition to the eligibility criteria in the *Approval of Care Recipient Principles 2014,* the assessor recommending and the assessment delegate will need to consider the following points when assessing eligibility for transition care:

- at the time of assessment (or re-assessment), the client must be admitted to a hospital, medically stable and ready for discharge.
- a person accessing hospital-in-the-home is deemed to be admitted to a hospital.
- if transition care is to be delivered in a home setting, a person should enter into transition care within 24 hours from their date of discharge from hospital; however up to 48 hours is acceptable if the person's health service provider is confident of a safe discharge and support is in place while awaiting TCP care to commence.
- if transition care is to be delivered in any other setting, a person must enter care directly upon discharge from hospital (within 24 hours).
- clients waiting for a residential aged care placement, pending availability, and do not have the capacity to benefit from a further therapeutic care program are not eligible and should not be approved for transition care.
- the assessor should assess the client in consultation with the hospital geriatric rehabilitation service or equivalent, or members of the treating multidisciplinary team including a registered nurse, physician, occupational therapist, physiotherapist, speech therapist or social worker.

- the assessor must ensure that the full range of clinical and rehabilitation support to be provided by the hospital has been exhausted before a client enters transition care.

- Assessors should, wherever possible, facilitate liaison between hospital discharge planners and TCP approved providers to ensure that clients are able to access transition care in a timely manner.

- there is no limit on the number of transition care episodes a person may enter in a year, subject to meeting all eligibility requirements.

Breaks in Care for Re-admission to Hospital, Social or Other Reasons

On the client's request to the provider, TCP clients may take a break in their care for up to seven days in total during an episode of TCP. These "leave days" do not need to be consecutive. If the client takes more than seven break days for any reason, the TCP approval will expire.

If a person is re-admitted to hospital from transition care, or takes a break for social reasons:

- A person can take a break from receiving transition care for up to seven days in total during their transition care episode, for social reasons or if they need to return to hospital. Break days can be taken together continuously or in smaller periods.

- If the person is absent from care for more than a total of seven break days during their transition care episode, the episode will cease.

- To recommence care, a person will require a valid approval and must enter their new transition care episode directly after another hospital stay.

- A person who is hospitalised and their episode ceases, is able to enter a new transition care episode without the need for an additional transition care approval, if the person is subsequently able to be discharged from hospital within the entry period relevant to their initial transition care approval.

- The maximum duration of the new transition care episode is 84 days, with the possibility of an extension to 126 days, regardless of the duration of the earlier episode.

Transition Care Extension

The assessor must assess that a transition care extension is required and specify the duration of the extension up to 42 days.

A transition care service provider is able to submit the extension request through the My Aged Care Service and Support portal to the assessment organisation on, or before, the 84 days has expired. The assessment organisation will receive and action the request through the My Aged Care assessor portal. The approved provider should submit the request to the assessment organisation well in advance of the 84 days ending to allow

the assessment organisation sufficient time to review and consider the request to make a decision.

For the assessor to assess that the client has further transition care needs, the approved provider is required to provide the following information within the extension request such as:

- reasons why goals were not achieved in 84 days
- physical, cognitive and psychosocial goals that the care recipient would be working on during the extension
- team action required to achieve care recipient goals and discharge
- action required by external services to achieve care recipient goals and discharge
- relevant information from other sources such as the care recipient (or representative) or health professionals; or
- the proposed number of days of extension.

Based on the information provided by the service provider, and other sources such as the care recipient and relevant health professionals as appropriate, the assessor needs to be satisfied that the client has further therapeutic care needs and wishes to continue transition care. The assessment delegate will determine whether to grant the extension and specifies the number of days of extension (up to 42 days).In some cases, the assessor may decide to undertake a reassessment prior to granting the extension or may decide not to extend the transition care period and to conduct a reassessment towards the end of the transition care episode.

While a decision to extend or not extend a care recipient's episode of transition care is not a reviewable decision under the Act, the department will review the decision not to extend the episode of care if a complaint is made (see section **15** Complaints).

Further information
Department of Health, Disability and Aged Care website: Service Delivery for Aged Care (Flexible Care) and Transition Care Programme Federal Register of Legislation website: Aged Care Act 1997 (Cth) (see Part 2.3, Section 21-4 – Eligibility to receive flexible care and Section 23-3(1) – Expiration, lapse or revocation of approvals; Part 3.3, Section 49-3 – Meaning of flexible care) Approval of Care Recipients Principles 2014 (see Part 2, Section 8 Flexible care – transition care, Part 5, Section 15 – Entry period, and Part 5, Section 16 – Circumstances in which an approval lapses)

13.2 Short-Term Restorative Care (STRC)

STRC is aimed at reversing or slowing functional decline in older Australians through the provision of a package of care and services designed for, and approved by, the care recipient. It is intended to improve physical and cognitive functioning, and as a result a person's independence, delaying the need for higher levels of care. STRC can be provided in a residential care setting, a home care setting, or a combination of both.

Services provided by STRC

STRC is a time-limited program and provides a tailored, multidisciplinary package of care and services – including clinical care, support services and personal care.

Each episode should be developed by a STRC multidisciplinary team which must include at least three disciplines. One of these must be a medical practitioner, and where possible this will be the care recipient's GP or geriatrician. The other disciplines forming the multidisciplinary team must be selected to meet the client's needs and may include disciplines such as physiotherapy, occupational therapy and social work. STRC services are designed to slow or reverse the client's functional decline, in turn increasing their capacity for independent living and overall wellbeing.

STRC services can be delivered anywhere within the specified state or territory that a service provider has an allocation of places. STRC providers must give priority of access to clients within the aged care planning region the service provider's places have been allocated to. Prior to referral to an out of region service provider, the service provider should be consulted.

Duration of care

The maximum number of days for an STRC episode is 56 paid days (eight weeks), however some clients may complete the program in less time. On the client's request to the provider, STRC clients may take up to seven days unpaid leave from the program (except for residential respite care). Leave days do not need to be consecutive.

Episodes of care in any 12 month period

The client can receive up to a maximum of two episodes of STRC in any 12-month period with no specified timeframe between the episodes. A client must be assessed and approved by an assessment organisation for both episodes, regardless of whether or not the second episode falls within the 6 month validity period of the first approval.

STRC eligibility and assessment

In assessing a person's eligibility for STRC, the assessment organisation must use the eligibility criteria listed at section 8A of the *Approval of Care Recipients Principles.* The assessment delegate will only approve a person if the person meets all the eligibility criteria for STRC.

A person is eligible to receive STRC only if they meet all the following criteria:

- The person is assessed as experiencing functional decline that is likely to be reversed or slowed through short-term restorative care.

- The person is at risk of losing independence to such a degree that, without short-term restorative care, it is likely that the person will require home care, residential care or flexible care provided through a multipurpose service.

- The person is not receiving (or on leave from) residential care, home care through a Commonwealth Home Care Package or flexible care in the form of transition care. The person **is** eligible for STRC services if they have not yet entered into an agreement with the HCP provider, however they will no longer be eligible to receive STRC services once an agreement to receive HCP services has been confirmed.

- The person is not on leave from a residential care service or a flexible care service through which the person is receiving flexible care in the form of transition care.

- The person would not be assessed as eligible to receive flexible care in the form of transition care if the person applied for flexible care in the form of transition care.

- The person has not, at any time during the six months before the date of assessment[5], received flexible care in the form of transition care.

- The person has not, at any time during the three months before the date of assessment, been hospitalised for a condition related to the functional decline which would be the focus of that episode of STRC.

- The person is not receiving end of life care; and

- In receiving the proposed episode, the person will not have received more than two episodes of short-term restorative care in any 12-month period.

When considering STRC services for a client, a number of factors need to be taken into account:

- That the client **is** eligible for STRC. Where an assessment delegate approves a person for STRC that is later found to be ineligible, the provider will not be paid the STRC subsidy (see STRC eligibility considerations below).

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[5] For data capture purposes the 'date of assessment' is considered to be the date of Delegation.

- The intent of STRC is to benefit clients through providing intensive multidisciplinary care designed to slow or reverse identified functional decline before there is a need for hospital, home care or residential care.

- Clients waiting for a residential aged care placement, pending availability, and who do not have the capacity to benefit from an intensive therapeutic care programme are not eligible and should not be approved for STRC.

- STRC is a high value and intensive programme that aims to facilitate independence and delay entry of clients into higher levels of care. Clients receiving STRC should have a desire to return to prior levels of independence or enhance their ability to undertake the activities of daily living.

- The STRC programme is not a package of client funding and clients do not have discretion to spend funds as they please. Rather, there are clear limits on what can be included in a client's care plan, which must be developed in conjunction with a multidisciplinary team of health professionals.

- STRC can also be considered as an early intervention for clients who have been assessed as being suitable for a Home Care Package but may benefit from STRC and, as a result, not require a Home Care Package until a later date or will require a lower level of Home Care Package following an episode of STRC.

- A person may receive STRC whilst also receiving CHSP services and/or the following DVA services:
  - Veterans' Home Care (VHC)
  - Community Nursing (CN)
  - Rehabilitation Appliances Program (RAP)
  - Attendant care
  - Household services
  - Home modifications
  - Counselling Services (VVCS)

When a client is assessed and approved for STRC, the assessor should also consider the client's longer-term care needs and recommend services that the client is eligible for that will meet these needs. In some cases, it may be more appropriate to undertake a reassessment towards the end of the STRC episode.

Some clients may get confused between STRC and HCP. It is important to explain to the client at assessment, that they cannot receive both at the same time and that their STRC services will cease if they accept a HCP.

Lapsing of STRC Approval

An approval for STRC will lapse if:

- the client's episode of STRC ends; or

- if the client is not provided STRC, for a period of at least one day after the entry period for the client's approval (which runs for six months from the day after the approval) ends, and the client's care has not been suspended for any of the non-care period (see the following, Breaks in Care).

Breaks in Care

On the client's request to the provider, clients may suspend their care for up to seven days in total during an episode of STRC. These "leave days" do not need to be consecutive. If care is suspended for more than seven days for any reason, the STRC approval will expire.

STRC interaction with Transition Care

At the time of undertaking a comprehensive assessment for consideration of STRC eligibility, the following should be noted with respect to TCP. Whilst having an approval for or receiving STRC should not affect a person's eligibility to receive TCP, under the Transition Care Guidelines, the same eligibility does not apply for STRC. A person, who has received TCP in the last six months or would be assessed as eligible for TCP, is not eligible for STRC. Therefore:

- A client cannot receive both programs at the same time.
- A client cannot receive STRC if they have had TCP within six months prior to their assessment.
- A client can, however, receive TCP if they have received STRC in the past.

> **Note:** Where a client has received TCP in the previous six months, if an assessment delegate incorrectly approves a person for STRC and the person enters STRC care, Services Australia will decline payment to the STRC provider for the STRC episode.

Assessors and assessment delegates are provided with checks in the My Aged Care system to assist correct decisions for STRC. In the My Aged Care assessor portal, the assessor can view the client's current or previous services (under the 'Services' tab). This tab will indicate when the TCP approval started and the date when TCP services started and ended as shown below. This will assist the assessor to ascertain if the client has received TCP in the six months prior to the date of assessment.

STRC and CHSP

People receiving STRC services may be eligible for CHSP services. CHSP and STRC can be accessed at the same time, however, it is expected that they would not duplicate each other but rather be different and complementary. Therefore, there must be no duplication of care and services in the service recommendations in the client's Support Plan. The STRC service provider is expected to liaise with the client's current CHSP provider to ensure care is coordinated with existing support/services.

Hospitalisation

Assessors and delegates must be aware of all eligibility criteria, including that the client has not (before the date of the assessment) been hospitalised in the last three months for a condition related to the functional decline which would be the focus of that episode of STRC.

The My Aged Care assessor portal is not linked to a hospital episode. The assessment delegate will need to rely on the client's report, hospital discharge planning and referral information and, if necessary, gather independent medical documentation and evidence concerning the client's hospitalisation.

Further information
Department of Health, Disability and Aged Care website:
Short-Term Restorative Care Manual Short-Term Restorative Care (STRC) Programme
Federal Register of Legislation website:
Aged Care Act 1997 (Cth) (see Part 2.3, Section 21-4(c) – Eligibility to receive flexible care and Part 2.3, Section 23-3(1)(a) - Circumstances .. approval for flexible care lapses)
Approval of Care Recipients Principles 2014 (see Part 2, Section 8A Flexible care—short-term restorative care and Part 5, Section 15(2) – Entry period)
Subsidy Principles 2014 (see Chapter 4, Part 1, Division 3, Section 106A – Short-term restorative care, and Chapter 4, Part 2, Division 5, Section 111A – Periods in respect of which flexible care subsidy is payable)

13.3 Multi-Purpose Services

The Multi-Purpose Services (MPS) Program is a joint initiative of the Australian Government and state and territory governments. It aims to deliver flexible and integrated health and aged care services to some small rural and remote communities that could not viably support stand-alone hospitals or aged care homes. The majority of MPSs are located in outer regional or remote areas and are co-located with a hospital.

Services provided by an MPS

All MPSs must deliver residential care and at least one other service, which would generally include acute or sub-acute care, primary care or other health services. Some MPSs also deliver flexible care in a community setting.

Approval for flexible care provided by an MPS

An assessment delegate approval is not a legislative requirement for clients to access flexible care in an MPS; however, it is good practice that all older Australians requiring aged care services are assessed prior to entry. This ensures that the client's aged care needs are assessed and that the most appropriate type and level of aged care services are recommended to meet those needs. This may include flexible care delivered by an MPS. Where an assessor refers a client to an MPS they must record the decision and decision reason in the Support Plan. Assessors can also record their decision in the approval letter.

Most MPSs will request clients have a current comprehensive assessment prior to entry, which will also help inform care planning processes. Should the need arise for a client to transfer from an MPS to a residential aged care service, the process will be streamlined if the client already has an assessment approval for residential care.

MPSs are included in the My Aged Care Service finder and can receive assessment and client information through the My Aged Care Service and Support portal.

Further information
Department of Health, Disability and Aged Care website: Multi-Purpose Services Program

13.4 Innovative care

The current range of innovative care services are only available to the existing cohort of clients; that is, no new clients are eligible to access innovative care services.

Further information
Department of Health, Disability and Aged Care website: Innovative Care Programme

14 Other

14.1 The National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC)

NATSIFAC funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. These services are mainly located in remote and very remote locations.

Services provided by a Flexible Aged Care Service

NATSIFAC services can deliver a mix of residential and community services in accordance with the needs of the community. Services are located mainly in rural and remote areas, and not regulated under the Act.

Eligibility and approval for care provided by a NATSIFAC Service

People aged 50 years and older who:

- are of Aboriginal and or/ Torres Strait Islander descent;
- identify as an Aboriginal and/or Torres Strait Islander; or
- are accepted by the community they live in or come from.

Potential care recipients are not required to be assessed by an assessor and approved by an assessment delegate. However, a holistic and culturally appropriate assessment by a health professional or assessor where possible is good practice and is recommended. If CHSP services or services under the Act are not available and the client has aged care needs that could be met through NATSIFAC, the assessor can refer the client to these services, and should record the decision and decision reason in the Support Plan. Clinical assessors can also record this decision in the approval letter.

Further information
Department of Health, Disability and Aged Care website: National Aboriginal and Torres Strait Islander Flexible Aged Care Program

14.2 Dementia specific programs and supports

National Dementia Support Program

Counselling, education, information, and other early intervention support for people living with dementia or experiencing cognitive decline, and their care partners and families is available by contacting the National Dementia Helpline on **1800 100 500**.

The Helpline is available 24 hours a day, 7 days a week. Dementia Australia provides this support as part of the National Dementia Support Program (NDSP).

Section 7.4 outlines a system to refer carers of My Aged Care clients with dementia or experiencing cognitive decline to the National Dementia Helpline, with their consent. A trained professional from Dementia Australia would then call the client and speak to them about dementia specific services and supports that might assist to help improve or maintain their quality of life. **Please note, a client does not need a cognitive diagnosis to be referred to Dementia Australia for support.**

Dementia Carer Respite and Wellbeing Program

The Dementia Carer Respite and Wellbeing Program delivers innovative models of respite care through a shared respite experience, attended by both the person living with dementia and their care partner.

The program will expand on existing supports to:

- maintain or improve quality of life for care partners and people living with dementia
- increase care partner knowledge, skills and capability to care for a person living with dementia at home
- improve the experience and quality of respite care for care partners and people living with dementia
- support people living with dementia to stay at home for longer
- provide peer support connections for care partners and people living with dementia

Care providers (through Dementia Support Australia) deliver the Staying at Home program. The program provides carers with practical strategies for supporting people who live with dementia and helps people living with dementia to remain at home for as long as possible. Informal carers can register their interest on the website or by contacting the 24-hour DSA helpline on **1800 699 799.**

Dementia behaviour supports

Dementia Behaviour Management Advisory Service (DBMAS), delivered by [Dementia Support Australia](#) (DSA), provides free support and advice to service providers and individuals caring for people with dementia. It provides support when the behavioural and psychological symptoms of dementia (BPSD) start to impact a person's quality of care. Family carers can contact the 24-hour DSA helpline for advice on **1800 699 799**.

Severe Behaviour Response Teams (SBRT), also delivered by DSA, is a mobile service that responds onsite within 48 hours. It offers free support and advice where there is a heightened risk to the person living with dementia, or their care network. Approved aged care providers can request SBRT assistance to address the needs of people living with severe behavioural and psychological symptoms of dementia. SBRT will partner with the person living with dementia and their care network

to understand the causes that led to changes in behaviour. Providers can contact the 24-hour DSA helpline for advice on **1800 699 799**.

Specialist dementia care

The **Specialist Dementia Care Program (SDCP)** supports people with very severe BPSD whose support needs cannot be met in a residential aged care facility. Care is provided in small groups in a cottage-like dementia friendly environment. The program enables specialised care for people living with dementia in circumstances where:

- the person has very severe dementia complicated by physical aggression or other behaviours
- the person's residential care facility or carer partners cannot manage the behaviours, even with help from other services.

The program provides transitional care aimed at stabilising behaviours over an approximately a 12 month period prior to transitioning the resident to an appropriate care setting.

Referral and eligibility for the program is undertaken by Dementia Support Australia (DSA) through the Needs Based Assessment Program. DSA can be contacted on **1800 699 799**.

Further information
Dementia Australia
Needs Based Assessment for SDCP – Dementia Support Australia
Staying at Home
Department of Health, Disability and Aged Care website:
Dementia Behaviour Management Advisory Service (DBMAS)
Specialist Dementia Care Program (SDCP) information booklet

14.3 Department of Veterans' Affairs (DVA)

Veterans have the same right of access to community and aged care programs as any other member of the community. The Act lists veterans in the special needs group. Veterans should not be discriminated against or refused care when accessing services from other community and aged care programs on an assumption that DVA will provide for all their care needs. DVA provides some entry-level care services but does not provide higher-level care services.

Veterans' Home Care (VHC) Program

Veterans' Home Care (VHC) is a DVA program designed to assist veterans and war widows/widowers who need a small amount of practical help to continue living

independently in their own home. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance. VHC is not designed to meet complex or high-level care needs.

Community Nursing (CN)

CN provides clinical nursing and/or personal care services to eligible members of the veteran community in their own home. CN services can assist with medication, wound care, hygiene and dressing. CN services can help to restore or maintain health and independence at home, and assist to avoid early admittance to hospital or residential care. Veterans requiring high-level care require prior approval by DVA.

CN services are provided by a mix of personnel including registered and enrolled nurses and nursing support staff, who work within the framework of their relevant national standards.

Duplication of services

As long as there is no duplication of services between the programs, Veterans may access DVA's VHC and CN services at the same time as accessing different services from:

- a Home Care Package
- CHSP
- TCP
- STRC

For Home Care Packages, this access can occur regardless of the level of the package.

CHSP offers services that are not available through the VHC Program or other DVA arrangements, such as a wide range of social support, food services, community transport and centre-based day respite.

DVA Fees

DVA may contribute to or pay the fees depending on the type of aged care and the eligibility of the veteran.

DVA will pay the fee for Home Care Packages, TCP and STRC veterans who are Australian former Prisoners of War or Victoria Cross recipients.

Further information
The Department of Veterans' Affairs website: Community nursing Community Nursing Services and Providers

Further information
[Help so you can stay in your home](#)
[Respite care](#)
[Services and Support to Help You Access Aged Care (for Former Prisoners of War and Victoria Cross Recipients)](#)

14.4 NDIS Participants

For NDIS participants who have turned 65 requesting access to CHSP, assessors must ensure a person is not referred for services they are already receiving through the NDIS and/or other Commonwealth, state, territory or local government programs. For younger people (those aged under 65), assessors should advise the client to test eligibility for other programs, including the NDIS, to ensure they access the most appropriate program(s) (see section **6.1** for Aboriginal and Torres Strait Islander people under 65).

An assessment delegate should be aware of and advise NDIS participants that under the *NDIS Act 2013* (NDIS Act) an under 65 NDIS participant can remain in the NDIS if they are an aged care recipient who subsequently turns 65. However, a NDIS participant whose first permanent entry to residential care or home care (but not residential respite care) is after the age of 65, ceases to be a NDIS participant. (NDIS Act section 29 (1)(b)). This does not apply to the CHSP.

Also see section **7.3** Younger People Seeking Aged Care Services.

14.5 Disability Support for Older Australians (DSOA) and aged care

The Disability Support for Older Australians (DSOA) Program commenced 1 July 2021. It is a closed program with no new clients and provides funding for a range of services including Assistance in Supported Independent Living, Assistance with Self-Care Activities, Specialist/Behavioural Intervention Support, Therapy, and Case Management.

DSOA supports older Australians with a disability who were accessing state funded specialist disability services and were ineligible for the NDIS at the time it was rolled out.

From 1 January 2025, the DSOA Program is being refocused to continue supports to older people with disability with high care needs who cannot be supported by the aged care system. Around about 200 DSOA funded clients have been advised they will need to contact My Aged Care for an assessment and, if eligible, transition to the aged care system by 31 December 2024.

Assessments for aged care services can impact a person's eligibility for funding under DSOA, and assessors should ensure a person has provided informed consent before proceeding to undertake an assessment.

The following services under CHSP will not affect DSOA funding:

- Assistance with care and housing
- Community Access (Social Supports Group and Individual)
- Goods, Equipment and Assistive Technology
- Home Modifications
- House Cleaning and Other Household Activities (Domestic Assistance)
- House Maintenance (Home and Garden Maintenance)
- Meals
- Transport
- Specialised Support Services

Flexible Care services also do not affect DSOA funding (i.e. TCP and STRC).

All other assessment outcomes will affect DSOA funding, and will do so in the following ways:

- An eligibility assessment for permanent Residential Aged Care or a Home Care package will result in DSOA funding being capped at current levels. This also applies to CHSP service referrals not listed above.
- When a person accesses permanent Residential Aged Care or a Home Care package, they are no longer eligible to receive funding through DSOA (similar to the NDIS). This also applies to CHSP services not listed above (note, there is an exception to this provision if a person was already receiving these services prior to 1 July 2021 when DSOA commenced).

If an assessor receives a referral for a DSOA client they should:

- establish if the client has advised their DSOA service coordinator (provider) that they are seeking a referral for an aged care assessment;
- establish if the client discussed with their DSOA service coordinator their options to increase supports under the DSOA Program prior to an aged care assessment;
    - establish if the DSOA service coordinator has initiated a Change of Needs application and reviewed the DSOA client's Individual Support Package prior to consideration of an aged care assessment; and
    - establish that the DSOA clients understands the impacts on their DSOA funding should they proceed to assessment.

Aged care assessors should keep these policy settings in mind when making recommendations for aged care supports for a DSOA client. That is, in making a recommendation, the aged care assessor needs to consider whether aged care services can appropriately support the client were they to exit the DSOA Program.

Further information
Department of Health, Disability and Aged Care website:

14.6 Carer Support

Assessors should inform carers there is support and services specifically for carers in their own right. This support is available through Carer Gateway, funded through the Department of Social Services, as well as the National Dementia Helpline (for care partners of people with dementia or experiencing cognitive decline), funded by the department (see section **7** Other Groups and 14.2 Dementia specific programs and supports).

Carer Gateway provides early-intervention and preventative supports and services to carers to help improve their well-being and long-term outcomes.

Carer Gateway is for all carers, no matter their age or the condition of the person they are caring for.

Carer Gateway consists of a website (www.carergateway.gov.au) and a national network of Carer Gateway service providers (CGSPs) (located in each state and territory).

CGSPs support carers with access to in person and digitally based supports and services including support planning, counselling, peer support, coaching, tailored support packages (including access to planned respite), emergency respite, and information and practical advice:

- Support Planning – assess the carer's needs and work with the carer to develop an agreed individual support plan.

- Counselling – professional counsellors for carers who are experiencing difficulties with anxiety, stress, depression and low mood as a result of their caring role.

- Peer Support – a service for carers to connect with people in similar caring circumstances and learning from their peers through the sharing of lived experiences.

- Coaching – carers work one to one with a coach, taking time to think about their own wellbeing and steps towards personal life goals.

- Tailored Support Packages – offers a range of practical supports to support carers access education and/or employment or assist carers in their caring role (e.g., access to planned respite, assistance with transport).

- Emergency Respite – help with accessing emergency respite support when a carer can no longer maintain the caring role due to illness for example.

CGSPs also assist with navigating relevant, local services available to carers, including My Aged Care, National Disability Insurance Scheme, Dementia Australia and referrals to other state/territory government funded carer support services.

CGSP staff talk with carers about the registration and support planning process, and then work with them to provide access to supports and services based on their individual needs and caring circumstances. The intent of the support planning is for carers to have the most appropriate supports in place to help maintain their wellbeing, which in turn helps maintain their capacity to continue their caring role and also to participate in their communities.

Assessors should collect carer information in the Assessor Portal or Aged Care Assessor App and register the client and their carer's consent to request a call back from Carer Gateway and/or the National Dementia Helpline. The carer's local CGSP and/or the National Dementia Helpline will then contact them to assist with accessing supports to help them in their caring role.

Alternatively, assessors may inform carers they can contact their local CGSP by calling 1800 422 737 (selecting Option 1), Monday to Friday, between 8am and 5pm, or by visiting the Carer Gateway website (www.carergateway.gov.au) and completing the online 'Request for Call Back' form.

The Carer Gateway website also provides carers with practical advice, information and resources to help them in their caring role, as well as access to: a national carer phone counselling service to help them manage daily challenges, reduce stress and strain, and plan for the future;

- an online peer support forum, connecting carers with other carers for knowledge and experience sharing, emotional support and mentoring;
- online self-guided coaching resources with simple techniques and strategies for goal-setting and future planning; and sources to increase skills and knowledge of carers relating to specific caring situations, to build confidence and improve wellbeing.

Assessors should also **note**, that CGSPs currently **do not** have the capability to receive referrals to book flexible, centre-based, cottage or residential respite for carers of My Aged Care clients.

Assessors should also be aware that under the Carer Gateway model, assistance for young carers to continue with or commence study through the Young Carer Bursary Program is available. Further information on the Young Carer Bursary Program and the application process is available at www.youngcarersnetwork.com.au/young-carer-bursary.

Further information
Carer Gateway website: Carer Gateway service provider free call 1800 422 737

Further information
Department of Health, Disability and Aged Care website:
[My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships](#)
[Young Carers Network](#)

14.7 Aged Care Volunteer Visitors Scheme

The Aged Care Volunteer Visitors Scheme (ACVVS) provides friendship and companionship to older people who are feeling lonely or socially isolated by matching them with a volunteer visitor. The ACVVS is a free program for eligible aged care recipients. Visits are available to anyone receiving Australian government-subsidised residential aged care or Home Care Packages. This includes care recipients approved or on the National Priority System and excludes those with a Commonwealth Home Support Program (CHSP).

The program requires the volunteer to make 20 ACVVS visits per year. These occur for approximately an hour a fortnight.

Anyone can refer an eligible older person to the ACVVS, including My Aged Care Assessors, aged care service providers, health professionals, family members and friends. Older people can also refer themselves.

You can request a volunteer for an older person via the ACVVS website.

Further information
Department of Health, Disability and Aged Care website: [Aged Care Volunteer Visitors Scheme (ACVVS) | Australian Government Department of Health, Disability and Aged Care](#)

14.8 Translating and Interpreting Service (TIS) National for people from culturally and linguistically diverse backgrounds

TIS National's interpreting services are available 24 hours a day, 7 days a week, and can be accessed by aged care providers at no cost via telephone or through face-to-face sessions.

TIS National has offered interpreting services for more than 70 years and has access to more than 2,300 interpreters, in over 170 languages and dialects, across Australia.

To access TIS National interpreting services, you first need to register by calling 1300 655 820 or emailing tispromo@homeaffairs.gov.au. Speak to your team manager, who

will be able to provide you with your team's client code so that you can book an interpreter.

14.8.1   Sign language interpreting services

Older Australians who are deaf, deafblind or hard of hearing, who are seeking to access or are in receipt of Commonwealth funded aged care services can access **free** sign language interpreting and captioning services. Sign language services can be provided face-to-face or by Video Remote, and live captioning services are available to support clients to better engage and fully participate in their aged care journey and activities of daily living.

Information on how service providers can access interpreting services is available online at My Aged Care (or by calling 1800 200 422) or Deaf Connect (or by calling 1300 773 803).

If a client enquires about sign language interpreting for daily activities, not aged care related, please refer them to Deaf Connect where they can also receive free services.

Sign language services are available in Auslan, American Sign Language, International Sign Language, and Signed English for Deaf or people who are hard of hearing, and tactile signing and hand over hand for people who are deafblind.

14.9 Interpreting services for Aboriginal and Torres Strait Islander people

It is important for Aboriginal and Torres Strait Islander Elders accessing or thinking of accessing Australian Government-funded aged care services to be able to communicate in a First Nations language if that is their preference.

To access Interpreter Connect, the Aboriginal and Torres Strait Islander Elder should call My Aged Care on 1800 200 422 and ask for an interpreter from the following list of languages. Through the interpreter, My Aged Care will answer the person's aged care questions and then, if asked to, will assist them with accessing services. List of interpreters:

- Alyawarre
- Anmatyerr
- Arrernte (Eastern and Central)
- Arrernte (Western)
- Burarra
- Djambarrpuyngu
- Kala Kawaw Ya
- Kala Lagaw Ya
- Kriol (Top End)

- Meriam Mir
- Ngaatjatjarra
- Pintupi-Luritja
- Pitjantjatjara
- Torres Strait Creole/Yumpla Tok
- Warlpiri
- Yankunytjatjara

If an interpreter from the above list is not available at the time of the call, an appropriate time that suits the Aboriginal and Torres Strait Islander Elder will be arranged. This service aims to make it easier for older Aboriginal and Torres Strait Islander people, their families and carers to access information on ageing and aged care, to have their needs assessed and to be supported to find the most appropriate services.

14.10   Care finders

Care finders assist vulnerable older Australians who do not have someone who is able to help them access aged care services and other relevant supports in the community.

An older person fits in the target population for care finders if they:

- Are eligible for aged care services:
- Have one or more reasons for requiring intensive support to:
  - interact with My Aged Care (through the website, telephone, or face to face)
  - access aged care services
  - access other relevant supports in the community

One or more reasons a person may need the intensive support provided by a care finder include:

- being isolated or they don't have available support (including because they are uncomfortable receiving the support, or their support is not able to assist).
- communication barriers, such as limited English language or literacy skills.
- difficulties processing information to make decisions.
- being unsafe or they may end up in a crisis situation (within the next year), however they are resistant to engage with aged care.
- their past experiences mean they are reluctant to engage with aged care, institutions, or government.

Care finder or Elder Care Support program clients, including prematurely aged people between the age of 50 and 65 (or between 45 and 50 for Aboriginal and Torres Strait Islander people) who are homeless or at risk of homelessness, may also be eligible to access CHSP services targeted at avoiding homelessness or reducing the impact of

homelessness. All care finder and Elder Care Support program clients must be assessed by My Aged Care via the assessment services to determine eligibility and need to receive additional CHSP services.

Further information
Department of Health, Disability and Aged Care website:
2024-25 CHSP Program Manual
Fact sheet for Assessors on care finders
My Aged Care website: Help from a care finder

14.11   Elder Care Support

The Elder Care Support Program was established to recruit and train a trusted workforce to support older Aboriginal and Torres Strait Islander people and their families throughout their aged care journey. This support contributes to elders achieving a better, safer experience when accessing aged care services and having the information to make decisions on the care they need and receive.

The Elder Care Support program provides services that include:

- supporting older Aboriginal and Torres Strait Islander people to understand aged care services, navigate the assessment process and help with choosing a provider
- supporting families, friends and carers to understand how to access aged care services
- advocating for older Aboriginal and Torres Strait Islander people by working with assessors and providers to meet their needs
- supporting older Aboriginal and Torres Strait Islander people while they receive aged care services
- assisting with other types of health needs, such as disability supports.

The National Aboriginal Community Controlled Health Organisation (NACCHO) Aged Care Programs team can provide further information about the program at agedcare@naccho.org.au.

Further information
Department of Health, Disability and Aged Care website:
Elder Care Support.

PART F – COMPLAINTS & REVIEW (for Assessors, Team Leaders, Delegates and Managers)

The primary audience for this section is Assessors, Team Leaders, Delegates and Managers. Assessors should be aware that they are providing a valuable and trusted, public role in the delivery of quality aged care assessment services on behalf of the Commonwealth. A necessary part of a quality assessment is having supporting processes that allow the client the right to complain without fear of reprisal.

15 Complaints

15.1 Right to Complain

Clients (and/or their carer/advocate/family representative) have the right to raise their concerns about the information, service or care they have received from My Aged Care, their assessor or service provider.

There are different ways to make a complaint depending on the part of My Aged Care that the concern relates to, such as:

- the contact centre
- home support assessment with an assessor
- comprehensive assessment with an assessor
- the outcome of the comprehensive assessment; or
- the care and services received from a service provider.

15.2 Concerns about My Aged Care

A person, client or representative should discuss their concerns about the service or information they receive from My Aged Care with the contact centre in the first instance.

If they are unable to resolve the issue, My Aged Care will provide a reference number to track the progress of the complaint. A person can make a complaint by:

- Calling My Aged Care on **1800 200 422.**
- Posting their complaint to:

  My Aged Care Complaints
  PO Box 1237
  Runaway Bay QLD 4216

An Assessor can make a complaint or escalate an issue about contact centre services by:

- Calling the My Aged Care Service Provider and Assessor Helpline on 1800 836 799

If a client, assessor or provider is not satisfied with the response received, they can take further action by sending an email with the detail of their complaint, and their My Aged Care reference number to: myagedcaresupport@health.gov.au

15.3 Concerns about the assessment

Assessment organisations are required to have complaints procedures in place.

If a person has concerns about their assessment, they are advised to contact the assessor or their organisation in the first instance.

If the department receives a complaint through My Aged Care it will be referred to the relevant assessment organisation for investigation and/or resolution. The assessment organisation will report back to the department on the outcome.

If the person cannot first resolve the issue with their assessor or their organisation, they are advised to call My Aged Care for assistance on **1800 200 422**. Complaints relating to assessment organisations are escalated to the department for investigation.

15.4 Complaints about a Provider

If clients (and/or their carer/advocate/family representative) are unhappy with any aspect of the care or services being received in an aged care home, in their own home through a Home Care Package or CHSP service, or through flexible care services, there are two ways to make a complaint:

- speak to the service provider about their concerns; or
- make a complaint to the Aged Care Quality and Safety Commission (ACQSC) by phone (**1800 951 822**) online form or by writing a letter to:

  Aged Care Quality and Safety Commission

  GPO Box 9819, in your capital city

In addition to the above, complaints about care received from MPSs or TCP can be referred to the relevant state and territory health department complaints bodies.

If an assessor has concerns about a provider, they can also make a complaint with the ACQSC.

Please note that complaints related to Australian Government Aged Care policies, guidelines or decisions should be referred to the department.

Further information
Aged Care Quality and Safety Commission website: Aged Care Service Provider Complaints and Lodge a Complaint
My Aged Care website: My Aged Care Complaints and Quality in Aged Care

15.5 The Right of Review / Reconsideration Process

If a person or someone whose interests are affected by an assessment delegate decision does not agree with an assessment delegate decision, they should contact the assessment organisation to discuss their concerns in the first instance.

If the person still has concerns, they can ask for a reconsideration of the decision by writing to the Secretary of the Australian Government Department of Health, Disability and Aged Care , outlining why they think the decision should be changed:

> The Secretary
> Department of Health, Disability and Aged Care
> Attn: Single Assessment System Program
> GPO Box 9848
> ADELAIDE SA 5001

Under section 85-5 of the Act, a person whose interests are affected by a reviewable decision may request the Secretary to reconsider the decision. A person whose interests are affected by a decision may include a client or a person closely associated with the client (such as the authorised or regular representative, spouse or family member) and considers their interests are personally affected by the decision regarding the client's eligibility. The right of review could relate to decisions such as a non-approval, a limitation of the approval to a certain level or type of aged care, or an approval only for a certain time period.

The power to reconsider a reviewable decision is delegated by the Secretary to officers within the department. A request for reconsideration must be made in writing within 28 days of the date on which the person first received written notice of the decision. However, the departmental delegate may allow a longer period for submitting the request.

Once a request has been received, the decision must be reconsidered if the requirements of section 85-5 of the Act are met. After receiving the request, the departmental delegate must reconsider the decision and has the discretion to either confirm the decision, vary the decision, or set the decision aside and substitute a new decision. Each decision is to be decided on a case-by-case basis with the care recipients' protection and wellbeing as the guiding principle.

The reconsideration will involve an administrative review of all available evidence, including the documentation supporting the original decision and additional information collected during the reconsideration process. This additional information may be obtained from a range of relevant parties such as the care recipient's family, health professionals and/or service providers.

Delegate Decisions that are Reviewable

Division 85 of the Act deals with the reconsideration and review of decisions. 'Reviewable decisions' are listed in section 85-1 of the Act. Of these, ten decisions relate to the approval or non-approval of people as care recipients, as shown in Table 11 below. The assessment delegate has the power to make most of these reviewable decisions (Items 19, 20, 21, 22, 23, 24, 25, 25A, 25B). The departmental delegate can make all the decisions in the table, including the decision in blue concerning revocation of an approval of a person as a care recipient.

Table 12. Reviewable decisions approval of care recipient

Item	Decision	Provision under which decision is made
19	To reject an application to approve a person as a care recipient	subsection 22-1(2)
20	To limit a person's approval as a care recipient	subsection 22-2(1)
21	To limit a person's approval as a care recipient to one or more levels of care	subsection 22-2(3)
22	To vary a limitation on a person's approval as a care recipient	subsection 22-2(4)
23	As to when a person urgently needed care and when it was practicable to apply for approval	paragraph 22-5(2)(b)
24	To extend the period during which an application for approval as a care recipient can be made	subsection 22-5(3)
25	To reject an application to extend the period during which an application for approval as a care recipient can be made	subsection 22-5(3)
25A	To determine a person's priority for home care services	subsection 22-2A(1)
25B	To vary a person's priority for home care services	subsection 22-2A(2)
26	To revoke an approval of a person as a care recipient	subsection 23-4(1)

Further information
Federal Register of Legislation website: [Aged Care Act 1997](#) (Cth) (see Part 6.1, Section 85-1 – Reviewable decisions)

15.6 The role of assessment organisations in the Reconsideration Process

As part of the request for reconsideration, the departmental delegate will discuss the request with the assessment organisation via the operational manager, to clarify matters relating to the case.

The assessment organisation plays an important role in the reconsideration process, as the assessment organisation will be invited to provide additional information in response to the person's claims, which will then be considered as part of the review.

If required, the department's delegate may request that an independent assessment organisation reassess the client. The independent reassessment is usually done by an assessment organisation that was not involved in the original decision. The assessor undertaking the reassessment can consult the original assessors and assessment delegate, and as many relevant parties as required to ensure all necessary information required of the departmental delegate is collected.

There will be occasions where the departmental delegate requires an assessment organisation to complete an off-line reassessment (not as part of the online IAT on the My Aged Care system) to inform their decision making. These off-line reassessments form part of the evidence for the departmental delegate's decision in conjunction with evidence provided by the applicant and other sources (such as the care recipient's GP). The off-line reassessment is usually done by an assessment organisation that was not involved in the original decision or a different assessor within the same assessment organisation. To ensure a thorough assessment, the new (reassessing) assessor can consult with the original assessors, the original assessment delegate and any other relevant parties.

There are some points to note about a reassessment that may be undertaken as part of the reconsideration process:

- The Application for Care form is not signed by the client, however the informed consent of the client to the reassessment is still required and must be obtained prior to undertaking the reassessment.
- Through the operational manager, the departmental delegate will request in writing the information the assessment organisation needs to collect and how it is to be recorded. Depending upon the request, it may be necessary to use the

paper-based version of the IAT (accessible from the My Aged Care assessor portal) or other form as specified by the departmental delegate.

- The reassessment includes comprehensive information and recommendations, including any recommendations about limitations on approvals for the client.

The assessor does not discuss the reassessment with the applicant, the client or any other party in any way after completing the reassessment. The outcome of the off-line reassessment is not recorded on My Aged Care by the assessment organisation.

Change in Circumstances

A reconsideration officer may determine that there has been a significant change in a care recipient's circumstances since the date of the original assessment necessitating a new comprehensive assessment. If so, the officer will instruct the assessment organisation to conduct the new comprehensive assessment and to discontinue the reconsideration process. This is known as "cease to deal" with the matter.

15.7 Advice on the Outcome of the Reconsideration

A determination is usually made within 90 days after receiving the person's request. When the determination is made, the departmental delegate will write to the person seeking the reconsideration to let them know the outcome of the review and give reasons for the decision. The departmental delegate will also advise the assessment organisation of the outcome.

The 'notice of the reconsideration decision' includes additional information on further review rights available to the applicant.

The reconsideration decision is usually recorded on My Aged Care to be effective from the date of the original assessment delegate decision that is being reconsidered.

15.8 Administrative Review Tribunal (ART)

If the person who has requested a reconsideration of a decision is dissatisfied with the outcome, an application may be made to the ART for a review of the decision. There is a cost to the applicant for this process.

Assessment organisations must ensure that all information used in making approval decisions, including information gathered to support reviews of reviewable decisions is properly maintained and available for review by the ART.

The departmental delegate and the assessment delegate who made the original decision may be required to appear before the ART.

Further information
[Administrative Review Tribunal](#) website

15.9 Ombudsman

The Commonwealth Ombudsman's role is to review the administrative actions and decisions of Australian Government agencies. The Ombudsman's office handles complaints, conducts investigations, performs audits and inspections, and carries out specialist oversight tasks to see if the actions and decisions of agencies are wrong, unjust, unlawful, discriminatory or unfair.

Clients (and/or their carer/advocate/family representative) can contact the Commonwealth Ombudsman through their website.

Further information
[Commonwealth Ombudsman](#) website

PART G – FEES AND PAYMENTS (for Assessors)

The primary audience for this section is assessors.

It is important that aged care clients understand the potential costs of care early in their interaction with the aged care system.

Assessors are not responsible for providing detailed financial information about the fees or charges that a person may be charged to access aged care services, but assessors have a role in advising clients about where they can access the information they need and what the process may entail. They should be able to assist clients in access to appropriate support should there be financial disadvantage (see section **17.5**. Financial Hardship).

Ideally, clients should be referred to the My Aged Care website and the contact centre for information regarding care costs and fees prior to the face-to-face assessment. This gives the client time to consider the information prior to the assessment.

> **Note**: After the assessment, rather than the assessor handing out Services Australia hard copy forms to the client (which may lead the client to complete a form unnecessarily), assessors can leave booklets specific to their service recommendations which contain necessary fee information for that program or type of care. Assessors may wish to point out the section in the booklet which provides information about fees, who to contact about whether they need to complete a form and how to access to forms if required (see section **22**. Aged Care Resources for Consumers).

16 Aged Care Program Fees

16.1 Fees for CHSP

A client does not need a financial assessment to access CHSP services.

Under the CHSP, the Client Contribution Framework outlines the principles service providers can adopt in setting and implementing their own client contribution policy, with a view to ensuring that those who can afford to contribute to the cost of their care do so whilst protecting those most vulnerable. Under the Client Contribution Framework, client contributions should not exceed the actual cost of service provision.

During the assessment, explain to a client that they are expected to contribute toward the costs of the CHSP services they receive if they can afford to do so.

Each service provider is required to have their own client contribution policy to determine the amount client's will pay. Clients are expected to discuss client contributions with their service provider before commencement of these services, after they have been assessed.

Where a DSOA client transitions to CHSP they will not need to pay any more for their current services under the CHSP than they have been paying for their current specialist disability services. For example, if the client does not pay fees now, then they will not pay fees under CHSP.

Home care consumers accessing CHSP service types are generally required to be paid on a full cost-recovery basis and not from their HCP individualised budget. If they meet one of the six defined circumstances, they may be able to access some specific CHSP-subsidised services in addition to the services they receive from their HCP budget (see **10.8** CHSP Interaction with Home Care Packages).

Further information
Department of Health, Disability and Aged Care website: [Commonwealth Home Support Programme Manual](#) and [Commonwealth Home Support Programme Resources](#)

16.2 Fees for Home Care Consumers

For home care consumers, an income assessment determines the person's contribution to their care, known as an 'income-tested care fee'. It is an extra contribution that some people pay. Full pensioners will not be asked to pay an income-tested care fee.

Services Australia will have the income information of anyone in receipt of a means-tested income support payment and will be able to determine the income-tested care fee (if any) without the person completing an income assessment form.

Where a person is not in receipt of a means-tested income support payment and elects not to complete an income assessment form, their income-tested care fee will be set at the maximum per day rate at the second cap. The second cap is the daily cap applying on income tested care fees where the consumer's income exceeds the income threshold. Information about the current rates of fees and charges is available on the [Fees for Aged Care services website.](#)

Providers do not need to wait for an income assessment to be completed before a consumer can commence a Home Care Package. However, providers maintain their own individual admissions policies. Some providers may require the income assessment to be completed prior to a consumer being offered a Home Care Package. There is nothing in the Act which prevents a provider from setting this requirement.

Further information
Department of Health, Disability and Aged Care website: [Fees for people entering Home Care Packages from 1 July 2014](#), [Home Care Packages Program Operational Manual](#), [Schedule of Fees and Charges for Residential and Home Care](#).
My Aged Care website: [Aged Care Resources](#) and [Home Care Package Costs and Fees](#)
Services Australia website: [Home Care (Fee and Other Information)](#) and [Residential Care (Fee and Other Information)](#)

16.3 Clients Entering Permanent Residential Care

If a person is interested in taking up permanent residential care or home care, the process is simpler if a combined income and asset assessment (means assessment) has been completed prior to the commencement of care.

A means assessment made before entering care is valid for 120 days unless there is a significant change in the person's circumstances.

For care recipients entering permanent residential care from 1 July 2014, a means assessment is required to determine the person's contribution to their care costs, and whether the person is eligible to receive Government assistance with their accommodation costs.

Providers do not need to wait for a means assessment to be completed before a care recipient can be admitted to residential care. However, providers maintain their own individual admissions policies. Some providers may require the means assessment to be completed prior to the care recipient being admitted to determine which rooms to offer the care recipient. There is nothing in the Act which prevents a provider from setting this requirement.

16.4 Interim Fees Pending Income and Assets Assessment

A provider may choose to charge an interim fee while waiting on the results of the assessment. However, the Government does not set an amount of interim fee. Once Services Australia has advised of the fees payable any overpayment would need to be refunded.

Where the care recipient is already known to Services Australia and they **do not** own their own home, Services Australia have all of the information they need to complete the means assessment automatically.

Where the care recipient is already known to Services Australia and they **do** own their own home, Services Australia only require information about the person's home to complete the means assessment.

For everybody else, Services Australia needs the care recipient to submit a means assessment.

Further information
Department of Health, Disability and Aged Care website: [Fees for people entering Home Care Packages from 1 July 2014](#) Financial Hardship Services Australia website: [Aged Care Homes Accommodation Costs and Fees](#) and [Aged Care Calculation of your cost of care](#)

16.5 Financial Hardship

A client may be eligible to apply for financial hardship assistance with:

- Home Care (post 1 July 2014 only):
    - o basic daily care fee; and/or
    - o income-tested care fee.
- Residential Care:
    - o basic daily fee; and/or
    - o income tested fee (pre-1 July 2014); and/or
    - o means-tested care fee (post-1 July 2014); and/or
    - o accommodation costs.

If a person is granted financial hardship, the Australian Government will pay some or all of their aged care costs. The amount payable by the person will be reduced by the amount paid by the Australian Government, including nil payment. Each case is

assessed on an individual basis, taking into consideration a range of issues that may be unique to the resident.

To apply for financial hardship assistance, the client or their representative will need to complete an application for financial hardship assistance and submit the form to Services Australia. A copy of this form and associated guidelines can be found on the Services Australia [website](#).

Further information
Department of Health, Disability and Aged Care website: [Hardship Supplement for Aged Care](#)
My Aged Care website: [Financial Hardship Assistance](#)
Services Australia website:
[Financial Hardship Assistance for Home Care and Residential Respite Care Form (SA462)](#)
[Financial Hardship Assistance for Residential Aged Care form (SA462)](#)

16.6 Fees for Flexible Care Programmes (STRC and TCP)

STRC and Transition Care service providers may charge clients a daily care fee.

The care fee that clients may be charged for both programmes is calculated on a daily basis for every day the client receives care.

For care delivered in a residential care setting, the maximum value of the care fee is 85% of the basic daily rate of the single basic age pension.

For care delivered in the home, the maximum care fee is 17.5% of the basic daily rate of the single basic age pension.

The above rules on maximum fees apply to both single and married clients.

Further information
Department of Health, Disability and Aged Care website:
[Short-Term Restorative Care Programme Manual](#) and [Transition Care Programme Guidelines](#) (see sections 4 – 6)
Federal Register of Legislation website: [User Rights Principles 2014](#) (see Part 3A, Division 2, Section 23AB Maximum amount …charged for care and services - STRC)

16.7 Non-Australian Residents

The CHSP does not have any exclusion from services based on citizenship, residency status or eligibility for Medicare support.

Non-Australian residents are not excluded from entitlements under the Act and Visa holders do not require a Medicare Card in order to access a comprehensive assessment.

Under the Act, non-Australian residents may be eligible for Government assistance with their aged care costs, if the person has been approved by an assessor and has had their income (for home care) or means (for residential care) assessed by Services Australia.

While the Australian Government is the majority funder of aged care, beyond this support it is expected that people will use their income and/or assets, depending on their care type, to contribute to the costs of their care, where they can afford to do so. The amount that the person can be asked to contribute will be assessed by Services Australia under the same rules as any other aged care recipient. Similarly, the basic daily fee payable for residential care by the person cannot be more than 85 per cent of the single rate of the basic age pension, irrespective of whether or not the person receives the age pension. The same applies for home care, but the basic daily fee is a maximum 17.5%.

In the event that a non-Australian resident client requests advice from an assessor regarding what fees and payments they may be required to contribute towards their home care or residential care services, they should be advised to complete an income or means assessment to determine their contribution. This applies for all clients who wish to receive Government assistance with the cost of their care, regardless of residency status.

Further information
Services Australia website: [Assessment for Aged Care](#)

PART H – OPERATIONAL PROCEDURES (for Managers)

The primary audience for this section is assessment organisation program managers and outlet managers. Managers have an obligation to ensure all assessors are aware and comply with privacy legislation. All staff should exercise caution in handling the personal information of aged care clients.

17 Information Management

17.1 Privacy Act 1988 (Cth)

The Privacy Act applies to the collection, retention and use of personal information by assessors and regulates the handling of personal information about individuals, including the collection, use, storage and disclosure of personal information and access to and correction of that information.

The Privacy Act includes 13 Australian Privacy Principles (APPs) in Schedule 1 that apply to the handling of personal information by most Australian and Norfolk Island Government agencies and some private sector organisations. Use and disclosure of personal information is covered by APP 6.

The collection of personal and sensitive information is regulated by APP3.

The collection of sensitive information (defined by the Privacy Act to include health information) is regulated by APP 3.3 and is more rigorous than the requirements relating to personal information that is not also sensitive information. Assessors will invariably collect persons' sensitive information as part of the assessment process.

APP 3.3 provides that sensitive information can only be collected by an agency where the individual consents to the collection of information and the information is reasonably necessary for, or directly related to, one or more of the agency's functions or activities.

However, an agency does not require an individual's consent where an exception applies – for example, if 'required or authorised by or under an Australian law' (APP 3.4(a)).

Assessment organisations must ensure that they only release information which they have appropriate authority to release. As a general rule, under APP 6, personal information collected for one purpose cannot be used or disclosed for another purpose without the consent of the person it relates to. This means that information collected for the purposes of an assessment cannot be used for another purpose, unless an exception in APP 6.2 or APP 6.3.

Penalties may apply to organisations for breaches of the *Privacy Act*.

The Office of the Australian Information Commissioner website has resources that assist in the process of ensuring compliance with the *Privacy Act*.

Further information
Federal Register of Legislation website: Aged Care Act 1997 (Cth) (see Part 6.2 – Protection of Information) Archives Act 1983 Healthdirect website: Healthdirect Privacy policy Office of the Australian Information Commissioner website: Australian Privacy Principles and the Privacy Act 1988 (Cth)

17.2 Aged Care Act 1997 (Cth)

Assessment information collected for purposes of assessments recommending Act based services (including home support assessments that are converted to a comprehensive assessment) is 'protected information' under Division 86 of the Act.

Protected information is defined under s 86-1 of the Act as information that was acquired under or for the purposes of this Act or the *Aged Care (Transitional Provisions) Act* 1997, and either is personal information, or relates to the affairs of an approved provider, or relates to the affairs of an applicant for a grant under Chapter 5 of the Act.

A person commits an offence if they make a record of, disclose or otherwise use information that is protected information (see section 86-2(1) of *the Act*) acquired in the course of performing duties or exercising powers or functions under the Act or the *Aged Care (Transitional Provisions) Act 1997* (Cth). The maximum penalty for this offence is imprisonment for two years.

The Act provides for very specific exceptions to the general prohibition on the use or disclosure of information under section 86-2(2). This includes allowing assessment organisations:

- to use protected information in the course of undertaking powers, functions or duties as a delegate of the Secretary. This includes using information relating to a person for the purposes of the provision of aged care, assessing needs, reporting on, and conducting research into, the level of need of and access to aged care, (see section 86-2(e) and section 86-4 of the Act);
- to disclose information only to the person to whom it relates under section 86-2(2)(b) of the Act (i.e.; about the client only to the client, and information about a family member to the family member). Assessors should note that section 86-2(2)(b) does not allow them to disclose information about the client to a family member;

- to use protected information in ways that have been authorised by the person to whom the information relates (see section 86-2(2)(d) of the Act). If the client has given permission, this subsection allows the assessor to disclose information about the client to a family member. If a family member has given permission, it also allows the assessor to disclose information about the family member to the client; and to use protected information as otherwise authorised under the (Aged Care) Act or any other Act (see section 86-2(2)(e)).

Section 86-4 of the Act allows persons conducting assessments to record, use or disclose protected information, therefore reasonable steps should be taken to protect client information in these circumstances.

17.3 Collection and Protection

Assessors collect information about clients and their families as part of the assessment and approval process and are required to comply with the legislative requirements under the Privacy Act which regulates the handling of personal information about individuals, including the collection, use, storage and disclosure of personal information, and access to and correction of that information. Assessors must seek and gain informed consent using the My Aged Care Assessment Consent Form (the Consent Form) including reading the consent scripts to the client or their authorised representative. The Consent Form includes the consent scripts and can be located via the Reports and documents tile within the My Aged Care assessor portal.

Any information collected for the purpose of assessing recipients for the provision of Commonwealth-subsidised aged care is collected on behalf of the Commonwealth and is therefore Commonwealth property. This includes client notes or any other material and documents created for the purpose of preparing the client record.

The Act has further provisions to protect this information that applies to assessment organisations. Personal information as defined under the Act means information or an opinion about an identified individual, or an individual who is reasonably identifiable:

a) whether the information or opinion is true or not; and
b) whether the information or opinion is recorded in a material form or not.

It is critical that assessment organisations have systems, protocols and processes in place to ensure the safety of client records from loss, interference, misuse, unauthorised access, modification or disclosure. This requirement relates to APP 11. Penalties may apply to agencies and individuals for breaches of the Privacy Act. Assessment organisations may refer to the Office of the Australian Information Commissioner website for more instruction on the handling of personal information and the handling and consequences of misuse.

If a record of an assessment is a state or territory government record as well as being a Commonwealth record, there may be further requirements to retain and store the information under state or territory legislation. Assessment organisations should seek

advice from their state or territory government on any state or territory requirements and meet all the requirements set by both levels of government.

All staff should exercise caution in handling the personal information of aged care clients. If an assessor is aware of a potential privacy breach they will need to discuss this with their assessment organisation manager and follow their organisation's procedures.

Further information
Department of Health, Disability and Aged Care website: [Fact Sheet for Assessors - My Aged Care Consent](#)

17.4 Storage and Retention

Records are now created, stored and managed electronically in the My Aged Care portal. In some circumstances, it may be necessary for records to be created in a hard copy paper format (e.g., the Application for Care form). In these cases, the paper records are to be uploaded to the My Aged Care portal as soon as possible and the paper copy destroyed in accordance with the destruction guidelines (see Destruction below).

Should you require information about the management of legacy records, those records that were created prior to the My Aged Care Gateway please contact your assessment organisation manager who can liaise with the department if necessary for further advice.

17.5 Destruction

The destruction of new paper records should be undertaken as soon as the record has been captured digitally in the My Aged Care portal, and a true electronic copy has been confirmed. Destruction can be undertaken using class B paper shredders that shred to P-5 security level. Level P-5 provides more security with cross-cut shreds that are only ≤ 30 mm² particles with width ≤ 2 mm.

Alternatively, destruction can also be through a [Protective Security Policy Framework](#) endorsed T4 accredited waste management agency.

The destruction of electronic records requires the deletion of all copies of the record from any system in such a way that it is impossible to restore the record. For records that are destroyed and not uploaded to My Aged Care, assessment organisations must also maintain evidence of identifying what has been destroyed and the means of destruction.

17.6 Use

Assessors and other staff must be aware that information they acquire in the course of their work that is personal information may not be recorded or disclosed or otherwise used apart from the purpose for which it is collected and that the person consents (see section 5.1. Consent). For instance, clients may not be discussed with the staff member's family or friends in any way that would allow a client to be identified. Written records of 'interesting cases' may not be kept by staff members, and cases may not be referenced in public discussion such as in a Letter to the Editor or in social media. There are some exceptions under the Act, as noted in Manual section at 18.2.

Any systems developed for the collection and analysis of data should incorporate adequate procedures to protect the privacy of people being assessed. If data is to be used for purposes other than assessment, or individual care planning, assessors must have procedures in place to ensure that client confidentiality is maintained and individuals cannot be identified.

17.7 Release

Assessors must ensure that they only release information for which they have appropriate authority to release. As a general rule, under APP 6, personal information collected for one purpose cannot be used or disclosed for another purpose without the consent of the person it relates to. This means that information collected for the purposes of an assessment cannot be used for another purpose, unless an exception in APP 6.2 or APP 6.3. Assessment organisations must note the specific exceptions to the general prohibition on the use or disclosure of protected information under section 86-2(2) of the Act (See section 17.2 Aged Care Act 1997 (Cth)).

Clients and representatives/agents should be encouraged to access their My Aged Care online account. This gives direct access to their own assessment information, which they can disclose to other parties as they wish.

In situations where the assessor has concerns for the client's welfare, the assessor can disclose information regarding risk of family violence and/or elder abuse to relevant state and territory organisations at the consent of the client from whom the information is collected.

In cases where there is no consent to release information or any doubt about the release of information, the assessor should discuss this situation with the organisation's manager. The manager may further consult the assessment organisation's auspice organisation, the state or territory government, the department or obtain independent legal advice if any doubt remains, before releasing information.

Further information
Australian Security Intelligence Organisation website: ASIO T4 Protective Security

18 Freedom of Information

The Commonwealth *Freedom of Information Act 1982 (*FOI Act*)* gives members of the public rights of access to official documents of the Commonwealth and its agencies. The FOI Act extends, as far as possible, the right of the Australian community to access information (generally documents) in the possession of the Commonwealth, limited only by considerations of the protection of essential public interest and of the private and business affairs of persons in respect of whom information is collected and held by departments and public authorities.

19 Aged Care Assessment Quality Framework

Assessment organisations are required to conduct aged care needs assessments using the IAT in a manner that focusses on the older person and attributes to delivering timely, safe and nationally consistent high-quality assessments, guided by the Aged Care Assessment Quality Framework (the Framework).

The Framework describes essential organisational skills required to support assessors to reach and maintain a high-quality assessment experience for every older person. It also incorporates the good practice of the three-tiers of quality management, focusing on assuring quality assessments including those in relation to younger people, older Aboriginal and/or Torres Strait Islander people and those from diverse backgrounds.

The Framework aligns with the consumer-focused principles of the Aged Care Quality Standards from the Aged Care Quality and Safety Commission (ACQSC) single set of

aged care quality standards and identifies a high-quality assessment as one that meets the following four quality goals:

- **PERSONAL** –the assessment process is conducted as a respectful conversation and is responsive to the person's individual situation, context, goals, and aspirations – it includes and respects the role of carers and family and ascertains the sustainability of this support. Further, the support plan accurately reflects the older person's personal and unique circumstances (i.e., physical, medical, psychological, cultural, social, and personal) and the older person's specific goals and aspirations reflective of their assessed care needs.

- **EFFECTIVE** – the older person feels that the assessment process culminates in them being able to exercise choice and control in accessing the right services (as available and as eligible) to assist them to remain in a setting most appropriate to their needs. There is a reduced need for the older person to tell their story more than once.

- **CONNECTED** – the older person feels connected to their My Aged Care pathway to services; understands how and why the assessment process contributes to their journey and what the likely timeframes are for approval decisions and access to services.

- **SAFE** – the older person is provided a physically, emotionally and culturally safe assessment where their unique experiences are respected and factored into the way they are assessed for aged care. All assessments are delivered in a safe environment and free from harm.

The Framework provides detail of the key components and elements in Section 4 that must be in place to achieve high-quality assessment for every older person.

Detailed measures and performance targets against the four quality goals are described in Section 5 of the Framework. The tools used to manage a quality assessment align to a three-tiered approach to managing quality.

Assessment organisations are required to comply with the guidance as set out in the Framework and this Assessment Manual. Assessment organisation managers play an important role in providing program support, training and information to their assessment staff to enable them to undertake quality assessments. Operational managers are required to distribute documents and products relating the Aged Care Assessment Quality Framework to their assessment workforce.

Further information
Department of Health, Disability and Aged Care website: Aged Care Assessment Quality Framework

20 Separation of assessment services and delivery of aged care services

The assessment organisation delivers the assessment of client needs independent of provider preferences, and ensures clients are referred only to the services that will fulfil their needs and goals.

It is a requirement for assessment organisations to contractually have operational separation of assessment services from service delivery (where applicable) for all contracted assessment organisations and any relevant sub-contractors (including consortiums).

Assessment organisations that deliver both assessment services and service delivery must ensure there is a clear separation of service, particularly in the facilitation and management of assessments and referrals to aged care services. Assessment organisations must have policies and procedures in place to assure the separation of assessment from service delivery**.**

Assessment organisations must seek prior approval from the department before engaging or using assessment organisations and any relevant sub-contractors to provide aged care services.

21 Branding

Assessment organisations that are contracted to (or in an agreement with) the Australian Government (under the oversight of the department) are required to comply with branding guidance that is included in the following style guides:

- Single Assessment System Program style guide
- Subcontractors are required to consult with their prime contractor on branding requests.

22 Aged Care Resources for Consumers

The department makes a number of resources available for consumers, for example:

- general information on My Aged Care, including brochures and magnets
- a range of detailed hard copy booklets about specific aged care programs, including:
    - o Short-Term Restorative Care
    - o Commonwealth Home Support Programme
    - o Home Care Packages Program
    - o Residential aged care

Hard copy booklets contain detailed information about accessing services for specific aged care programs and are not suitable as a general information resource. The client should only be provided with the booklet relevant to the program for which they are assessed as eligible. Translated copies of many of these resources are also available to view, download and print from the My Aged Care website.

These resources can be ordered by assessors to distribute to their clients at the time of assessment. For clients who would prefer to access resources online, relevant resources are also available on the My Aged Care website.

Assessors should encourage their clients to keep these resources as they provide key information to support them as they progress through the journey of accessing aged care services.

Further information
My Aged Care website: Aged Care Resources. Hard copies of the booklets, brochures, posters and magnets are available from National Mailing and Marketing by emailing: health@nationalmailing.com.au or (02) 6269 1025.

23 Training

23.1 My Aged Care training requirements

The My Aged Care Workforce Learning Strategy 2025 (Workforce Learning Strategy), and subsequent editions of this strategy defines and sets the minimum training requirement for the Single Assessment System workforce and the My Aged Care workforce, including timeframes for completion.

The Workforce Learning Strategy explains the blended approach to mandatory training requirements including on-line training, on-the-job learning and learner appraisal. This approach reflects that the Single Assessment System workforce and My Aged Care workforce undertakes functions broader than just screening and assessment. This approach also acknowledges existing knowledge and skills of the workforce, and that learning is ongoing.

To complement the Workforce Learning Strategy, a Quality Learning Framework establishes processes by which the My Aged Care workforce can attain and maintain the capabilities they require, including the mechanisms by which capabilities are verified through on-line learning, on-the-job training, and learner appraisals. It defines the quality standards and guidelines that govern the implementation of the minimum training requirements through a blended model of learning and training.

Training Delivery

Assessment organisations are responsible for ensuring their workforce undertake relevant minimum training requirements. Learners can only complete the training that is relevant to their role and are working in an organisation that delivers that service. The department will consider exceptions for operational requirements. To find out more email myagedcare.capability@health.gov.au

The department delivers learning and support training through a learning management system called MAClearning. The MAClearning platform supports delivery of minimum training requirements described in the Workforce Learning Strategy, supported by guides that outline the requirements for successful completion.

Access to MAClearning is provided by the department. Workplace trainers and operational managers are responsible for providing the details of new learners to the department for registration on MAClearning. Registration requests should be sent to maclearninghelp@Health.gov.au.

Delegates are also required to complete specified delegate training through the MAClearning system.

From time to time, the department may require assessors to undertake additional training when changes are made to programs, policies or processes. Generally, this training will be provided through MAClearning.

Further information
Department of Health, Disability and Aged Care website: My Aged Care Workforce Learning Strategy 2025.   My Aged Care Quality Learning Framework   New training and learning system for My Aged Care workforce

24 Reporting and Performance

Assessment organisations are expected to meet measures on timeliness and performance according to their agreements with the Commonwealth.

The department makes available various business intelligence (BI) and management reports which support assessment organisations in monitoring and managing their performance against agreed KPIs and other measures. These reports will progressively become available during the establishment of the Single Assessment System workforce. These reports will be detailed in this section once they become available.

APPENDIX 1 – GLOSSARY of TERMS

Term	Acronym/abbreviation	Definition
Administrative Review Tribunal	ART	The Administrative Review Tribunal (ART) provides independent merit reviews of a wide range of administrative decisions made by the Australian Government. The ART can review decisions made under Commonwealth and Norfolk Island laws. The ART aim to make their review process accessible, fair, just, economical, informal and quick.
Aged Care Act 1997 (Cth)	The Act	The *Aged Care Act 1997* (Cth) provides the regulatory framework for Australian Government-funded aged care providers and provide protection for aged care recipients. The legislative framework sets out the requirements to be an approved provider of Australian Government-funded aged care, for the allocation of aged care places, the approval and classification of care recipients, the responsibilities of approved providers, and the subsidies paid by the Australian Government. The framework also sets out the responsibilities of providers in relation to aged care quality and compliance.
Aged Care Assessment Quality Framework	Framework	Assessment organisations are required to use the Aged Care Assessment Quality Framework to maintain a consistent, high quality assessment experience for every client.
Aged Care Diversity Framework		The Aged Care Diversity Framework is an overarching set of principles designed to ensure an accessible aged care system where people, regardless of

Term	Acronym/abbreviation	Definition
		their individual social, cultural, linguistic, religious, spiritual, psychological, medical and care needs are able to access respectful and inclusive aged care services.
Aged care needs assessor		A person who conducts aged care assessments, for home support and comprehensive assessments. An aged care needs assessor can be a clinical assessor or a non-clinical assessor.
Aged Care Principles		The Aged Care Principles are made under subsection 96–1 (1) of the *Aged Care Act 1997*. The Act enables the Minister to make Principles that are required or permitted under the Act, or that the Minister considers necessary or convenient to carry out or give effect to a Part or section of the Act. There are currently 17 sets of Principles made under the Act. In addition, the Aged Care (Transitional Provisions) Principles 2014 was made under the Aged Care (Transitional Provisions) Act 1997. These Principles may be amended at any time. The Principles used frequently by assessment organisations are the Approval of Care Recipient Principles 2014 and the Subsidy Principles 2014.
Assessment organisations	N/A	An entity engaged by the Department to provide Aged Care Needs Assessment Services and/or RAC Funding Assessment Services.

Term	Acronym/abbreviation	Definition
Assessor	N/A	An aged care needs assessor.
Assistance with Care and Housing – Hoarding and Squalor Sub-Program	ACH – Hoarding and Squalor	The Assistance with Care and Housing - Hoarding and Squalor Sub-Program of the CHSP is designed to support those who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need. Hoarding Disorder can be associated with health risks and can impact on an individual's friends and family. People experiencing Hoarding Disorder can be assisted by specialist intervention. The range of Hoarding and Squalor services may include: developing a client plan; one-off clean-ups; review care plans and linking clients to specialist support services.
Aged Care Specialist Officer	ACSO	ACSO, located in some [Services Australia service centers](#), help people with their aged care matters and provide in-depth support including in relation to financial information and means assessment.
Australian Privacy Principle/s	APP/s	The Privacy Act includes 13 APPs in Schedule 1 that apply to the handling of personal information by most Australian and Norfolk Island Government agencies and some private sector organisations.

Term	Acronym/abbreviation	Definition
Care finder		Care finders assist vulnerable older Australians who do not have someone who is able to help them access aged care services and other relevant supports in the community. Contact information for care finder services in each region is on the My Aged Care website at [Help from a care finder | My Aged Care](#)
Clinical aged care needs assessor		A clinically trained assessor who meets the qualification and training requirements outlined in the assessment organisation's contractual agreement with the Commonwealth. A clinical assessor undertakes complex (comprehensive) aged care needs assessments with older people and will be required to exercise clinical judgement.
Commonwealth Continuity of Support Programme	CoS	The Continuity of Support Programme has been replaced with Disability Support for Older Australians (DSOA).
Commonwealth Home Support Programme	CHSP	The Commonwealth Home Support Programme provides a broad range of entry-level support services to assist frail, older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) to live independently in their homes and communities. From 1 July 2015 Commonwealth Home Support Programme combined together the Home and Community Care Programme (HACC), National Respite for Carers Programme, Day Therapy Centres and

Term	Acronym/abbreviation	Definition
		Assistance with Care and Housing Sub-Program. The operation of the CHSP is governed by the CHSP Program Manual 2022–23.
Comprehensive assessment		An assessment type for people with more complex needs. Comprehensive assessments are undertaken by clinical assessors.
Departmental delegate		A departmental employee whose position has been delegated powers and functions under a section of the *Aged Care Act 1997* (Cth) by the Secretary of the department.
Disability Support for Older Australians	DSOA	DSOA provides funding for a range of services including Assistance in Supported Independent Living, Assistance with Self-Care Activities, Specialist/Behavioural Intervention Support, Therapy, and Case Management.
Elder Care Support Program		The workforce will help Aboriginal and Torres Strait Islander Elders, their families and carers, to access aged care services across urban, regional and remote Australia to meet their physical and cultural needs.
Aboriginal and Torres Strait Islander Assessment Organisation	FNAO in My Aged Care System	Aboriginal and Torres Strait Islander assessment organisations are assessment organisations that specialise in providing a culturally safe, trauma aware and healing informed assessment experience for Aboriginal and Torres Strait Islander people.

Term	Acronym/abbreviation	Definition
Flexible Care		There are flexible aged care places provided through a number of different programs which provide an alternative to more traditional community and residential care. These include Multipurpose Services, the Transition Care Program and Innovative Care.
Formal Services		Where formal services are referred to in this Manual these are paid services, such as government funded support.
Good Practice / Best Practice		Good practice is a matter of action. Best Practice is a recommendation.
Home Care Packages Program	HCP	The Home Care Packages Program supports older Australians with complex care needs to live independently in their own homes. There are 4 levels of Home Care Packages — from level 1 for basic care needs to level 4 for high care needs.
Informal Services		Where informal services are referred to in this Manual this is the unpaid support provided by carers, family, neighbours or other community organisations.
Integrated Assessment Tool	IAT	The IAT is an online assessment tool used to assess eligibility for all aged care programs.
ISBAR		The ISBAR framework represents a standardised approach to communication which can be used in any situation. It stands for Introduction, Situation, Background, Assessment and Recommendation.

Term	Acronym/abbreviation	Definition
Multi-Purpose Service	MPS	The Multi-Purpose Services Program is a joint initiative of the Australian Government and state and territory governments. It aims to deliver flexible and integrated health and aged care services to some small rural and remote communities that could not viably support stand-alone hospitals or aged care homes.
My Aged Care contact centre	The contact centre	The My Aged Care contact centre is the starting point to access Australian Government-funded aged care services. The Freecall phone line (1800 200 422) and website https://www.myagedcare.gov.au/contact-us can help older Australians, their families and carers to get the help and support they need.
My Aged Care service provider and assessor helpline	Helpline	My Aged Care service provider and assessor helpline (1800 836 799) is the industry helpline for My Aged Care portal issues. They provide a reference number to track the progress of a complaint or issue and notification when the ticket is closed. Issues can be escalated to other teams within the department as appropriate. Call from 8am to 8pm Monday to Friday or 10am to 2pm Saturday.
My Aged Care Assessment Screening and Assessment Workforce Learning Strategy		The department's Registered Training Organisation is responsible for ensuring national consistency of My Aged Care Training and supporting the My Aged Care Learning Environment. The My Aged Care Assessment Workforce

Term	Acronym/abbreviation	Definition
		Learning Strategy can be found at this [link](#).
My Aged Care Learning Management System	MAClearning	The delivery of training to the My Aged Care Screening and Assessment Workforce organisations occurs via the My Aged Care Learning Management System (MAClearning). MAClearning provides assessors with: • access to mandatory and optional online learning, • information about mandatory appraisal activities, and • a record of all completed learning and appraisals
My Health Record	MHR	My Health Record is a secure online summary of key patient health information. Healthcare providers can access the system to view and add information.
National Aboriginal and Torres Strait Islander Flexible Aged Care Program	NATSIFAC	The National Aboriginal and Torres Strait Islander Flexible Aged Care Program funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. These services are mainly located in remote and very remote locations.
National Disability	NDIS or	The NDIS is a way of providing support for people with disability, their families and carers in Australia. The NDIS will

Term	Acronym/abbreviation	Definition
Insurance Scheme/Agency	NDIA	provide all Australians under the age of 65 with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life. This may include personal care and support, access to the community, therapy services and essential equipment.
National Screening and Assessment Form	NSAF	Prior to the introduction of the Integrated Assessment Tool, the National Screening and Assessment Form supported skilled assessors to determine a client's aged care needs.
Non clinical aged care needs assessor	Non clinical assessor	An assessor who meets the qualification and training requirements outlined in the assessment organisation's contractual agreement with the Commonwealth. A non-clinical assessor undertakes simple (home support) aged care needs assessments with older people.
Privacy Act 1988	The Privacy Act	The *Privacy Act 1988* applies to the collection, retention and use of personal information by assessors and regulates the handling of personal information about individuals, including the collection, use, storage and disclosure of personal information and access to and correction of that information.
Residential Respite Care		Residential respite care is short-term care provided in an aged care home. It can be on a planned or emergency basis. Respite gives a carer or care recipient a break from their usual care arrangements.

Term	Acronym/abbreviation	Definition
		A clinical assessor and approves care recipients to access respite care.
Short-Term Restorative Care Programme	STRC	The Short-Term Restorative Care (STRC) Programme is an early intervention program that aims to reverse and/or slow 'functional decline' in older Australians and improve wellbeing through the delivery of a time-limited (up to 56 paid days), goal-oriented, multi-disciplinary and coordinated range of services designed for, and approved by, the client. STRC services may be delivered in a home care setting, a residential care setting, or a combination of both.
Single Assessment System program		The Commonwealth Government funds assessment organisations to administer aged care needs assessments, which include both home support and comprehensive assessments. This term is used to define the assessment program which includes all assessment types.
Single Assessment System workforce		Refers to the aged care assessment workforce from late 2024. This term also includes organisations that deliver Residential Aged Care Funding assessments.
(Commonwealth) Subsidised and non-subsidised aged care services		Commonwealth subsidised aged care programs broadly include CHSP and aged care under the *Aged Care Act 1997* (Cth) (home care, flexible care and residential care). These services can receive My Aged Care portal referrals and can be service recommendations on the Support Plan. Non-subsidised

Term	Acronym/abbreviation	Definition
		services are those services and supports that are NOT Commonwealth funded aged care. These services cannot receive referrals through the My Aged Care portal, are NOT listed in the My Aged Care service finder and are noted as general recommendations on the Support Plan.
Support Plan		The Support Plan is an important and ongoing document for the client that can be updated as a client's needs change. It details the outcomes of discussions with, and assessments of, the client, including what the client would like to improve and achieve (their goals), and agreed actions to be taken. It is a continuous document (i.e. a client only has one Support Plan).
Support Plan Review	SPR	A Support Plan Review relates to the effectiveness and appropriateness of the client's Support Plan. An assessor may set a review date on the Support Plan at the time of the assessment or initiated on an ad-hoc basis. A review may also be requested by a client or a service provider where there is a change in the client's needs or circumstances. It may be completed over-the-phone with the client.
Transition Care Programme	TCP	Transition Care provides short-term, goal oriented and therapy-focused care for older Australians after hospital stays either in a home or community setting or in a residential aged care setting.

APPENDIX 2 – CLINICAL GOVERNANCE GUIDANCE FOR AGED CARE NEEDS ASSESSMENT ORGANISATIONS

Guidance purpose

This guidance aims to help aged care assessment organisations to meet their responsibilities for ensuring the quality of needs assessments, through the implementation of effective clinical governance. The sections below are for people within an assessment organisation responsible for developing their clinical governance framework. It describes the importance of good clinical governance, details the elements of an effective clinical governance framework in an aged care needs assessment context and outlines the minimum supports that must be in place to support clinical and non-clinical staff.

This guidance should be considered in conjunction with the resources on clinical governance in the provision of aged care services available on the Aged Care Quality and Safety Commission's website.

What is a clinical governance framework and why is it important for aged care assessment organisations?

Clinical governance is an integrated system of organisational behaviours, policies, procedures, responsibilities, and quality assurance mechanisms that support consistent and high-quality care in organisations across the health, aged care and many social services sectors. A clinical governance framework is a framework that describes an organisation's approach to clinical governance.

Your assessment organisation's clinical governance framework must describe the practical, clinical supports that are in place for staff who may need to exercise clinical judgement or undertake elements of an aged care needs assessment that are clinical in nature.

Good clinical governance supports everyone in your assessment organisation to achieve high quality aged care assessments that deliver accurate and appropriate outcomes for all older people. High quality assessments are defined in the Aged Care Assessment Quality Framework as:

- Personal: an assessment is a respectful conversation and is responsive to an older person's individual situation, context, goals and aspirations.

- Effective: assessments are undertaken in depth and to completion, ensuring an older person's needs are fully identified and an older person can exercise choice and control in accessing the right services appropriate for them (as available and as eligible)

- Connected: the older person understands how and why the assessment process connects to their aged care journey.

- Safe: the older person is provided a physically, emotionally and culturally safe assessment where their unique experiences are respected and factored into the way they are assessed for aged care. All assessments are delivered in a safe environment and free from harm.

Importantly, clinical governance must be embedded in your organisational culture. Leaders must foster a culture that supports and promotes consistent, high quality assessments and integrates clinical governance into the broader organisational governance. Your organisation's governing body is accountable for ensuring adequate clinical support is in place for staff, understanding the risks associated with undertaking assessments, monitoring performance, and continuously driving improvement.

How to use this guidance

This guidance outlines the elements that your assessment organisation must include in its clinical governance framework, and

details the minimum, practical clinical supports that must be in place for your workforce who may need to exercise clinical judgement or undertake an assessment that is clinical in nature.

Your assessment organisation may develop its clinical governance framework in a format that suits them and include additional elements that are not covered in this guidance. For assessment organisations with an existing clinical governance framework, a review will be required to ensure all elements in this guidance are included.

Elements of a clinical governance framework

At a minimum your assessment organisation's clinical governance framework must demonstrate how it will:

Define **roles and responsibilities** to provide clarity on how clinical governance will operate.Recruit, **train and accredit staff** to build a highly skilled and qualified assessor workforce.

- Provide **clinical support** to assessors.
- Monitor assessment quality and drive continuous improvement.
- Build relationships to foster innovation and continuous improvement.

The minimum clinical support requirements that sit under each of these elements are detailed in the next section.

Element 1: Define roles and responsibilities to provide clarity on how clinical governance will operate

Clinical Support Requirement	Implementation
Staff understand the boundaries of their role as a clinical assessor or clinical delegate, and the functions that are not suitable to perform when undertaking those roles. E.g. Clinical assessors who are registered nurses should not dress wounds when undertaking an assessment.	Each staff member is assigned the correct clinical role/s in the My Aged Care Assessor portal. The organisation's Work, Health and Safety framework outlines procedures that uphold staff safety. Completion of workplace training on the organisation's clinical attendance policy and clinical governance framework.
Staff understand the boundaries of their role as a non-clinical assessor and non-clinical assessment delegate and understand when and how they will need to operate under their organisation's clinical governance throughout the assessment process.	Completion of workplace training on the organisation's clinical attendance policy and clinical governance framework.

Element 2: Recruit, train and accredit staff to build a highly skilled and qualified assessor workforce

Clinical Support Requirement	Implementation
Every assessor has capability to perform a needs assessment, prior to undertaking an assessment with an older person.	Completion of training outlined in the My Aged Care Workforce Learning Strategy 2024 (and subsequent versions) and mandatory online learning on the My Aged Care Learning. On-the-job appraisal to validate assessor capabilities.
Prior to a clinical assessment delegate approving their first service recommendation, the delegate is competent to approve service recommendations.	Completion of training outlined in the My Aged Care Workforce Learning Strategy 2024 (and subsequent versions) and mandatory online learning on the My Aged Care Learning.
Prior to a triage delegate triaging their first assessment referral, the delegate is competent to undertake triage.	Completion of training outlined in the My Aged Care Workforce Learning Strategy 2024 (and subsequent versions) and mandatory online learning on the My Aged Care Learning.
All non-clinical assessors are competent in seeking clinical attendance in the event they trigger clinical questions in the Integrated Assessment Tool (IAT)	Completion of training outlined in the My Aged Care Workforce Learning Strategy 2024 (and subsequent versions) and mandatory online learning on the My Aged Care Learning.
Relevant staff are qualified to undertake a clinical role.	Staff who are recruited to clinical roles within the assessment organisation meet the qualification requirements outlined in the assessment organisation's contractual agreement.

Element 3: Provide clinical support to assessors

Clinical Support Requirement	Implementation
Provide ongoing support for assessors in the field	Provide ongoing clinical governance support for assessors in the field including providing peer support and advice on emerging and specific issues as well as providing supervision to non-clinical staff during the clinical attendance process and in finalising support plans. Ongoing support is provided through various communication channels via the assessment organisation's standard operating procedures.

Element 4: Monitor assessment quality and drive continuous improvement

Clinical Support Requirement	Implementation
Clinical staff are supervised and mentored by a clinically trained Team Leader	Team leaders regularly engage with triage delegates, assessment delegates and assessors in peer review processes
Staff receive regular feedback about the quality of their assessments and the performance of their organisation	Assessment organisations measure and report the extent to which it achieves the quality standards, and quality goals included in the Aged Care Assessment Quality Framework. The Assessment organisation's leadership team use quality assurance data to drive continuous improvement in clinical governance policies and processes. The Assessment organisation actively participates in any external evaluation or quality assurance processes.

Element 5: Build relationships to foster innovation and continuous improvement

Clinical Support Requirement	Implementation
Build effective working relationships with local support services	Implement systems and processes to ensure positive communication between service and care providers within the aged and health care systems.
Foster an organisational culture of regular and effective communication that addresses risks and issues and promotes continuous improvement	Assessment organisations hold regular team meetings/teleconferences to address issues arising, share experiences and clinical expertise (including case study discussions)
Assessment Organisation's representatives participate in relevant forums organised by the Department	Assessment organisations must send representatives in person to attend forums for assessment organisations as organised by the Department.

APPENDIX 3 – CLINICAL ATTENDANCE

Questions in the IAT that require clinical attendance

IAT Clinical Questions	When these questions will be triggered	Detail
Advanced Medical Assessment section	Answers 'Moderately' or 'Quite a bit' to Q Impact of health issues on normal activities.	This question set identifies whether the client has had recent contact with a GP and/or has regular health checks, has been admitted to hospital in the past 12 months and whether the older person has and/or has had allergies and/or sensitivities such as food, medication and environmental allergies and/or sensitivities. See IAT User Guide: [Integrated Assessment Tool user guide (health.gov.au)](health.gov.au)
Urinary incontinence and Revised Urinary Incontinence Scale (RUIS)	Answers No to 'Is the client managing urinary incontinence issue?'	An assessor should use the RUIS to assess urinary incontinence. Urinary incontinence refers to the involuntary loss of bladder control. The severity can vary, including occasional leakage of urine when coughing or sneezing. It would become an issue at the more severe end when a client often experiences a sudden and strong urge to urinate (urgency) that doesn't allow enough time to reach a toilet. Continence is a sensitive and private issue. The assessor must use clinical judgement to determine the

IAT Clinical Questions	When these questions will be triggered	Detail
		appropriateness of administering the RFIS with the client at assessment. [Urinary incontinence | healthdirect](#) [(PDF) Technical Manual and Instructions: Revised Incontinence and Patient Satisfaction Tools, Version 2 (researchgate.net)](#) [(tool on pg 27)](#)
Bowel incontinence and Revised Faecal Incontinence Scale (RFIS)	Answers 'No' to 'Is the client managing bowel incontinence issue?'.	[Technical Manual and Instructions for Revised Incontinence and Patient Satisfaction Tools 1 (anzctr.org.au)](#) An assessor should use the RFIS is used to assess faecal incontinence. Continence is a sensitive and private issue. The assessor must use clinical judgement to determine the appropriateness of administering the RFIS with the client at assessment.
GPCog- Step 2 and extended cognitive assessment	If the client has answered any of the Qs in GPCog- Step 1 incorrectly.	The GPCog- step 2 and extended cognitive assessment is a screening tool for cognitive impairment. It builds on the questions asked in GPCog- step 1. [GPCOG | Home](#)

IAT Clinical Questions	When these questions will be triggered	Detail
		[The GPCOG: A New Screening Test for Dementia Designed for General Practice](#) (Step 2 Qs at bottom of the journal article)
Extended Behaviour Assessment	Answers YES to the question. *Are there any reported changes in the client's personality?*	This question set identifies changes in an older person's behaviour across several behavioural types. See IAT User Guide: [Integrated Assessment Tool user guide (health.gov.au)](#)
Advanced Psychological Assessment (PHQ-4)	If there is a total score of three or more from the first two PHQ questions (Feeling nervous, anxious or on edge AND not being able to stop or control worrying), additional questions on advanced psychological assessment will be prompted.	This question set identifies the extent to which an older person experiences psychological distress. See IAT User Guide: [Integrated Assessment Tool user guide (health.gov.au)](#)
Geriatric Depression Scale (GDS)	Additional question in advanced psychological assessment. Answer 'yes' to *Do you want to complete the Geriatric Depression Scale?*	The GDS is a basic screening measure for depression in older people. [Geriatric Depression Scale (stanford.edu)](#)

Client scenarios — clinical attendance

Meet Clyde

Clyde is 78 years old and needs some extra support so that he can continue to live in his home. He applies for an aged care assessment through My Aged Care. When Clyde is contacted by the assessment organisation, he is asked some preliminary questions (known as triage) before his assessment is scheduled. Clyde has heard some bad stories recently about residential aged care and he is worried that the assessment will result in him moving into an aged care home. Clyde feels nervous when answering the questions at triage and he doesn't fully disclose his health concerns during the conversation.

Clyde is triaged for a home support assessment. A non-clinical assessor is assigned to undertake the assessment, and travels to Clyde's home. During his assessment, Clyde answers some questions which trigger questions that require clinical judgement. The assessor explains to Clyde that there are some questions that will need to be asked with a clinical assessor, who they can call on their tablet. Clyde agrees and a clinical assessor is video called. Clyde and his assessor explain his situation to the clinical assessor, and the IAT questions that have been triggered. Together, the assessors undertake the whole assessment and record Clyde's needs in the IAT.

When the non-clinical assessor gets back to the office, they finalise the assessment, consulting with the clinical assessor to make the recommendations. Clyde is found eligible for Home Care Package services. The assessor converts the assessment to a comprehensive assessment. Clyde's assessment is finalised and is sent to an assessment delegate for approval.

Meet Jane

Jane is 70 years old and lives alone. Jane and her family have spoken about her needing some support to help with home duties. Jane has chronic arthritis and sometimes this can affect her activities. At the time she first speaks to an assessment organisation about her health and abilities (triage), the weather is warm, and Jane is feeling good. Her arthritis is not affecting her day-to-day activities.

Jane is triaged for a home support assessment. A non-clinical assessor is assigned to undertake the assessment, and travels to Jane's home. On the day of the assessment, the weather is cold, and Jane isn't feeling as well as she did at triage. During her assessment, Jane answers a question which triggers a question set that requires clinical judgement. The assessor knows that a clinical assessor is not available to be in attendance during the assessment. The assessor selects 'no' to the declaration and makes a note of the questions that are triggered. The assessor explains that they can only ask certain questions in the assessment today and that some questions will need to be asked with a clinical assessor at a later time. The assessor asks the questions that do not require clinical judgment. The assessment concludes.

When the assessor gets back to the office, the assessor speaks to their Team Leader or a clinical assessor about the assessment. At this stage it is determined that the clinical assessor can complete the clinical questions by calling Jane and asking the questions raised during the assessment. The original, non-clinical assessor arranges a time to contact Jane with the clinical assessor to ask the remaining questions. Together they finalise the assessment and although the clinical questions were triggered during the assessment, Jane is found eligible for CHSP services.

Meet Alex

Alex loves working with older people and is excited about their new role as a non-clinical aged care needs assessor. Alex arrives at the house of an older person to undertake a home support assessment. Alex is welcomed inside, and they note straight away that the older person's needs seem more complex than what was recorded at triage.

Not long into the assessment, a clinical question is triggered that requires clinical judgement. Alex explains to the older person that there are some questions that they will need to ask with the support from a clinical assessor who they can call on Alex's phone. The older person agrees and a clinical assessor is called. Alex explains the situation, including the clinical questions that have been triggered. The clinical assessor considers the questions that have been triggered, Alex's experience as an assessor and the older person's situation. Based on these factors, the clinical assessor advises that it would be best for a clinical assessor to undertake the whole assessment.

Alex concludes the assessment and the older person's assessment is reassigned to a clinical assessor with high priority which occurs on another day.

APPENDIX 4 – REASSESSMENT (For services under the Aged Care Act 1997)

While an Assessor should always check whether a reassessment is required for unusual cases, Table 14 is a resource to guide when a reassessment is required for a comprehensive assessment on or after 1 July 2009 for approvals that are not time limited. Also disregard any periods when the person is on leave under the Act. For approvals prior to 1 July 2009, please seek advice from your team.

Approval	Is reassessment required?	Changes to legislation
High level residential care	**No** – for approvals dated on or after 1 July 2009.	Lapsing of approval for high level residential care was removed on 1 July 2009. On 1 July 2014 approval for low and high levels of care was removed and care type became permanent residential care which does not lapse. From 20 March 2008, a person's approval for residential care did not lapse if they left a residential care service and re-entered care within 28 days.
Low level residential care	**Yes** – if approved on or before 30 June 2013 and the person did not enter care within 12 months of the approval. **Yes** – for approvals dated on or before 30 June 2013: if there was a break in care for more than 28 days between 20 March 2008 and 1 July 2014, and after the 12 month entry period had ended.	On 1 July 2014 approval for low and high levels of care was removed and care type became permanent residential care which does not lapse. Prior to 1 July 2014, section 23-3(1) of the Aged Care Act 1997 (Cth) provided that an approval lapsed if the person did

Approval	Is reassessment required?	Changes to legislation
		not enter care within 12 months.
		From 20 March 2008, a person's approval for residential care did not lapse if they left a residential care service and re-entered care within 28 days.
Permanent Residential care	**No** – this care type does not lapse.	This care type was introduced on 1 July 2014 to replace approval for levels of care in permanent residential care (high and low). Since 1 July 2014, this does not lapse
Residential Respite Care	**No** – for approvals dated on or after 1 July 2009. **Yes** – if there has been a change to the person's care needs and they need a higher residential respite funding classification. .	Lapsing of approval for respite care (at any level) was removed on 1 July 2009 A new process for classification of residential respite care funding was introduced from 1 October 2022 under section 35 of the Classification Principles 2014. Reclassifications are a reassessment of the care recipients care needs using the DEMMI-modified.
Home Care Level 1 or 2 or 3 or 4	**Yes** – if there has been a change to the person's care needs and they need a higher level of care.	Home Care for Level 1 and 2 was introduced on 1 August 2013 and replaced Community

Approval	Is reassessment required?	Changes to legislation
		Aged Care Packages (CACPs)
		Home Care for Level 3 and 4 was introduced on 1 August 2013 and replaced Extended Aged Care at Home (EACH) and Extended Aged Care at Home – Dementia (EACH-D)
		Removal of broad banding for home care was introduced 27 February 2017. A person who was eligible for Levels 1-2 home care was taken to be eligible for level 2, and a person who was eligible for levels 3-4 home care was taken to be eligible for level 4.
Home Care Priority	**Yes** – if the person's care needs warrant a change. The Secretary may vary the person's priority for home care services at any time under section 22-2A.	Home Care priority was introduced 27 February 2017
CACP	**Yes** – if approved on or before 31 July 2012 and the person did not commence receiving care within 12 months of the approval.	This care type was replaced by Home Care on 1 August 2013
EACH and EACH-D	**No** – for all approvals for EACH and EACH-D dated on 1 July 2008 or later.	Lapsing of approval for EACH and EACH-D was removed on 1 July 2009. This care type was replaced by Home Care on 1 August 2013

Approval	Is reassessment required?	Changes to legislation
Transition Care	**No** – if the client enters hospital from transition care for longer than an overnight stay, concludes their hospital episode and re-enters transition care (from hospital) within the 4 week entry period. Yes – if care is not provided within 4 weeks from the day after the approval date. **Yes** – if there is a break in care of at least one day after the 4 week entry period. **Yes** – a comprehensive assessment may be necessary if the transition care episode is to be extended. A transition care episode may be extended from 84 days up to a maximum of 126 days. A reassessment may be needed if the delegate is not satisfied with the information about the care recipient's further transition care needs supplied by the service provider in the extension request.	

Approval	Is reassessment required?	Changes to legislation
STRC	**Yes** – if the client is not provided with STRC within six months from the day after the approval date. **Yes** – if there is a break in care of at least one day (excluding a suspension of care, provided care has not been suspended for more than seven days during the episode) after care commences. **Yes** – if the client commences another type of care under the Act (residential, flexible or home care). **Yes** – if the short-term restorative care episode ends.	The *Aged Care Act 1997* (Cth) (the Act), and its subordinate legislation (*Approval of Care Recipients Principles 2014, Subsidy Principles 2014*) provide the legislative framework for the administration and delivery of the STRC Programme.
Flexible care in an MPS (multi-purpose service) or Innovative Care	A person does not need to be approved to receive care in an MPS or innovative care service. However, the person might happen to be approved for residential care or home care. If a person wishes to leave the MPS/innovative care service to enter a mainstream residential care service or to begin receiving home care, the assessor will need to check whether there is an existing approval and determine whether a new approval is needed.	Under the *Subsidy Principles 2014* the following persons do not need approval for flexible care: people who receive flexible care through an MPS, and people who receive flexible care through an innovative care service.

APPENDIX 5 – SUPPORTING INDEPENDENCE (WELLNESS & REABLEMENT)

Introduction

My Aged Care has been established to support frail older people to maximise their independence and enable them to remain living safely in their own homes and communities. The role of the assessor is to work with the client to develop an individualised Support Plan so the client can focus on their own strengths and goals to better support their continued independence. This means assessors should not refer the client for services they can do safely for themselves. The longer a client avoids reliance on ongoing services, the longer they are likely to maintain their functional independence, giving them more good days doing the things that matter to them most.

This approach (known as wellness and reablement) builds on people's strengths and goals to promote greater independence and autonomy, and it starts with the assessment. Referring for support that focuses on individual client goals and recognises the importance of client participation is fundamental to aged care.

Why Wellness and Reablement?

Over the past decade, emerging research has demonstrated the benefits of focussing on client independence. Traditional models of service delivery that focus on what a client can't do rather than what they can, leads to an over-reliance on services by clients, which has been linked with accelerated functional decline.

Understanding the ageing journey

Research suggests the largest influencer in age-related decline is not genetics, but rather lifestyle choices. People who continue to do things for themselves tend to remain independent and live better, longer.

Professor Peter Gore of the Institute of Aging at Newcastle University in the United Kingdom has developed a framework to understand the age-related decline. The framework, called the LifeCurve™, looks at the impact of maintaining independence on quality of life and the rate of age-related functional decline. It illustrates that the sooner someone stops performing certain tasks for themselves, the faster they tend to lose their functional ability. The aim is to assist people to perform these daily tasks independently for as long as possible, to maximise independence and autonomy. Retaining physical ability helps people to continue doing the things they enjoy for longer.

The LifeCurve™ is shown at **Figure 1**. The vertical axis lists activities of daily living that older people generally lose over time, in the order in which they tend to be lost, from top to bottom, with the horizontal axis representing elapsed time. The timeframe for this decline is variable and can be influenced by behaviour and interventions. For example, difficulty cutting one's toenails is typically seen as an early indicator that intervention may be needed. The graph shows two trajectories:

- a sub-optimal life curve with a fast early decline; and an optimal life curve in which the early decline is slowed down to give people more good days before losing the ability to undertake activities like walking, shopping and personal care.

Figure 1:
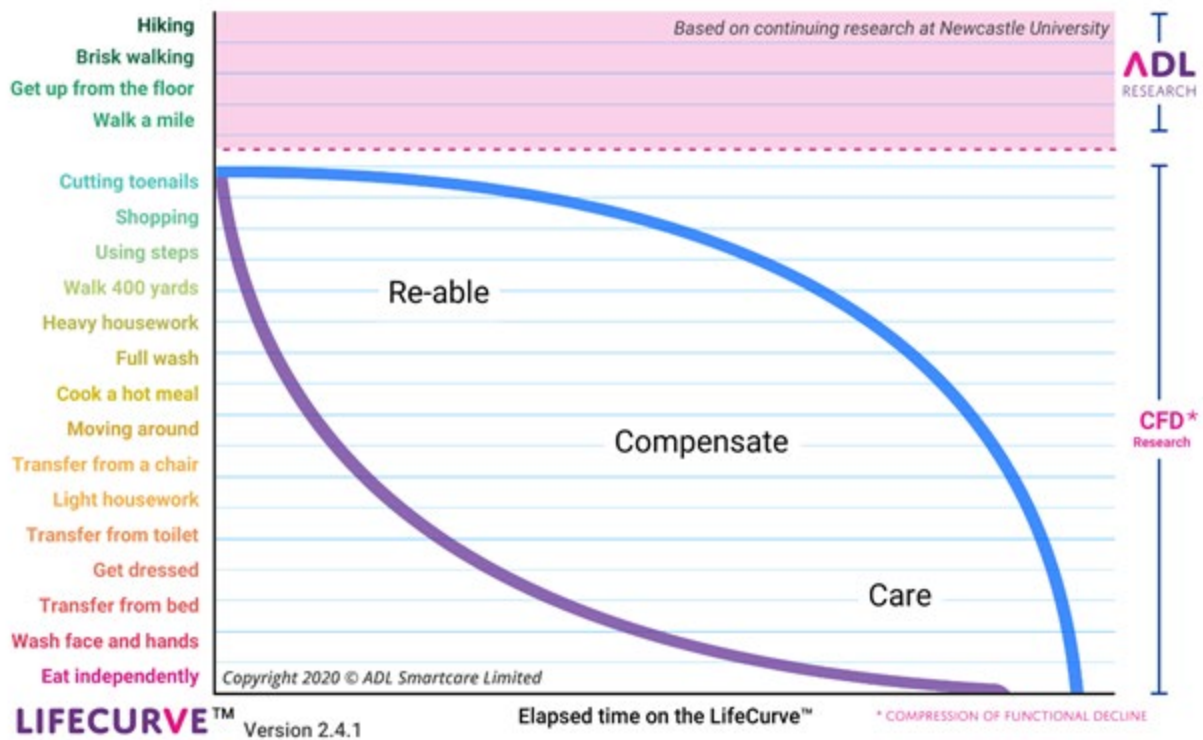
The LiveUp website enables Australians over 65 years of age to check their health and find personalised suggestions for products and services that promote healthy ageing. LiveUp can suggest low-cost assistive products and equipment to help people with everyday living, as well as personalised exercises and services, to help them or a loved one with age-related wellbeing.

At the LiveUp website anyone can download the free LifeCurve™ that can track a person's health, giving them easy to understand long term advice tailored to their needs. To learn more about LiveUp, go to www.liveup.org.au or call 1800 951 971.

Benefits of a wellness and reablement approach

Older Australians are not the only ones who benefit from wellness and reablement. Evidence suggests there are also significant benefits to assessment organisations, service providers, families and carers, and the broader community.

Benefits for consumers

Implementing a wellness and reablement approach at the earliest opportunity (with a focus on client goals to maintain or regain functional capacity and social connectedness) can have significant long-term benefits for clients including:

- clients appreciate being asked what is important to them, and to be included in decision-making
- improved sense of purpose, autonomy and self-worth
- improved physical and emotional health and wellbeing
- reduction in service delivery needs
- increased ability to remain living independently and safely in their own homes for longer
- greater quality of life and retention of pride and dignity
- improved connection with community; and
- reduced strain on family and carer relationships.

Benefits for home support assessment organisations

Reablement focused assessment has flow on benefits for aged care organisations as they can better utilise support workers to focus on more complicated tasks that their clients can't perform for themselves, resulting in more meaningful and fulfilling work. Importantly, it enables providers to broaden their client base by offering more short-term support by freeing up longer term service provision. All of which better aligns to aged care reform initiatives and improving the ability to assessment and provider organisations to respond to changes in aged care policy.

Implementing wellness and reablement provides significant benefits for assessors and their clients including:

- reablement focussed (active) assessment better demonstrates need. This benefit extends to clients with poor reablement prospects, as active assessment better identifies if ongoing services are needed, or if short-term reablement support will help the client get back to previous levels of independence
- reablement focussed assessment provides a more holistic approach to assessment
- greater job satisfaction by actively helping clients to identify goals and become more independent; andimproved business reputation based on providing person-centred, holistic assessments that focus on individual client goals, needs and preferences.

Benefits for families and carers

Wellness and reablement approaches can have significant benefits for family members and carers, including:

- an opportunity to be involved in supporting their loved one to reach their outcomes
- the benefit of knowing their loved one is retaining or regaining their independence; and
- reduced strain and pressure due to a decrease in caring requirements

Client scenarios — Applying a wellness and reablement approach

HARRY is a 70-year-old man who lives alone. After contacting My Aged Care, a face-to-face home support assessment was undertaken which identified Harry needed some assistance with clothes-washing and meals. The assessor applied a wellness and reablement approach in the assessment, asking Harry to show how he performed tasks around the home, observing what he could do for himself and asking him what goals he wanted to achieve.

At first, Harry didn't know what to say. He thought he was too old to set new goals, but indicated he was open to doing the cooking. Harry said he lacked confidence and skills as his wife, who recently passed away, had always done most of the cooking. With this information, the assessor referred Harry for support with planning his grocery shopping and meal preparation. With this support, Harry could work out what he wanted to cook, plan his shopping to obtain the necessary ingredients, and then helped his support worker prepare the meals while receiving basic cooking instructions.

Learning these skills built Harry's confidence to manage his shopping and cook his own meals, increasing his independence and quality of life.

During the assessment, the assessor also encouraged Harry by helping him identify task simplification strategies to do the laundry with some support. Instead of referring for domestic assistance three times a week, the assessor advised Harry to wash and hang his clothes using a trolley and an easy-to-reach drying rack inside, instead referring him for once-a-week support to help him hang out heavier washing, like sheets and towels.

ELSA is a 72-year woman with osteoarthritis who has been receiving domestic assistance under the CHSP for two hours a week to provide assistance with general housework and laundry. Elsa required no other assistance.

During a Support Plan Review, the non-clinical assessor applied a wellness and reablement approach to Elsa's continuing needs, asking Elsa to demonstrate how she completed light household chores such as dusting, wiping over surfaces, washing the dishes and using a lightweight carpet sweeper.

Applying a reablement approach, over a two-month period instead of 'doing for', Elsa was encouraged to undertake some of these tasks by herself, whilst the support worker completed more difficult tasks, such as vacuuming and mopping.

Elsa still requires ongoing support; however, she is now more involved and independent, has increased activity levels, and feels more satisfied about continuing to live at home.

Principles of wellness and reablement

Wellness and reablement describe an overall approach to service delivery. The following principles underpin a wellness and reablement approach.

- **Promote Independence** – people value their independence, loss of independence can have a devastating effect, particularly for older people who may find it more difficult to regain.
- **Identify clients' goals and motivation** – a person's independence requires more than just services to help them remain in their home and maintain their current capacity. Service delivery should focus on supporting the client to actively work towards their goals and improved independence wherever possible.
- **Consider physical and psychological needs** – independence is not limited to physical function, it includes both social and psychological function.

Encourage clien**t participation** – being an active participant, rather than a passive recipient of services, is an important part of being physically and emotionally healthy. Service delivery should focus on assisting a person to complete tasks, not taking over tasks that a person can do for themselves.

Regular assessment – client assessment should be ongoing, not one-off. It should focus on progress towards client goals and consider the support and duration of services required to meet these goals.

Focus on strengths – the focus should be on what a person can do, rather than what they can't. Wherever possible, services should aim to retain, regain, or learn skills rather than creating dependencies.

Support clients to reach their potential – help clients to maintain and extend their activities in line with their capabilities.

Individualised support – service delivery should be individualised and suited to the goals, aspirations and needs of the individual.

> **HELEN** is a 78-year woman with osteoarthritis. Lately, Helen has experienced difficulty performing household cleaning duties and doing her laundry. At assessment, the assessor undertook a reablement-focussed (active) assessment to better identify Helen's needs.
>
> By asking Helen to show the assessor how she did her housework (active assessment), the assessor identified still lighter tasks that Helen could still complete, but certain tasks impacted her arthritis. During the assessment, the assessor asked Helen what she enjoys and the goals she would like to achieve. Helen identifies she used to enjoy keeping her home clean and tidy but is feeling lonely because she worries visitors may think she isn't coping around the house as well as she used to.
>
> *Helen cont*. In working with Helen to develop a Support Plan, the assessor focusses on Helen's strengths and the things she wants to regain/maintain. As a result of the active

assessment, the Support Plan refers Helen for short-term reablement support over a two-month period where Helen does lighter housework while the support worker completes tasks that provoke Helen's arthritis, such as vacuuming and mopping.

Although Helen requires ongoing support with more difficult domestic duties, she has improved her functional capacity and feels more like herself. By adopting a strength-based approach to assessment and service delivery, focusing on 'doing with' not 'doing for', Helen is able to maintain some physical activity and by regaining some independence she is feeling more fulfilled and capable. Helen has begun engaging with her friends again which has improved her social connectedness.

Time-limited support

Wellness and reablement approaches often involve time-limited services. Time-limited care aims to address a client's specific barriers to independence and support them getting back to doing things for themselves. This involves a targeted timeframe, developed with the client, for achieving their goals.

Understanding what a good day looks like for a client and how it relates to their individual goals and outcomes is important for determining short-term support needs. This could be maintaining a level of activity or independence or working towards regaining it. Time-limited reablement services tend to be delivered within a 12-week period with the aim to wrap up services when the client has met their goal or specific outcome.

Restorative care services may also be involved where the client has the potential to make a functional gain. Restorative care involves the delivery of evidence-based interventions led by an allied health worker or health professional that allows a person to make a functional gain or improvement after a setback, or to avoid a preventable injury. These interventions may be delivered one-to-one or as group services and may involve a multi-disciplinary approach that goes beyond CHSP services, for example, involving primary health care providers. These services are coordinated by providers of allied health and therapy services based on clinical assessments of the clients.

Other time-limited support could include:

- training in a new skill or actively working to regain or maintain an existing skill
- modification to a person's home environment; or
- having access to equipment or assistive technology.

Wellness and reablement obligations and supports

As part of applying a wellness and reablement approach assessment organisations are required to:

- ensure that assessment referrals are targeted towards assisting clients to achieve their agreed realistic goals as outlined in the Support Plan
- apply a 'doing with' instead of 'doing for' approach where possible, offer time limited interventions
- monitor changes in client needs and regularly review Support Plans
- comply with wellness and reablement reporting requirements; and
- have an implementation plan outlining their organisation's approach to embedding wellness and reablement.

The department has developed online resources to help CHSP service providers embed wellness and reablement approaches into their practices and service delivery. This includes the Community of Practice used as a tool for providers to learn, share and engage with other providers across the CHSP sector. It is an online forum to support the sharing of ideas, best practice and practical examples to embed wellness and reablement into everyday service delivery practices.

Members of the CHSP online reablement community are able to: find information; ask questions; start discussions; post articles and other relevant information on wellness and reablement.

The CHSP Reablement Community of Practice can be found on the website at www.more-good-days.com.au.

Client scenario – Supporting greater independence[6]

ADELINA is a 77-year-old woman who had a stroke which affected her left side. Her speech was unaffected, but her movement was restricted. She has little function in her left arm - her left leg is slightly affected, requiring her to walk with the assistance of a stick.

Adelina felt that she was unable to do very much for herself. She really wanted to be able to make her own cup of tea, however because of the lack of function in her left arm she felt she was dependent on carers and unable to make a cup of tea between carer visits unless a friend or neighbour came by. Adelina had become resigned that this was how her life would be. She was dispirited and resistant to her son's suggestion that she might do a bit more for herself.

However, at the request of her son, Adelina's Support Plan was reviewed by the assessor who recommended a referral to an occupational therapist. An occupational therapist was engaged under the CHSP who suggested she could be assisted to learn to use the microwave oven, and a kettle fitted onto a tipper so she could make her own tea.

For a number of weeks, Adelina was supported to build up her confidence in her ability to use the microwave and the kettle. After a few months Adelina was able to make meals for herself, her own cup of tea and is living a more independent life. As a result, Adelina said she is feeling more hopeful and has started to invite friends over for a meal. Adelina's son has been delighted to see his mother's renewed sense of self and independence.

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[6] Wellness Approach to Community Home Care Information Booklet July 2008 produced by the Western Australian Department of Health

Strategies to assist embedding Wellness and Reablement

Experience of organisations that have successfully embedded a wellness and reablement approach suggests that there are a number of key drivers for success. These include:

- a whole-of-organisation approach, including commitment from both management and staff reflecting wellness and reablement in organisational policy and procedures, especially in recruitment, employment, orientation and induction practices

- providing and encouraging staff training and education program

- changing the mindset for management, staff, volunteers, clients and their families and carers

- establishing a staged approach to implementation and taking time to work with staff at the beginning of the process to ensure they understand the benefits and reasons for change.

- understanding your organisations maturity and readiness in terms of wellness and reablement is the first step to embedding the change; and ensuring communication materials need to reflect the wellness and reablement approach to assist with setting client and staff expectations.

Client scenarios — Short-term wellness and reablement, and restorative interventions

DAVID is an 81-year-old man who was referred to My Aged Care following a fall he had two weeks prior. Although he sustained no specific injuries, David was quite shaken following the fall, and now lacked confidence to shower himself independently.

David was referred for an assessment which identified that David was previously independent and was motivated to regain autonomy. The assessor also identified that David was still independent in many daily activities, but was struggling with his personal care.

Based on the assessment, a Support Plan was developed with David which identified his goal of being able to maintain his personal care independently. The support plan provided information on David's strengths and abilities, as well as his areas of difficulty and recommendations to achieve his goals. This included a referral to a CHSP service provider for an occupational therapy assessment, and the delivery of time-limited personal care services.

The occupational therapist used the support plan to work with David and his personal carer to achieve his goals. Initially, personal care services were provided to David three times a week to assist him with showering. Over a four-week period, the CHSP service provider worked with David to develop specific strategies such as how to step in and out of the shower safely, to help him to build his capacity and regain confidence in showering. After four weeks of service David was confident to shower independently again, and the services were withdrawn.

BILL is a 75 year old man who lives at home with his wife Irene. Bill had not previously received any aged care services since he and Irene had always enjoyed good health. Recently Bill had an accident which had resulted in him spending time in hospital. Although Bill recovered well from his accident, it had left him feeling anxious about leaving the house. Also, his hospital stay and inactivity had reduced his physical fitness, preventing Bill from doing as much around the house and garden as he had done before.

Bill's wife Irene contacted My Aged Care and Bill was referred for an assessment. Bill's assessor worked with him to identify the things that he liked to do and what he no longer felt comfortable doing. A Support Plan was developed with Bill, which included some time-limited interventions with a restorative care focus, including referral:

*to physiotherapy or exercise physiologist (to develop a suitable strength, balance and endurance program)

*to an occupational therapist (to identify energy conservation strategies and/or suitable equipment to promote functional independence)

*for some time-limited home maintenance and domestic assistance.

Following this time-limited support, Bill now feels more confident living at home and has regained much of his former capacity to undertake the home maintenance and domestic chores that he used to do. Applying this short-term restorative care intervention approach enabled Bill to regain his strength and confidence and prevented a possible longer-term dependence on ongoing support services.

Assessment and Support Planning

The role of the assessor is to work with the client to identify their needs and concerns, as well as their goals and aspirations. As part of the Integrated Assessment Tool (IAT), the assessment must include the client's:

- current level of support (formal and informal) and engagement
- carer availability and sustainability
- health concerns and priorities
- functional status
- psychosocial and psychological concerns, and
- home and personal safety considerations.

The assessor then works with the client to develop a Support Plan which focuses the support needed to assist them to achieve their goals. In developing a Support Plan with a client the assessor will:

- Focus on what a client can do and discuss what they need to complete more difficult tasks, such as breaking down into simpler components.

Discuss strategies to manage day-to-day tasks (e.g. transport planning to meet goals around the use of public transport to maintain usual activities).

- Explore the client's opportunity for supporting independence through wellness and reablement approaches (e.g. can the client benefit from time-limited support and/or the use of specific aids and equipment or home modifications such as installing shower rails to build confidence and independence).

Developing a Support Plan with the client helps to ensure that it accurately reflects the client's needs and achievable goals and discusses with the client the role they will need to play to achieve them how they feel about this (motivation). This will increase the likelihood that the client will be motivated to work towards the goals they have identified, including supporting their independence through wellness and reablement approaches.

In some circumstances, where the assessment has identified that a short-term intervention is appropriate, the assessor organisation is required take on a coordination role to ensure that all referrals in the Support Plan are linked to one or more service providers and that they will all be delivered within an agreed time frame.

For clients receiving wellness and reablement support, assessors should include review dates on the client's Support Plan to monitor the client's progress towards their goals and desired outcomes. The need for ongoing, or an adjustment in services will also be assessed. In these circumstances, CHSP service providers are required to provide time limited services in line with your Support Plan.

Client scenario – wellness and reablement-focused assessment with support planning

> **CECELIA** is an 81-year-old woman who lives alone. Before experiencing a stroke earlier in the year, Cecelia had been actively involved in her church and local community. However, following the stroke, Cecelia stopped going out on her own, fearing that her poor balance could result in a fall. Within her house she had also cut down on the heavier housekeeping tasks like vacuuming, large cleaning jobs, laundry and gardening.
>
> Cecelia was referred to My Aged Care by her doctor and following the initial registration process and triage, a face-to-face assessment was organised. Cecelia's assessment helped to identify her strengths and capabilities as well as her needs. The resulting support plan was centred around Cecelia's own goals which included getting stronger, resuming her church activities, doing more about the house and getting back out in the garden. Cecelia's support plan included:
>
> * referral to an allied health professional to assist with her goal of getting stronger,
>
> * referral to a CHSP domestic assistance service provider to provide assistance with the more difficult household chores and to help Cecelia to identify which chores she could still manage to do on her own,
>
> * assistance to identify and make contact with a pastoral care team member to discuss her continued interest in participating in church activities, and
>
> * referral to a home maintenance service for discussion and planning to convert her garden to be safer and more accessible, and lower maintenance.
>
> After mastering basic strength and balance exercises through a home exercise program designed by the allied health professional, Cecelia was eventually able to walk unaided inside her home. A more confident Cecelia then arranged a 'buddy' to drive her to and from church activities. At the same time, the CHSP domestic assistance service provider worked with Cecelia to assist her to take on some of the easier housekeeping chores enabling her to remain more active and independent. Cecelia was also delighted to find that the new raised garden beds enabled her to access and maintain her garden more safely without affecting her enjoyment of the garden.

APPENDIX 6 – ABORIGINAL AND TORRES STRAIT ISLANDER AGED CARE ASSESSMENT ORGANISATIONS

About Aboriginal and Torres Strait Islander assessments

Older Aboriginal and Torres Strait Islander people experience barriers to accessing aged care services, which can prevent them from receiving the care they need.

Aboriginal and Torres Strait Islander aged care assessment organisations will provide older Aboriginal and Torres Strait Islander people the choice of receiving culturally safe, trauma aware and healing informed aged care assessments.

A culturally safe assessment process will help to improve the experience for older Aboriginal and Torres Strait Islander people and increase their uptake of aged care services. This will support them to maintain their independence at home for longer.

The Aboriginal and Torres Strait Islander assessment pathway has been established in response to Royal Commission Recommendation 48.2.b to *'ensure, wherever possible, that aged care assessments of Aboriginal and Torres Strait Islander people are conducted by assessors who are Aboriginal or Torres Strait Islander people, or others who have undertaken training in cultural safety and trauma-informed approaches'.*

Aboriginal and Torres Strait Islander assessment organisations will work with other local Aboriginal and Torres Strait Islander community organisations such as Aboriginal Community Controlled Organisations, Aboriginal Community Controlled Health Organisations, and the Elder Care Support program. They will work together to help older people engage safely with the aged care system and help identify what supports they need.

Some Aboriginal and Torres Strait Islander assessment organisations will commence providing services from July 2025, as part of a pilot to inform the approach. Over time the service will extend its reach and progressively cover more of Australia.

Until an Aboriginal and Torres Strait Islander assessment service is available in their area, older Aboriginal and Torres Strait Islander people can receive aged care assessments in the existing Single Assessment System.

Supporting older Aboriginal and/or Torres Strait Islander people's choice and preferences

Some older Aboriginal and/or Torres Strait Islander people will prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, some may prefer the first available organisation regardless of who it is, and some may prefer to receive an assessment from a mainstream assessment organisation. This pathway supports the choice of each older Aboriginal and/or Torres Strait Islander person.

An older Aboriginal and/or Torres Strait Islander person may also wish to change or remove their preference at any time; assessors are expected to support the wishes, will and preferences of the older person.

From February 2025 new IT system functionality will be available to record if an Aboriginal and Torres Strait Islander client would prefer to have their assessment completed by an Aboriginal and Torres Strait Islander assessment organisation. This should be recorded when registering a client in the My Aged Care system and/or captured and confirmed when completing a client's demographic details during triage. It may also be recorded by an assessor during an assessment. The preference will then display in the client details as well as on the client's card.

During the establishment period, some clients will make it through to assessment without their preference captured. Information about an older person's preference to be assessed by an Aboriginal and Torres Strait Islander assessment organisation should still be captured if the Aboriginal and Torres Strait Islander assessment organisation is not yet available in the older person's area. The data collected will help to understand the demand for these services. Once Aboriginal and Torres Strait Islander assessment organisations become available, this information will be used to refer older people to these services for a reassessment or Support Plan Review.

Client Scenario – capturing the preference for an Aboriginal and Torres Strait Islander Assessment Organisation even though there is not one available in the region.

SHARON is an aged care assessor working for an assessment organisation under the Single Assessment System, who is assessing an older Aboriginal and Torres Strait Islander Client, **VIOLET**. Sharon is up to date with what organisations are available in the region and knows there is not a Aboriginal and Torres Strait Islander assessment organisation available yet; but that there may be one in future.

OPTION A: If there is no information in the FNAO preference field, Sharon needs to capture Violet's preference in case a Aboriginal and Torres Strait Islander assessment organisation becomes available in future.

"Violet, there are Aboriginal and Torres Strait Islander assessment organisations starting to provide aged care assessments across Australia from July this year (2025). I can see that there is no preference logged in your record. There is not one available in this local region yet, but there may be one in future. If an Aboriginal and Torres Strait Islander aged care assessment organisation becomes available, would you prefer to receive future assessments from them? If so, I can record your preference so that you can be directed to those services in the future"

Violet indicates that she would prefer to be transferred to a Aboriginal and Torres Strait Islander assessment organisation in the future, and Sharon records the preference then continues to conduct the assessment.

OPTION B: If there is a FNAO preference captured in the preference field. Sharon notes the preference for a Aboriginal and Torres Strait Islander assessment organisation and knows that there is not one available. Sharon understands that this would have been explained to Violet at the point of triage. Sharon continues with the assessment as planned without asking Violet to unnecessarily confirm her preference multiple times.

After the assessment Sharon advises Voilet that for continuity of care, any future reviews of her care will now come back to Sharon's organisation. Based on Violet's preferences, Sharon will keep that in place for now, and can transfer Violet to a Aboriginal and Torres Strait Islander organisation if available when the review is needed.

Providing assessment services during this transition period

Whilst Aboriginal and Torres Strait Islander assessment organisations are being established, older Aboriginal and/or Torres Strait Islander people will continue to be assessed by assessment organisations under the Single Assessment System.

If an Aboriginal and/or Torres Strait Islander client is already booked in with a Single Assessment System assessor where a Aboriginal and Torres Strait Islander assessment service has recently become available; the recommendation is that the assessor continue the assessment as planned with the agreement of the client. The client's condition needs to be taken into consideration, that their health condition and care needs would not be adversely impacted by a delay in assessment if they were to be referred to another organisation.

Any preferences for Aboriginal and Torres Strait Islander assessment organisations should be uncovered during the assessor's pre-assessment planning. This allows the assessor time to organise transferring the client prior to the assessment if needed. If this referral is cancelled by the assessor at the point of assessment, this may slow down the assessment process for the client which is not the desired outcome.

A conversation to discuss this with the client prior to the assessment is recommended, to ensure that they have choice and control and the ability to make decisions regarding their care.

If the client's preference is to be assessed by the Aboriginal and Torres Strait Islander assessment organisation, and they understand the timing impacts then the assessor can manage the referral as per current processes detailed in **Section 4.2** of this manual.

Client Scenario – prior to the assessment, the assessor sees the preference for a Aboriginal and Torres Strait Islander assessment oragnisation which has recently become available.

As Per Section 5.2.3 of this manual; assessors are expected to do pre-assessment planning prior to a client meeting.

In this pre-assessment planning, **STEVE** is an aged care assessor working for a assessment organisation under the Single Assessment System, who has an upcoming assessment with an older Aboriginal and Torres Strait Islander Client, **BILL**. Steve has had this assessment booked in for some time and knows that since the assessment was booked, a Aboriginal and Torres Strait Islander assessment organisation has become available in the area. Steve wants to get the best outcome for his client, so contacts the client in advance to talk about the availability of the service.

"Bill, there are Aboriginal and Torres Strait Islander assessment organisations starting to provide aged care assessments across Australia from this year (2025). I can see you have a preference to be assessed by an Aboriginal and Torres Strait Islander assessment organisation; and since we have had this appointment booked in, an Aboriginal and Torres Strait Islander assessment service has become available in this area.
As we are meeting soon, would you like us to continue with the assessment?

If you would prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, I can refer you to them instead. This may take time. We would connect you with the organisation, and then they willl be in touch as soon as they can to book an assessment with you. How would you like to proceed?"

Option A: Bill indicates that he would prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation in the future, but to keep the process moving given his health and care needs, would continue the conversation with Steve as planned.

Steve advises Bill that for continuity of care, any future reviews of his care will now come back to Steve's organisation. Based on Bill's preferences, Steve can keep that in place, or transfer Bill to an Aboriginal and Torres Strait Islander assessment organisation when the review is needed.

Option B: Bill indicates that he would prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, he understands that this may take time to get booked in, understands the impacts to his health and aged care needs; and is happy to wait for the referral to be re-directed. Steve makes arrangements to transfer the referral for Bill (referrals and rejections are covered in Section 4.2 of the manual).

Best practice for the client is that Steve supports the client's choice and his organisation makes contact with the Aboriginal and Torres Strait Islander assessment organisation in the region to ensure that they have capacity, and support a warm handover to transfer Bill.

Reviews and Re-assessments

During the establishment phase, some older Aboriginal and/or Torres Strait Islander people may have their initial assessment with one assessment organisation, and prefer to have re-assessments and support plan reviews conducted with a Aboriginal and Torres Strait Islander assessment organisation as they become available.

The transfer process could occur after the assessment or before the Support Plan review. The process is as per Section 4.2 of this manual, where the referring organisation makes contact with the receiving organisation to ensure a smooth transfer.

Further information
Department of Health, Disability and Aged Care website: Aboriginal and Torres Strait Islander Assessment Organisations   Supporting clients with the rollout of Aboriginal and Torres Strait Islander assessment organisations | Australian Government Department of Health, Disability and Aged Care

APPENDIX 7 – NATIONAL ASSESSMENT FRAMEWORK

The purpose of the National Assessment Framework (the Framework) is to ensure a nationally consistent approach to assessing people's aged care needs and eligibility for government-funded services. The Framework provides assurance that the aged care assessment workforce, funded by the Australian Government to conduct the processes involved in assessing a person's aged care needs, is supported appropriately, and that reporting requirements by and for organisations and government are enabled. Governance arrangements support its implementation and delivery. **Table** below includes the Framework components and sub-components.

Component	Sub-component
Workforce	Contact centre staff in the My Aged Care contact centre Assessment Organisations
Funding	Commonwealth funding to operate the Workforce
Processes	Mandatory training, developed by the Department, for all assessment staff Nationally consistent assessments Complaints Compliance Quality Assurance
Support	ICT platform that operationalises My Aged Care, including the Assessor Portal User Guides (IAT User Guide, Assessor Portal User Guide) Aged Care Assessment Quality Framework My Aged Care Assessment Workforce Learning Strategy 2024 (or subsequent versions) Departmental Administration
Reporting	Mandatory reporting Business reporting Organisation reporting
Governance	Legislation The *Aged Care Act 1997* (the Act)

Component	Sub-component
	Workforce contracts and agreements
	Internal governance within the department focussing on operational control, policy, clinical guidance and engagement with other government agencies
	External governance including with consumers, stakeholders and peak bodies and engagement with delivery partners

APPENDIX 8 – CONTACT DETAILS

Contact point	Details
Act Based Services Right of Review	A person can request a review to an assessment outcome by writing to: The Secretary Department of Health, Disability and Aged Care Attn: Single Assessment System Program GPO Box 9848 ADELAIDE SA 5001
Assessment Operational manager	Please contact your assessment organisation operational manager in the first instance for all queries and/or issues.
Authorised Representative	Authorised Representative documentation can be sent to My Aged Care by: • Uploading to the My Aged Care Online Account • Sending a digital copy via the My Aged Care online form available at: https://www.healthdirect.gov.au/myagedcareupload or • posting to: My Aged Care PO Box 1237 Runaway Bay, QLD 4216
Carer Gateway	1800 422 737
My Aged Care contact centre	1800 200 422
My Aged Care Service Provider and Assessor Helpline	1800 836 799 8am to 8pm Monday to Friday or 10am to 2pm Saturday
My Aged Care complaints	A person can make a complaint by: • calling My Aged Care on **1800 200 422** • lodging an online feedback form on the My Aged Care website at myagedcare.gov.au/contact-form • posting their complaint to: My Aged Care Complaints PO Box 1237 Runaway Bay QLD 4216

Contact point	Details
Services Australia	**1800 227 475 (Aged Care Line - consumers)**