Australian Government

myagedcare

Assessor Portal User Guide 6 - Completing an Assessment

This user guide outlines the different assessors' roles during an Aged Care assessment using My Aged Care. This includes non-clinical (who are able to complete home support assessments) and clinical (who are able to complete comprehensive assessments) assessor roles in the system.

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

- the assessor portal (this guide),
- the Aged Care Assessor app and uploading information onto the assessor portal when the assessor next has internet connectivity, or
- a printed or blank copy of the IAT and entering information onto the assessor portal after the assessment has been undertaken.

If you have only been assigned an organisation or outlet administrator role, you will not be able to view or complete assessments in the assessor portal. For more information about completing an assessment, refer to the Integrated Assessment Tool (IAT) User Guide.

! On 1 November 2025, the *Aged Care Act 2024* and the Support at Home program come into effect with significant change to support plans in the IAT.

To ensure the right IAT is used, and triage can continue for priority referrals, any assessments in the following statuses already started prior to 1 November 2025 and in progress on 1 November 2025 must be restarted:

- Triage complete, main assessment not started
- Triage complete, main assessment in progress (includes incomplete support plan)
- Main assessment completed, awaiting delegate decision (comprehensive assessments).

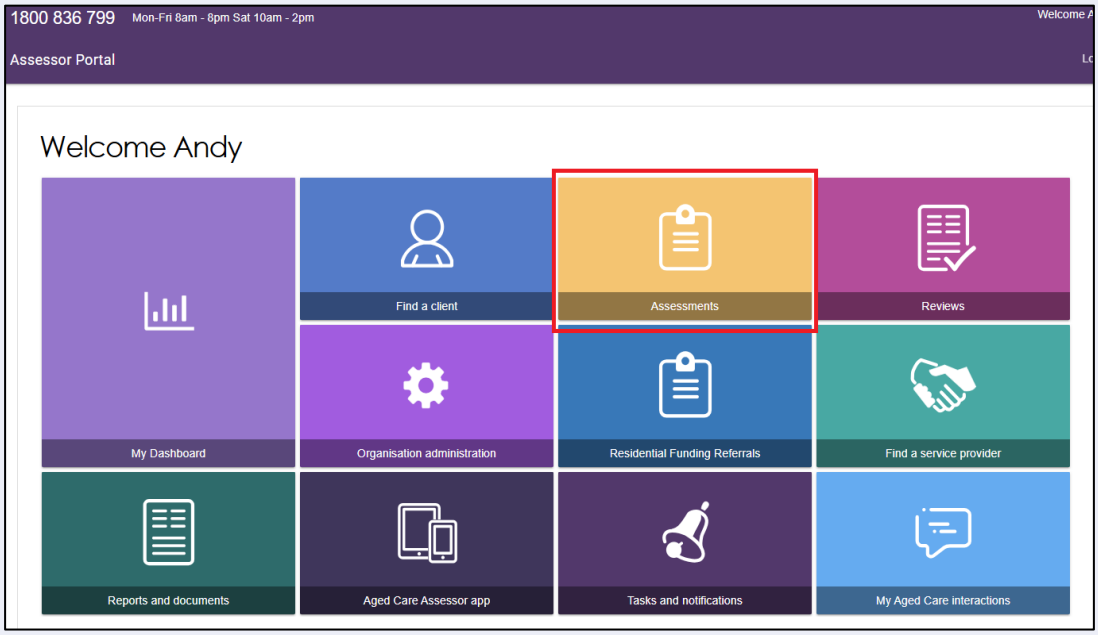
For information on the **Restart Assessment Process**, please refer to *Management of active assessments for 1 November 2025 transition – Standard Operating Procedure* and *Restarting In Progress Assessments for Support at Home* (instructional video).

CONTENTS

Viewing assessments

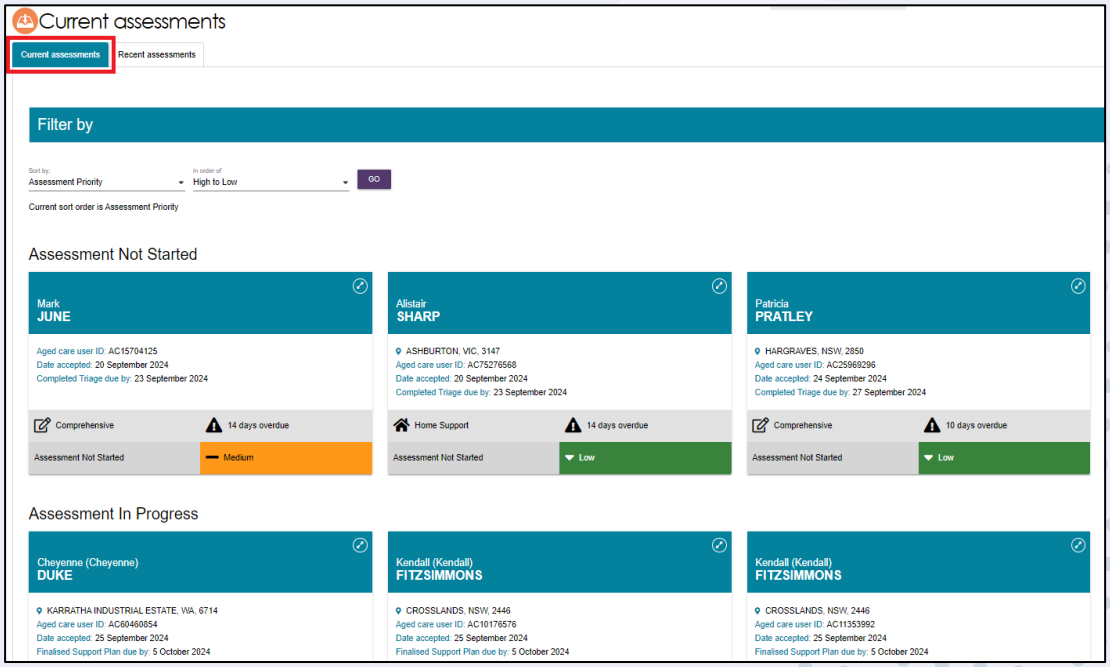
Follow these steps to view an assessment:

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



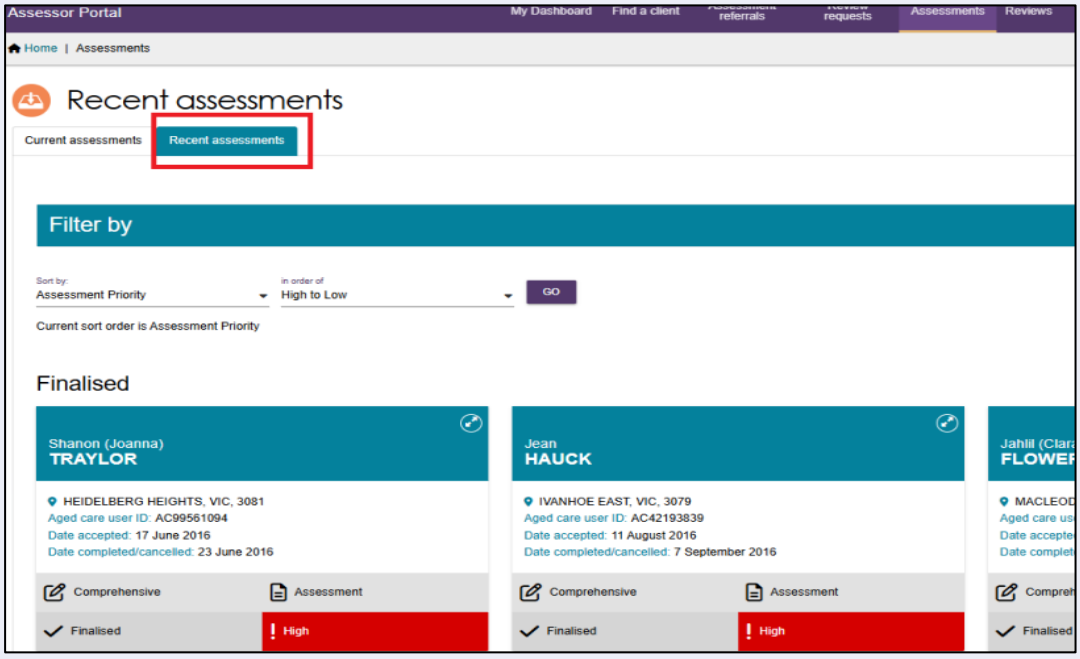
2. From the Assessments page, needs assessors will be able to view the assessments assigned to them in **Current assessments**.The **Current assessments** tab contains assessments that may have the following statuses:

   - Triage not started
   - Assessment not started
   - Assessment in progress
   - Assessment completed but not yet finalised
   - Assessment awaiting delegate decision (not applicable for reviews)
   - Delegate decision completed but not finalised (not applicable for reviews).



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

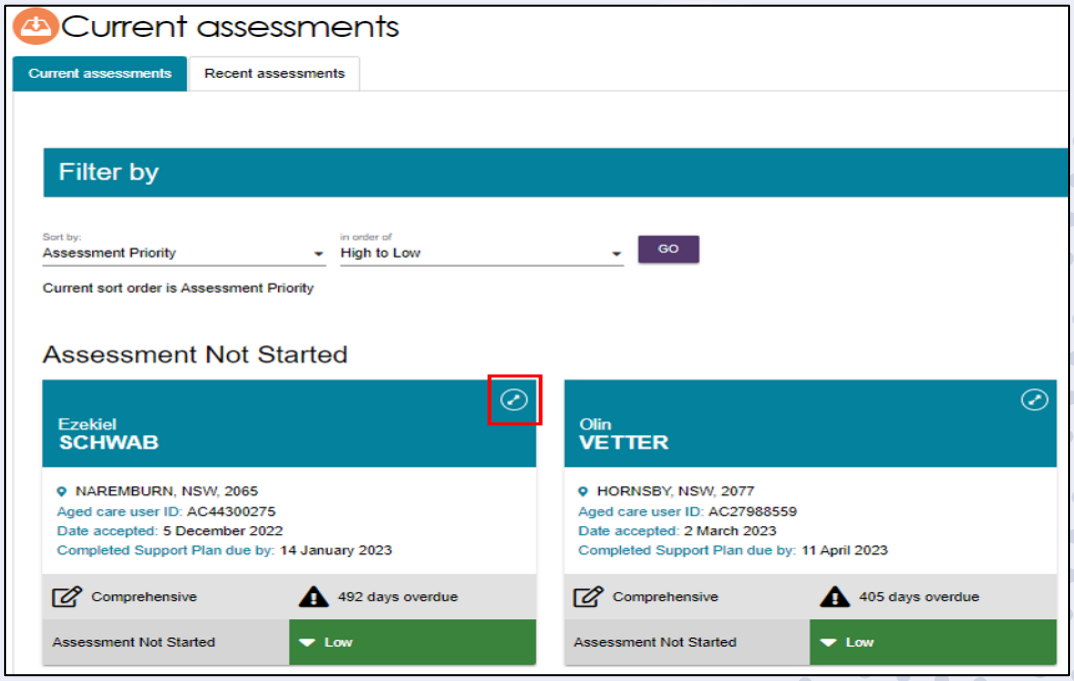
3. The **Recent assessments** tab contains finalised, cancelled and/or closed assessments. It also contains completed and cancelled Support Plan Reviews.



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

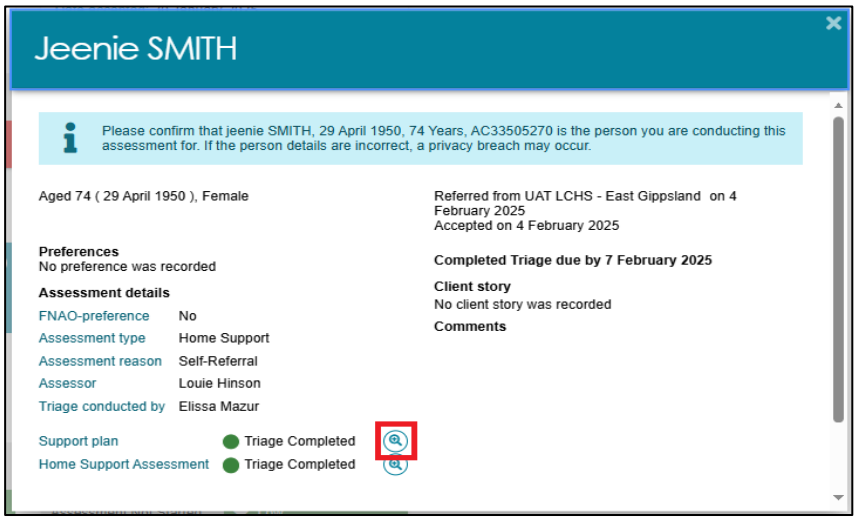
Starting an assessment

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

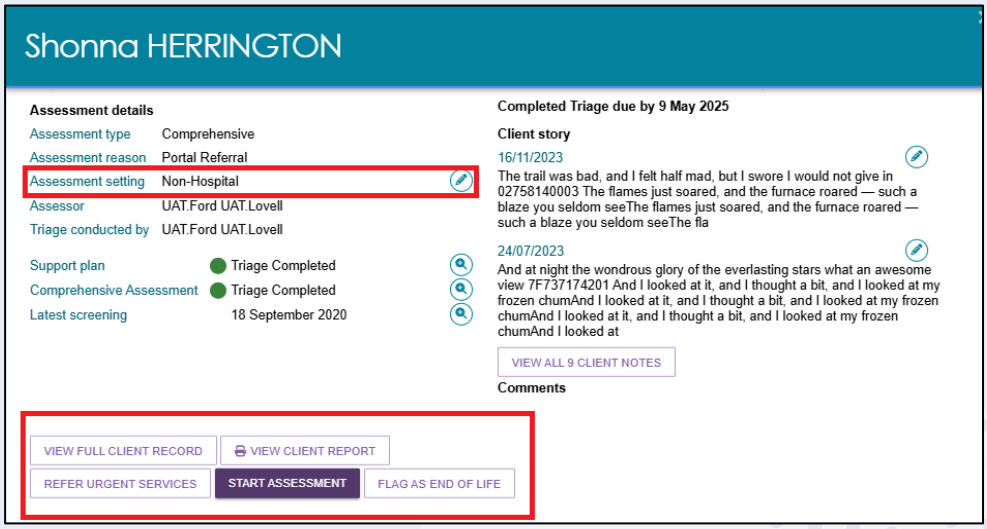


2. A summary of client information will be displayed. Assessors can access read-only versions of previous screening, triage and assessments, attachments relevant to the client's referral, and the client's support plan, if available.

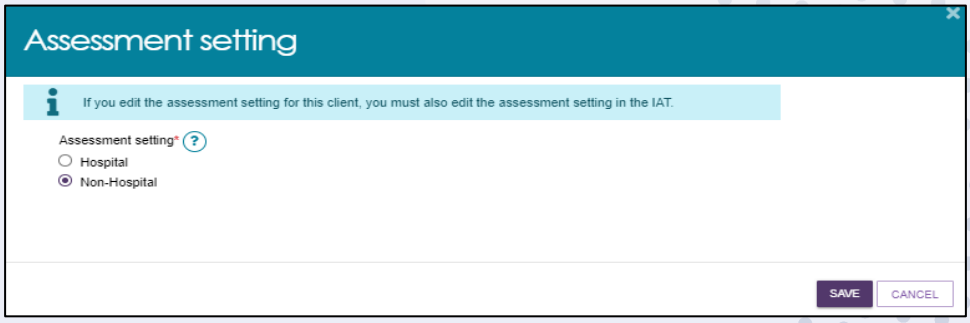
! When opening the client card, the Support plan status will be marked as **Triage Completed**. Assessors will also be able to view relevant details of both triage and screening by selecting the magnifying glass icon. For comprehensive assessments, clinical assessors will be able to indicate the assessment setting before starting the assessment.



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



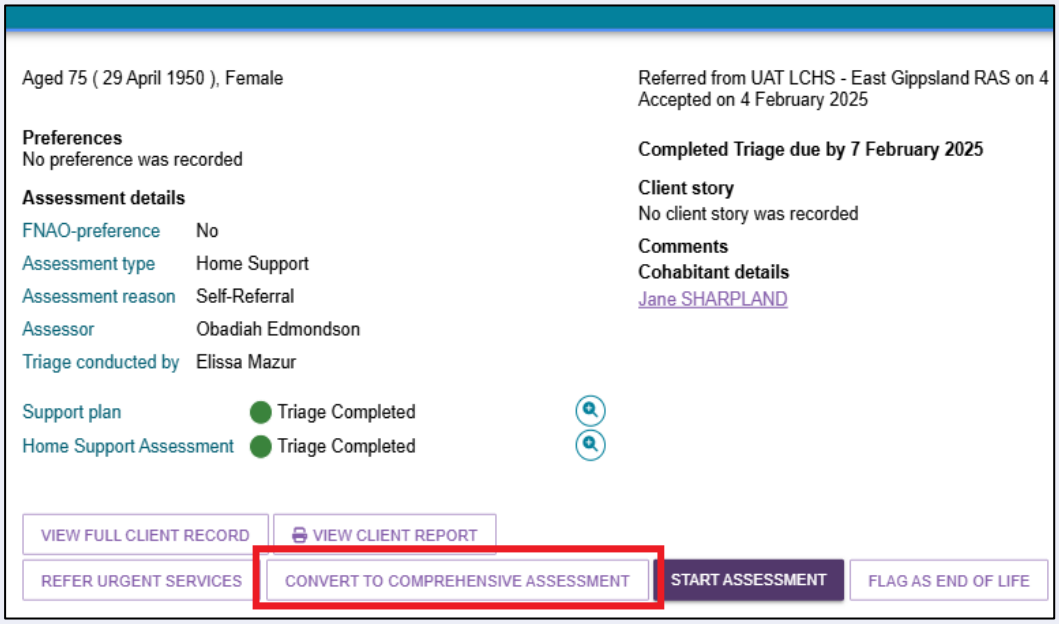
4. The **Assessment setting** pop up will appear. Select **Hospital** or **Non-Hospital** and select **Save**.



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

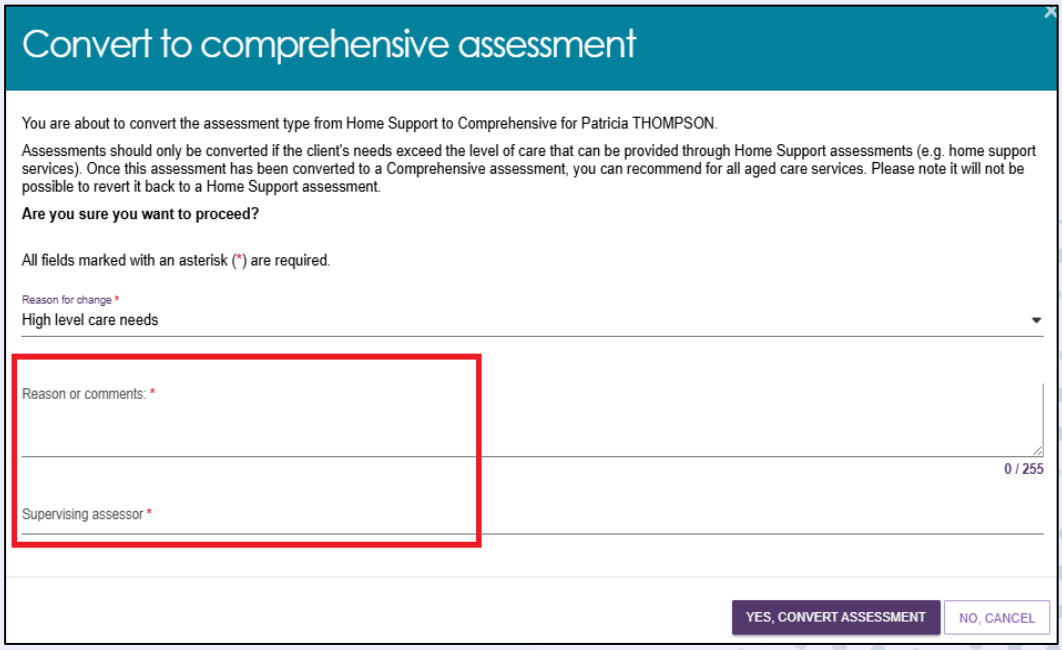
   Clinical assessors will have the ability to convert Home Support Assessments to Comprehensive Assessments prior to commencing an assessment.

   To change the assessment type select **CONVERT TO COMPREHENSIVE ASSESSMENT**.

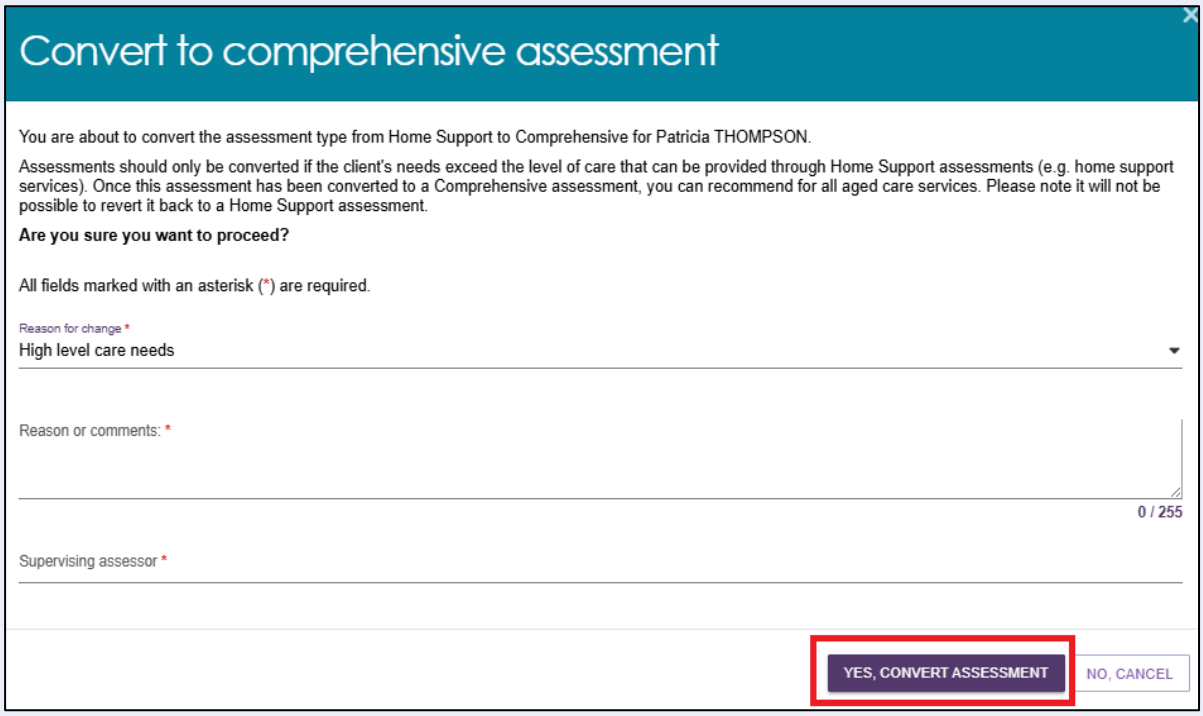


6. The reason for the change will be automatically filled. Enter your **Reason or comments** about converting the assessment.

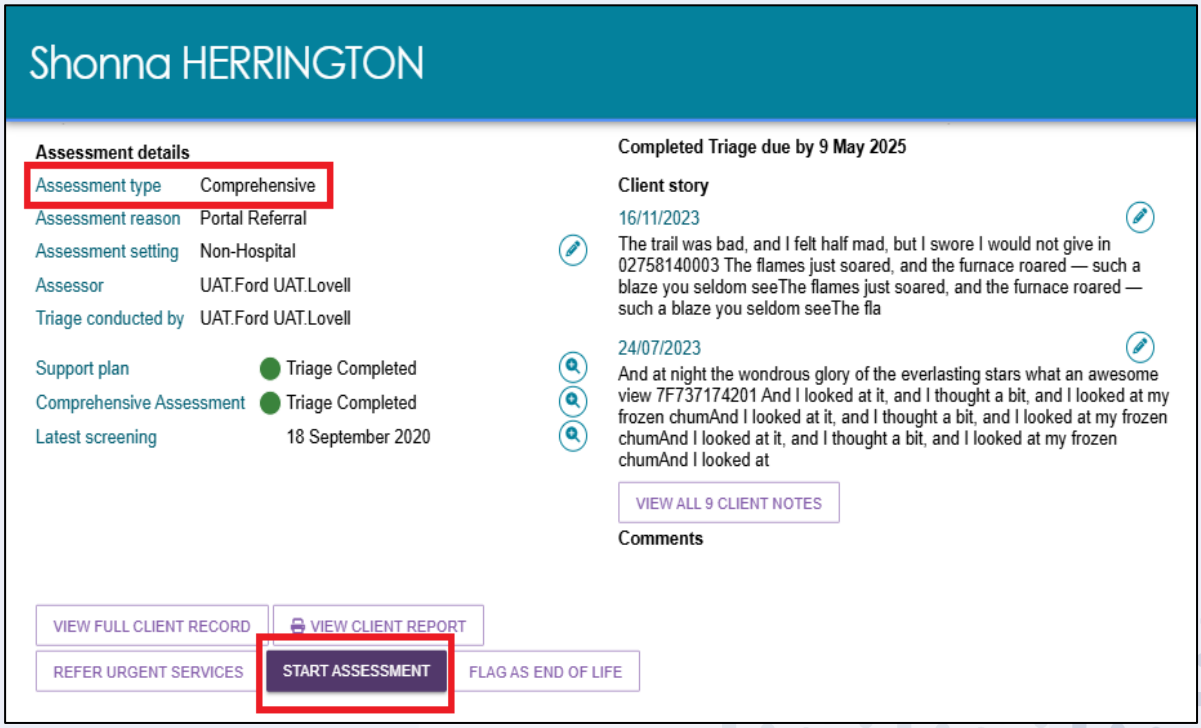
   Non-clinical assessors who wish to convert the home support assessment to a comprehensive assessment will also be required to enter the name of the supervising clinical assessor.



7. Once completed, select **YES, CONVERT ASSESSMENT** to continue. Once you convert to a comprehensive assessment you cannot change it back to a home support assessment. The assessment type will now reflect as Comprehensive Assessment.



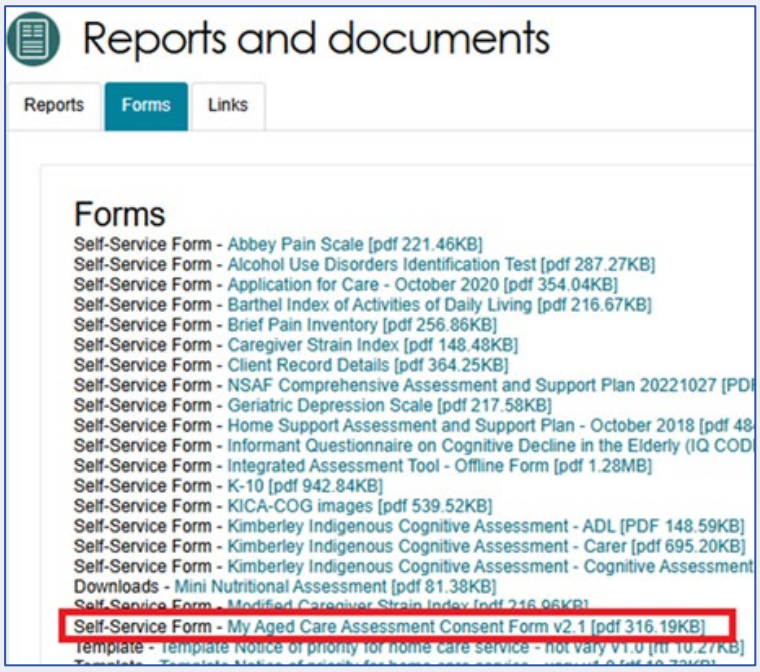
8. The assessment type will now reflect a Comprehensive Assessment. When you are ready to start the assessment, select **START ASSESSMENT**.



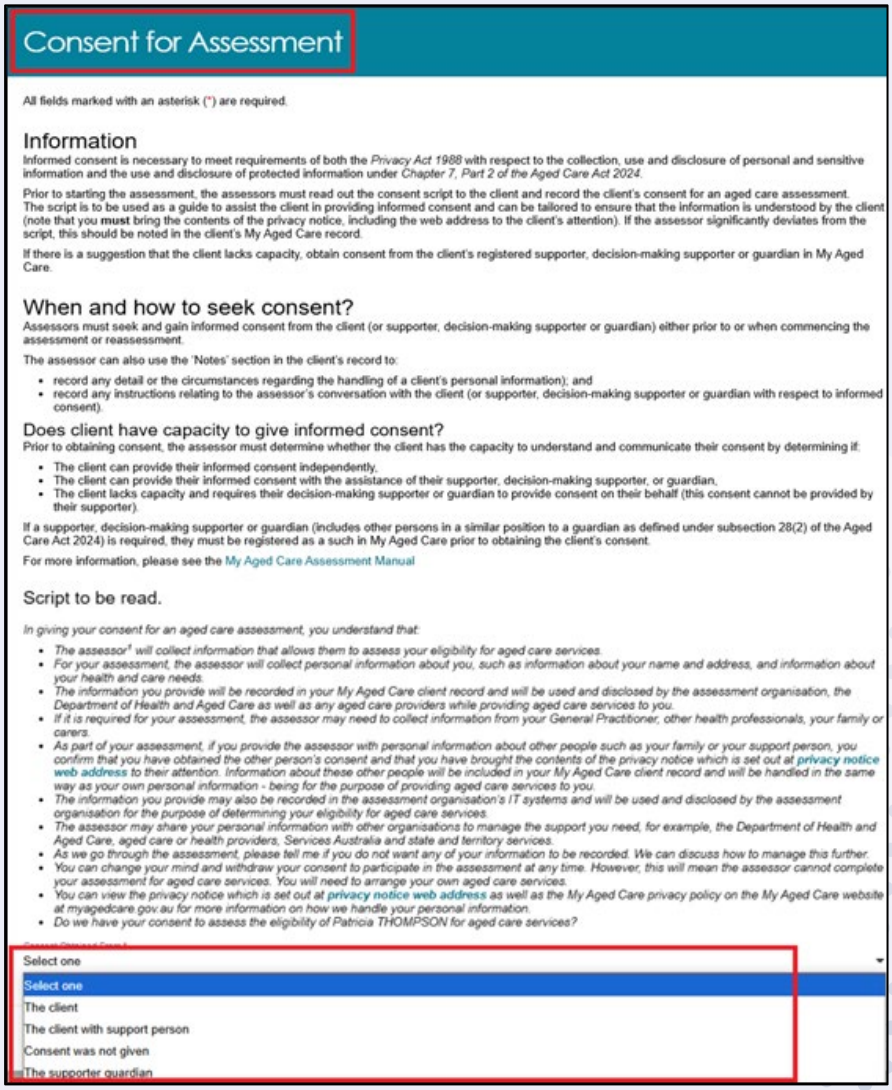
9. <u>You will then be asked to record client consent.</u>

   To do this, you will be required to read the relevant consent script, which is in the **My Aged Care Assessment Consent Form**, to the individual and record their response.

   If there is a suggestion that the client lacks capacity for consent, complete this form with the client's confirmed supporter-guardian in My Aged Care. The **My Aged Care Assessment Consent Form** is available for download from the **Reports & Documents** tile of the assessor portal.



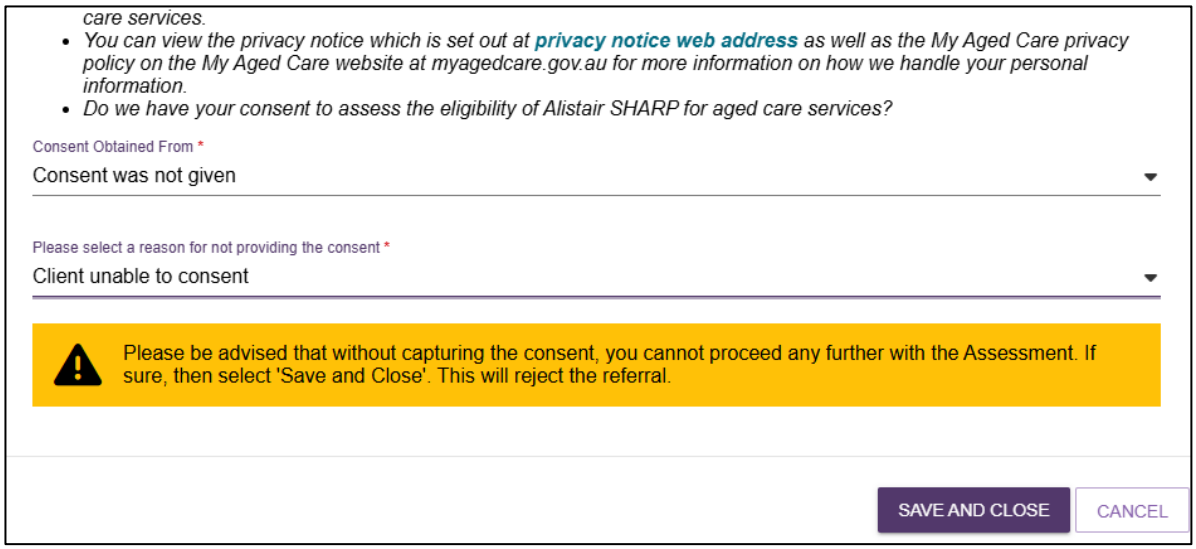
10. If consent is given, select the applicable consent options and then select **CONTINUE**. A signed copy of the Aged Care Assessment Consent form should be obtained during this step.



! If a client does not provide consent, a warning message will display advising assessors that the assessment cannot proceed.

If this is the case, you must enter a reason as to why the assessment could not be completed. If the response is **Other, please specify** you will be required to enter free text.

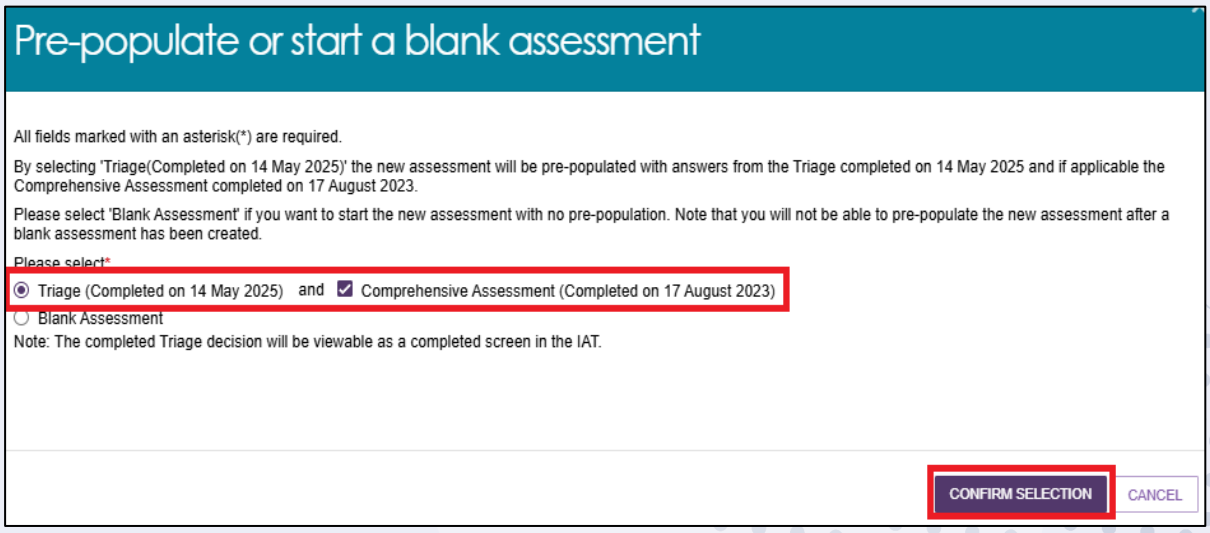
Selecting **SAVE AND CLOSE** will then cancel the assessment.



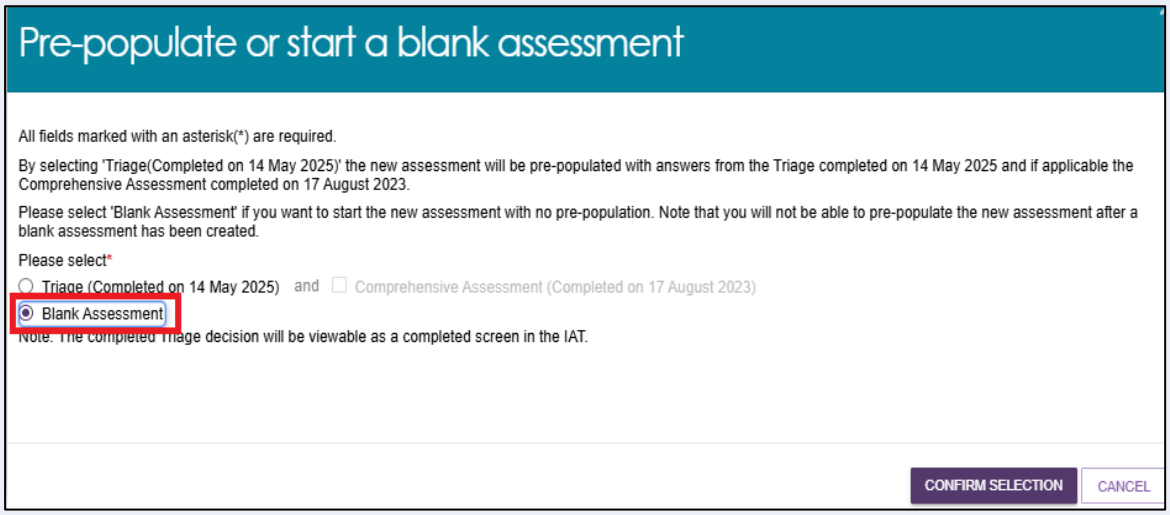
11. Before you start the assessment, you will be given the option to **Pre-populate the IAT**.

    For new clients who have not undertaken screening or have a previous assessment, you will have the option to pre-populate the IAT with their information from triage only.

    If the client has undergone screening, you can also select to pre-populate the IAT with their previous screening. Similarly, if the client has had a previous assessment you can select to pre-populate the IAT using that information.



12. Once you have selected the relevant pre-population options, select **CONFIRM SELECTION**. If you do not wish to pre-populate the IAT select **Blank Assessment**.

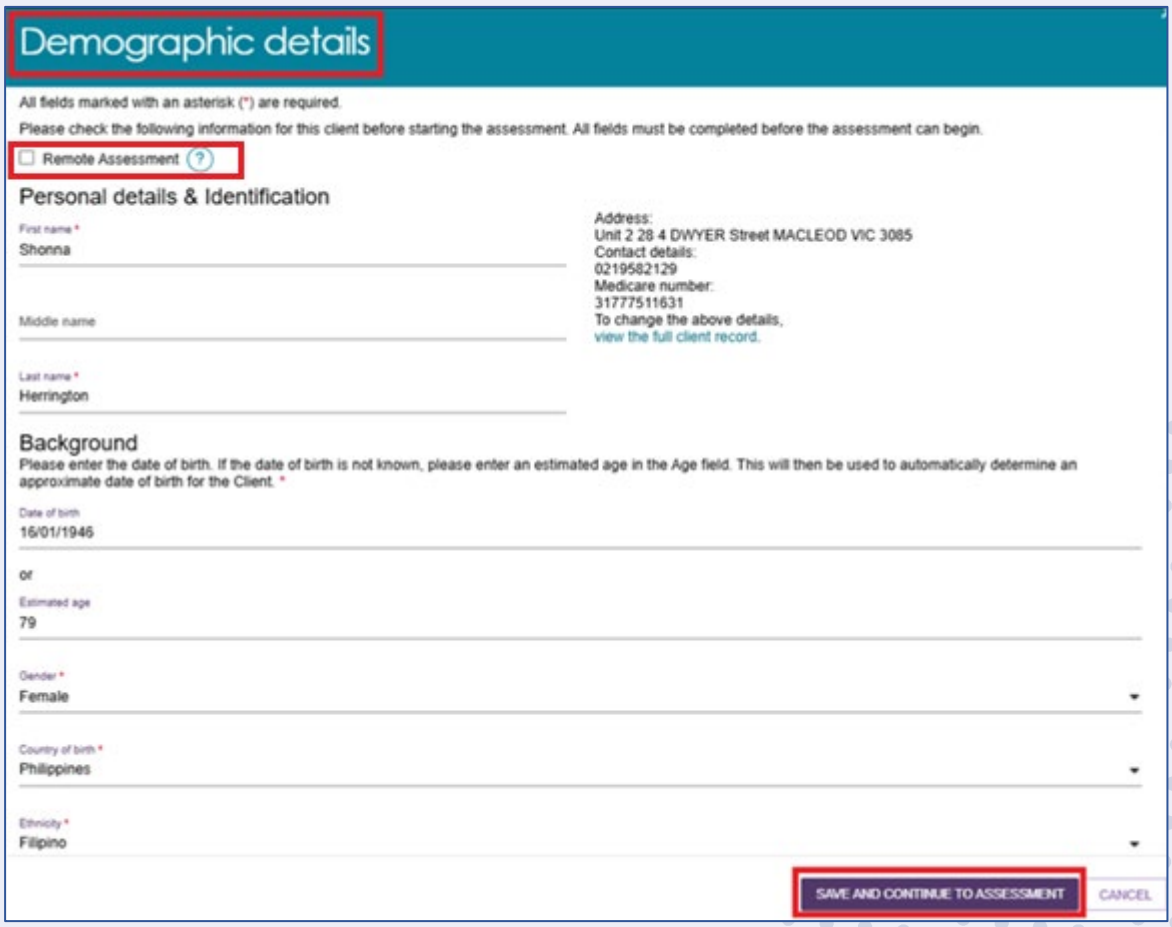


! If you select **Blank Assessment**, you cannot reverse this decision during the assessment.

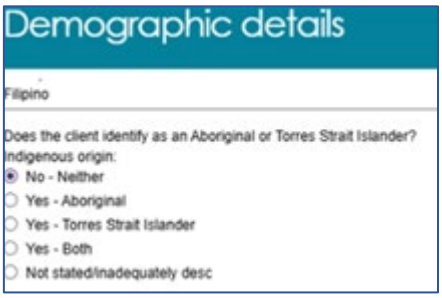
13. You will then be prompted to review and update information regarding the client's **Demographic details**, including whether this is a remote assessment, the client's personal details and background, if the client would prefer a First Nations Assessment Organisation for their assessment (if available)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

    These details will be pre-populated from triage but can be edited if required.

    After confirming the correct details are entered, select **SAVE AND CONTINUE TO ASSESSMENT**.

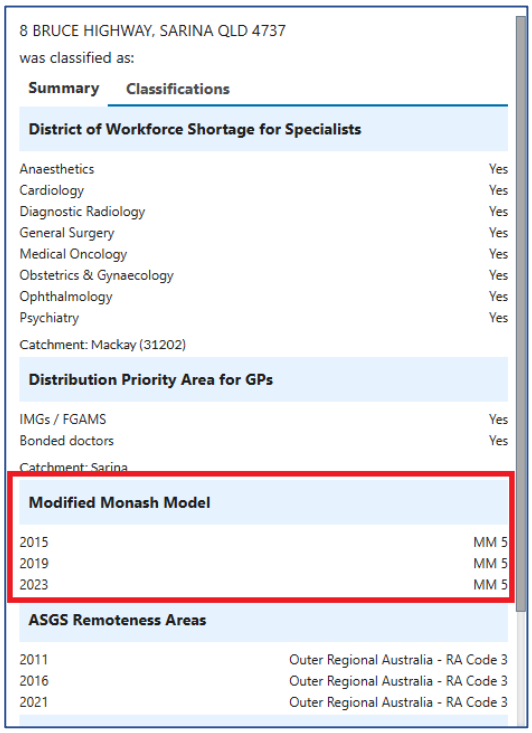


! It is important to ensure that the client's **Aboriginal or Torres Strait Islander identity** is accurately captured, as this will trigger the system to display Validated Assessment Tools that are appropriate to use with First Nations people if required.

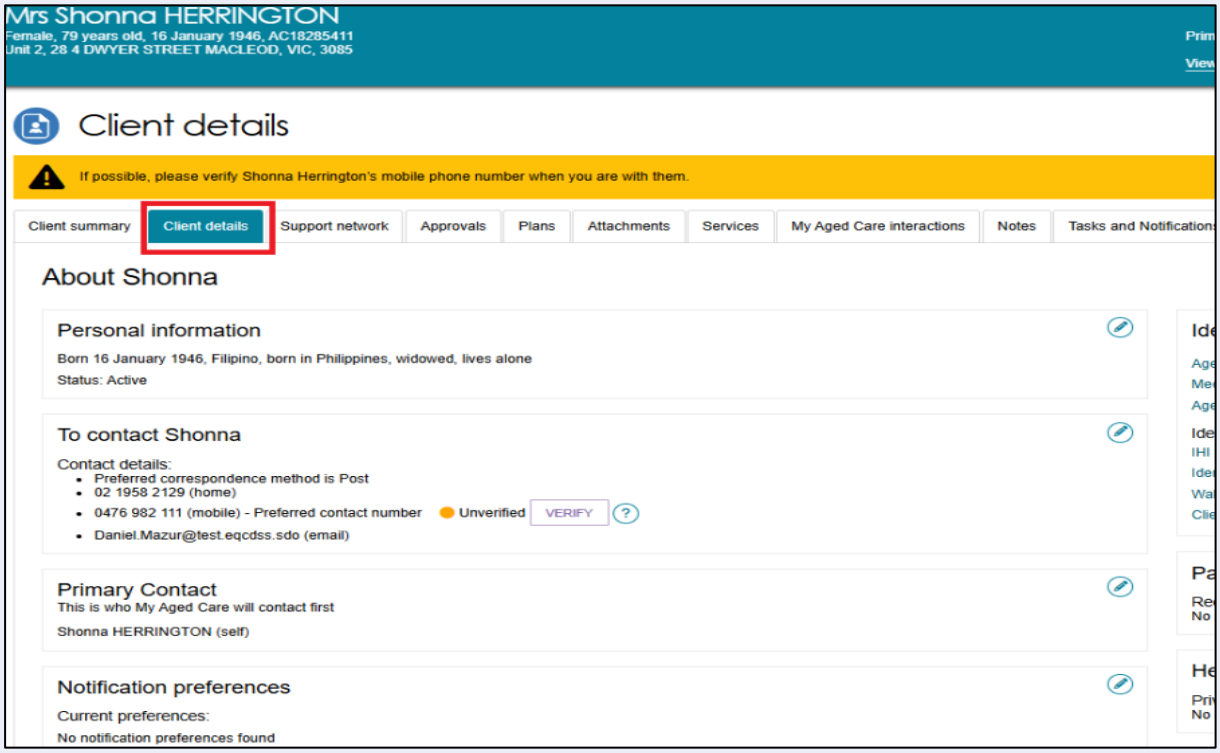


A client's **Medicare card** number must be correctly entered to ensure that their My Health Record can be successfully linked if they consent to do so.

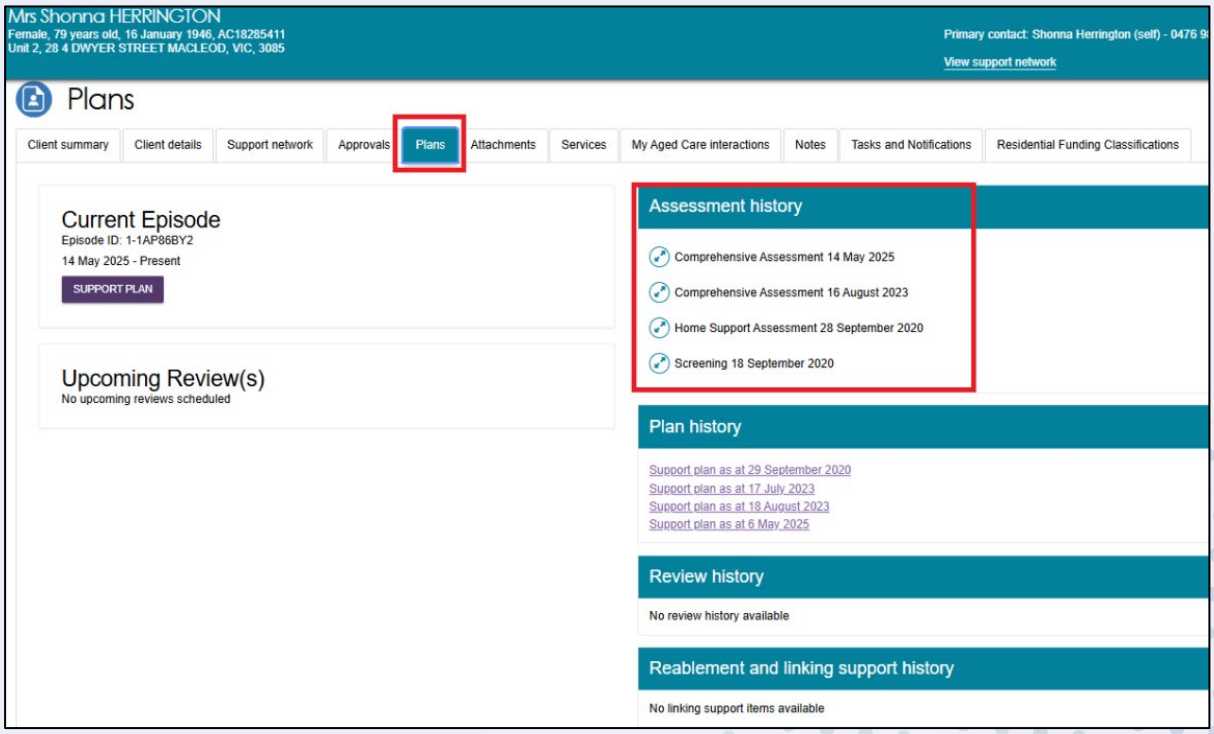
! **Remote assessment** should be selected when an assessment is conducted in a remote area. This is to help improve reporting and inform future decision making in consideration of this client demographic. Geographical remoteness is defined using the Modified Monash Model (MMM). Based on this, remote assessments should only be selected where a face-to-face assessment is undertaken in a remote (MM6) or very remote (MM7) area. You can check the MMM classification of a client's address on the Health Workforce Locator. From the homepage select **Start the locator now** and enter the client's address. The MM will then be displayed in the **Summary** section.



14. If an assessor needs to update a client's demographic details after they have commenced the assessment, they can do so from the **CLIENT DETAILS** tab of the Client Record by navigating through the **FIND A CLIENT** tile from the homepage.



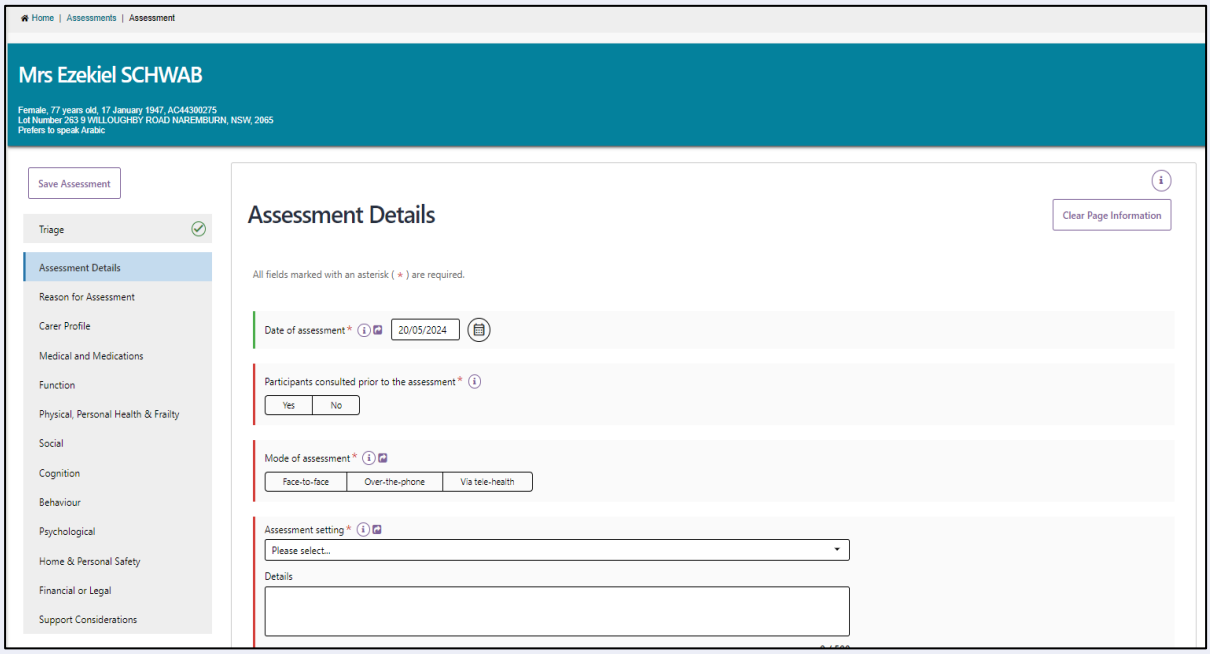
15. A record of any previous screenings or assessments will be accessible through the **PLANS** tab of the client record under **ASSESSMENT HISTORY**.



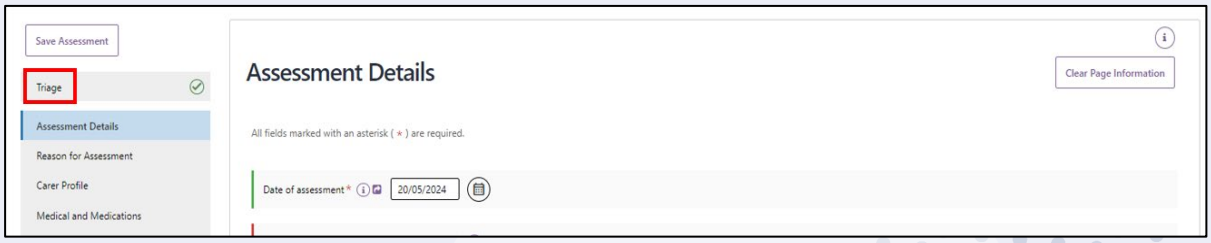
Completing an assessment

! The IAT contains an algorithm to ensure consistent client outcomes based on their needs. The algorithm will draw on assessment responses and the client's current care approvals and recommend an aged care service. This will display in the **SUPPORT PLAN AND SERVICES PAGE** under the **GOALS AND RECOMMENDATIONS** tab after an assessor finalises the IAT.

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



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

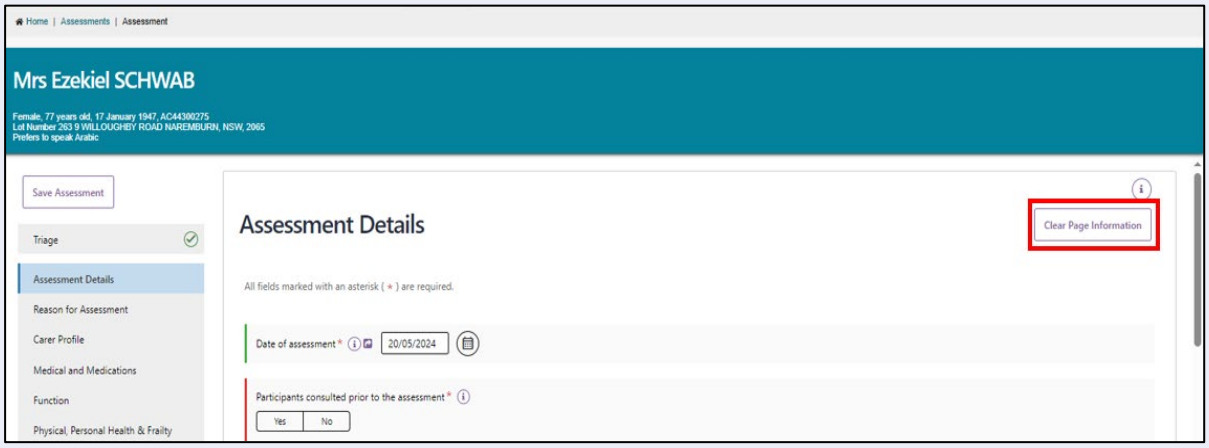


3. The navigation bar will move up and down the page as you scroll. A tick will display in the navigation bar to confirm completion.

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

Assessment features

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



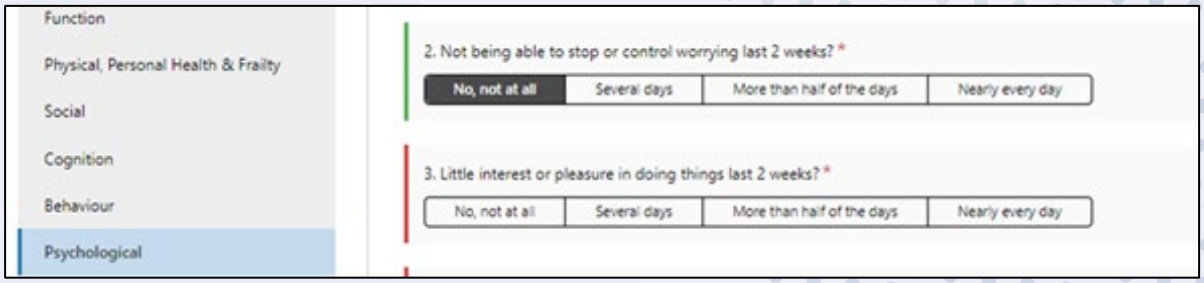
2. A pop-up will then display. Select **Yes, clear page information**.

! Pages that do not contain Validated Assessment Tool triggering questions will only have the option to **Yes, clear page** and **cancel**. However, pages with Validated Assessment Tools trigger questions, will have a fourth option to **Clear all**.

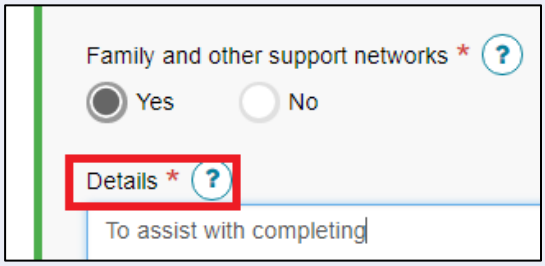
Selecting **Clear page** will trigger an in-action symbol which demonstrates that the clearing is in progress. Selecting **Clear page information** will also remove the check box that triggers the display of Validated Assessment Tools.

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

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



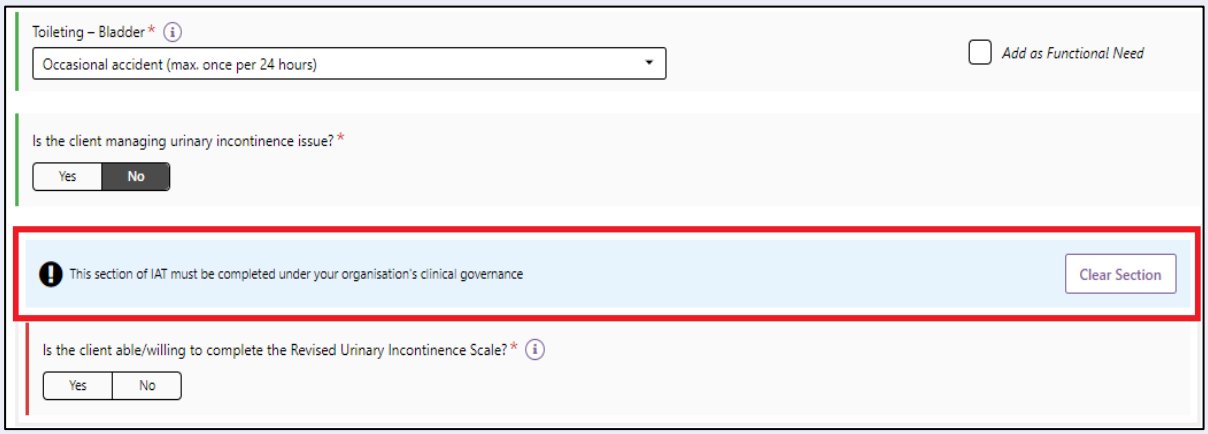
4. Some questions will require additional mandatory details depending on the answer. In these cases, an asterisk will appear next to the details section to indicate that it is now mandatory to complete.



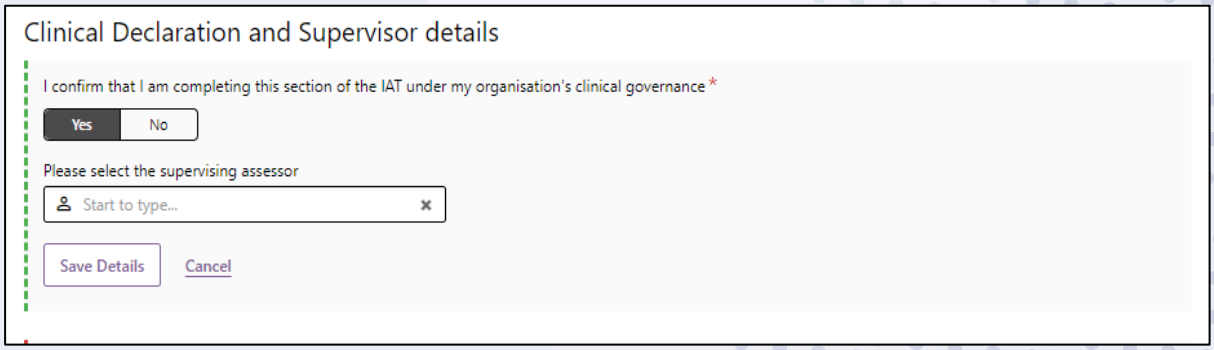
5. Additional questions may also display if triggered by an answer given to a base IAT question. These questions are used to capture additional information about the client's needs as indicated by the answer given within the base questions.

Clinical attendance (for non-clinical assessors)

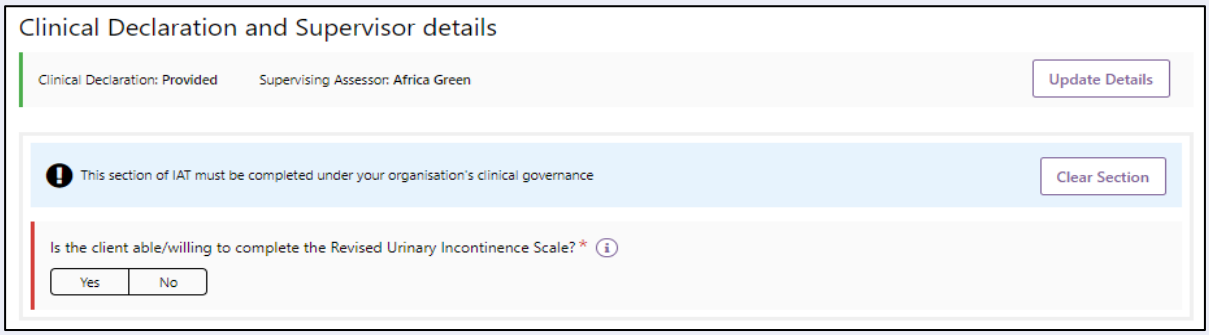
1. Threshold questions are also used throughout the IAT to trigger moving the assessment into clinical/comprehensive areas. These questions are identified by a blue banner. For example, if you answer **No** to the question '*is the client managing urinary incontinence issue?*' then additional questions will be displayed that require clinical attendance to complete.



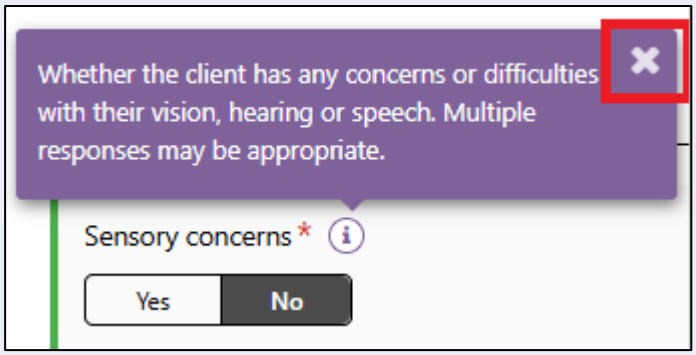
2. For non-clinical assessors, these questions can only be completed under the clinical attendance process which is supported by an assessment organisation's clinical governance framework. To proceed in answering these questions, the clinical supervisors (clinical assessor) details, who has provided clinical attendance, must be selected from the drop-down menu and **SAVE DETAILS** selected.



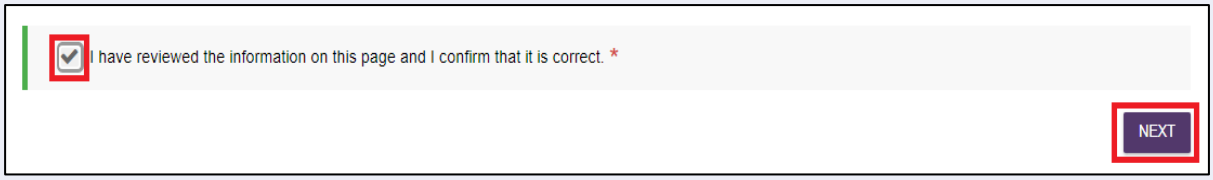
3. Once the details have been saved, they will display in the IAT, and the non-clinical assessor can proceed with clinical supervision.



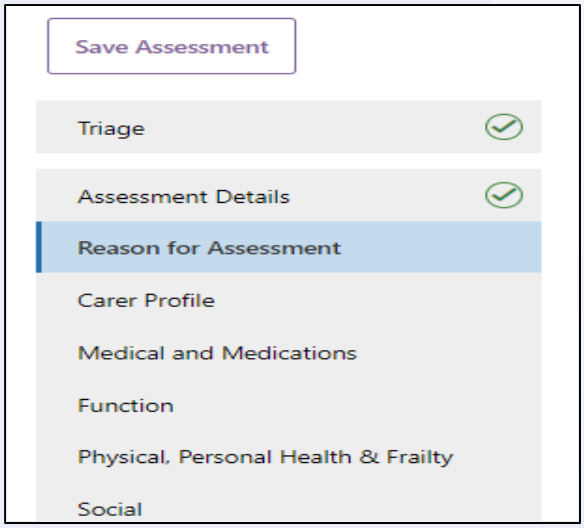
4. View on-screen help text for each question by selecting the Information icon next to the question. Help text can be moved around the screen by dragging the text with the cursor and will remain visible until the **X** is selected, or a new help text box is opened.



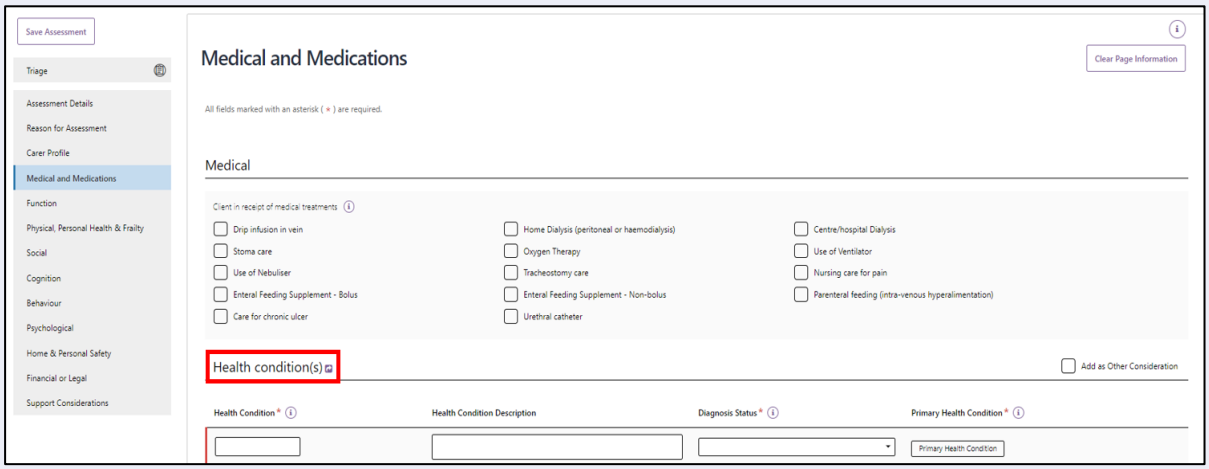
5. A mandatory confirmation box must be completed at the bottom of each section, then you can navigate to the next assessment page by selecting the **NEXT** button at the bottom right-hand corner or by selecting the relevant section from the navigation bar. Assessment information will also be saved.



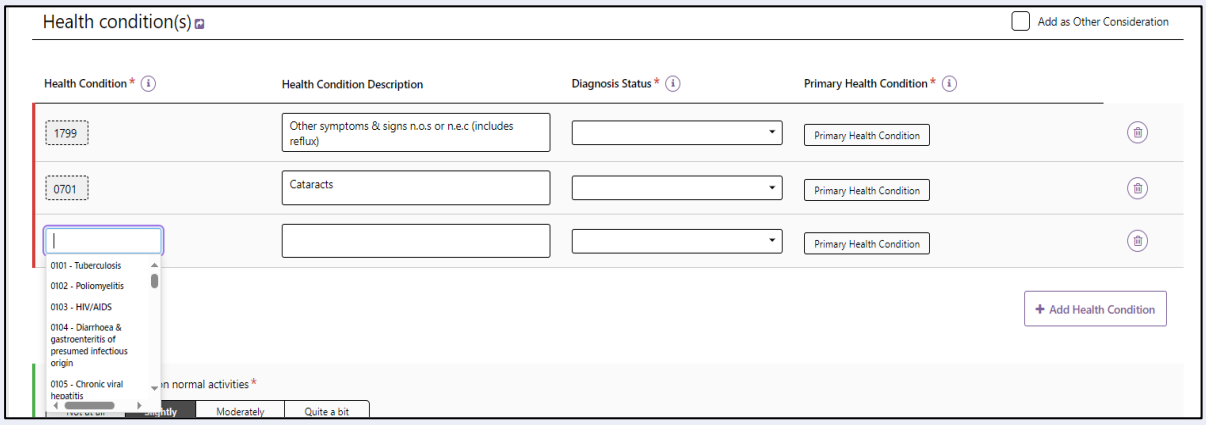
6. When all mandatory questions (marked with an asterisk and red line) on a page have been completed, a green tick will appear on the navigation bar.



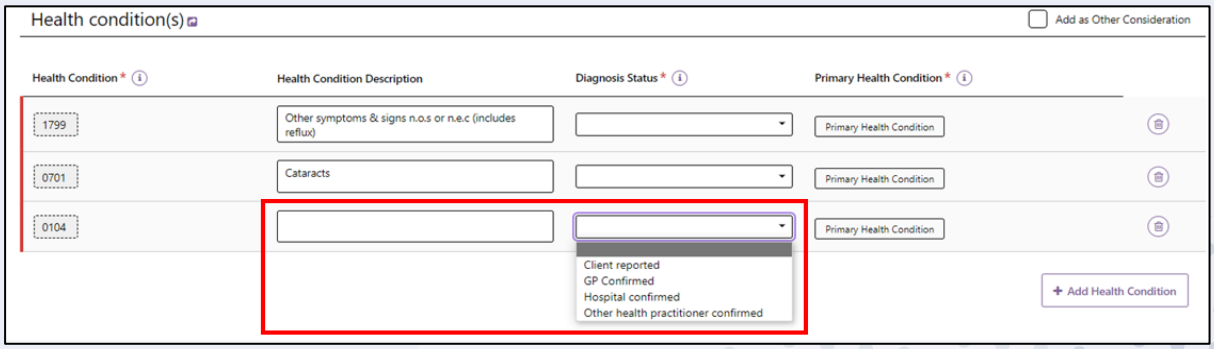
7. In the **Medical and Medications** section you can enter health conditions into the assessment by name or code.



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

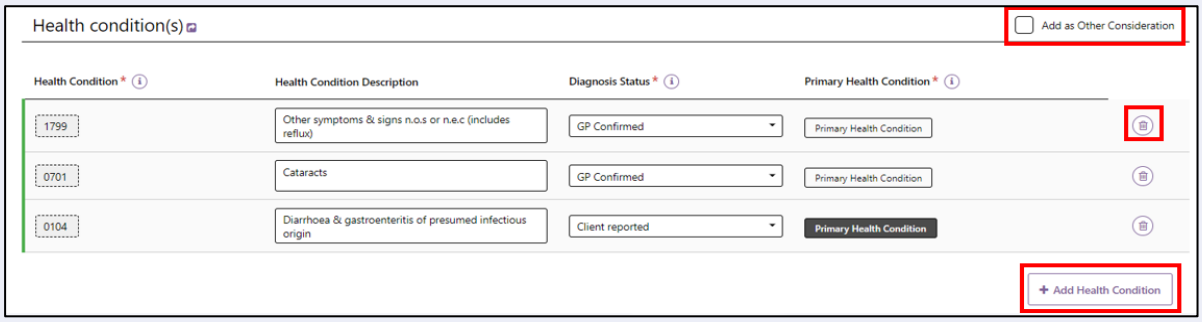


Once you select a health condition, the description can be edited specific to the client's health condition and select the appropriate **Diagnosis Status** option.

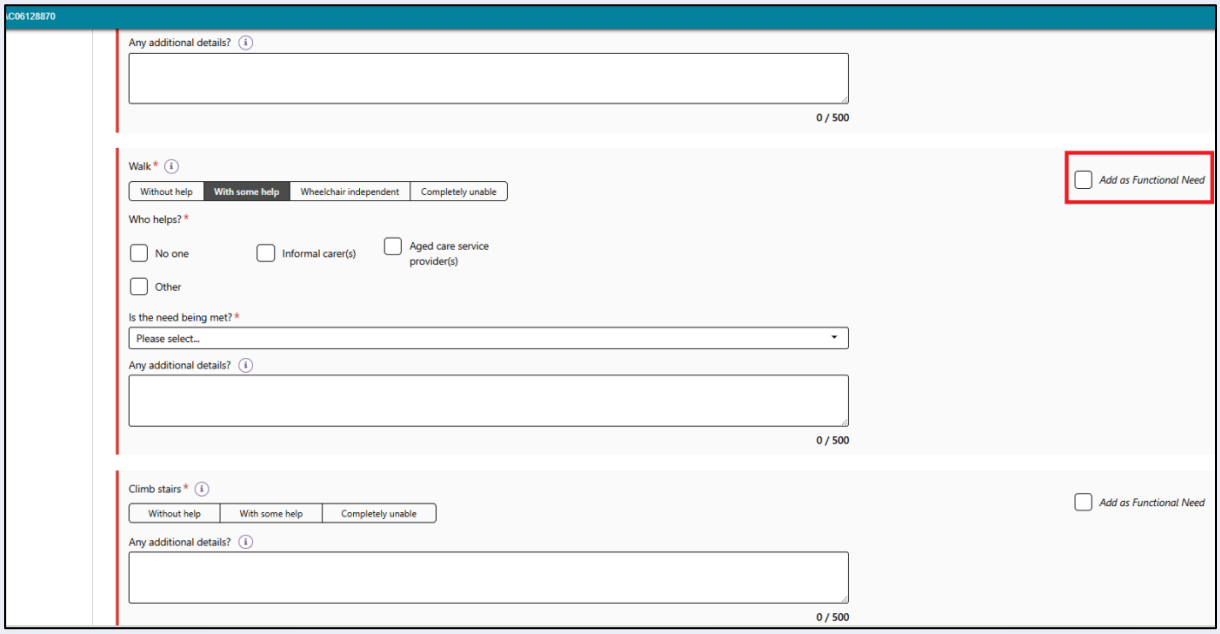


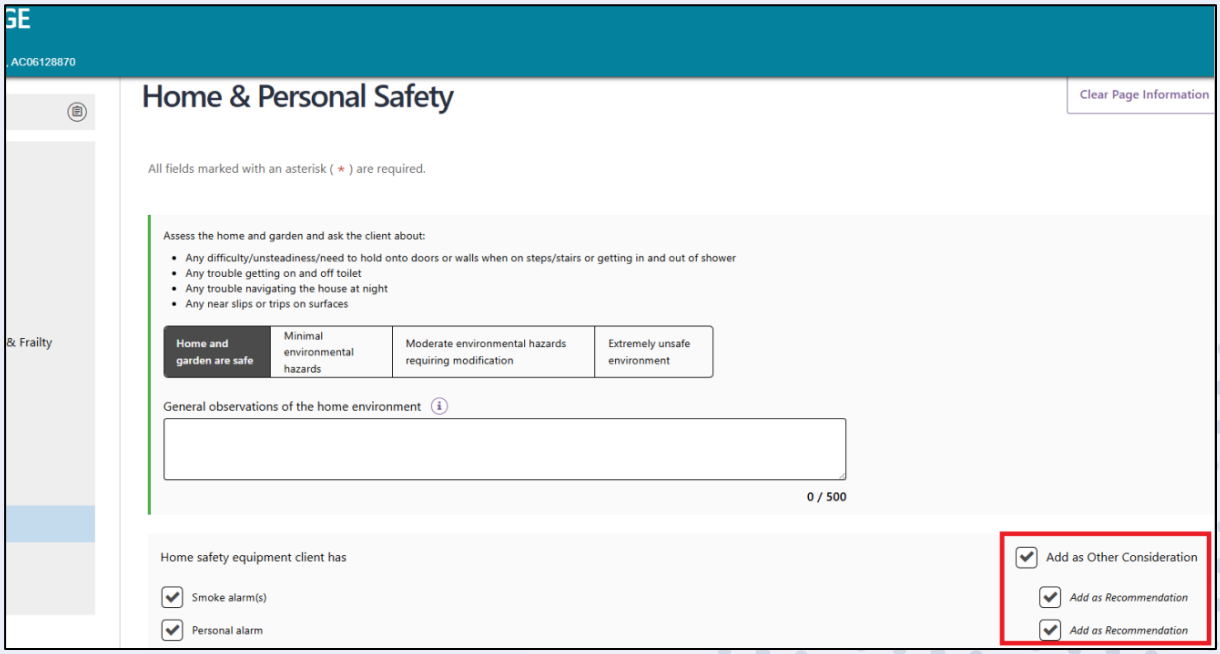
Additional health conditions can be added by selecting **+ Add Health Condition** or removed by selecting the bin icon.

Assessors can also indicate whether the health condition is the **Primary Health Condition**, or whether to as an **Other Consideration** in the client's Support Plan.

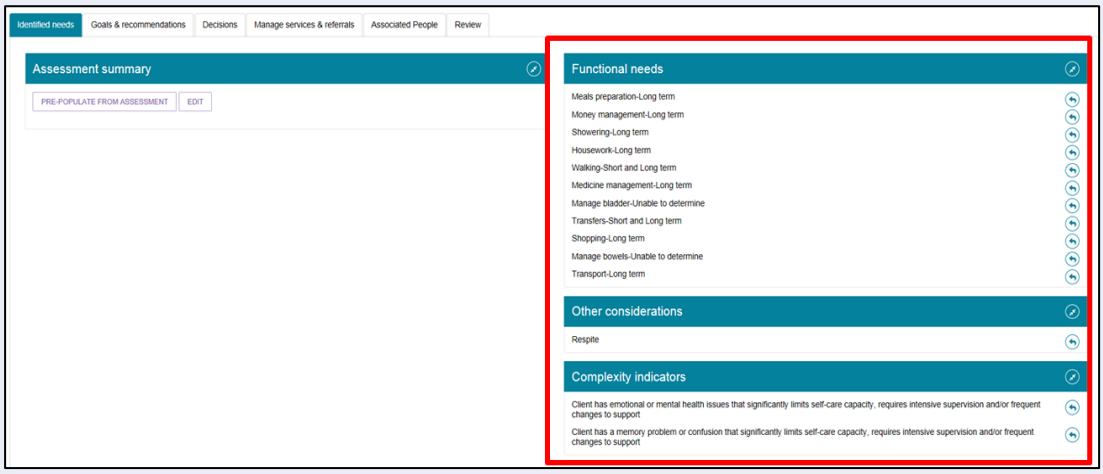


8. When completing the assessment, assessors will be able to select to **Add as Functional Need**, **Add as Complexity Indicator**, **Add as Other Considerations** and **Add as recommendation**.





9. Upon selecting the checkbox, the Needs will appear on the **Identified needs** tab of the **Support Plan**. Recommendations will appear in the **Goals & recommendations** tab.



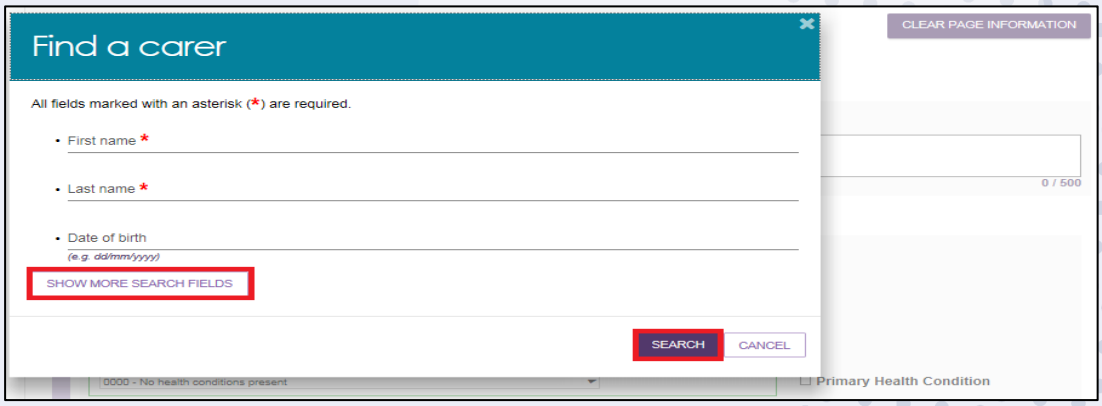
Viewing and adding carers in the assessment

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

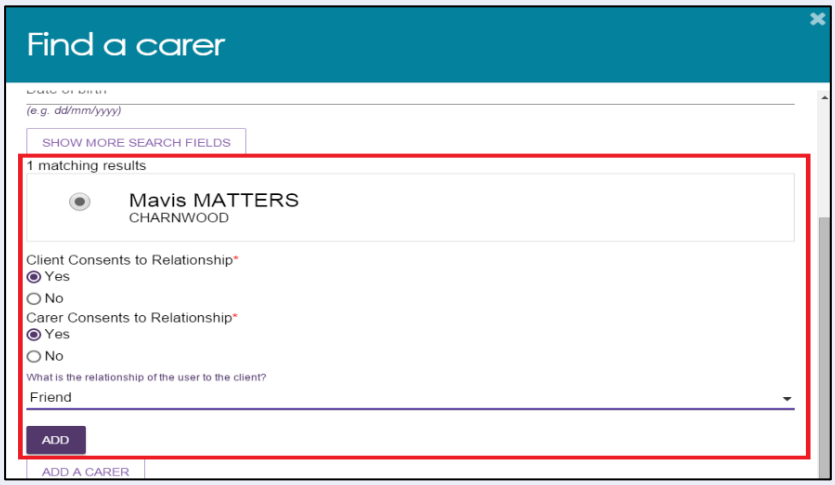
1. Select the **Carer Profile** section of the assessment from the navigation menu and then select **View/add carers**.

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

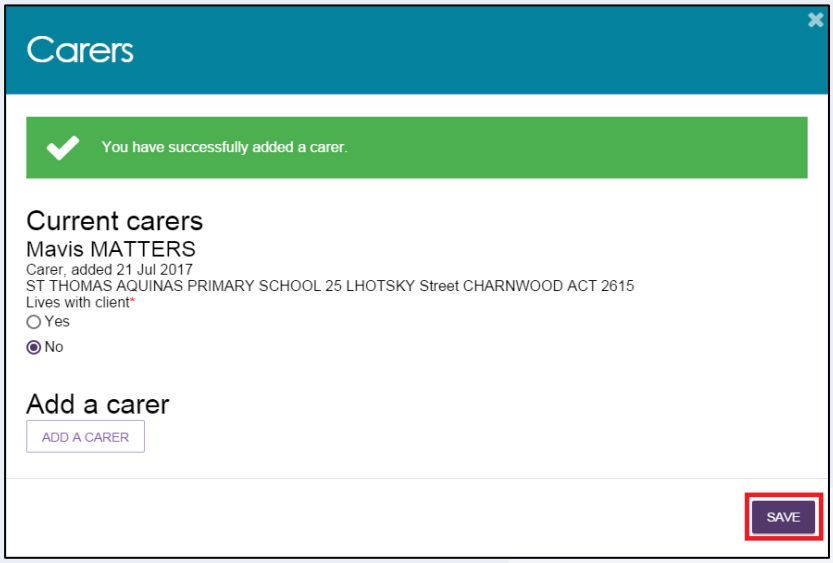
3. Enter the first and last name of the person and select **Search**. You can search with more details by selecting **Show more search fields** and populating the appropriate fields.



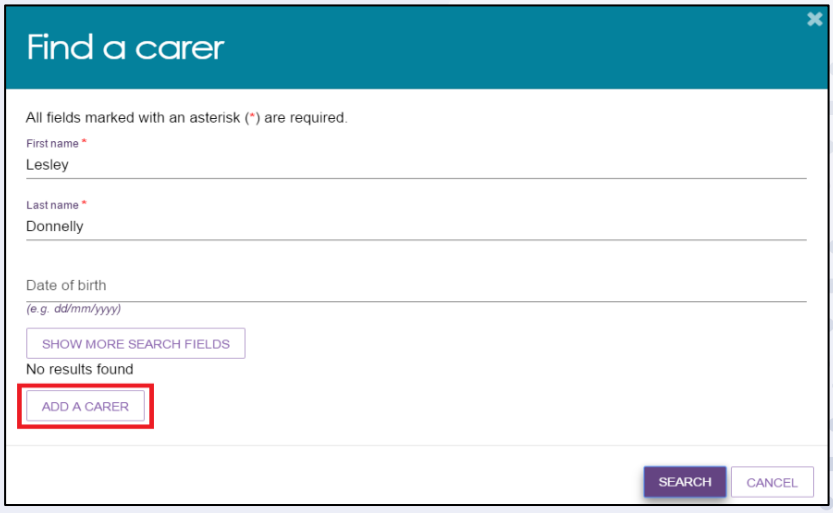
4. If there is already a record for the person, they will be displayed in matching results. By selecting the radio button next to the person's name, it will open more fields including both client and carer consent to the relationship, and the relationship of the user to the client. Select **ADD**.



5. You will receive a confirmation message on screen, notifying that **You have successfully added a Carer**. Select **SAVE** to save changes.



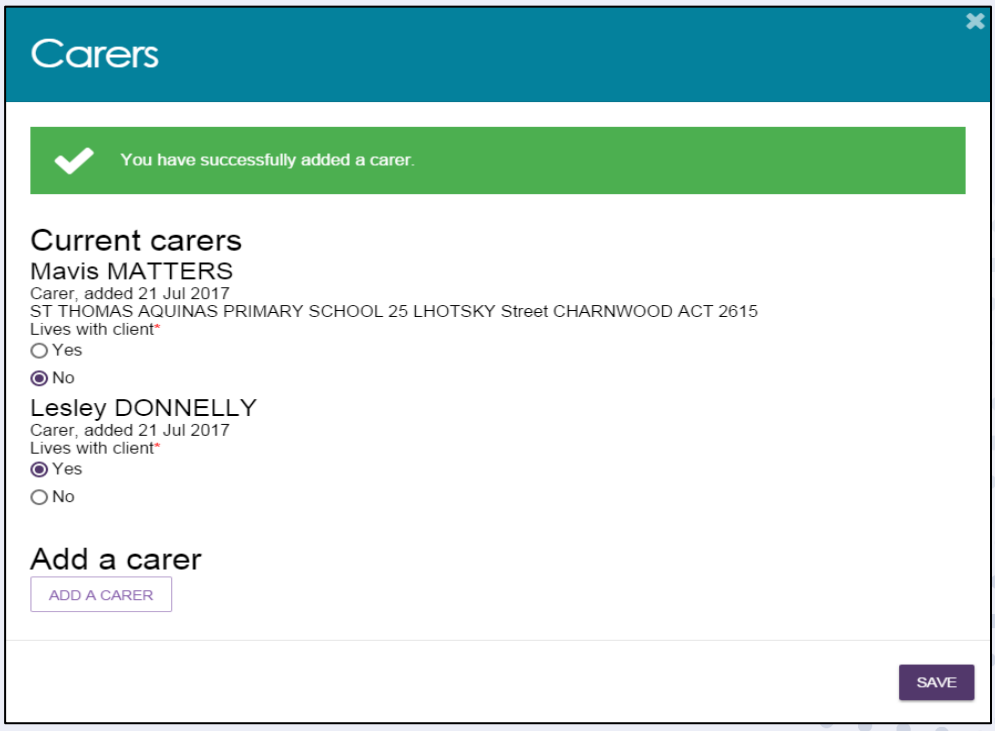
6. If there are no results, or you want to add a different carer, select **ADD A CARER**.



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

! The consent for registration during this stage is solely to create the client-carer relationship within the My Aged Care system. By creating this relationship, the carer will display in the client's support network and also appear as an option to be added to the client's support plan at a later stage. Consent will be sought for any changes to this carer relationship throughout the process. For information on how to capture a client and carer's consent for call-backs from the Carer Gateway and/or National Dementia Helpline, go to Assessor Portal User Guide 2 – Registering support people and adding relationships.

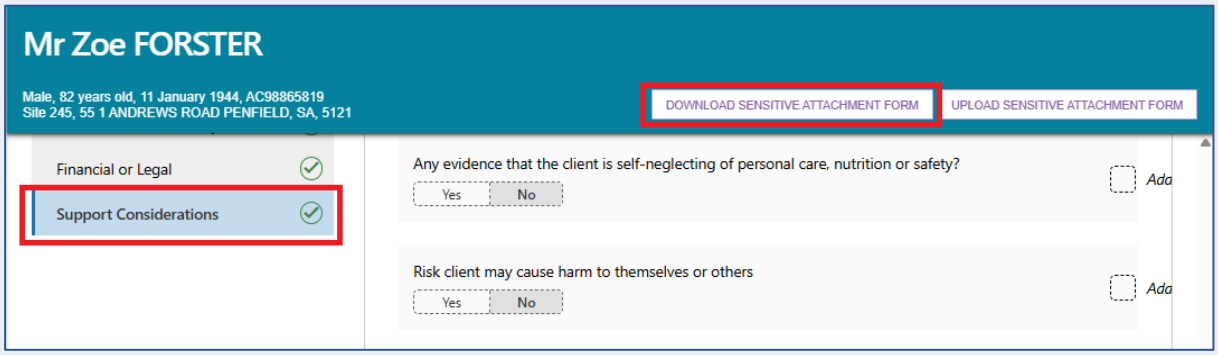
8. You will receive a confirmation message on the screen, notifying that **You have successfully added a Carer**. Select **SAVE** to save changes.



Adding a Sensitive Attachment in the assessment

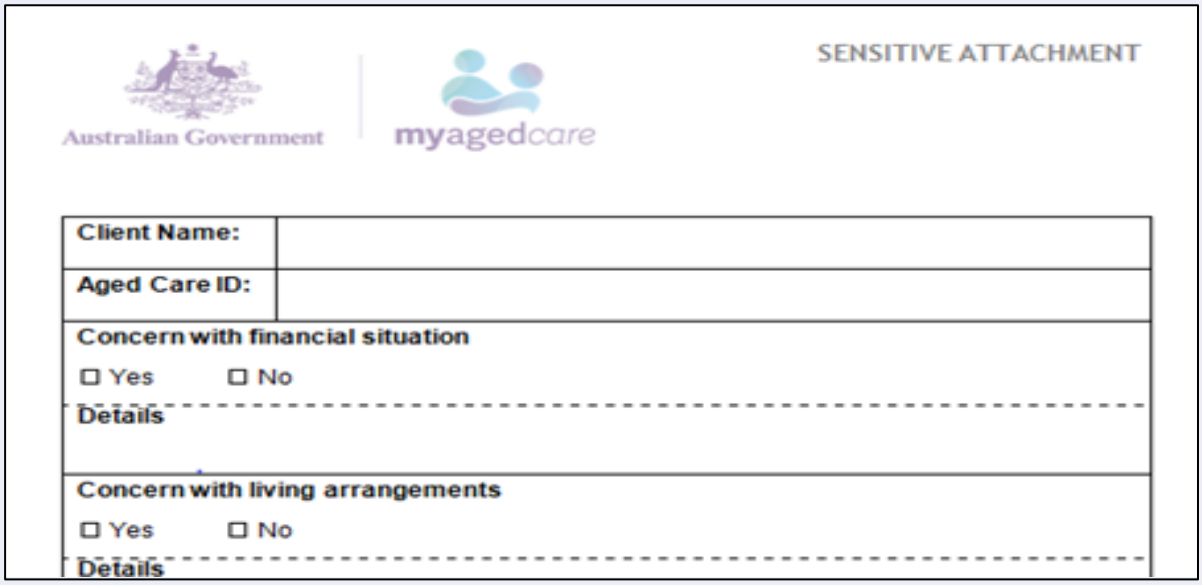
Assessors can add attachments for client information of a sensitive nature as part of the assessment.

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



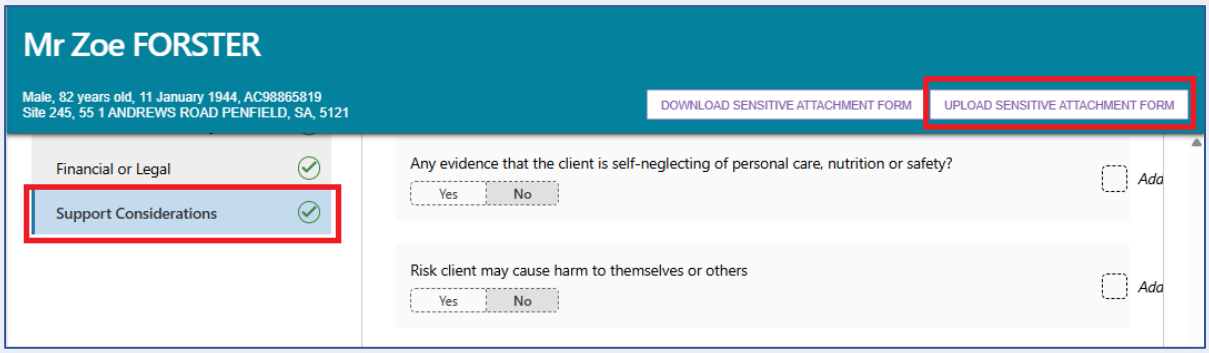
2. The **Sensitive Attachment** form can also be downloaded from the **FORMS** tab in the **REPORTS AND DOCUMENTS** section of the portal.

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



3. When you have completed the form, select **Upload Sensitive Attachment Form** from the **Support Considerations** page. Alternatively you can attach it in the Attachments page via **Add An Attachment**.

Support Considerations page of the IAT assessment

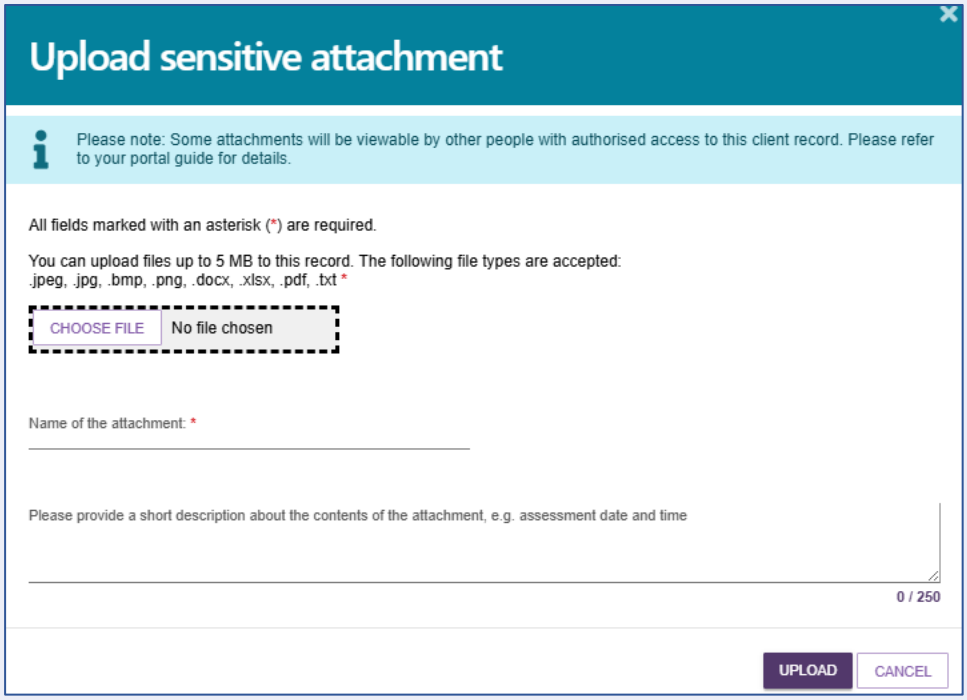


Attachments Page

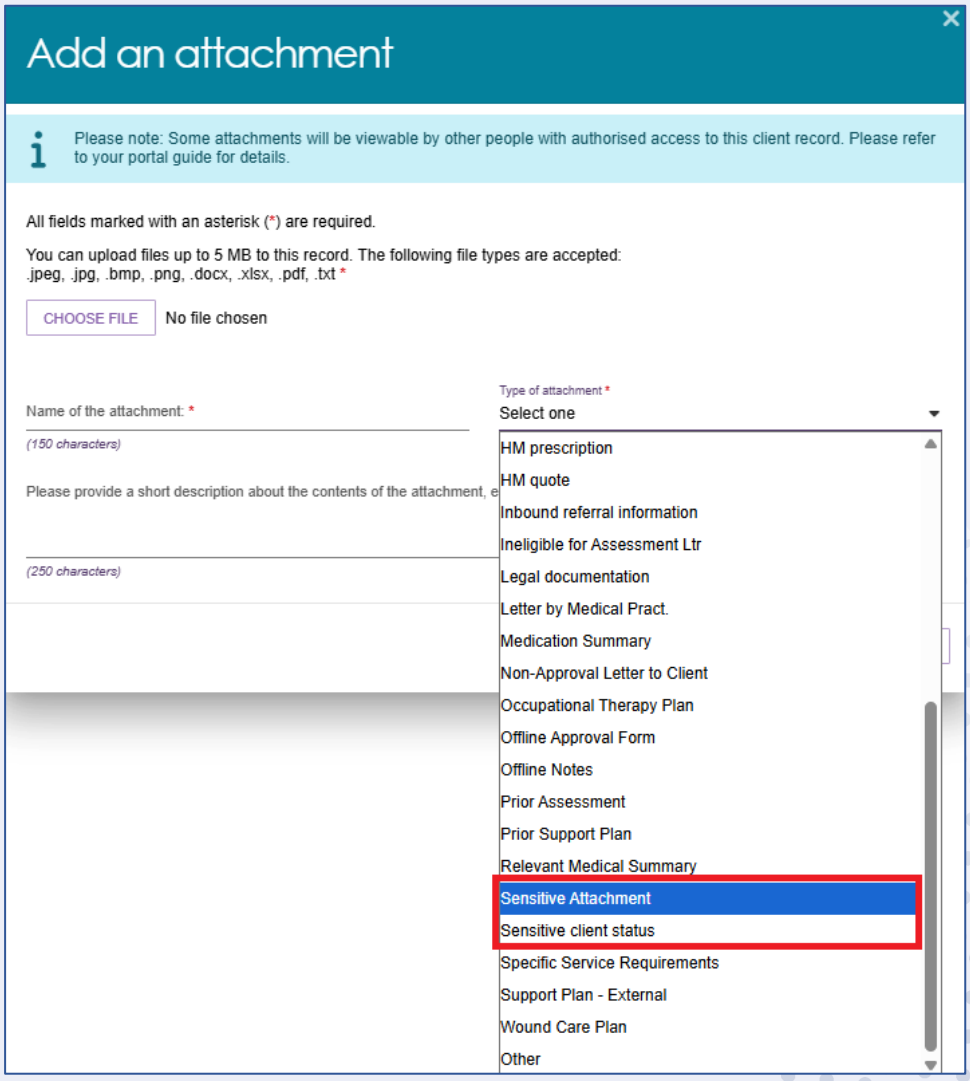
4. The Upload sensitive attachment pop up, or the Add an attachment pop up, appears. You will be prompted to enter information relating to the Sensitive Attachment. For the Add an attachment pop up, select the attachment type: 'Sensitive attachment' or Sensitive client status'.

   Once you have entered this information select **Upload**.

Upload sensitive attachment pop up



Add an attachment pop up with the Type Of Attachment drop down expanded

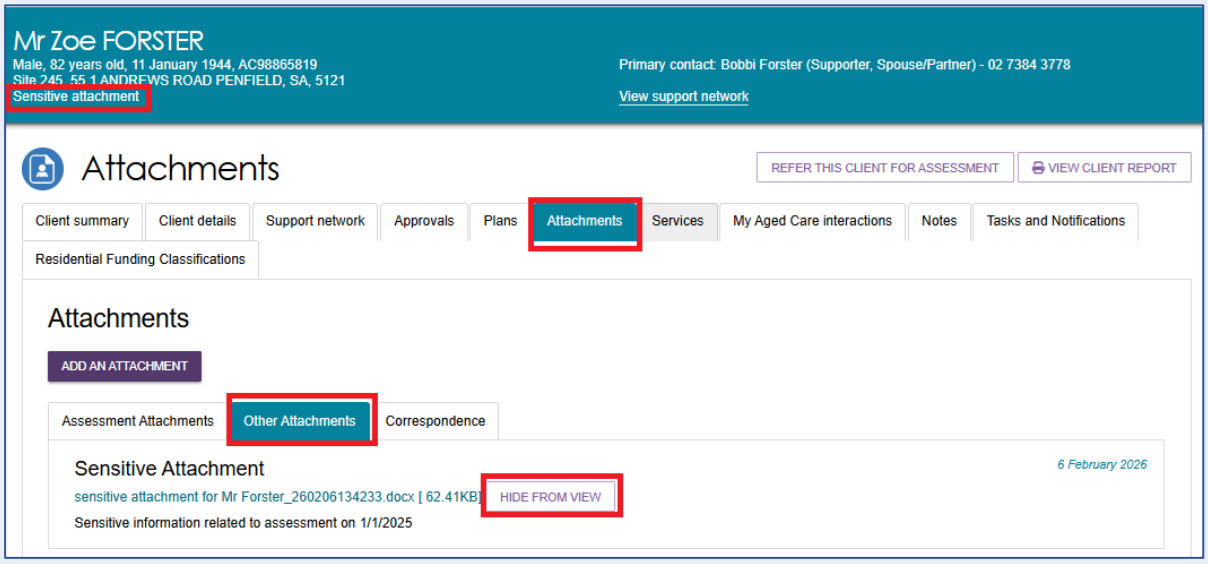


5. Once successfully uploaded, a green banner will display at the bottom of the screen.

6. The Sensitive Attachment will then appear under **OTHER ATTACHMENTS tab** on the **ATTACHMENTS** screens of the Client record.

   There will also be 'Sensitive attachment' text underneath the client's personal details.

   Select **HIDE FROM VIEW** if you do not want to display the sensitive attachment file and details in the Attachments page.

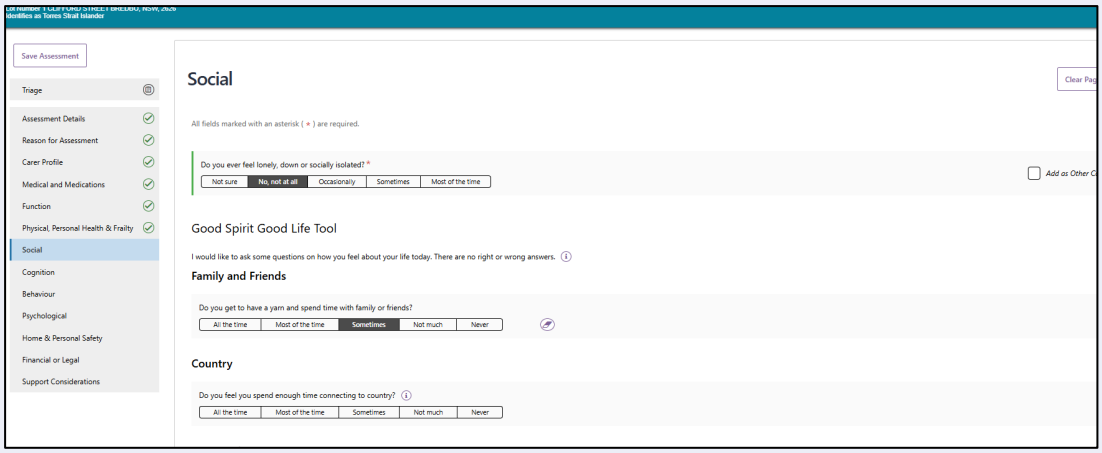


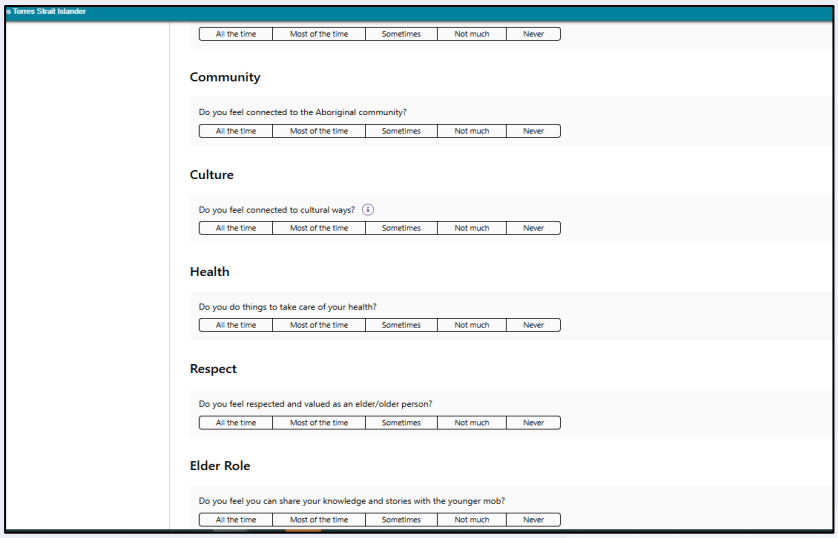
! If you have added a Sensitive Attachment as part of the assessment, you should record this in the **Support Considerations** page. Sensitive attachments will not display to providers or to clients viewing their information through the My Aged Care online account. The My Aged Care contact centre and assessors will be able to view this attachment. Service providers who have accepted a client's referral will receive an alert notifying them that sensitive information is available and are advised to contact the client's assessor or My Aged Care contact centre to access this information.

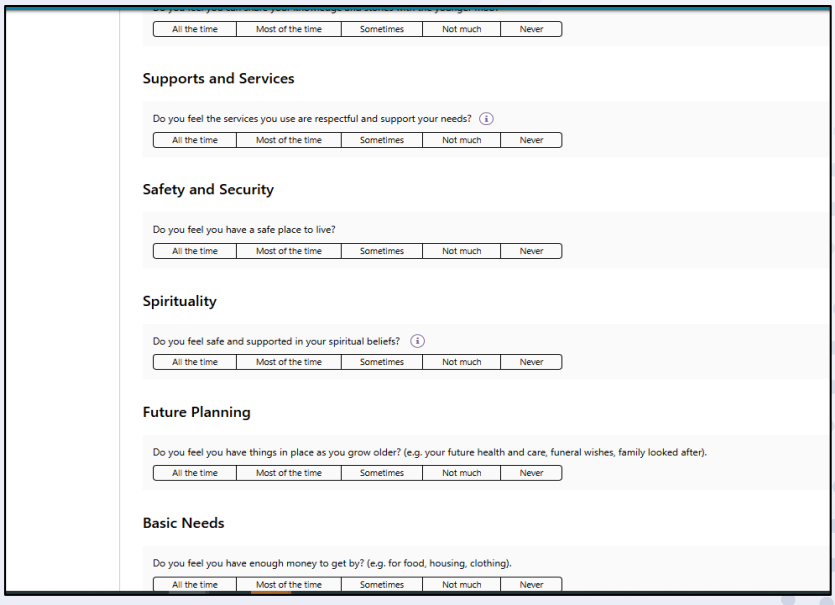
Navigating the Validated Assessment Tools

1. There are a range of Validated Assessment Tools (VATs) available for assessors to help support a client assessment. A number of these are either embedded within the IAT itself or are available as prompts to be utilised as needed. For example, the Duke Social Support Index is incorporated in the IAT under the **Social section.**

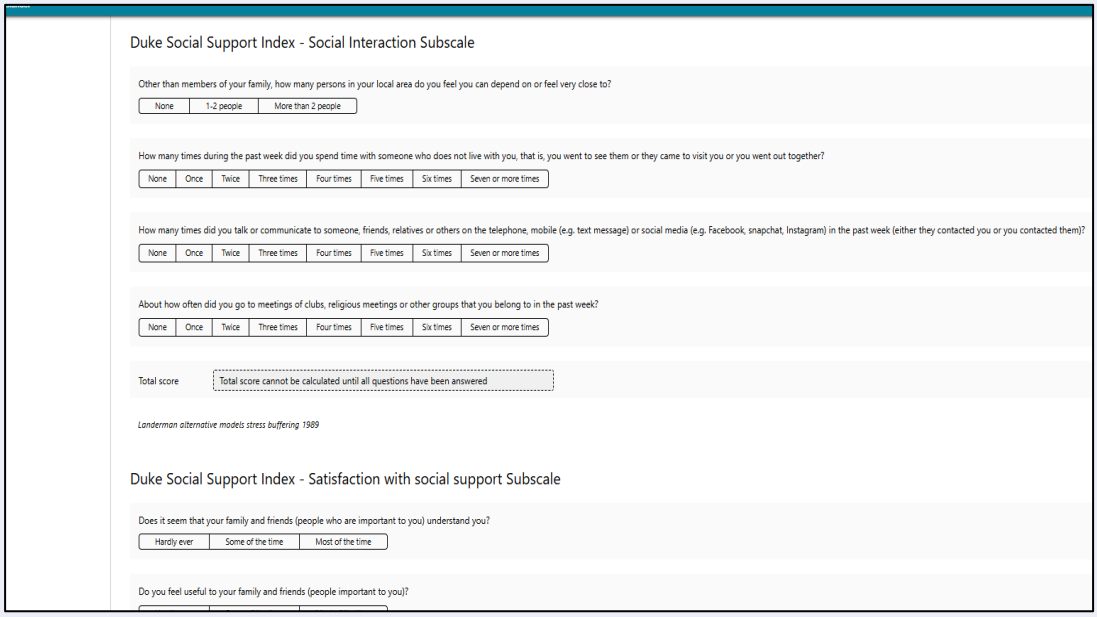
Social section of the IAT

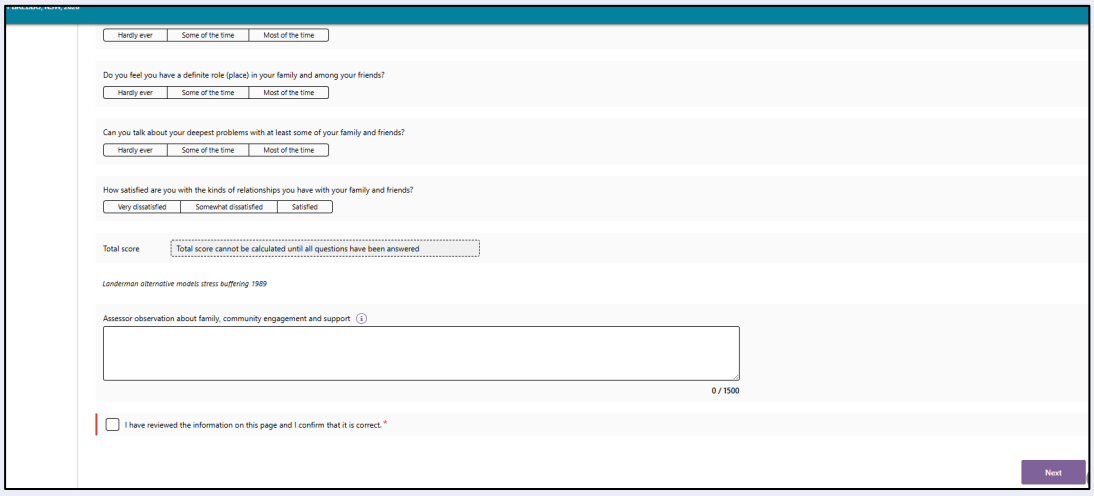




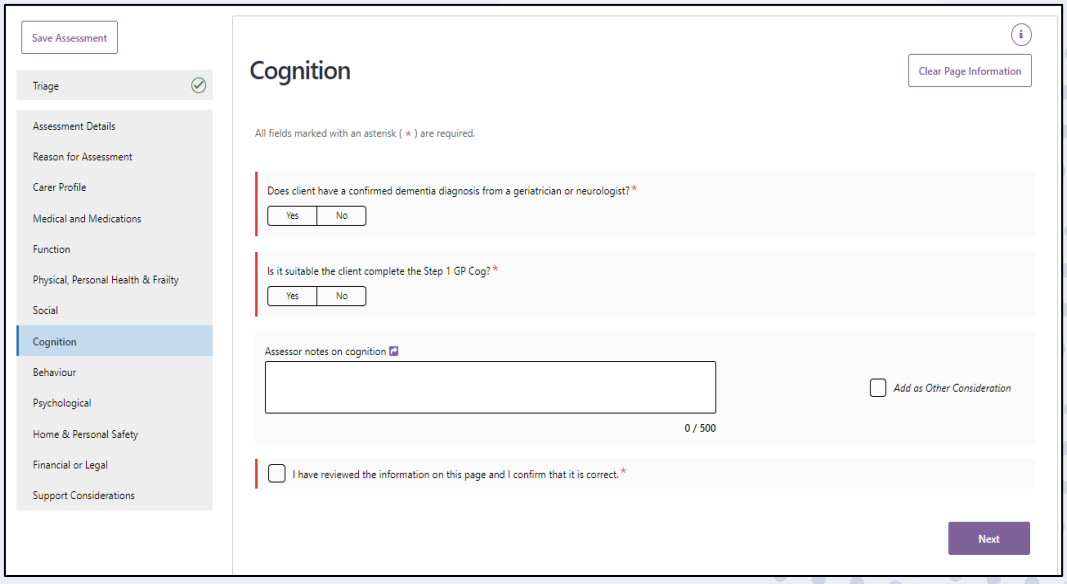


Duke Social Support Index

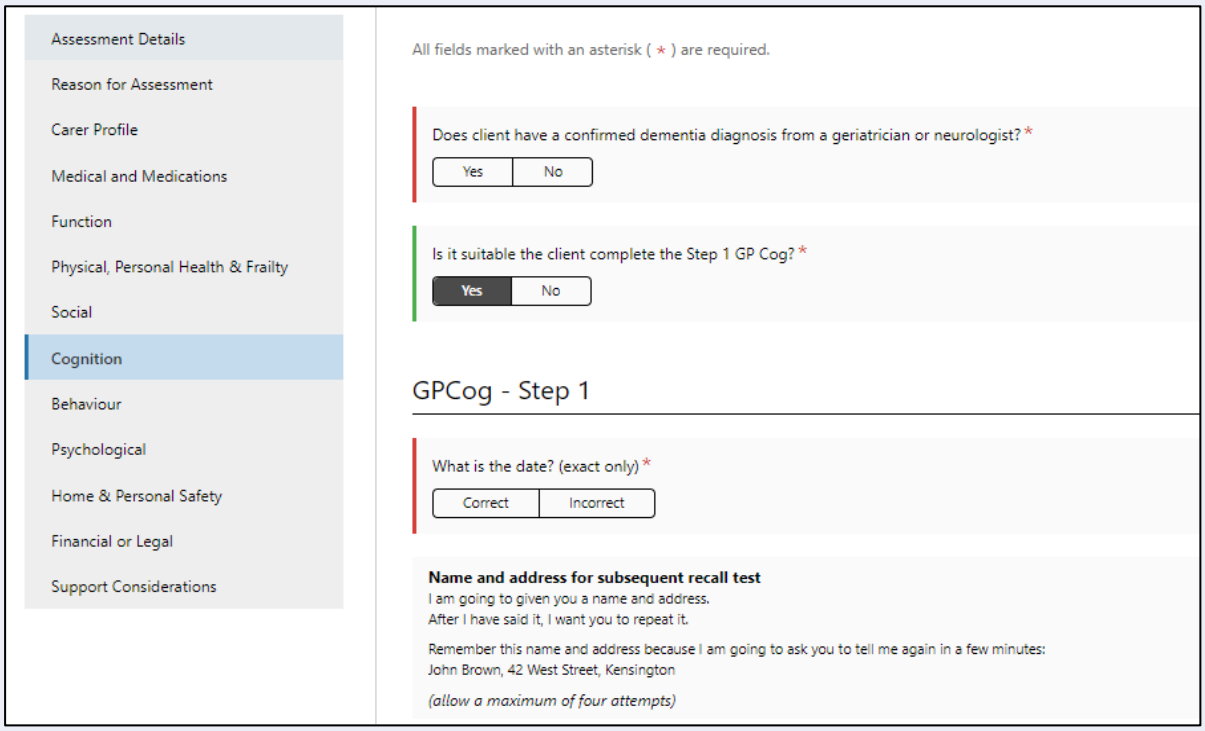




2. Other Validated Assessment Tools within the IAT will only display if required and agreed to by the client. For example, the **Step 1 GP Cog** tool is available under the **Cognition** section of IAT assessment.



If the answer is **YES** to the question *"Is it suitable the client complete the Step 1 GP Cog?"* **another set of** questions will then be displayed as shown in the example below.



3. The total score for these validated assessment tools will be auto generated based on the client's answers. Use of validated assessment tools that are not included in IAT is at the discretion of the assessment organisation. If used, you can upload the completed tools as attachments to the client record. Blank versions of these tools are available in the **Reports and Documents** section in the assessor portal.
4. The eraser button can be used to clear the responses of Validated Assessment Tools if required.

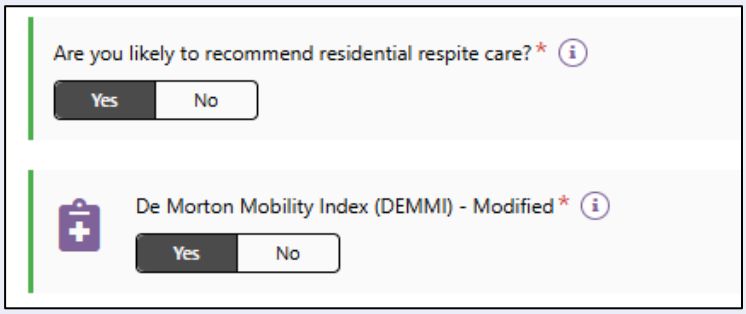
Modified de Morton Mobility Index (DEMMI) and Residential Respite Care (Clinical assessor)

The IAT includes a validated assessment tool called the DEMMI-Modified, that may only be used by clinical assessors in a face-to-face setting when assessing individuals' care needs for residential respite services.

Non-clinical assessors should **not** complete the DEMMI-Modified tool even with clinical attendance. The responses captured as part of the Modified de Morton Mobility Index (DEMMI) tool becomes part of the Australian National Aged Care Classification (AN-ACC) initiative.

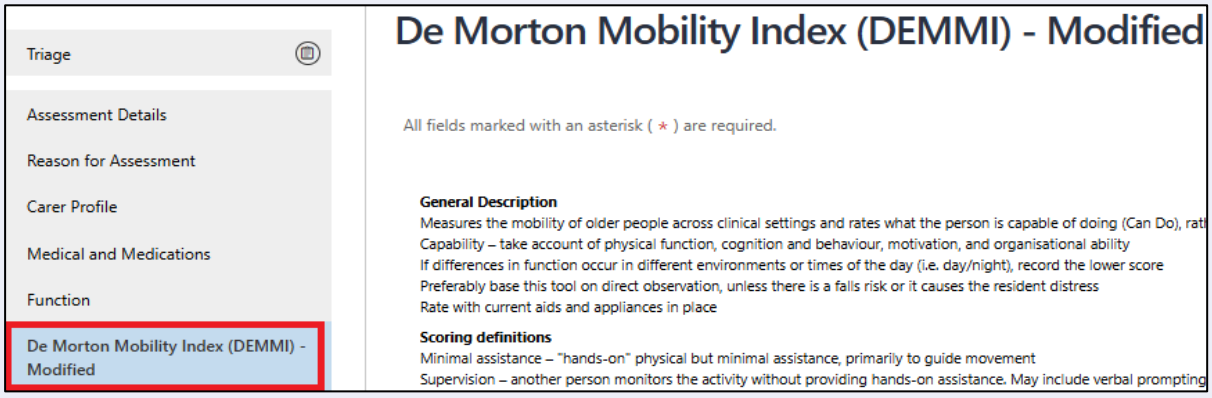
1. Under the Function section of the IAT, clinical assessors will be asked **Are you likely to recommend residential respite care?** Answer **Yes** or **No.**

   If you answer **Yes** to this question, you will be prompted with a new question: **De Morton Mobility Index?** Answer **Yes** or **No.**



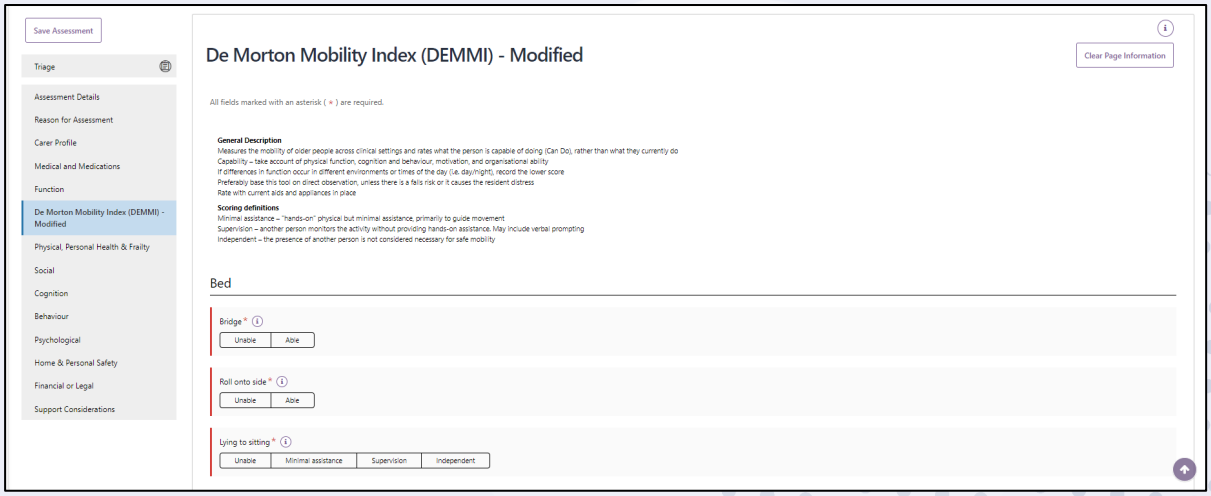
2. If you are a clinical assessor and answer **Yes** to the above question, you must complete the DEMMI assessment tool.

   The **De Morton Mobility Index (DEMMI) Modified** will appear in the navigation bar below the **Function** section.



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

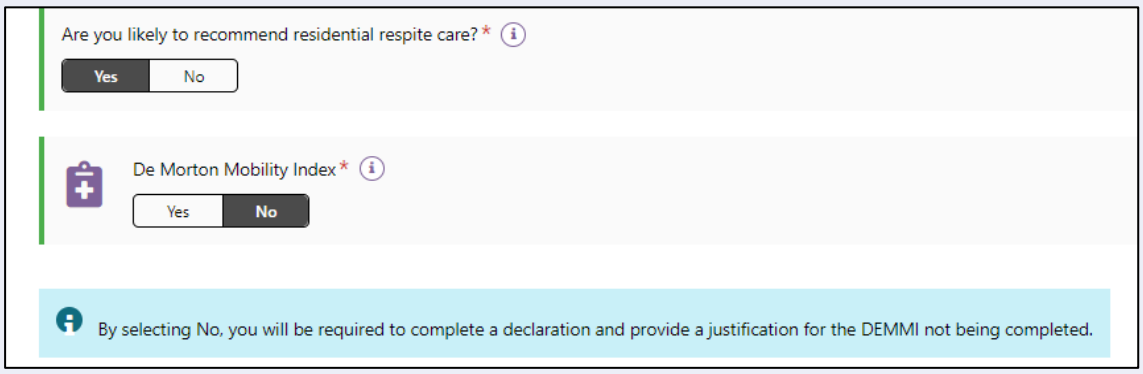
   - Bed;
   - Chair;
   - Static balance – no gait aid; and
   - Walking.



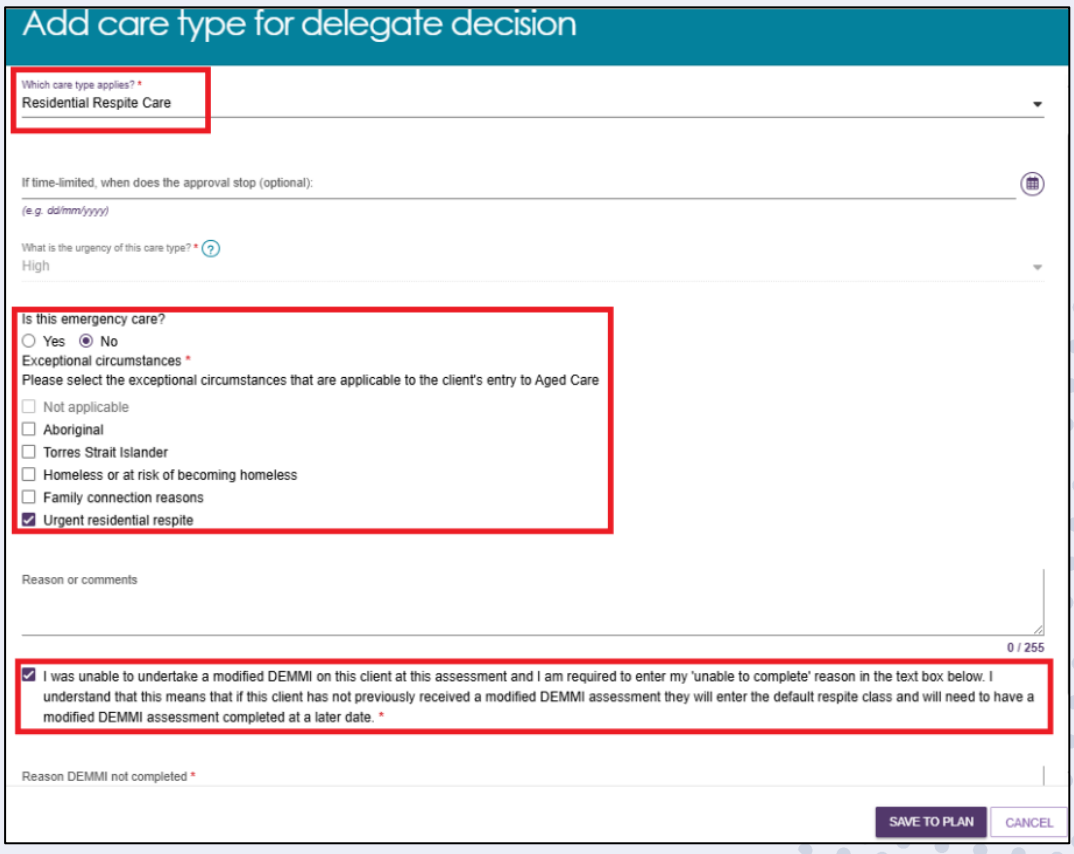
4. Once you have completed the required sections select **NEXT**.

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

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

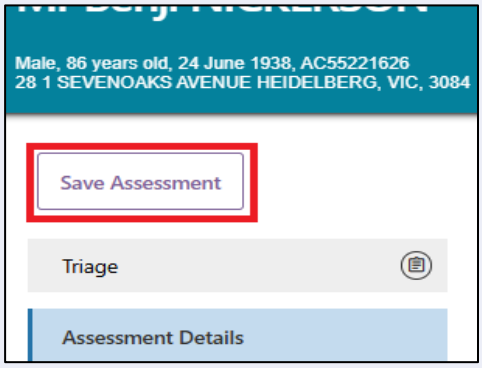


6. This screenshot shows the declaration and the text field for not completing the DEMMI in the **ADD CARE TYPE FOR DELEGATE DECISION** pop up.

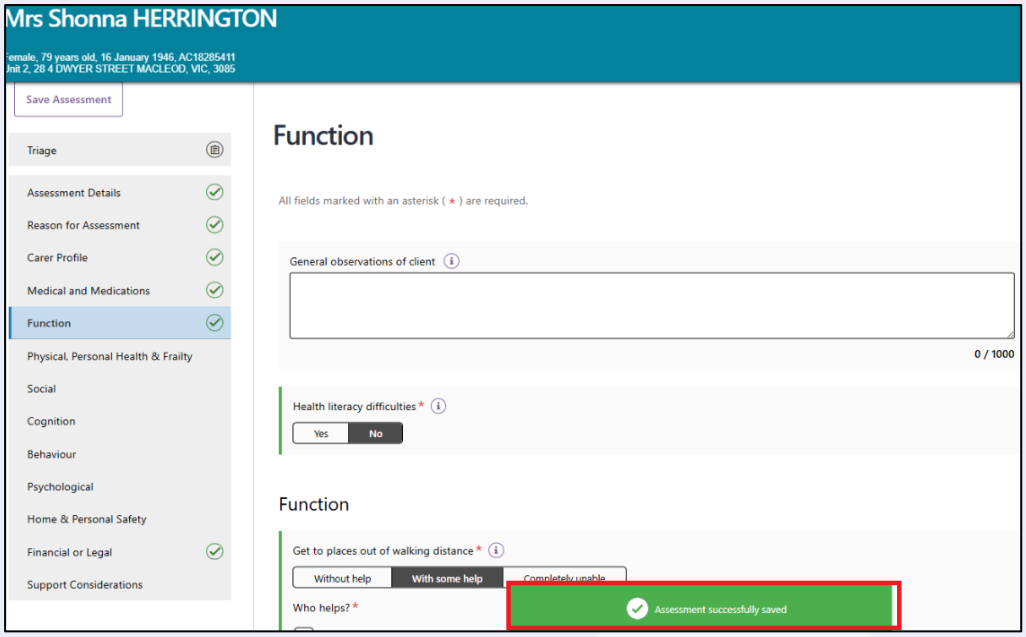


Saving an assessment

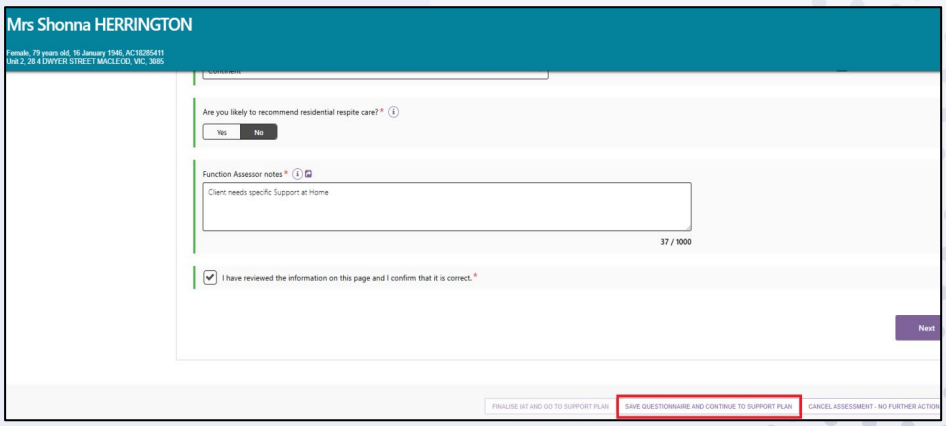
1. If you have not finished completing the assessment and want to complete it later, you can select **Save Assessment**.



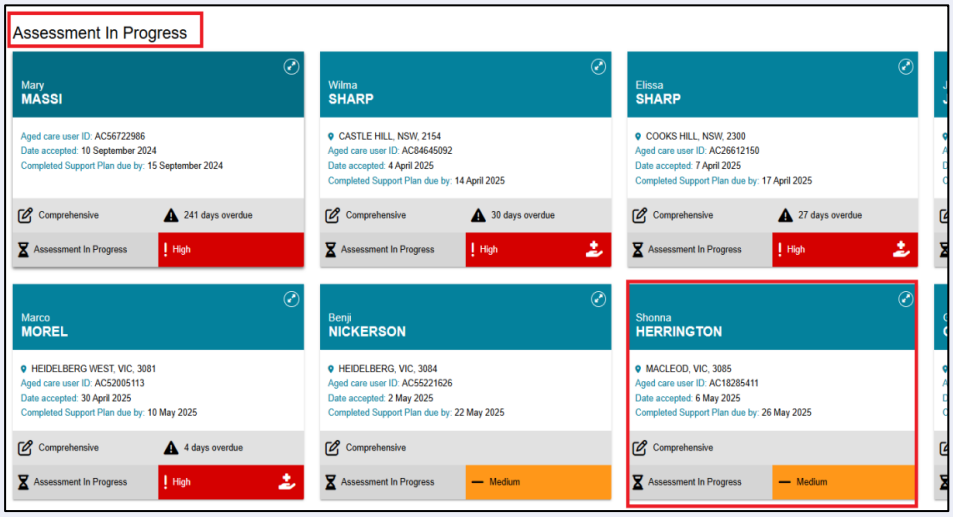
2. A green banner will then display at the bottom of your screen advising of the successful save.



3. You can then continue completing the assessment with the client at another time. You can also select **SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN** down the bottom of the assessment if you wish to navigate to the support plan but are not yet finished with the assessment.

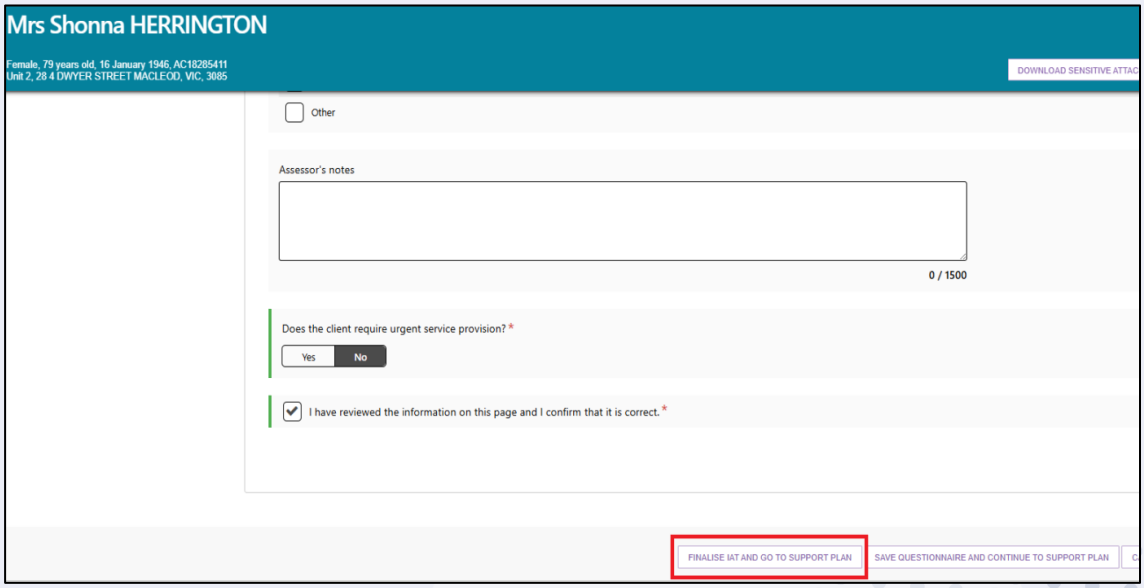


4. The record will appear under **Assessment In progress** in your **Current assessments** tab. To prevent any potential loss of information captured during the assessment, or when the portal is idle, the assessment will auto-save regularly.

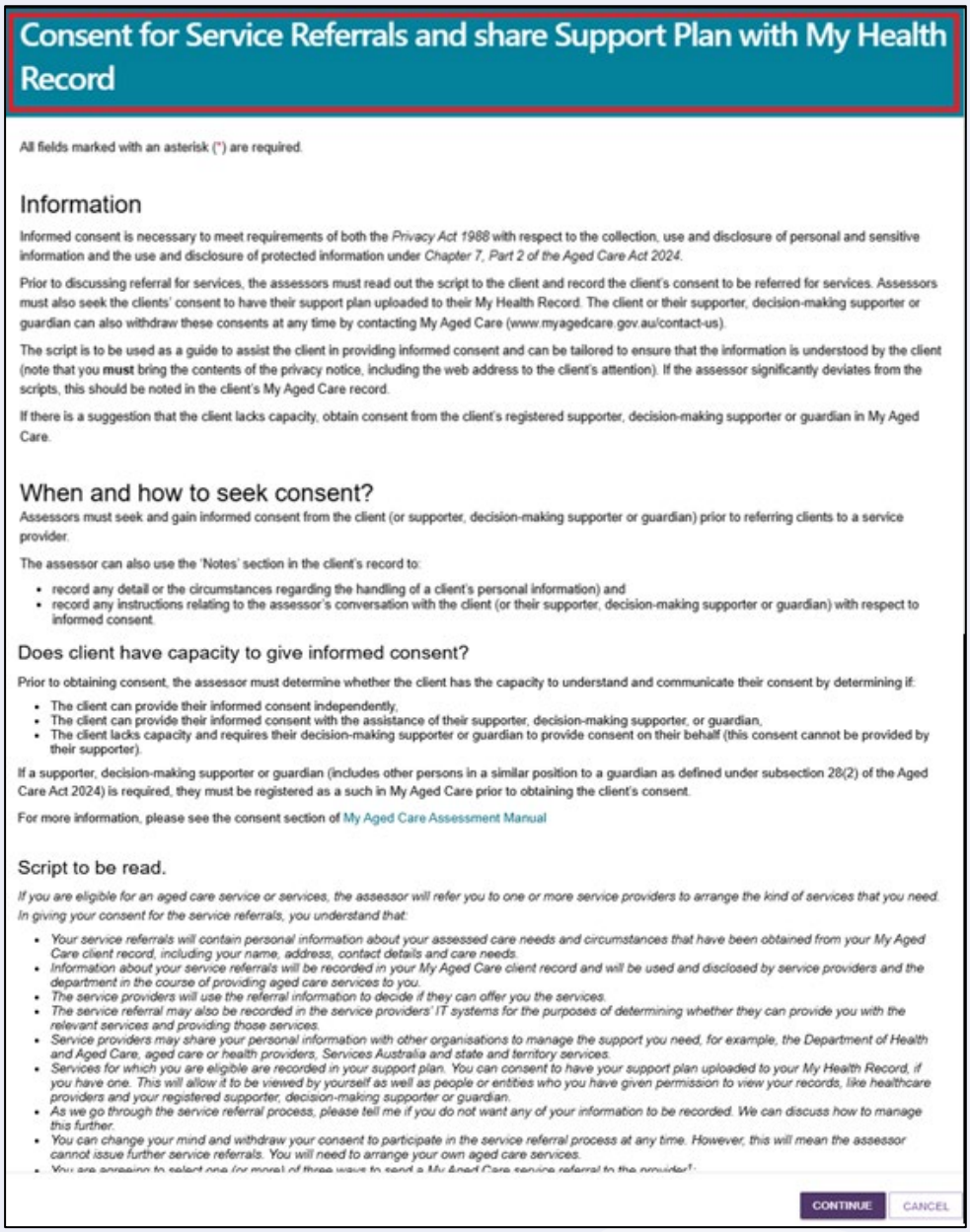


Finalising an assessment

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



2. A pop-up will then display asking for consent to share their support plan via their My Health Record.



Consent for Service Referrals and share Support Plan with My Health Record

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

Information

Informed consent is necessary to meet requirements of both the *Privacy Act 1988* with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under *Chapter 7, Part 2 of the Aged Care Act 2024*.

Prior to discussing referral for services, the assessors must read out the script to the client and record the client's consent to be referred for services. Assessors must also seek the clients' consent to have their support plan uploaded to their My Health Record. The client or their supporter, decision-making supporter or guardian can also withdraw these consents at any time by contacting My Aged Care (www.myagedcare.gov.au/contact-us).

The script is to be used as a guide to assist the client in providing informed consent and can be tailored to ensure that the information is understood by the client (note that you **must** bring the contents of the privacy notice, including the web address to the client's attention). If the assessor significantly deviates from the scripts, this should be noted in the client's My Aged Care record.

If there is a suggestion that the client lacks capacity, obtain consent from the client's registered supporter, decision-making supporter or guardian in My Aged Care.

When and how to seek consent?

Assessors must seek and gain informed consent from the client (or supporter, decision-making supporter or guardian) prior to referring clients to a service provider.

The assessor can also use the 'Notes' section in the client's record to:

- record any detail or the circumstances regarding the handling of a client's personal information) and
- record any instructions relating to the assessor's conversation with the client (or their supporter, decision-making supporter or guardian) with respect to informed consent.

Does client have capacity to give informed consent?

Prior to obtaining consent, the assessor must determine whether the client has the capacity to understand and communicate their consent by determining if:

- The client can provide their informed consent independently,
- The client can provide their informed consent with the assistance of their supporter, decision-making supporter, or guardian,
- The client lacks capacity and requires their decision-making supporter or guardian to provide consent on their behalf (this consent cannot be provided by their supporter).

If a supporter, decision-making supporter or guardian (includes other persons in a similar position to a guardian as defined under subsection 28(2) of the Aged Care Act 2024) is required, they must be registered as a such in My Aged Care prior to obtaining the client's consent.

For more information, please see the consent section of My Aged Care Assessment Manual

Script to be read.

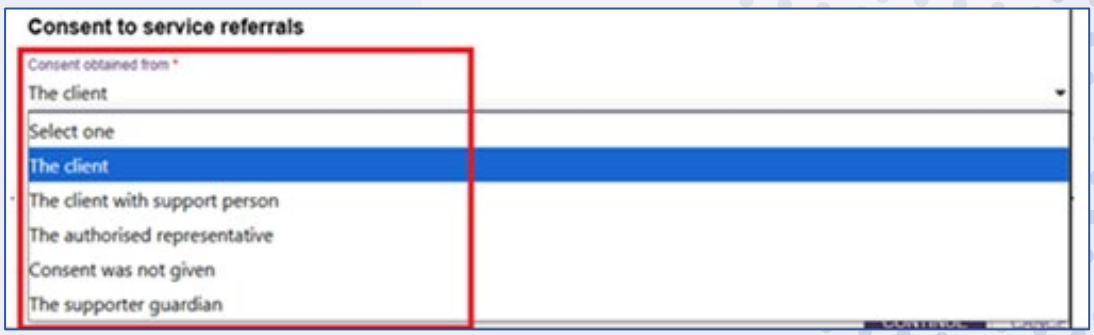
If you are eligible for an aged care service or services, the assessor will refer you to one or more service providers to arrange the kind of services that you need.
In giving your consent for the service referrals, you understand that:

- *Your service referrals will contain personal information about your assessed care needs and circumstances that have been obtained from your My Aged Care client record, including your name, address, contact details and care needs.*
- *Information about your service referrals will be recorded in your My Aged Care client record and will be used and disclosed by service providers and the department in the course of providing aged care services to you.*
- *The service providers will use the referral information to decide if they can offer you the services.*
- *The service referral may also be recorded in the service providers' IT systems for the purposes of determining whether they can provide you with the relevant services and providing those services.*
- *Service providers may share your personal information with other organisations to manage the support you need, for example, the Department of Health and Aged Care, aged care or health providers, Services Australia and state and territory services.*
- *Services for which you are eligible are recorded in your support plan. You can consent to have your support plan uploaded to your My Health Record, if you have one. This will allow it to be viewed by yourself as well as people or entities who you have given permission to view your records, like healthcare providers and your registered supporter, decision-making supporter or guardian.*
- *As we go through the service referral process, please tell me if you do not want any of your information to be recorded. We can discuss how to manage this further.*
- *You can change your mind and withdraw your consent to participate in the service referral process at any time. However, this will mean the assessor cannot issue further service referrals. You will need to arrange your own aged care services.*
- *You are agreeing to select one (or more) of three ways to send a My Aged Care service referral to the provider[1]:*

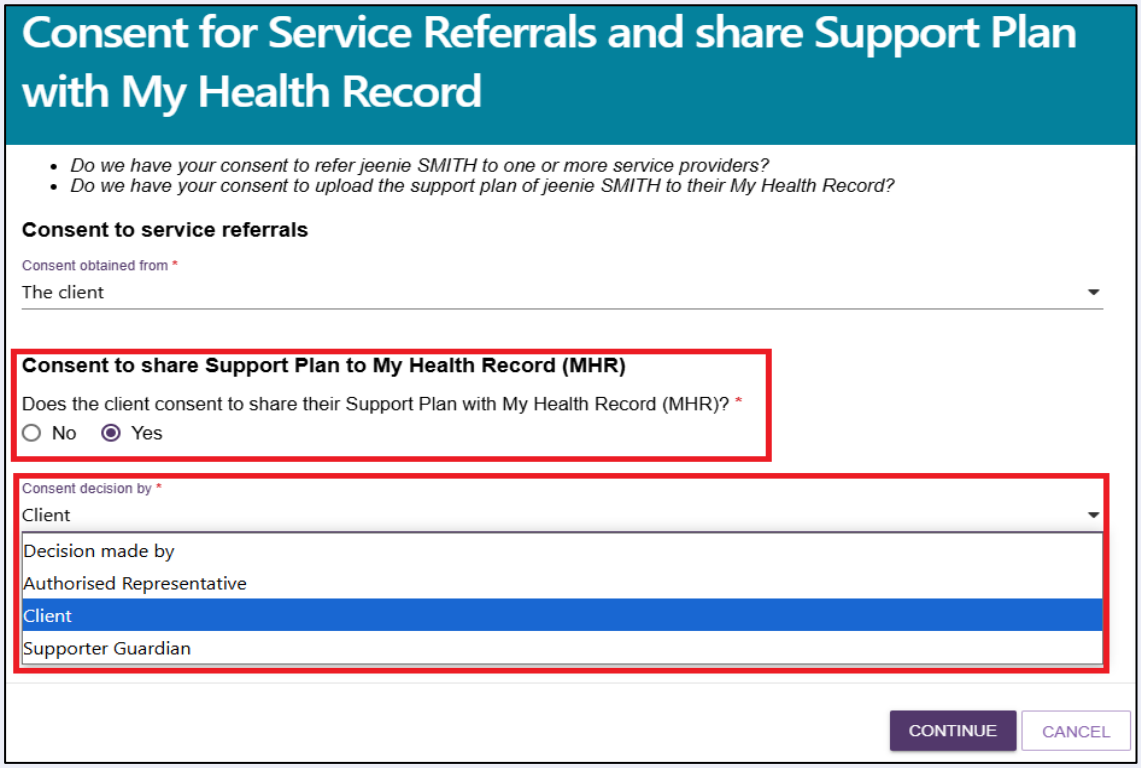
CONTINUE CANCEL

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

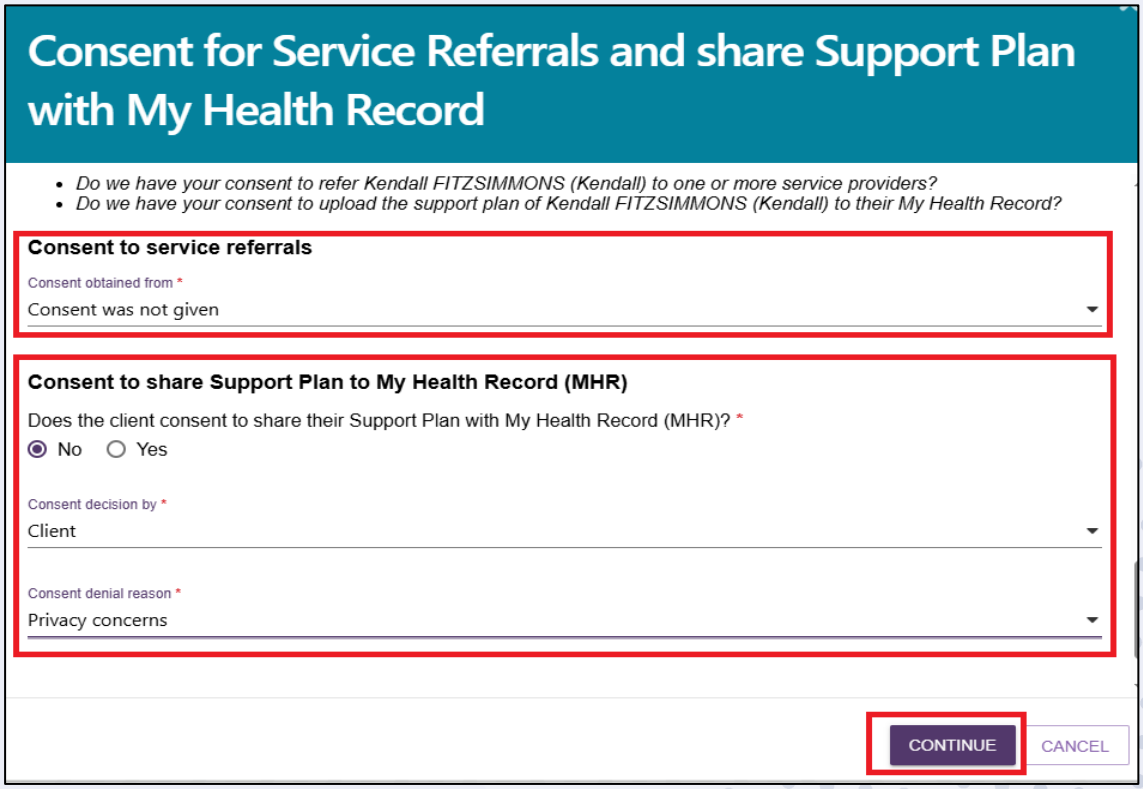
3. After reading the Consent to Service Referrals information to the client or their supporter, select the applicable consent option based on their consent decision.



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



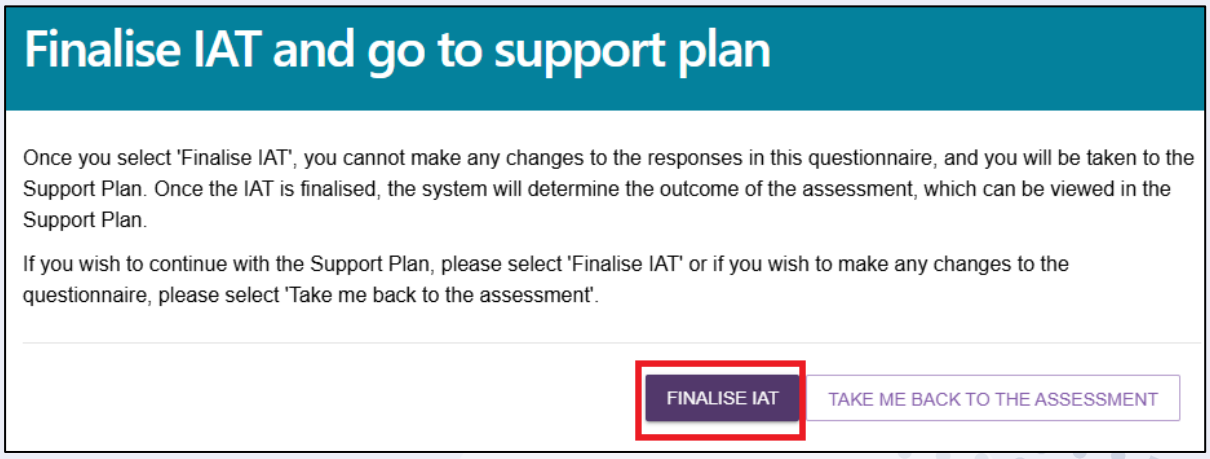
If consent has not been provided, select **No**. You will then be required to select a reason for the decision not to provide consent from the drop-down menu. Next, select **CONTINUE**.



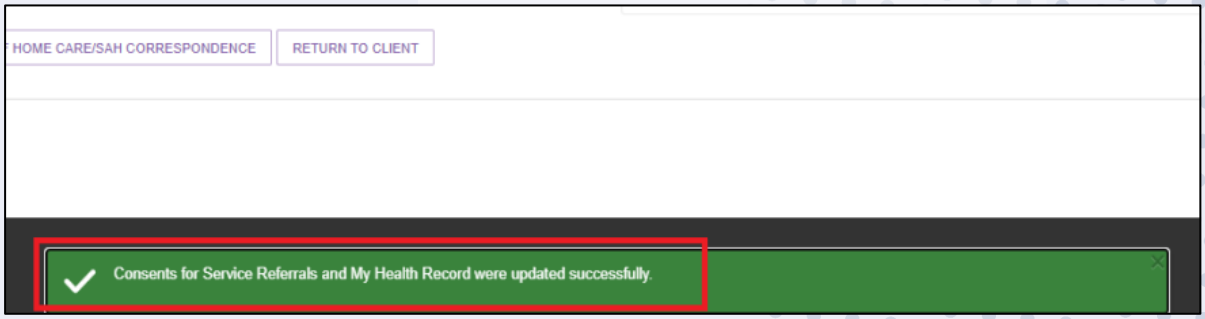
5. If the consent decision has been made by a Supporter guardian, then the Supporter guardian's first name must be entered before selecting **CONTINUE**.

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

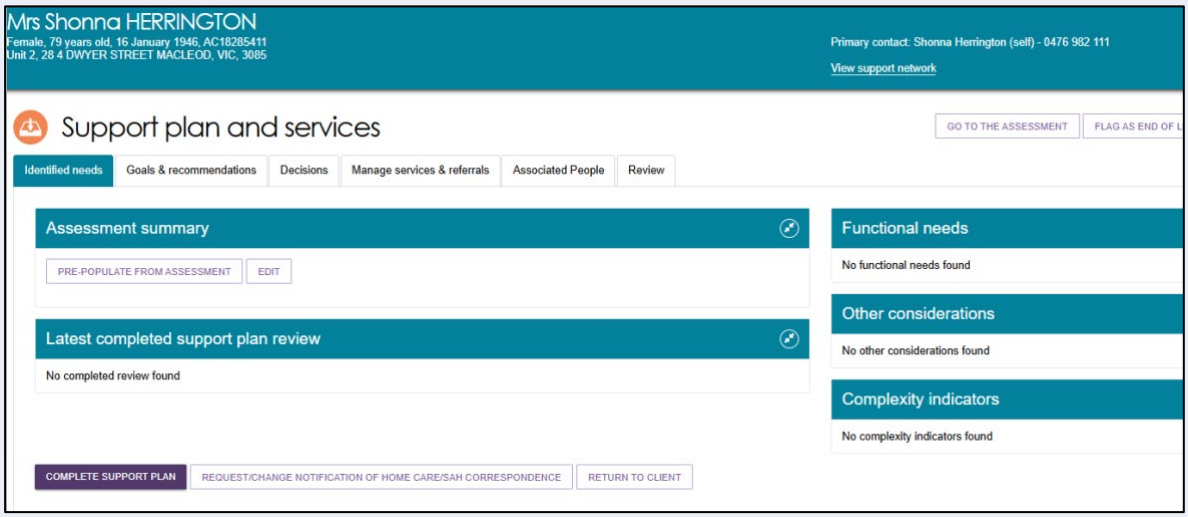
! Once the IAT has been finalised it cannot be edited. Therefore, it is important to ensure all information has been correctly captured before selecting **FINALISE IAT**.



7. A green banner *"***Consents for Service Referrals and My Health Record were updated successfully"** will appear at the bottom of the screen confirming that the save was successful.



8. You will then be re-directed to the client's **Support plan and services** page to complete the client's support plan. If the client consented to sharing their support plan via their My Health Record, a green banner will display at the bottom of the **Support plan and services** page if this was successfully linked.

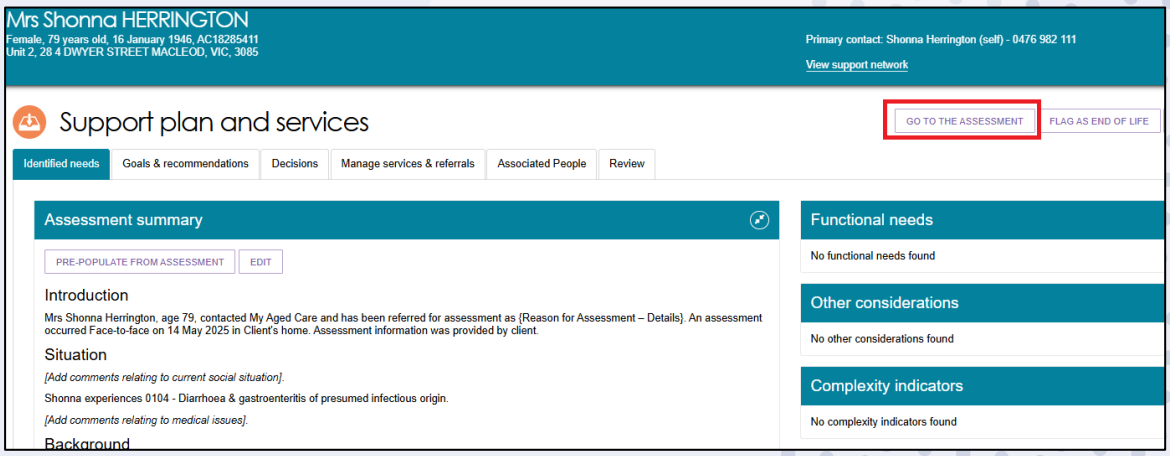


! If the client's My Health Record is not successfully linked an amber error banner will display in place of the green banner. If the 'Unable to share data as the system could not find an active My Health Record' error message displays the assessor should inform the client that their support plan will not be uploaded to their My Health Record and that they should contact the **My Health Record helpline on 1800 723 471** for assistance if required.

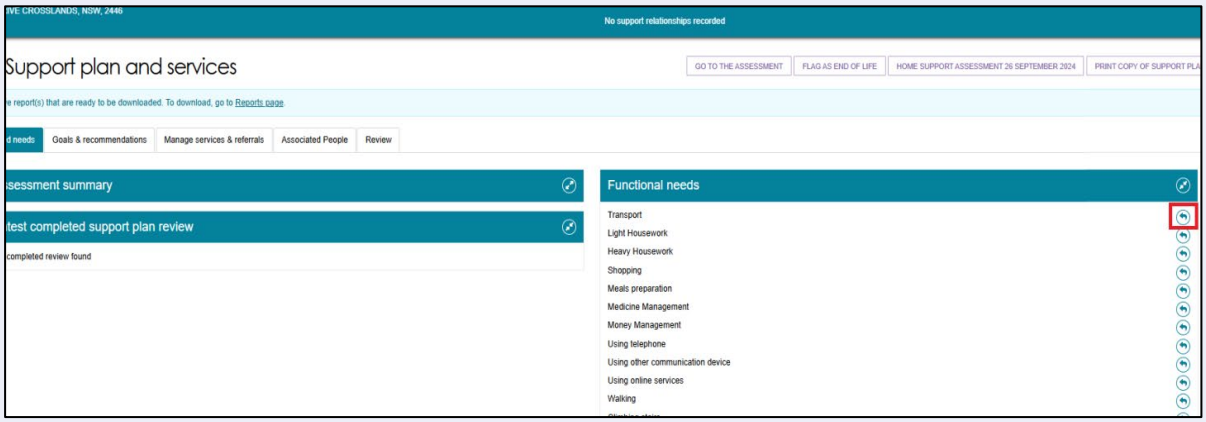
If the 'Unable to retrieve the client's Healthcare Identifier, so we cannot match them with their My Health Record. Their Support Plan cannot be made available in their My Health Record' error message displays the assessor should call the **My Aged Care service provider and assessor helpline on 1800 836 799**.

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

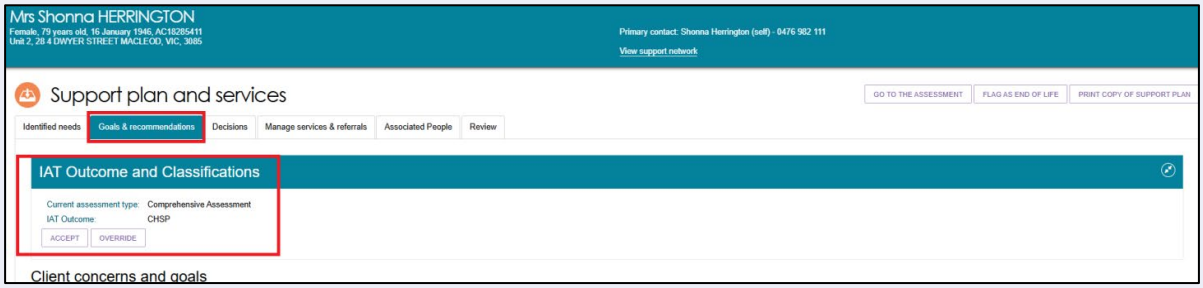
9. From the **Support plan and services** page, you can reopen the assessment by selecting **GO TO ASSESSMENT** button on the **Identified needs** tab.



10. You can also re-open the Functional needs, other considerations, complexity indicators from the Support plan and Services page by selecting the return arrow.

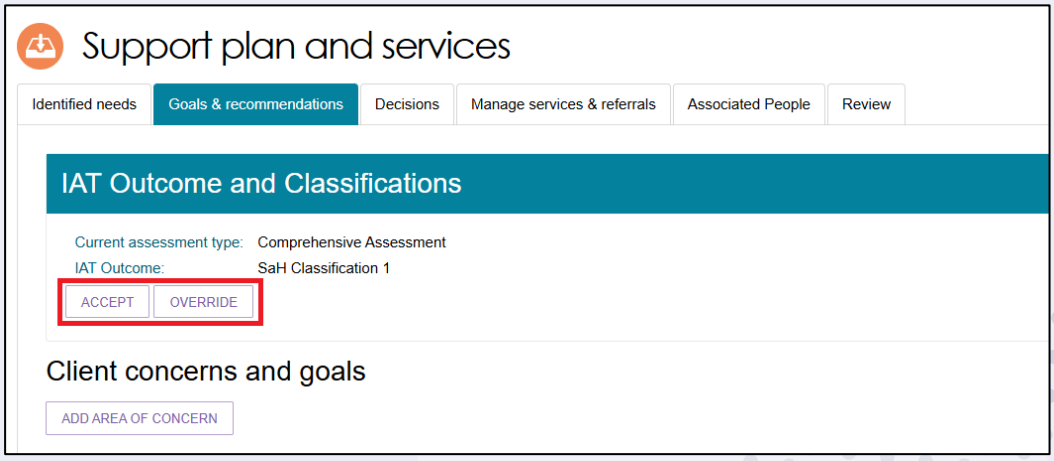


11. The IAT outcome will be displayed in the **GOALS AND RECOMMENDATIONS** tab.



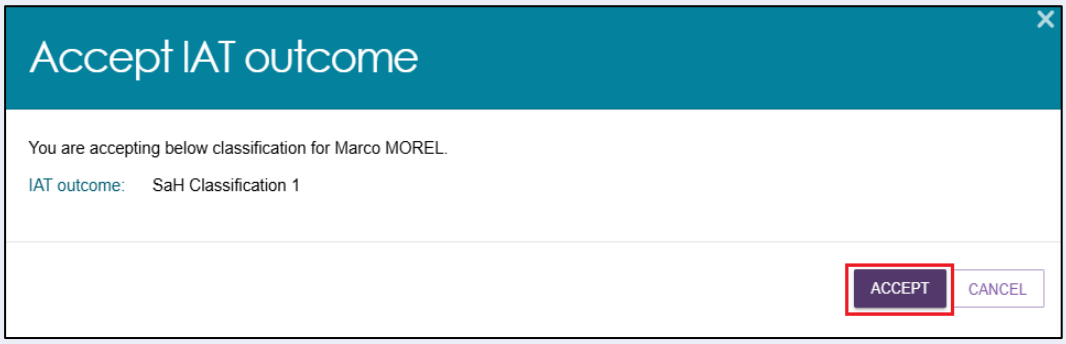
Accepting or Overriding an Assessment

1. Assessors will have the option to either **ACCEPT** or **OVERRIDE** the IAT outcome once it is displayed

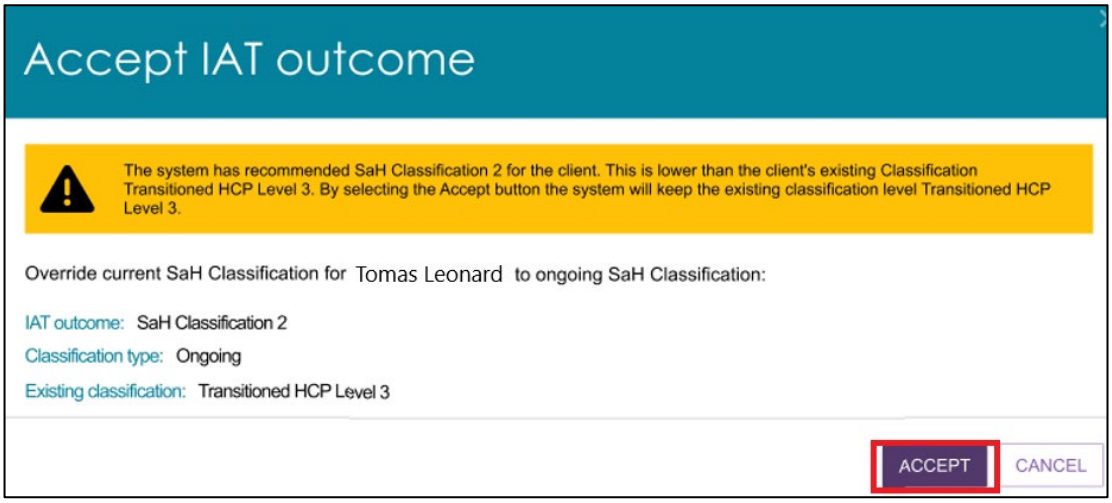


! The IAT will allow an ongoing Support at Home Classification to be overridden to a different ongoing classification level. However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs. An ongoing SaH classification outcome cannot be overridden to an ongoing lower or higher SaH classification outcome (in line with section 81-10 of the Aged Care Rules).

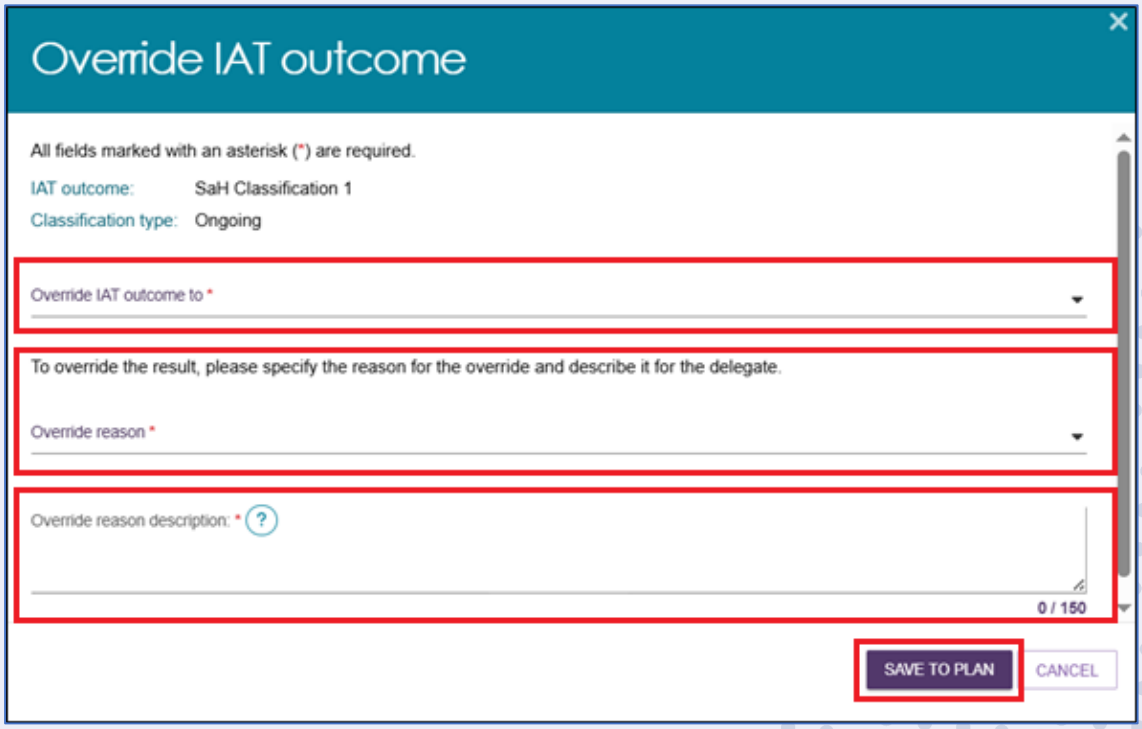
2. Selecting **ACCEPT** will bring up the **Accept IAT outcome** pop-up box as a final clarification of your decision. Then select the **ACCEPT** if you still wish to proceed.



! When completing a reassessment for a Transitioned client, if the IAT (Integrated Assessment Tool) outcome recommends a classification of **Transitioned HCP Level 1-4** a warning message will appear in the **Accept IAT Outcome** screen.



3. Selecting **OVERRIDE** will bring up the **Override IAT outcome** pop-up box in which you will need to provide the information to **Override IAT outcome to**, the **Override reason** and **Override reason description** and then select **SAVE TO PLAN**.



4. If the recommended classification is Support at Home Classification, End of Life or a Residential Care Program you will be navigated to the **Add Home support services** page to then select on the services you wish to accept or override.

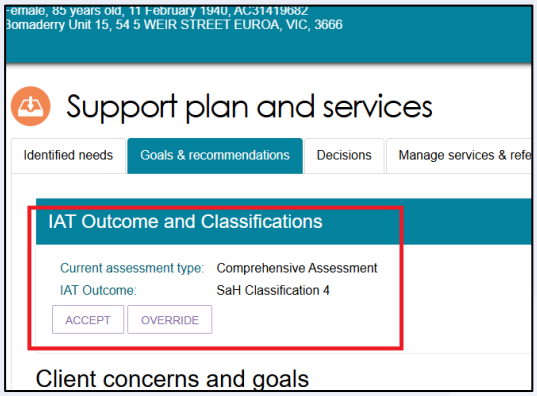
> **! Overriding from CHSP to Restorative Care Pathway**
> The IAT also allows a CHSP classification to be overridden to RCP during a comprehensive assessment. However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs. Where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules). An ongoing SaH classification must be generated to override and recommend RCP for approval.

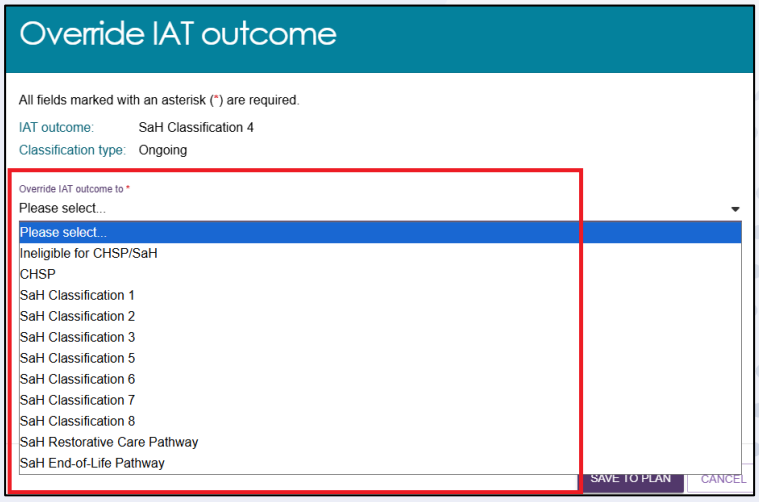
a) Assessors can override an **IAT outcome** (i.e. Ineligible for CHSP/SaH, and SaH Classifications 1–8) to **SaH Restorative Care Pathway (RCP)**. This applies to both initial assessments and reassessments, and to transitioned and non-transitioned clients.

For transitioned clients undergoing reassessment:

- The dropdown displays all SaH classifications that are equal to or higher than the client's Active Transitioned Classification.
- It also includes **SaH Restorative Care Pathway** and **SaH End-of-Life Pathway**.
- The current IAT outcome is excluded from the dropdown.
- If the IAT outcome is higher than the Active Transitioned Classification, the dropdown also includes the Active Transitioned Classification.

b) When **SaH End-of-Life Pathway** is selected and the override is confirmed, the system sets the latent classification according to the rules defined in the Override Classification Table.

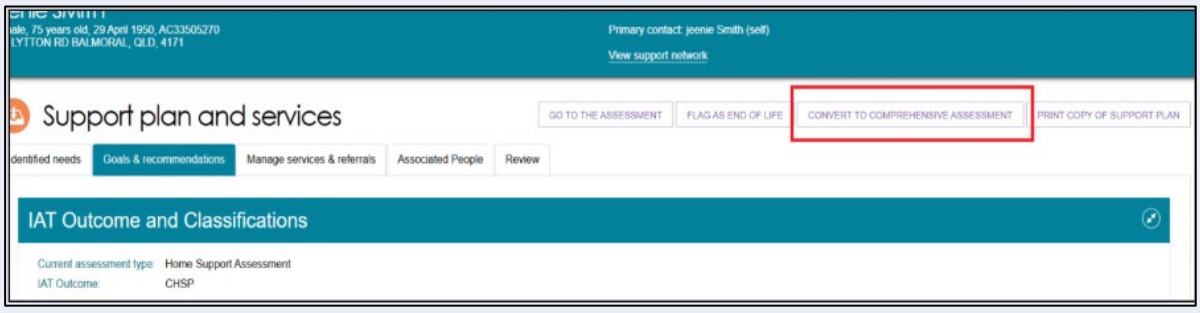




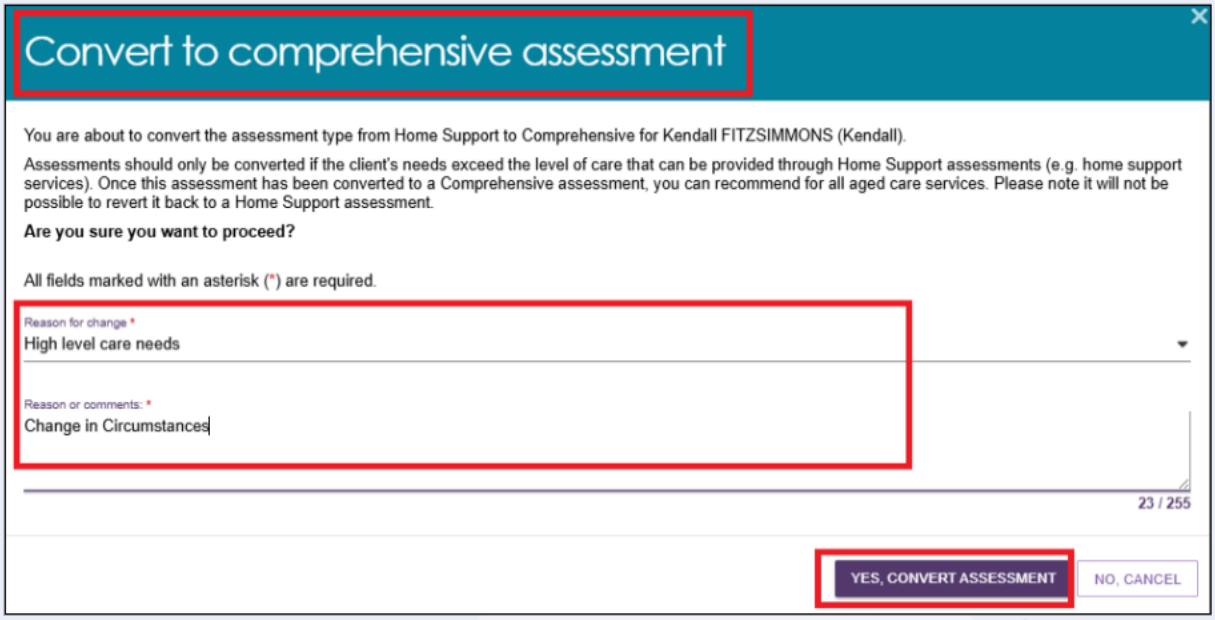
Converting to Comprehensive Assessment

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

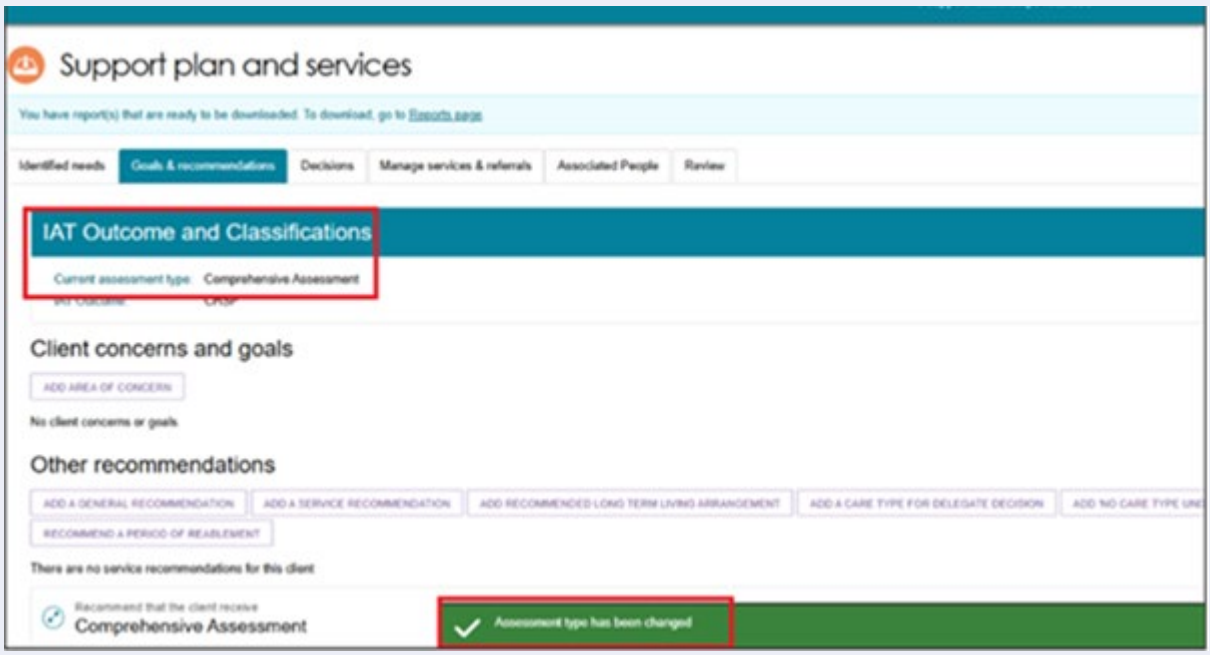
1. From the **Goals & recommendations** tab select **CONVERT TO COMPREHENSIVE ASSESSMENT** from the top right-hand side.



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



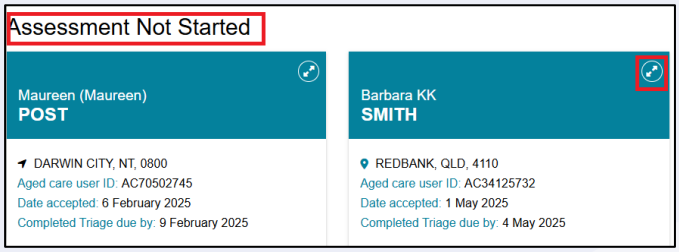
3. A green banner will then be displayed at the bottom of the screen confirming the assessment has been successfully changed. The IAT outcome will now also reflect that a comprehensive assessment has been completed.



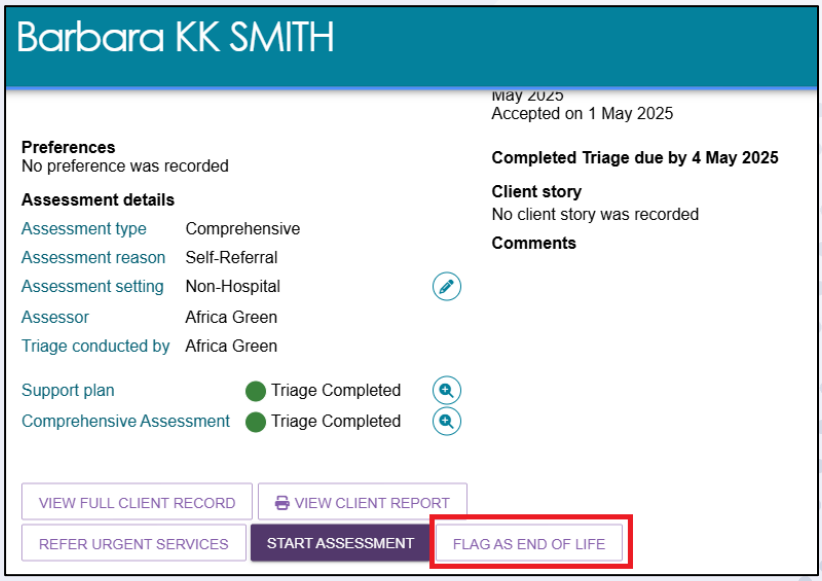
Flagging an Assessment as End of Life

Based on the clinical assessment and supporting documentation from a qualified health professional that a client is approaching **End of Life**, the assessor can flag the client as End of Life.

1. From the **CURRENT ASSESSMENTS** tab, under Assessment Not Started section select the expand card icon of the client to the flagged as End of Life.

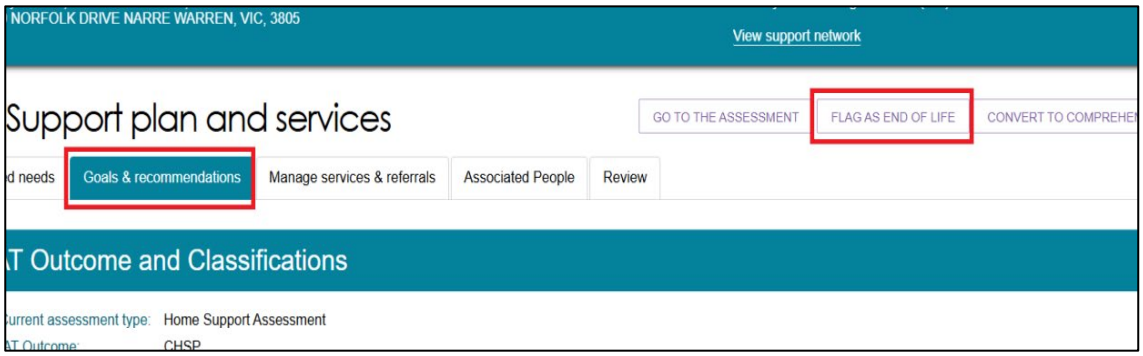


2. From the pop-up screen, Select **FLAG AS END OF LIFE** button.

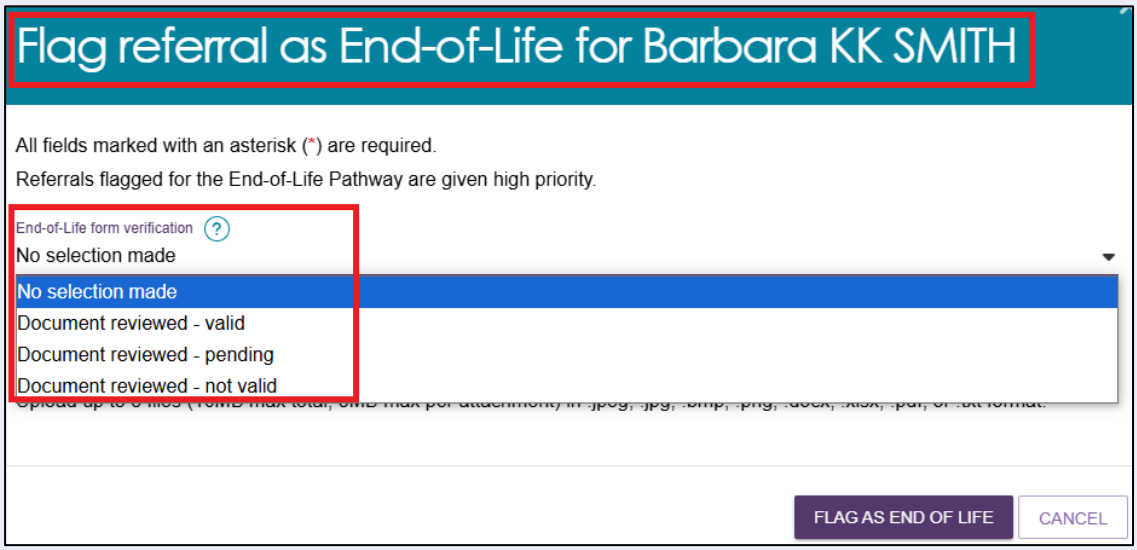


! The **END-OF-LIFE** process can also be initiated when an assessment is in progress.

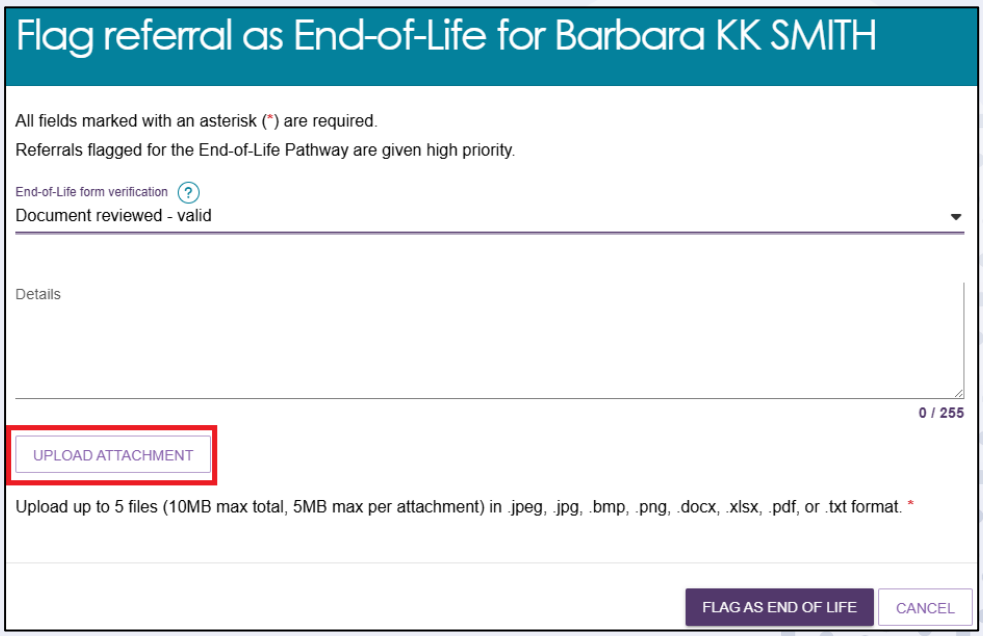
From the client's **GOALS AND RECOMMENDATIONS** tab, select the **FLAG AS END OF LIFE** button and continue through the following steps.



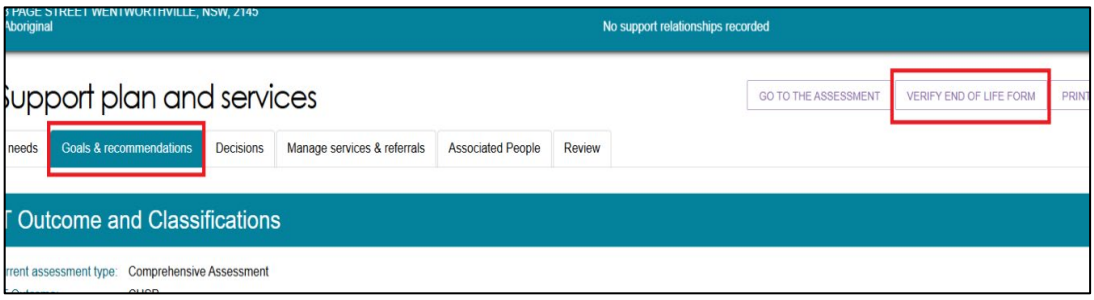
3. A pop-up screen will open prompting **END OF LIFE VERIFICATION**. Based on the documents verified, chose the relevant selection from the dropdown list.



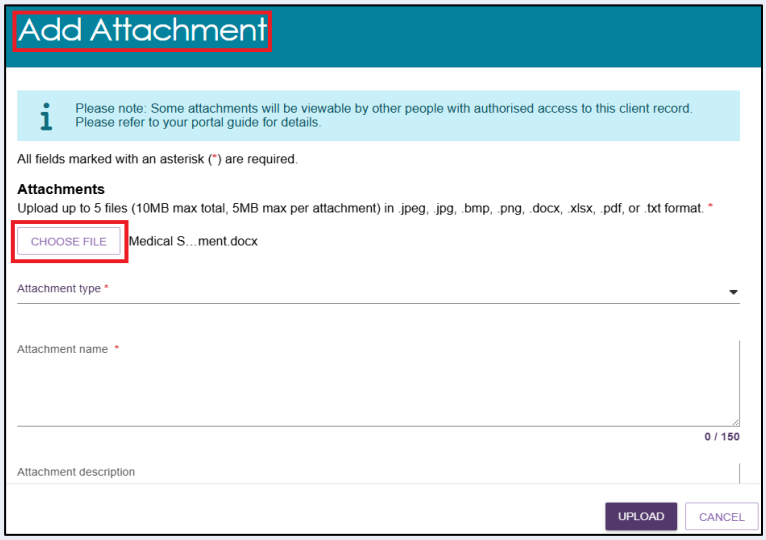
4. Select the **UPLOAD ATTACHMENT** button.



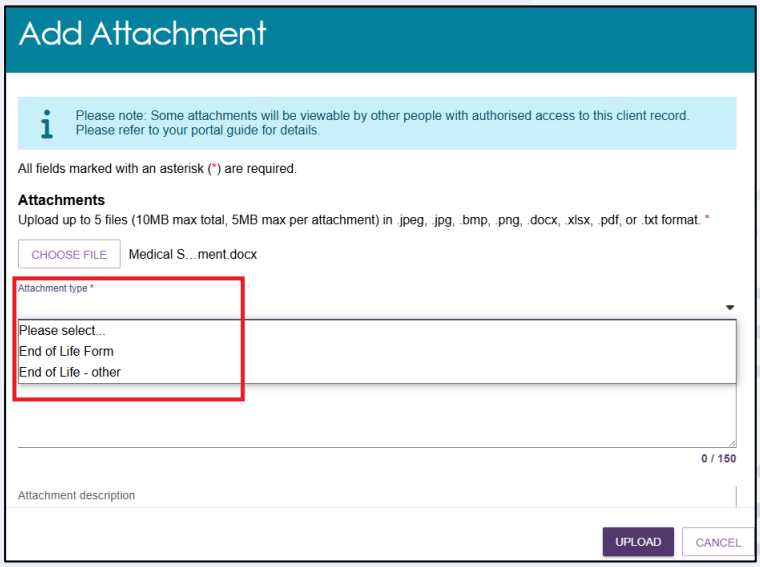
! If the relevant verification documents are not produced by the client or the produced documentations are not valid, verification process can be performed from the **GOALS AND RECOMMENDATIONS** tab by selecting **VERIFY END OF LIFE FORM** button from the top right-hand corner of the screen.



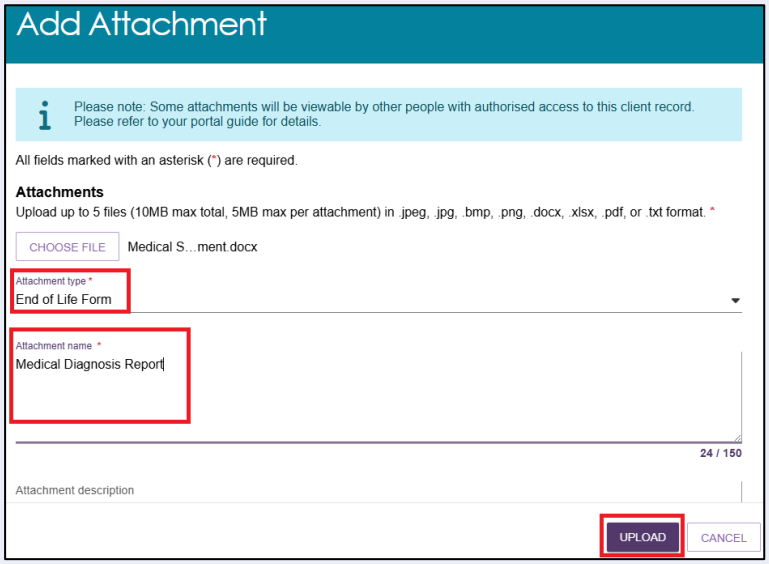
5. A Pop-up screen **ADD ATTACHMENT** will appear to add the relevant documentation supporting the Client's diagnosis by a qualified medical professional. Select **CHOOSE FILE** button to attach the documentations (Please ensure the document meets all the criteria described on the screen).



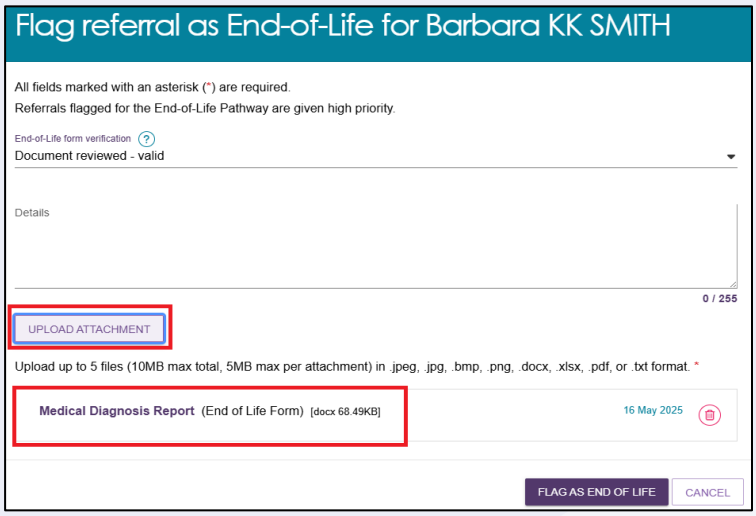
6. Select **ATTACHMENT TYPE** from the dropdown list and type the **ATTACHMENT NAME**.



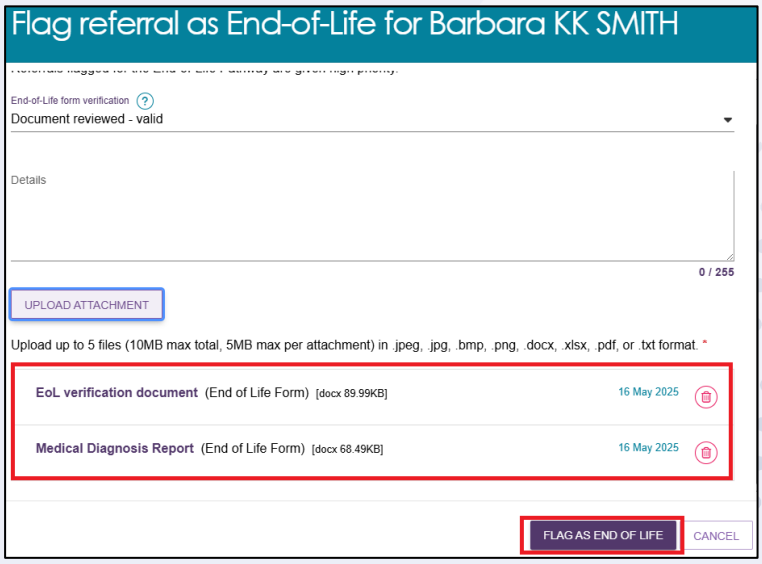
7. Select **UPLOAD**



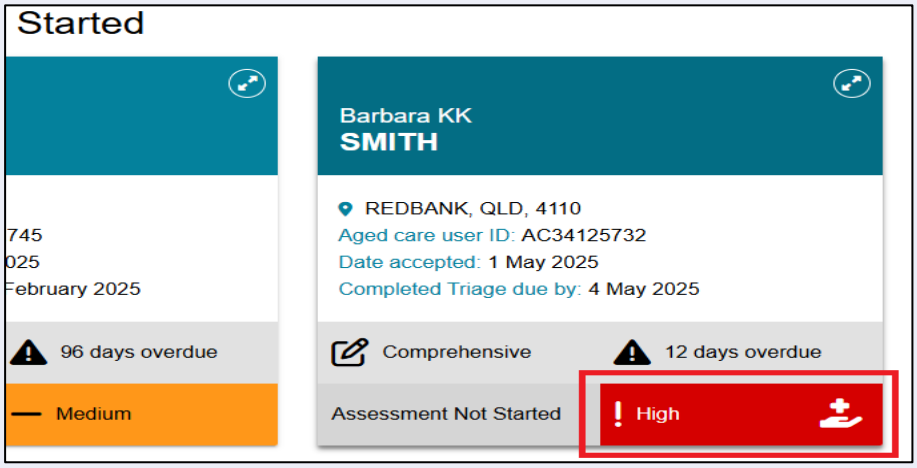
8. A pop-up screen will appear with the document attached. To attach more documentation, select **UPLOAD ATTACHMENT** (up to 5 files can be attached. Please ensure the attachments meets all the required criteria).



9. Once all relevant documents are attached, Select **FLAG AS END OF LIFE**.



10. On the **CURRENT ASSESSMENTS** screen, the client will be displayed under **ASSESSMENT NOT STARTED** section with a red **HAND** icon with a cross as shown in the example below.

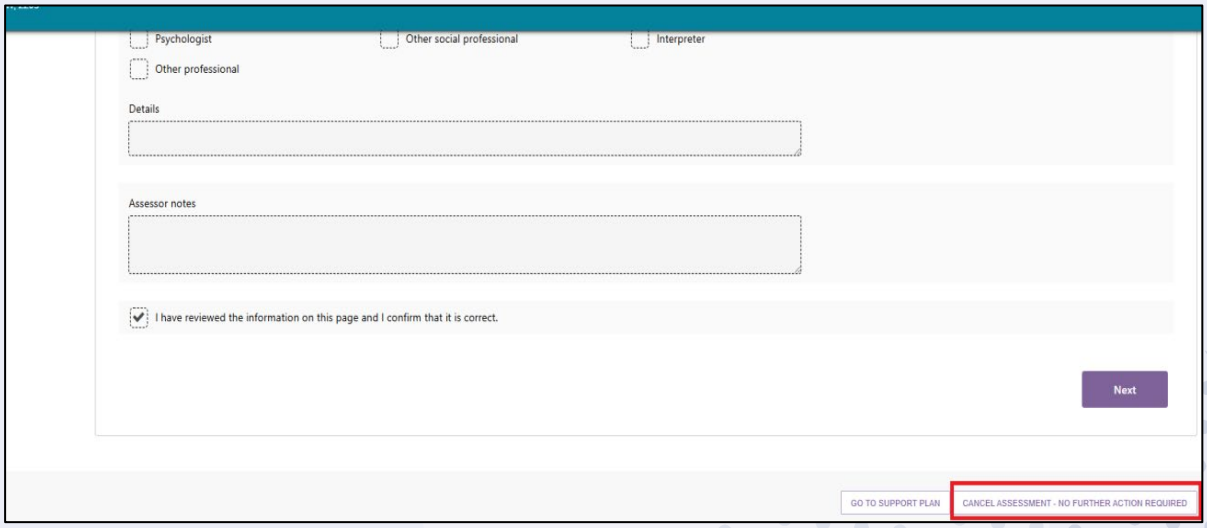


! More information on flagging a referral as End of Life can be found in Assessor Portal – User Guide 7 – Completing a Support Plan and Support Plan Review.

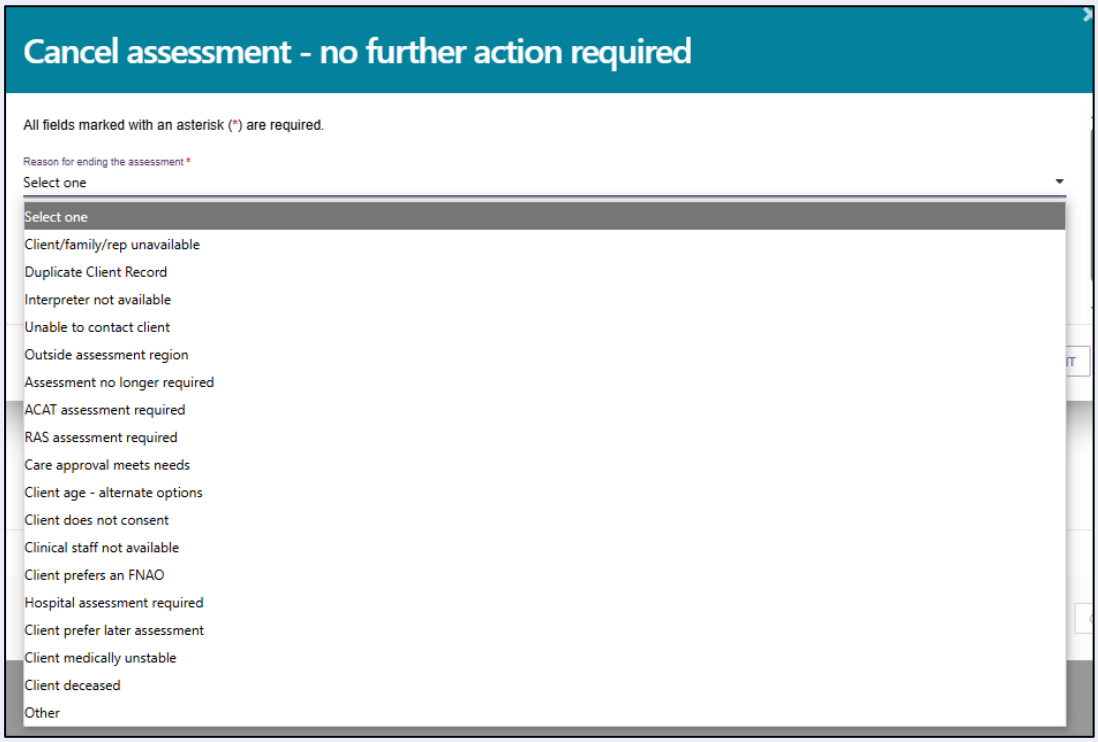
Cancelling an assessment

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

1. To cancel an assessment, Select **CANCEL ASSESSMENT- NO FURTHER ACTION REQUIRED** in the assessment.

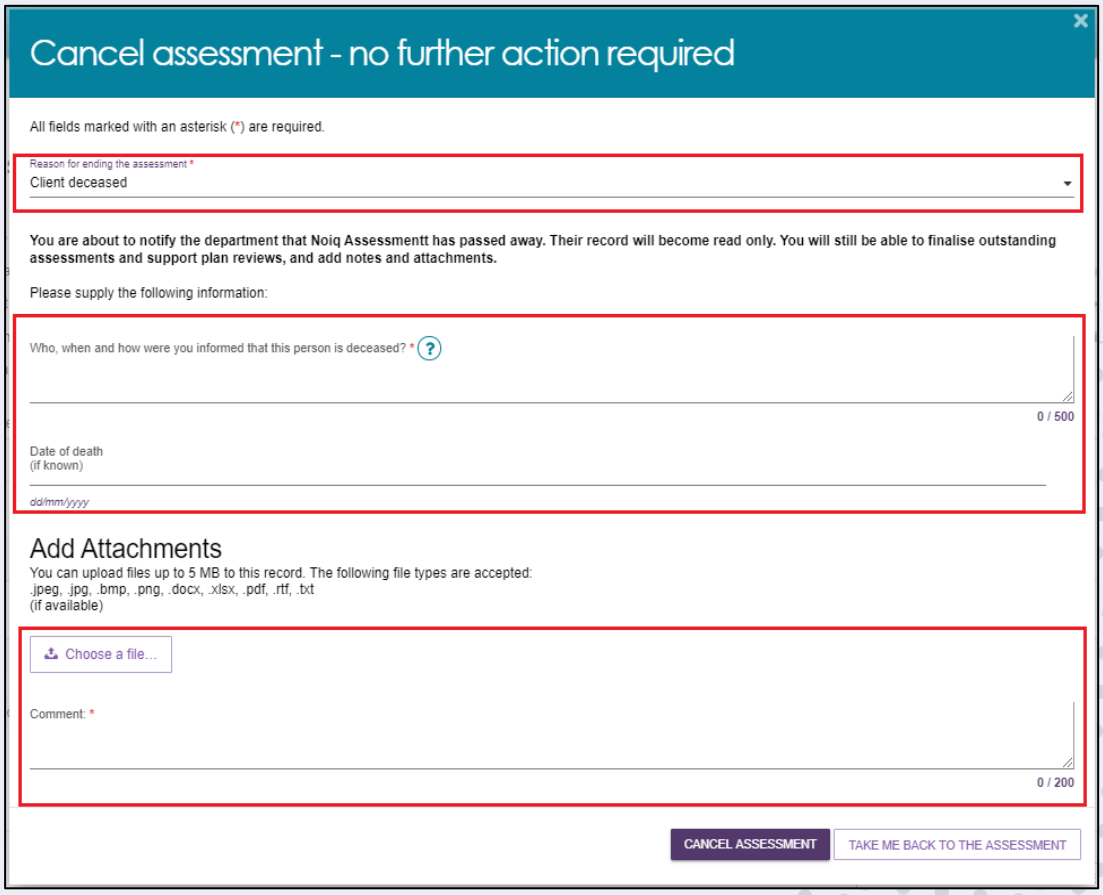


2. Record the reason for cancelling the assessment.



3. If you cancel an assessment because a client is deceased, you will need to supply the following:

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



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

Where a client is active in the Support at Home Priority System or has been assigned an aged care service, this will remove the client from the Support at Home Priority System and withdraw any assigned services.

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

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