



## 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).

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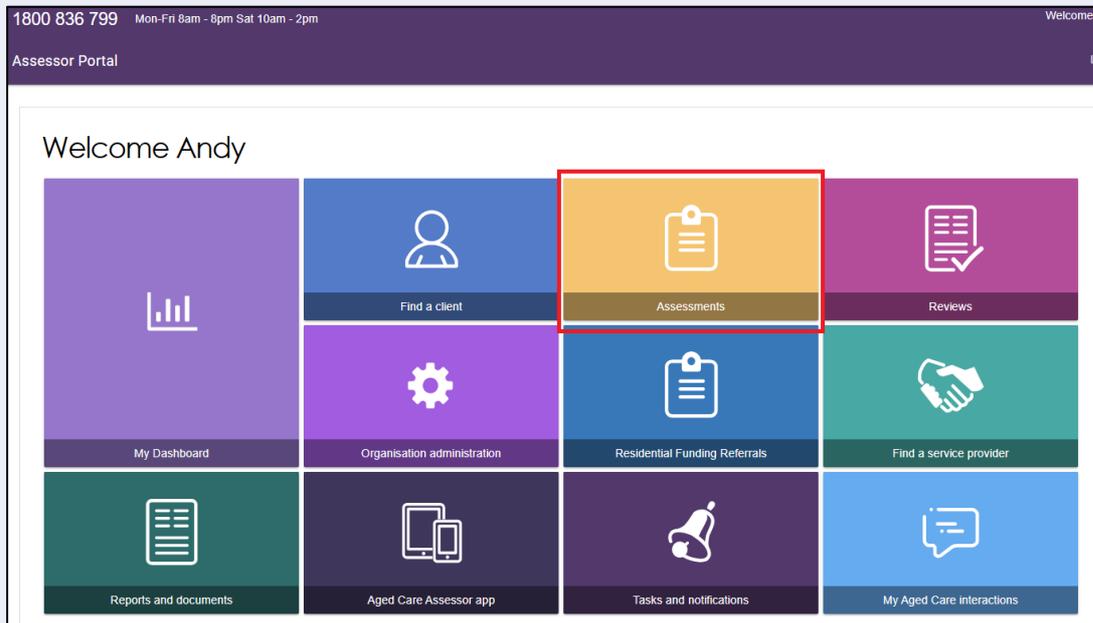
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## Viewing assessments

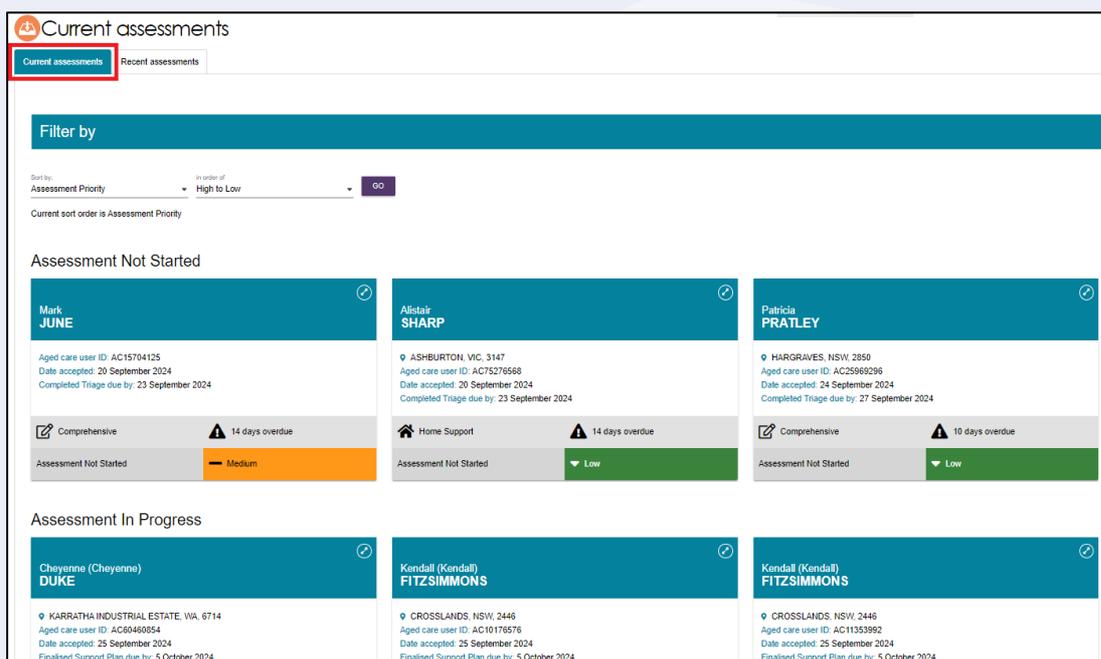
Follow these steps to view an assessment:

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.

Assessor Portal

My Dashboard Find a client referrals requests Assessments Reviews

Home | Assessments

### Recent assessments

Current assessments **Recent assessments**

Filter by

Sort by: Assessment Priority in order of: High to Low GO

Current sort order is Assessment Priority

#### Finalised

<b>Shanon (Joanna) TRAYLOR</b> HEIDELBERG HEIGHTS, VIC, 3081 Aged care user ID: AC99561094 Date accepted: 17 June 2016 Date completed/cancelled: 23 June 2016 Comprehensive Assessment Finalised High	<b>Jean HAUCK</b> IVANHOE EAST, VIC, 3079 Aged care user ID: AC42193839 Date accepted: 11 August 2016 Date completed/cancelled: 7 September 2016 Comprehensive Assessment Finalised High	<b>Jahill (Clarissa) FLOWER</b> MACLEOD VIC, 3042 Aged care user ID: AC42193839 Date accepted: 11 August 2016 Date completed/cancelled: 7 September 2016 Comprehensive Assessment Finalised
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! 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.

Current assessments

Current assessments Recent assessments

Filter by

Sort by: Assessment Priority in order of: High to Low GO

Current sort order is Assessment Priority

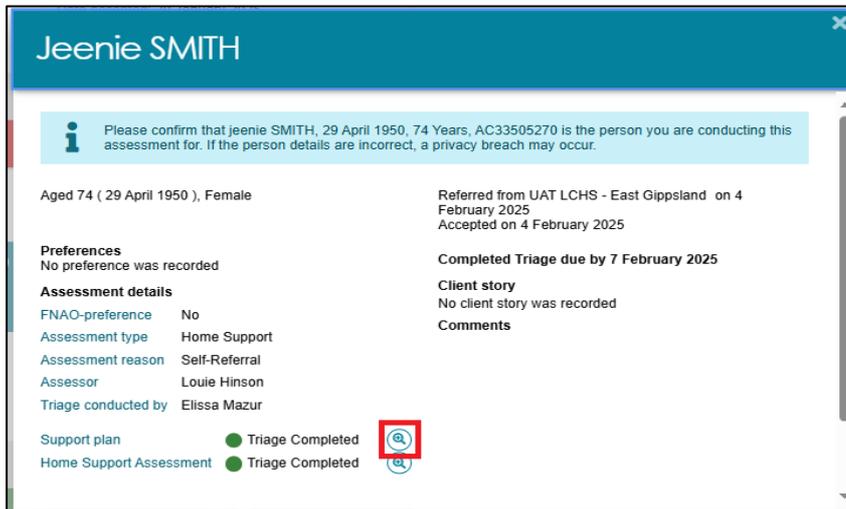
#### Assessment Not Started

<b>Ezekiel SCHWAB</b> NAREMBURN, NSW, 2065 Aged care user ID: AC44300275 Date accepted: 5 December 2022 Completed Support Plan due by: 14 January 2023 Comprehensive 492 days overdue Assessment Not Started Low	<b>Olin VETTER</b> HORNSBY, NSW, 2077 Aged care user ID: AC27988559 Date accepted: 2 March 2023 Completed Support Plan due by: 11 April 2023 Comprehensive 405 days overdue Assessment Not Started Low
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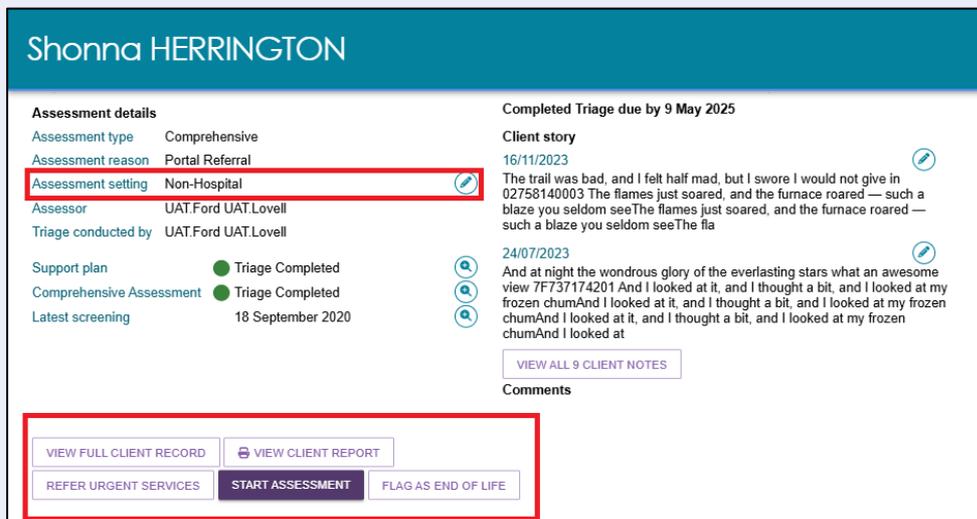


2. A summary of client information will be displayed. Assessors can access read-only versions of previous screening, triage and assessments, attachments relevant to the client's referral, and the client's support plan, if available.

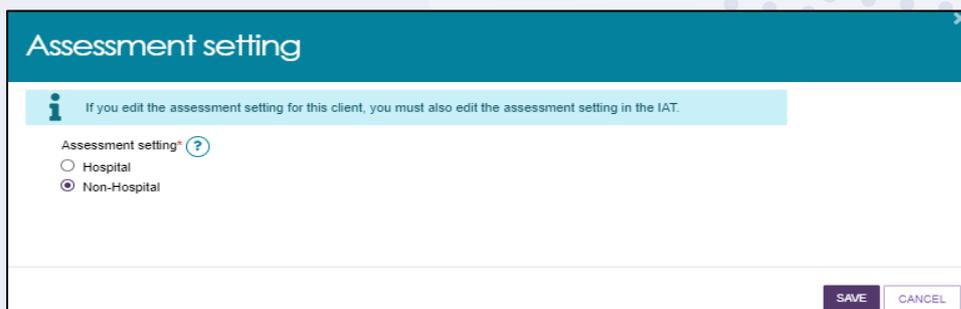
**!** When opening the client card, the Support plan status will be marked as **Triage Completed**. Assessors will also be able to view relevant details of both triage and screening by selecting the magnifying glass icon. For comprehensive assessments, clinical assessors will be able to indicate the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

Aged 75 ( 29 April 1950 ), Female

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

**Preferences**  
No preference was recorded

**Assessment details**

FNAO-preference	No
Assessment type	Home Support
Assessment reason	Self-Referral
Assessor	Obadiah Edmondson
Triage conducted by	Elissa Mazur

**Support plan** ● Triage Completed

**Home Support Assessment** ● Triage Completed

**Completed Triage due by** 7 February 2025

**Client story**  
No client story was recorded

**Comments**

**Cohabitant details**  
[Jane SHARPLAND](#)

[VIEW FULL CLIENT RECORD](#) [VIEW CLIENT REPORT](#)

[REFER URGENT SERVICES](#) **CONVERT TO COMPREHENSIVE ASSESSMENT** [START ASSESSMENT](#) [FLAG AS END OF LIFE](#)

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.

### Convert to comprehensive assessment

You are about to convert the assessment type from Home Support to Comprehensive for Patricia THOMPSON.

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

**Are you sure you want to proceed?**

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

Reason for change \*  
High level care needs

Reason or comments: \*  
0 / 255

Supervising assessor \*

[YES, CONVERT ASSESSMENT](#) [NO, CANCEL](#)

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.



## Convert to comprehensive assessment

You are about to convert the assessment type from Home Support to Comprehensive for Patricia THOMPSON.

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

Are you sure you want to proceed?

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

Reason for change \*

High level care needs

Reason or comments: \*

0 / 255

Supervising assessor \*

YES, CONVERT ASSESSMENT

NO, CANCEL

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

## Shonna HERRINGTON

### Assessment details

Assessment type Comprehensive

Assessment reason Portal Referral

Assessment setting Non-Hospital

Assessor UAT.Ford UAT.Lovell

Triage conducted by UAT.Ford UAT.Lovell

Support plan ● Triage Completed

Comprehensive Assessment ● Triage Completed

Latest screening 18 September 2020

Completed Triage due by 9 May 2025

### Client story

16/11/2023

The trail was bad, and I felt half mad, but I swore I would not give in  
02758140003 The flames just soared, and the furnace roared — such a  
blaze you seldom seeThe flames just soared, and the furnace roared —  
such a blaze you seldom seeThe fla

24/07/2023

And at night the wondrous glory of the everlasting stars what an awesome  
view 7F737174201 And I looked at it, and I thought a bit, and I looked at my  
frozen chumAnd I looked at it, and I thought a bit, and I looked at my frozen  
chumAnd I looked at it, and I thought a bit, and I looked at my frozen  
chumAnd I looked at

VIEW ALL 9 CLIENT NOTES

### Comments

VIEW FULL CLIENT RECORD

VIEW CLIENT REPORT

REFER URGENT SERVICES

START ASSESSMENT

FLAG AS END OF LIFE

- You will then be asked to record client consent.

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

If there is a suggestion that the client lacks capacity for consent, complete this form with the client's confirmed 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.



## Reports and documents

Reports **Forms** Links

### Forms

- Self-Service Form - Abbey Pain Scale [pdf 221.46KB]
- Self-Service Form - Alcohol Use Disorders Identification Test [pdf 287.27KB]
- Self-Service Form - Application for Care - October 2020 [pdf 354.04KB]
- Self-Service Form - Barthel Index of Activities of Daily Living [pdf 216.67KB]
- Self-Service Form - Brief Pain Inventory [pdf 256.86KB]
- Self-Service Form - Caregiver Strain Index [pdf 148.48KB]
- Self-Service Form - Client Record Details [pdf 364.25KB]
- Self-Service Form - NSAF Comprehensive Assessment and Support Plan 20221027 [PDF]
- Self-Service Form - Geriatric Depression Scale [pdf 217.58KB]
- Self-Service Form - Home Support Assessment and Support Plan - October 2018 [pdf 48]
- Self-Service Form - Informant Questionnaire on Cognitive Decline in the Elderly (IQ COD)
- Self-Service Form - Integrated Assessment Tool - Offline Form [pdf 1.28MB]
- Self-Service Form - K-10 [pdf 942.84KB]
- Self-Service Form - KICA-COG images [pdf 539.52KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - ADL [PDF 148.59KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Carer [pdf 695.20KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Cognitive Assessment
- Downloads - Mini Nutritional Assessment [pdf 81.38KB]
- Self-Service Form - Modified Caregiver Strain Index [pdf 216.06KB]
- Self-Service Form - My Aged Care Assessment Consent Form v2.1 [pdf 316.19KB]**
- Template - Template Notice of priority for home care service - not vary v1.0 [pdf 10.27KB]
- Template - Template Notice of priority for home care service - not vary v1.0 [pdf 10.27KB]

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.

## Consent for Assessment

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 starting the assessment, the assessors must read out the consent script to the client and record the client's consent for an aged care assessment. 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 script, 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) either prior to or when commencing the assessment or reassessment.

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 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 [My Aged Care Assessment Manual](#)

### Script to be read.

In giving your consent for an aged care assessment, you understand that:

- The assessor\* will collect information that allows them to assess your eligibility for aged care services.
- For your assessment, the assessor will collect personal information about you, such as information about your name and address, and information about your health and care needs.
- The information you provide will be recorded in your My Aged Care client record and will be used and disclosed by the assessment organisation, the Department of Health and Aged Care as well as any aged care providers while providing aged care services to you.
- If it is required for your assessment, the assessor may need to collect information from your General Practitioner, other health professionals, your family or carers.
- As part of your assessment, if you provide the assessor with personal information about other people such as your family or your support person, you confirm that you have obtained the other person's consent and that you have brought the contents of the privacy notice which is set out at [privacy notice web address](#) to their attention. Information about these other people will be included in your My Aged Care client record and will be handled in the same way as your own personal information - being for the purpose of providing aged care services to you.
- The information you provide may also be recorded in the assessment organisation's IT systems and will be used and disclosed by the assessment organisation for the purpose of determining your eligibility for aged care services.
- The assessor 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.
- As we go through the assessment, 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 assessment at any time. However, this will mean the assessor cannot complete your assessment for aged care services. You will need to arrange your own aged care services.
- You can view the privacy notice which is set out at [privacy notice web address](#) as well as the My Aged Care privacy policy on the My Aged Care website at [myagedcare.gov.au](#) for more information on how we handle your personal information.
- Do we have your consent to assess the eligibility of Patricia THOMPSON for aged care services?

Select one

Select one

- The client
- The client with support person
- Consent was not given
- The supporter/guardian



! 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.

care services.

- You can view the privacy notice which is set out at [privacy notice web address](#) as well as the My Aged Care privacy policy on the My Aged Care website at [myagedcare.gov.au](#) for more information on how we handle your personal information.
- Do we have your consent to assess the eligibility of Alistair SHARP for aged care services?

Consent Obtained From \*

Consent was not given

Please select a reason for not providing the consent \*

Client unable to consent

 Please be advised that without capturing the consent, you cannot proceed any further with the Assessment. If sure, then select 'Save and Close'. This will reject the referral.

**SAVE AND CLOSE** CANCEL

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.

### Pre-populate or start a blank assessment

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

By selecting 'Triage(Completed on 14 May 2025)' the new assessment will be pre-populated with answers from the Triage completed on 14 May 2025 and if applicable the Comprehensive Assessment completed on 17 August 2023.

Please select 'Blank Assessment' if you want to start the new assessment with no pre-population. Note that you will not be able to pre-populate the new assessment after a blank assessment has been created.

Please select\*

Triage (Completed on 14 May 2025) and  Comprehensive Assessment (Completed on 17 August 2023)

Blank Assessment

Note: The completed Triage decision will be viewable as a completed screen in the IAT.

**CONFIRM SELECTION** CANCEL

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**.



## Pre-populate or start a blank assessment

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

By selecting 'Triage(Completed on 14 May 2025)' the new assessment will be pre-populated with answers from the Triage completed on 14 May 2025 and if applicable the Comprehensive Assessment completed on 17 August 2023.

Please select 'Blank Assessment' if you want to start the new assessment with no pre-population. Note that you will not be able to pre-populate the new assessment after a blank assessment has been created.

Please select\*

Triage (Completed on 14 May 2025) and  Comprehensive Assessment (Completed on 17 August 2023)

Blank Assessment

Note: The completed triage decision will be viewable as a completed screen in the IAT.

CONFIRM SELECTION

CANCEL

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

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

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

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

## Demographic details

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

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

Remote Assessment ?

### Personal details & Identification

First name\*  
Shonna

Middle name

Last name\*  
Herrington

Address:  
Unit 2 28 4 DWYER Street MACLEOD VIC 3085  
Contact details:  
0219582129  
Medicare number:  
31777511631  
To change the above details,  
[view the full client record.](#)

### Background

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

Date of birth  
16/01/1946

or

Estimated age  
79

Gender\*  
Female

Country of birth\*  
Philippines

Ethnicity\*  
Filipino

SAVE AND CONTINUE TO ASSESSMENT

CANCEL



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

**Demographic details**

Filipino

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

- No - Neither
- Yes - Aboriginal
- Yes - Torres Strait Islander
- Yes - Both
- Not stated/inadequately desc

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

**Government ID references**

Department of Veterans' Affairs (DVA) card number

---

Medicare card number

4 digits	5 digits	1 digit	Reference
3177	- 75116	- 3	- 1

! **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.

8 BRUCE HIGHWAY, SARINA QLD 4737  
was classified as:

**Summary**    Classifications

**District of Workforce Shortage for Specialists**

Anaesthetics	Yes
Cardiology	Yes
Diagnostic Radiology	Yes
General Surgery	Yes
Medical Oncology	Yes
Obstetrics & Gynaecology	Yes
Ophthalmology	Yes
Psychiatry	Yes

Catchment: Mackay (31202)

**Distribution Priority Area for GPs**

IMGs / FGAMS	Yes
Bonded doctors	Yes

Catchment: Sarina

**Modified Monash Model**

2015	MM 5
2019	MM 5
2023	MM 5

**ASGS Remoteness Areas**

2011	Outer Regional Australia - RA Code 3
2016	Outer Regional Australia - RA Code 3
2021	Outer Regional Australia - RA Code 3

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.

The screenshot shows the 'Client details' page for Mrs Shonna HERRINGTON. The page header includes her name and contact information. A yellow warning banner states: 'If possible, please verify Shonna Herrington's mobile phone number when you are with them.' The navigation tabs include 'Client details' (highlighted with a red box), 'Support network', 'Approvals', 'Plans', 'Attachments', 'Services', 'My Aged Care interactions', 'Notes', and 'Tasks and Notifications'. The main content area is titled 'About Shonna' and contains several sections: 'Personal information' (Born 16 January 1946, Filipino, born in Philippines, widowed, lives alone, Status: Active), 'To contact Shonna' (Contact details: Preferred correspondence method is Post, 02 1958 2129 (home), 0476 982 111 (mobile) - Preferred contact number - Unverified, Daniel.Mazur@test.ecqcss.sdo (email)), 'Primary Contact' (Shonna HERRINGTON (self)), and 'Notification preferences' (No notification preferences found).

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

The screenshot shows the 'Plans' page for Mrs Shonna HERRINGTON. The navigation tabs include 'Plans' (highlighted with a red box), 'Client details', 'Support network', 'Approvals', 'Attachments', 'Services', 'My Aged Care interactions', 'Notes', 'Tasks and Notifications', and 'Residential Funding Classifications'. The main content area is titled 'Plans' and contains several sections: 'Current Episode' (Episode ID: 1-1AP86BY2, 14 May 2025 - Present, SUPPORT PLAN), 'Upcoming Review(s)' (No upcoming reviews scheduled), 'Assessment history' (highlighted with a red box, listing: Comprehensive Assessment 14 May 2025, Comprehensive Assessment 16 August 2023, Home Support Assessment 28 September 2020, Screening 18 September 2020), 'Plan history' (Support plan as at 29 September 2020, Support plan as at 17 July 2023, Support plan as at 18 August 2023, Support plan as at 6 May 2025), 'Review history' (No review history available), and 'Reablement and linking support history' (No linking support items available).



## 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.

The screenshot shows the 'Assessment Details' page for Mrs Ezekiel SCHWAB. The page header includes the client's name and contact information. The left navigation bar has 'Assessment Details' selected. The main content area contains the following fields:

- Date of assessment\***: 20/05/2024
- Participants consulted prior to the assessment\***: Yes/No
- Mode of assessment\***: Face-to-face, Over-the-phone, Via tele-health
- Assessment setting\***: Please select...

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.

The screenshot shows the 'Assessment Details' page with the 'Triage' option selected in the navigation bar. The 'Triage' option is highlighted with a red box. The main content area is the same as in the previous screenshot.

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.

The screenshot shows the assessment interface for Mrs Ezekiel SCHWAB. The page title is "Mrs Ezekiel SCHWAB" with personal details: Female, 77 years old, 17 January 1947, AC44300275, Lit Number 203 9 WILLOUGHBY ROAD HAREMBURN, NSW, 2065, Prefers to speak Arabic. On the left is a navigation menu with "Assessment Details" selected. The main content area is titled "Assessment Details" and contains a "Save Assessment" button, a "Clear Page Information" button (highlighted with a red box), and a form with fields for "Date of assessment" (20/05/2024) and "Participants consulted prior to the assessment" (Yes/No).

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

The screenshot shows a "Clear page information" pop-up dialog. It has a purple header with a close button (X). The text inside says: "Select 'Yes, clear page information' to clear information on this page. Select 'Cancel' to go back to the questionnaire." At the bottom, there are two buttons: "Cancel" and "Yes, clear page information" (highlighted with a red box).

- !** 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.

The screenshot shows a section of the assessment form. On the left is a navigation menu with "Psychological" selected. The main content area shows two questions:

- Question 2: "2. Not being able to stop or control worrying last 2 weeks?\*" with radio button options: "No, not at all", "Several days", "More than half of the days", "Nearly every day". A green vertical line is on the left of the question.
- Question 3: "3. Little interest or pleasure in doing things last 2 weeks?\*" with radio button options: "No, not at all", "Several days", "More than half of the days", "Nearly every day". A red vertical line is on the left of the question.

- 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.

Family and other support networks \* ?

Yes  No

**Details \* ?**

[To assist with completing](#)

- 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)

- 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.

Toileting - Bladder \* ?

Occasional accident (max. once per 24 hours)  Add as Functional Need

Is the client managing urinary incontinence issue? \*

Yes  No

**!** This section of IAT must be completed under your organisation's clinical governance [Clear Section](#)

Is the client able/willing to complete the Revised Urinary Incontinence Scale? \* ?

Yes  No

- 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.

Clinical Declaration and Supervisor details

I confirm that I am completing this section of the IAT under my organisation's clinical governance \*

Yes  No

Please select the supervising assessor

Start to type...

[Save Details](#) [Cancel](#)

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

Clinical Declaration and Supervisor details

Clinical Declaration: Provided    Supervising Assessor: Africa Green    Update Details

**i** This section of IAT must be completed under your organisation's clinical governance    Clear Section

Is the client able/willing to complete the Revised Urinary Incontinence Scale? \* **i**

Yes     No

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

Whether the client has any concerns or difficulties with their vision, hearing or speech. Multiple responses may be appropriate. **X**

Sensory concerns \* **i**

Yes     No

- 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.

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

NEXT

- 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.

Save Assessment

Triage

Assessment Details

**Reason for Assessment**

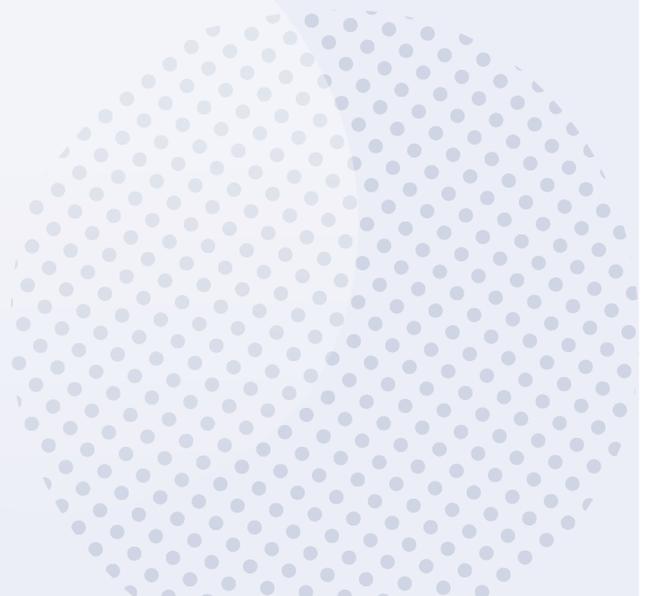
Carer Profile

Medical and Medications

Function

Physical, Personal Health & Frailty

Social



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.

Health condition(s)  Add as Other Consideration

Health Condition * <sup>1</sup>	Health Condition Description	Diagnosis Status * <sup>1</sup>	Primary Health Condition * <sup>1</sup>
1799	Other symptoms & signs n.o.s or n.e.c (includes reflux)	GP Confirmed	Primary Health Condition <span style="float: right;"><input type="checkbox"/></span>
0701	Cataracts	GP Confirmed	Primary Health Condition <span style="float: right;"><input type="checkbox"/></span>
0104	Diarrhoea & gastroenteritis of presumed infectious origin	Client reported	Primary Health Condition <span style="float: right;"><input type="checkbox"/></span>

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**.

Any additional details? <sup>1</sup>

0 / 500

Walk \* <sup>1</sup>

Without help | With some help | Wheelchair independent | Completely unable

Who helps? \*

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

Other

Is the need being met? \*

Please select...

Any additional details? <sup>1</sup>

0 / 500

Climb stairs \* <sup>1</sup>

Without help | With some help | Completely unable

Any additional details? <sup>1</sup>

0 / 500

Add as Functional Need

Home & Personal Safety Clear Page Information

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

Assess the home and garden and ask the client about:

- Any difficulty/unsteadiness/need to hold onto doors or walls when on steps/stairs or getting in and out of shower
- Any trouble getting on and off toilet
- Any trouble navigating the house at night
- Any near slips or trips on surfaces

Home and garden are safe | Minimal environmental hazards | Moderate environmental hazards requiring modification | Extremely unsafe environment

General observations of the home environment <sup>1</sup>

0 / 500

Home safety equipment client has

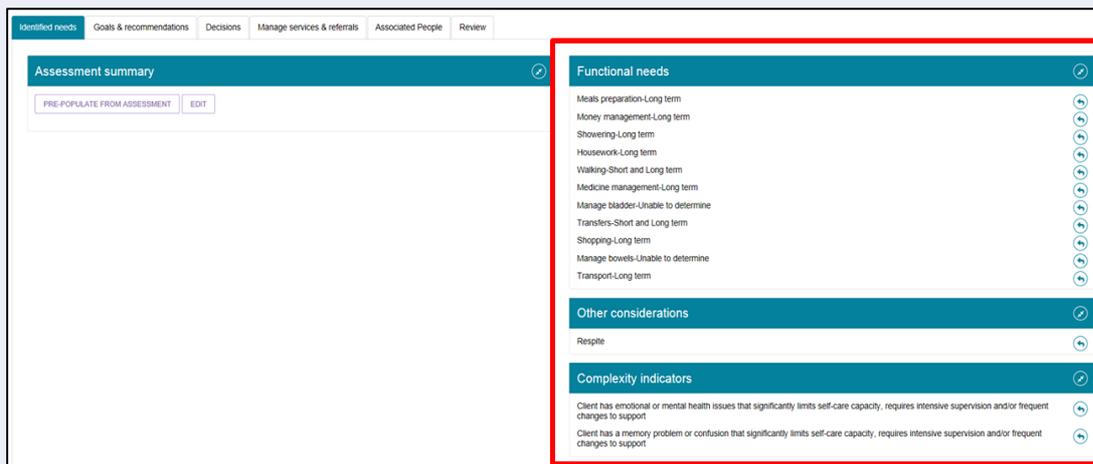
Smoke alarm(s)

Personal alarm

Add as Other Consideration  
 Add as Recommendation  
 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.





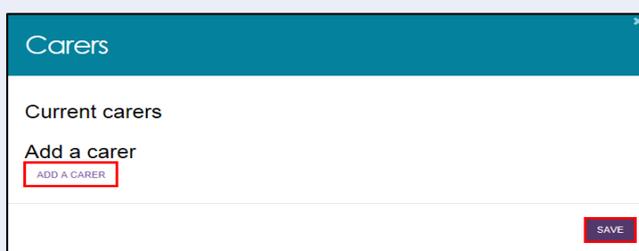
## Viewing and adding carers in the assessment

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

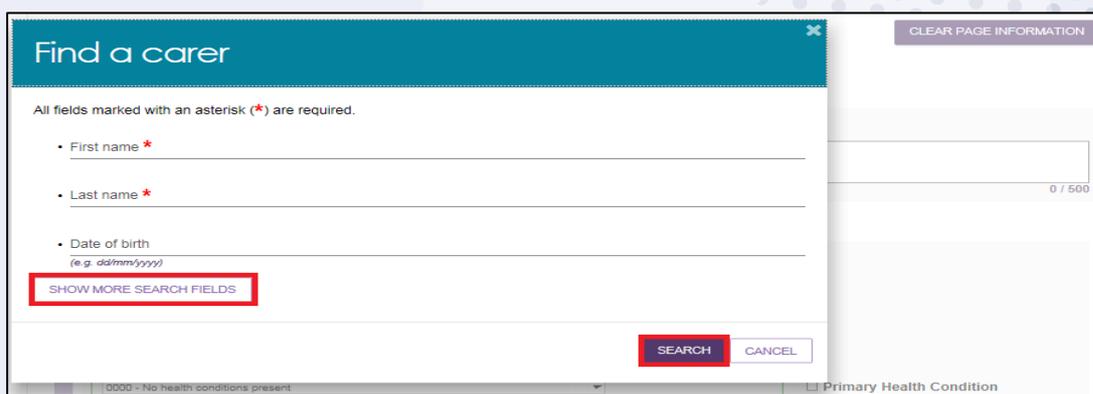
1. Select the **Carer Profile** section of the assessment from the navigation menu and then select **View/add carers**.



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.



- 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**.

**Find a carer**

(e.g. dd/mm/yyyy)

SHOW MORE SEARCH FIELDS

1 matching results

Mavis MATTERS  
CHARNWOOD

Client Consents to Relationship\*

Yes  
 No

Carer Consents to Relationship\*

Yes  
 No

What is the relationship of the user to the client?

Friend

ADD

ADD A CARER

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

**Carers**

✓ You have successfully added a carer.

**Current carers**

Mavis MATTERS  
Carer, added 21 Jul 2017  
ST THOMAS AQUINAS PRIMARY SCHOOL 25 LHOTSKY Street CHARNWOOD ACT 2615  
Lives with client\*

Yes  
 No

**Add a carer**

ADD A CARER

SAVE

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

**Find a carer**

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

First name \*  
Lesley

Last name \*  
Donnelly

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

SHOW MORE SEARCH FIELDS

No results found

ADD A CARER

SEARCH CANCEL

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](#).

**Add a person**

Last name\*  
Donnelly

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

Gender\*  
Female

Lives with client\*  
 Yes  
 No

Client Consents to Relationship\*  
 Yes  
 No

Carer Consents to Relationship\*  
 Yes  
 No

What is the relationship of the user to the client?\*

Parent

**SAVE** CANCEL

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

**Carers**

You have successfully added a carer.

**Current carers**

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

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

**Add a carer**

ADD A CARER

**SAVE**



## Adding a Sensitive Attachment in the assessment

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

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

Mr Zoe FORSTER  
Male, 82 years old, 11 January 1944, AC98865819  
Site 245, 55 1 ANDREWS ROAD PENFIELD, SA, 5121

DOWNLOAD SENSITIVE ATTACHMENT FORM    UPLOAD SENSITIVE ATTACHMENT FORM

Financial or Legal

**Support Considerations**

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

Yes    No

Risk client may cause harm to themselves or others  Add

Yes    No

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

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

Assessor Portal

My Dashboard    Find a client    Assessment referrals    Review requests    Assessments    Reviews    Delegate decisions    Organisation administration    Residential Funding Referrals    Find a service provider    **Reports and documents**    Aged Care Assessor app

## Reports and documents

Reports    **Forms**    Links

### Forms

- Self-Service Form - Abbey Pain Scale [pdf 221.46KB]
- Self-Service Form - Alcohol Use Disorders Identification Test [pdf 287.27KB]
- Self-Service Form - Application for Care - October 2020 [pdf 354.04KB]
- Self-Service Form - Barthel Index of Activities of Daily Living [pdf 216.67KB]
- Self-Service Form - Brief Pain Inventory [pdf 256.86KB]
- Self-Service Form - Caregiver Strain Index [pdf 148.48KB]
- Self-Service Form - Client Record Details [pdf 364.25KB]
- Self-Service Form - NSAF Comprehensive Assessment and Support Plan 20221027 [PDF 329.55KB]
- Self-Service Form - Geriatric Depression Scale [pdf 217.58KB]
- Self-Service Form - Home Support Assessment and Support Plan - October 2018 [pdf 484.48KB]
- Self-Service Form - Informant Questionnaire on Cognitive Decline in the Elderly (IQ CODE) [pdf 219.08KB]
- Self-Service Form - my-aged-care-assessment-iat-offline-form-v1 [pdf 1.28MB]
- Self-Service Form - K-10 [pdf 942.84KB]
- Self-Service Form - KICA-COG images [pdf 539.52KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - ADL [PDF 148.59KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Carer [pdf 695.20KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Cognitive Assessment (KICA-C... [pdf 895.96KB]
- Downloads - Mini Nutritional Assessment [pdf 81.38KB]
- Self-Service Form - Modified Caregiver Strain Index [pdf 216.96KB]
- Self-Service Form - My Aged Care Assessment Consent Form v2.1 [pdf 316.19KB]
- Template - Template Notice of priority for home care service - not vary v1.0 [rtf 10.27KB]
- Template - Template Notice of priority for home care service - vary v1.0 [rtf 10.73KB]
- Self-Service Form - Offline Approval Form Vary Time Limitation v2.0 - 20220523 [pdf 359.29KB]
- Self-Service Form - Offline Approval Form v2.0 20221027 [PDF 674.00KB]
- Self-Service Form - Older Americans Resources and Services (OARS) - Instrumental Activities ... [pdf 942.40KB]
- Self-Service Form - Oral Health Assessment Tool [pdf 218.42KB]
- Self-Service Form - Residents Verbal Brief Pain Inventory [pdf 248.45KB]
- Self-Service Form - Revised Faecal Incontinence Scale [pdf 217.63KB]
- Self-Service Form - Revised Urinary Incontinence Scale [pdf 148.13KB]
- Self-Service Form - Rowland Universal Dementia Assessment Scale [pdf 981.66KB]
- Downloads - Sensitive Attachment v1.0 [docx 62.40KB]**
- Self-Service Form - South Australian Oral Health Referral Pad [pdf 217.14KB]
- Self-Service Form - Standardised Mini-Mental State Examination (SMMSE) [pdf 290.84KB]



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

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

- 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*

**Mr Zoe FORSTER**

Male, 82 years old, 11 January 1944, AC98865819  
Site 245, 55 1 ANDREWS ROAD PENFIELD, SA, 5121

[DOWNLOAD SENSITIVE ATTACHMENT FORM](#) [UPLOAD SENSITIVE ATTACHMENT FORM](#)

Financial or Legal

**Support Considerations**

Any evidence that the client is self-neglecting of personal care, nutrition or safety?  Yes  No [Add](#)

Risk client may cause harm to themselves or others  Yes  No [Add](#)

*Attachments Page*

**Attachments**

Client summary   Client details   Support Network   Approvals   Plans   **Attachments**   Services

**ADD AN ATTACHMENT**

Assessment Attachments   Other Attachments   Correspondence

- 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

## Upload sensitive attachment

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

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

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

**CHOOSE FILE** No file chosen

Name of the attachment: \*

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

0 / 250

**UPLOAD** **CANCEL**

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

## Add an attachment

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

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

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

**CHOOSE FILE** No file chosen

Name of the attachment: \*  
(150 characters)

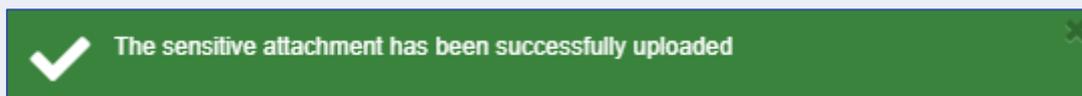
Please provide a short description about the contents of the attachment, e  
(250 characters)

Type of attachment \*  
Select one

- HM prescription
- HM quote
- Inbound referral information
- Ineligible for Assessment Ltr
- Legal documentation
- Letter by Medical Pract.
- Medication Summary
- Non-Approval Letter to Client
- Occupational Therapy Plan
- Offline Approval Form
- Offline Notes
- Prior Assessment
- Prior Support Plan
- Relevant Medical Summary
- Sensitive Attachment**
- Sensitive client status
- Specific Service Requirements
- Support Plan - External
- Wound Care Plan
- Other



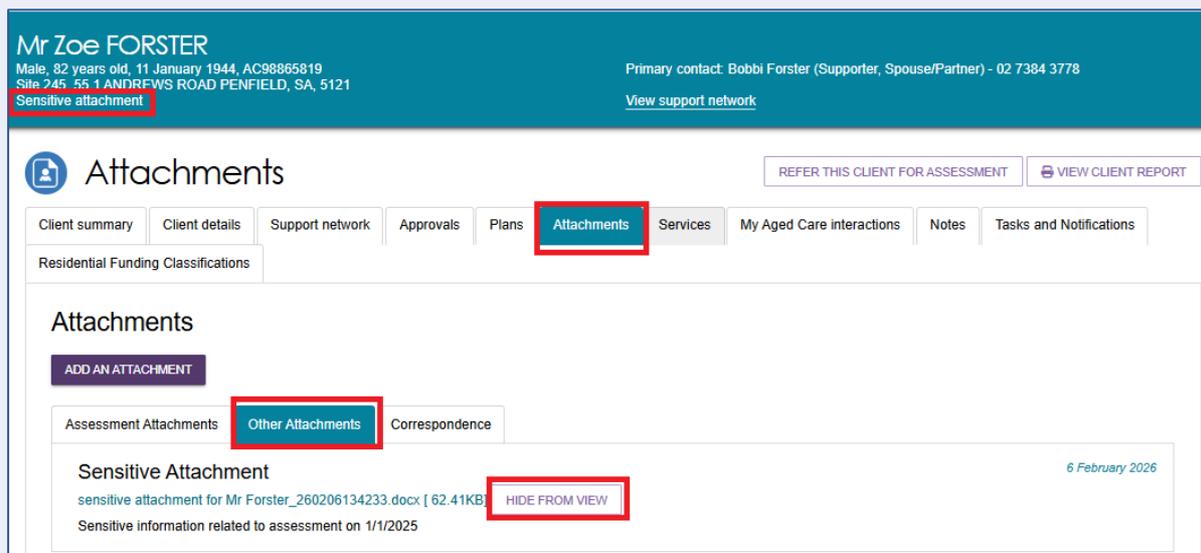
5. Once successfully uploaded, a green banner will display at the bottom of the screen.



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

The screenshot shows the 'Social' section of the IAT assessment tool. On the left is a navigation menu with categories: Triage, Assessment Details, Reason for Assessment, Carer Profile, Medical and Medications, Function, Physical, Personal Health & Frailty, Social (highlighted), Cognition, Behaviour, Psychological, Home & Personal Safety, Financial or Legal, and Support Considerations. The main content area is titled 'Social' and includes a 'Save Assessment' button. Below the title, there is a question: 'Do you ever feel lonely, down or socially isolated?' with radio button options: 'Not sure', 'No, not at all', 'Occasionally', 'Sometimes', and 'Most of the time'. There is also an 'Add as Other C' checkbox. Below this is the 'Good Spirit Good Life Tool' section with a note: 'I would like to ask some questions on how you feel about your life today. There are no right or wrong answers.' This is followed by the 'Family and Friends' section with the question: 'Do you get to have a yarn and spend time with family or friends?' and radio button options: 'All the time', 'Most of the time', 'Sometimes', 'Not much', and 'Never'. The 'Country' section has the question: 'Do you feel you spend enough time connecting to country?' and the same radio button options.

This screenshot shows the 'Community', 'Culture', 'Health', 'Respect', and 'Elder Role' sections of the IAT assessment tool. Each section has a question and radio button options: 'All the time', 'Most of the time', 'Sometimes', 'Not much', and 'Never'.  
- **Community**: 'Do you feel connected to the Aboriginal community?'  
- **Culture**: 'Do you feel connected to cultural ways?'  
- **Health**: 'Do you do things to take care of your health?'  
- **Respect**: 'Do you feel respected and valued as an elder/older person?'  
- **Elder Role**: 'Do you feel you can share your knowledge and stories with the younger mob?'

This screenshot shows the 'Supports and Services', 'Safety and Security', 'Spirituality', 'Future Planning', and 'Basic Needs' sections of the IAT assessment tool. Each section has a question and radio button options: 'All the time', 'Most of the time', 'Sometimes', 'Not much', and 'Never'.  
- **Supports and Services**: 'Do you feel the services you use are respectful and support your needs?'  
- **Safety and Security**: 'Do you feel you have a safe place to live?'  
- **Spirituality**: 'Do you feel safe and supported in your spiritual beliefs?'  
- **Future Planning**: 'Do you feel you have things in place as you grow older? (e.g. your future health and care, funeral wishes, family looked after).'  
- **Basic Needs**: 'Do you feel you have enough money to get by? (e.g. for food, housing, clothing).'



## Duke Social Support Index

**Duke Social Support Index - Social Interaction Subscale**

Other than members of your family, how many persons in your local area do you feel you can depend on or feel very close to?

None  1-2 people  More than 2 people

How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together?

None  Once  Twice  Three times  Four times  Five times  Six times  Seven or more times

How many times did you talk or communicate to someone, friends, relatives or others on the telephone, mobile (e.g. text message) or social media (e.g. Facebook, snapchat, Instagram) in the past week (either they contacted you or you contacted them)?

None  Once  Twice  Three times  Four times  Five times  Six times  Seven or more times

About how often did you go to meetings of clubs, religious meetings or other groups that you belong to in the past week?

None  Once  Twice  Three times  Four times  Five times  Six times  Seven or more times

Total score:

Landerman alternative models stress buffering 1989

**Duke Social Support Index - Satisfaction with social support Subscale**

Does it seem that your family and friends (people who are important to you) understand you?

Hardly ever  Some of the time  Most of the time

Do you feel useful to your family and friends (people important to you)?

Hardly ever  Some of the time  Most of the time

Hardly ever  Some of the time  Most of the time

Do you feel you have a definite role (place) in your family and among your friends?

Hardly ever  Some of the time  Most of the time

Can you talk about your deepest problems with at least some of your family and friends?

Hardly ever  Some of the time  Most of the time

How satisfied are you with the kinds of relationships you have with your family and friends?

Very dissatisfied  Somewhat dissatisfied  Satisfied

Total score:

Landerman alternative models stress buffering 1989

Assessor observation about family, community engagement and support (i)

0 / 1500

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

**Next**

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

Save Assessment

**Cognition** (i) Clear Page Information

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

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

Yes  No

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

Yes  No

Assessor notes on cognition (i)

Add as Other Consideration

0 / 500

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

**Next**

- Triage
- Assessment Details
- Reason for Assessment
- Carer Profile
- Medical and Medications
- Function
- Physical, Personal Health & Frailty
- Social
- Cognition**
- Behaviour
- Psychological
- Home & Personal Safety
- Financial or Legal
- Support Considerations



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**.

Are you likely to recommend residential respite care? \* 

Yes  No

---

 De Morton Mobility Index (DEMMI) - Modified \* 

Yes  No

- 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.

Triage 

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

De Morton Mobility Index (DEMMI) - Modified

## De Morton Mobility Index (DEMMI) - Modified

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

**General Description**  
Measures the mobility of older people across clinical settings and rates what the person is capable of doing (Can Do), rather than what they currently do  
Capability – take account of physical function, cognition and behaviour, motivation, and organisational ability  
If differences in function occur in different environments or times of the day (i.e. day/night), record the lower score  
Preferably base this tool on direct observation, unless there is a falls risk or it causes the resident distress  
Rate with current aids and appliances in place

**Scoring definitions**  
Minimal assistance – “hands-on” physical but minimal assistance, primarily to guide movement  
Supervision – another person monitors the activity without providing hands-on assistance. May include verbal prompting

- 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.

Save Assessment

Triage 

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

De Morton Mobility Index (DEMMI) - Modified

Physical, Personal Health & Frailty

Social

Cognition

Behaviour

Psychological

Home & Personal Safety

Financial or Legal

Support Considerations

## De Morton Mobility Index (DEMMI) - Modified

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

**General Description**  
Measures the mobility of older people across clinical settings and rates what the person is capable of doing (Can Do), rather than what they currently do  
Capability – take account of physical function, cognition and behaviour, motivation, and organisational ability  
If differences in function occur in different environments or times of the day (i.e. day/night), record the lower score  
Preferably base this tool on direct observation, unless there is a falls risk or it causes the resident distress  
Rate with current aids and appliances in place

**Scoring definitions**  
Minimal assistance – “hands-on” physical but minimal assistance, primarily to guide movement  
Supervision – another person monitors the activity without providing hands-on assistance. May include verbal prompting  
Independent – the presence of another person is not considered necessary for safe mobility

**Bed**

Bridge \* 

Unable  Able

Roll onto side \* 

Unable  Able

Lying to sitting \* 

Unable  Minimal assistance  Supervision  Independent

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

Walking

Walking distance +/- gait aid\* ⓘ

Unable 5 metres 10 metres 20 metres 50 metres

Walking independence\* ⓘ

Unable Minimal assistance Supervision Independent with gait aid Independent without gait aid

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

Next

- 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.

Are you likely to recommend residential respite care? \* ⓘ

Yes No

De Morton Mobility Index\* ⓘ

Yes No

By selecting No, you will be required to complete a declaration and provide a justification for the DEMMI not being completed.

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

Add care type for delegate decision

Which care type applies? \*  
Residential Respite Care

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

What is the urgency of this care type? \* ⓘ  
High

Is this emergency care?  
 Yes  No

Exceptional circumstances \*  
Please select the exceptional circumstances that are applicable to the client's entry to Aged Care

Not applicable  
 Aboriginal  
 Torres Strait Islander  
 Homeless or at risk of becoming homeless  
 Family connection reasons  
 Urgent residential respite

Reason or comments  
0 / 255

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

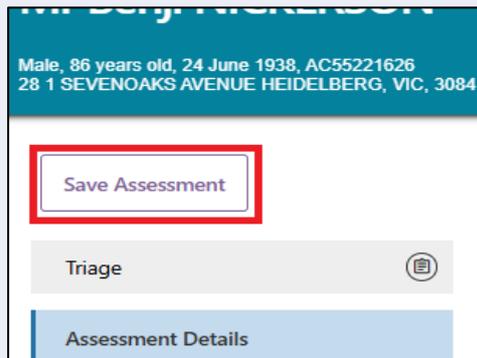
Reason DEMMI not completed \*

SAVE TO PLAN CANCEL



## Saving an assessment

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



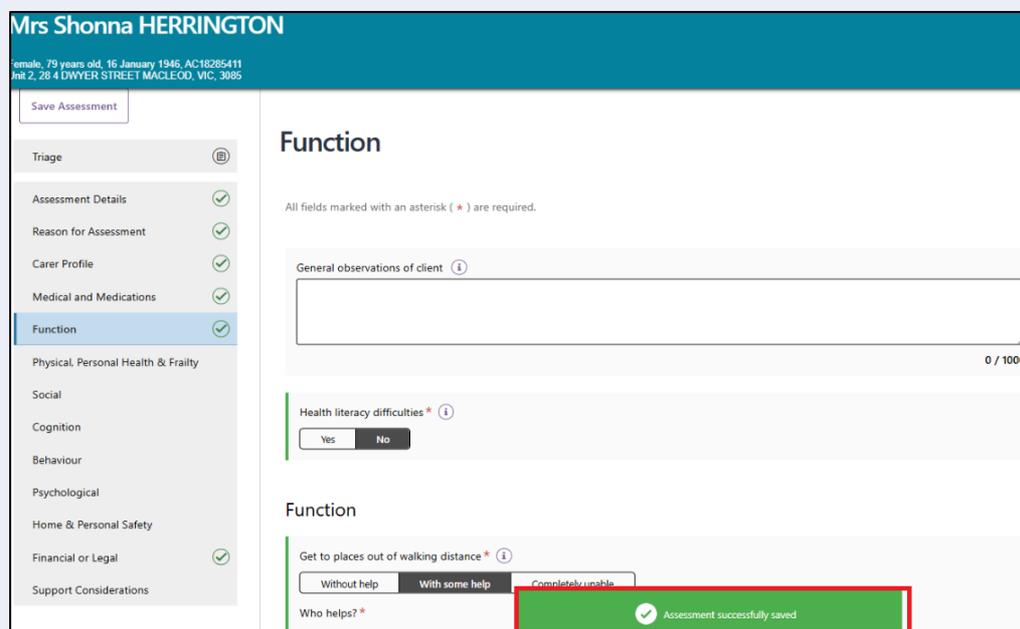
Male, 86 years old, 24 June 1938, AC55221626  
28 1 SEVENOAKS AVENUE HEIDELBERG, VIC, 3084

**Save Assessment**

Triage

Assessment Details

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



Mrs Shonna HERRINGTON  
Female, 79 years old, 16 January 1946, AC18285411  
Unit 2, 28 4 DWYER STREET MACLEOD, VIC, 3085

Save Assessment

Triage

Assessment Details ✓

Reason for Assessment ✓

Carer Profile ✓

Medical and Medications ✓

**Function ✓**

Physical, Personal Health & Frailty

Social

Cognition

Behaviour

Psychological

Home & Personal Safety

Financial or Legal ✓

Support Considerations

### Function

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

General observations of client ⓘ

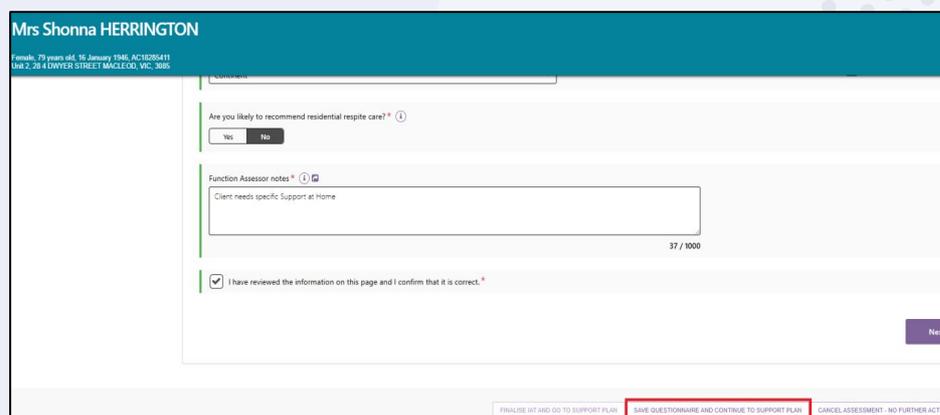
Health literacy difficulties \* ⓘ

Get to places out of walking distance \* ⓘ

Who helps? \*

Assessment successfully saved

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.



Mrs Shonna HERRINGTON  
Female, 79 years old, 16 January 1946, AC18285411  
Unit 2, 28 4 DWYER STREET MACLEOD, VIC, 3085

Are you likely to recommend residential respite care? \* ⓘ

Function Assessor notes \* ⓘ

Client needs specific Support at Home

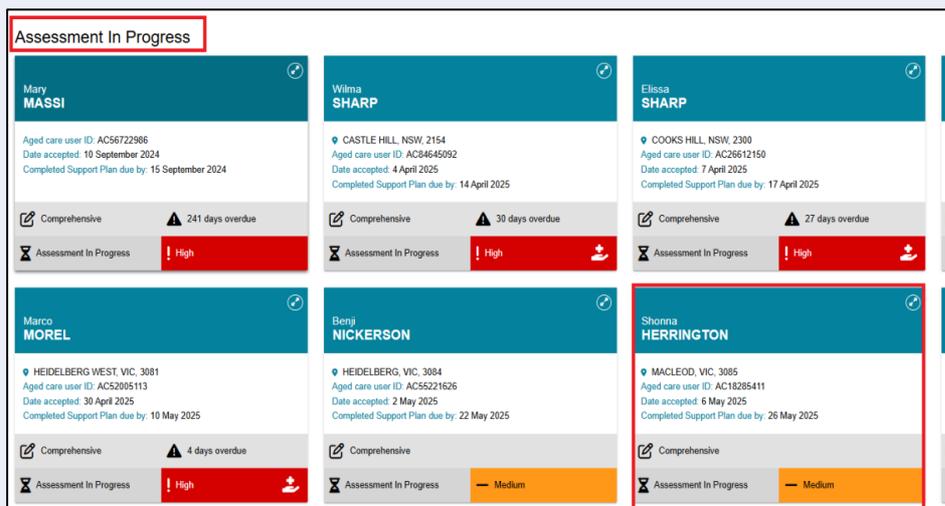
I have reviewed the information on this page and I confirm that it is correct. \*

Next

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



- 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

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

- 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.gov.au 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](http://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 of 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 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 asked to select one (or more) of these ways to send a My Aged Care service referral to the provider:

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](#).

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

**Consent to service referrals**

Consent obtained from \*

The client

Select one

The client

The client with support person

The authorised representative

Consent was not given

The supporter guardian

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

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

- Do we have your consent to refer jeenie SMITH to one or more service providers?
- Do we have your consent to upload the support plan of jeenie SMITH to their My Health Record?

**Consent to service referrals**

Consent obtained from \*

The client

**Consent to share Support Plan to My Health Record (MHR)**

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

No  Yes

Consent decision by \*

Client

Decision made by

Authorised Representative

Client

Supporter Guardian

**CONTINUE** **CANCEL**

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

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

- Do we have your consent to refer Kendall FITZSIMMONS (Kendall) to one or more service providers?
- Do we have your consent to upload the support plan of Kendall FITZSIMMONS (Kendall) to their My Health Record?

**Consent to service referrals**

Consent obtained from \*

Consent was not given

**Consent to share Support Plan to My Health Record (MHR)**

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

No  Yes

Consent decision by \*

Client

Consent denial reason \*

Privacy concerns

**CONTINUE** **CANCEL**

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**.



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

Consent obtained from \*  
Consent was not given

**Consent to share Support Plan to My Health Record (MHR)**  
Does the client consent to share their Support Plan with My Health Record (MHR)? \*  
 No  Yes

Consent decision by \*  
Supporter Guardian

Consent denial reason \*  
Privacy concerns

**Supporter Details**  
First name: \*  
Last name:

**CONTINUE** **CANCEL**

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**.

## Finalise IAT and go to support plan

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

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

**FINALISE IAT** TAKE ME BACK TO THE ASSESSMENT

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.

HOME CARE/SAH CORRESPONDENCE RETURN TO CLIENT

✓ Consents for Service Referrals and My Health Record were updated successfully.



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

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



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

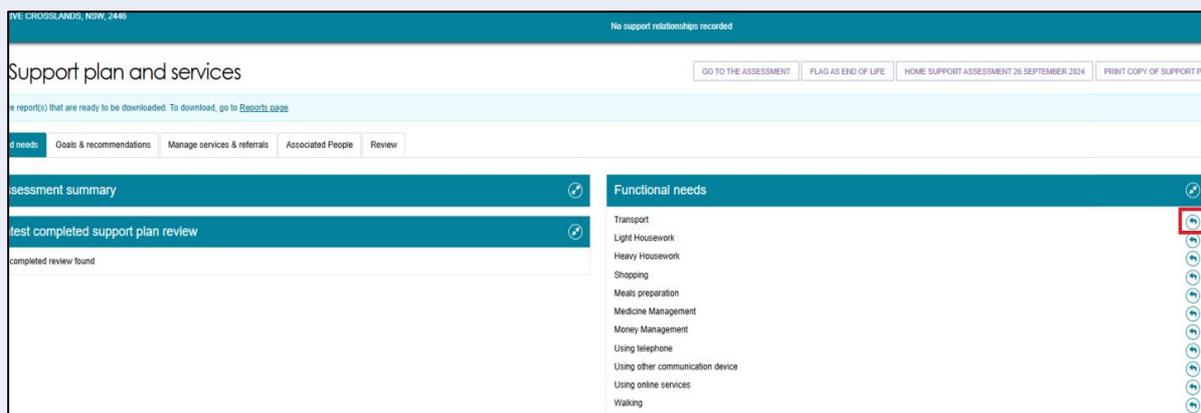


In both instances, you will still be able to proceed with the development of the Support Plan, but it will not be uploaded to My Health Record upon finalisation.

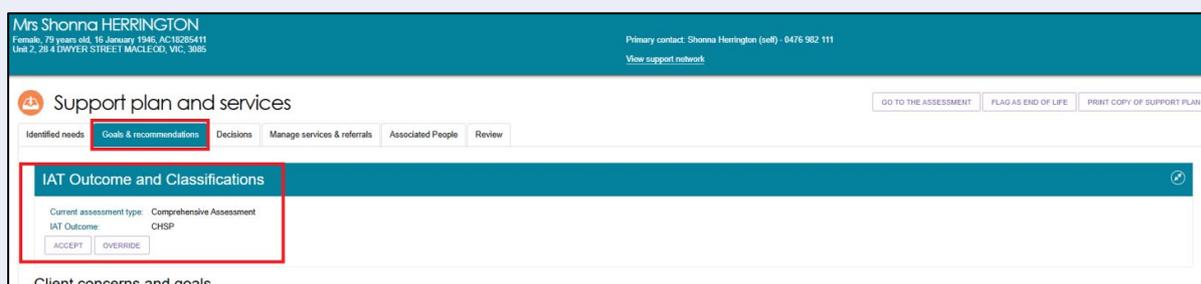
- From the **Support plan and services** page, you can reopen the assessment by selecting **GO TO ASSESSMENT** button on the **Identified needs** tab.



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

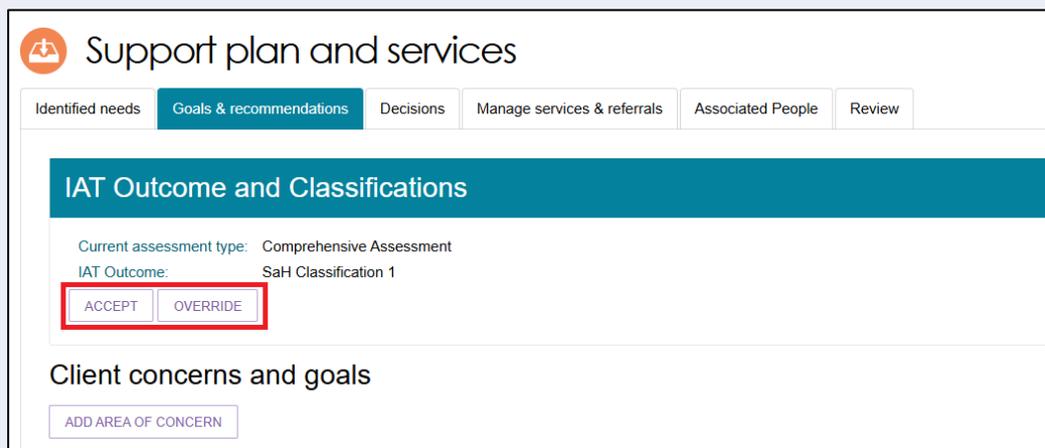


- The IAT outcome will be displayed in the **GOALS AND RECOMMENDATIONS** tab.



## Accepting or Overriding an Assessment

- 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).

- 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.



## Accept IAT outcome

You are accepting below classification for Marco MOREL.

IAT outcome: SaH Classification 1

ACCEPT
CANCEL

- !** 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.

## Accept IAT outcome

The system has recommended SaH Classification 2 for the client. This is lower than the client's existing Classification Transitioned HCP Level 3. By selecting the Accept button the system will keep the existing classification level Transitioned HCP Level 3.

Override current SaH Classification for Tomas Leonard to ongoing SaH Classification:

IAT outcome: SaH Classification 2  
 Classification type: Ongoing  
 Existing classification: Transitioned HCP Level 3

ACCEPT
CANCEL

3. Selecting **VERRIDE** 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**.

## Override IAT outcome

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

IAT outcome: SaH Classification 1  
 Classification type: Ongoing

Override IAT outcome to \*

To override the result, please specify the reason for the override and describe it for the delegate.

Override reason \*

Override reason description: \* ?

0 / 150

SAVE TO PLAN
CANCEL

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.

Female, 85 years old, 11 February 1940, AC3141968Z  
Somaderry Unit 15, 54 5 WEIR STREET EUROA, VIC, 3666

### Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage services & refer

**IAT Outcome and Classifications**

Current assessment type: Comprehensive Assessment  
IAT Outcome: SaH Classification 4

Client concerns and goals

### Override IAT outcome

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

IAT outcome: SaH Classification 4  
Classification type: Ongoing

Override IAT outcome to \*

Please select...

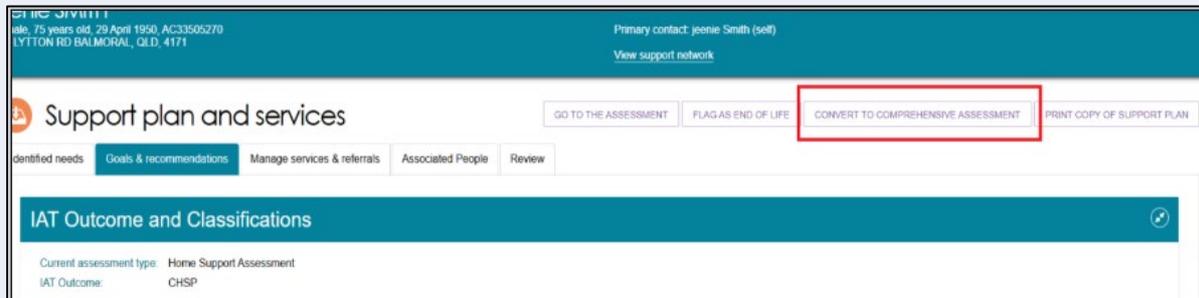
- Please select...
- Ineligible for CHSP/SaH
- CHSP
- SaH Classification 1
- SaH Classification 2
- SaH Classification 3
- SaH Classification 5
- SaH Classification 6
- SaH Classification 7
- SaH Classification 8
- SaH Restorative Care Pathway
- SaH End-of-Life Pathway



## Converting to Comprehensive Assessment

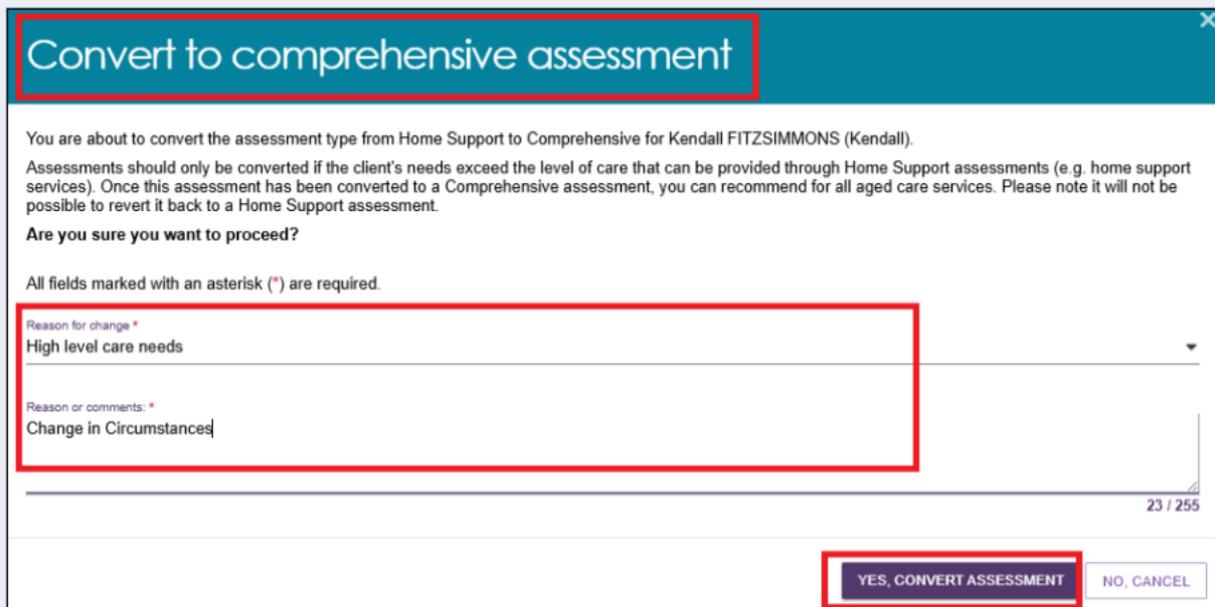
Non-clinical assessors will have the option to change the assessment from Home Support to Comprehensive once the IAT has been finalised and the algorithm has determined an outcome recommendation. This can only be done if the outlet supports both types of assessments.

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



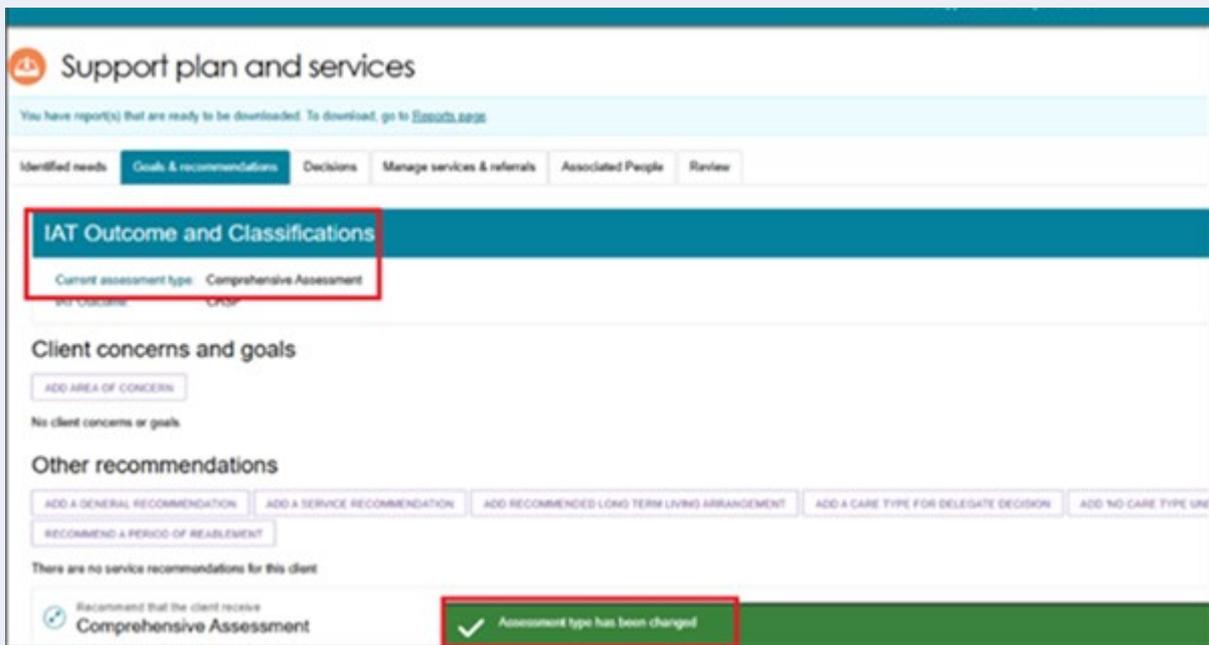
The screenshot shows the 'Support plan and services' page for a client named Kendall FITZSIMMONS. The page includes a header with client details and a primary contact. Below the header, there are navigation tabs: 'Identified needs', 'Goals & recommendations', 'Manage services & referrals', 'Associated People', and 'Review'. The 'Goals & recommendations' tab is active. In the top right corner, there are four buttons: 'GO TO THE ASSESSMENT', 'FLAG AS END OF LIFE', 'CONVERT TO COMPREHENSIVE ASSESSMENT' (highlighted with a red box), and 'PRINT COPY OF SUPPORT PLAN'. Below the navigation tabs, there is a section titled 'IAT Outcome and Classifications' with a sub-section 'Current assessment type: Home Support Assessment' and 'IAT Outcome: CHSP'.

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**.



The screenshot shows a dialog box titled 'Convert to comprehensive assessment'. The dialog contains the following text: 'You are about to convert the assessment type from Home Support to Comprehensive for Kendall FITZSIMMONS (Kendall). Assessments should only be converted if the client's needs exceed the level of care that can be provided through Home Support assessments (e.g. home support services). Once this assessment has been converted to a Comprehensive assessment, you can recommend for all aged care services. Please note it will not be possible to revert it back to a Home Support assessment. Are you sure you want to proceed? All fields marked with an asterisk (\*) are required.' Below this text, there are two input fields: 'Reason for change \*' with a dropdown menu set to 'High level care needs' (highlighted with a red box), and 'Reason or comments: \*' with a text area containing 'Change in Circumstances'. At the bottom right, there are two buttons: 'YES, CONVERT ASSESSMENT' (highlighted with a red box) and 'NO, CANCEL'. The dialog also shows a close button (X) in the top right corner and a page number '23 / 255' in the bottom right corner.

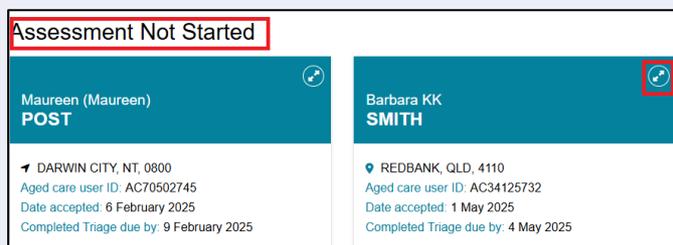
3. A green banner will then be displayed at the bottom of the screen confirming the assessment has been successfully changed. The IAT outcome will now also reflect that a comprehensive assessment has been completed.



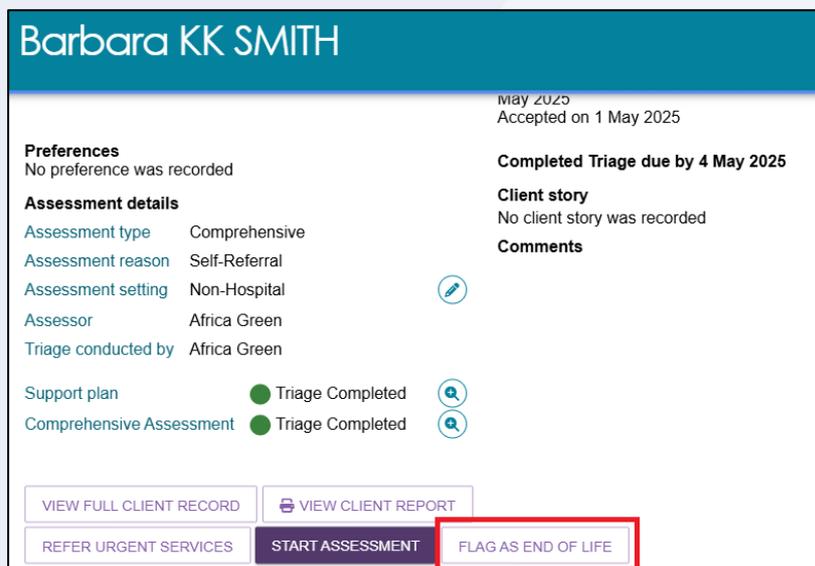
## Flagging an Assessment as End of Life

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.

- 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.



- 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.

NORFOLK DRIVE NARRE WARREN, VIC, 3805 View support network

## Support plan and services

GO TO THE ASSESSMENT **FLAG AS END OF LIFE** CONVERT TO COMPREHENSIVE

Needs **Goals & recommendations** Manage services & referrals Associated People Review

### Next Outcome and Classifications

Current assessment type: Home Support Assessment  
Next Outcome: CHSP

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

## Flag referral as End-of-Life for Barbara KK SMITH

All fields marked with an asterisk (\*) are required.  
Referrals flagged for the End-of-Life Pathway are given high priority.

End-of-Life form verification ?  
No selection made  
**No selection made**  
Document reviewed - valid  
Document reviewed - pending  
Document reviewed - not valid

Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format.

**FLAG AS END OF LIFE** CANCEL

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

## Flag referral as End-of-Life for Barbara KK SMITH

All fields marked with an asterisk (\*) are required.  
Referrals flagged for the End-of-Life Pathway are given high priority.

End-of-Life form verification ?  
Document reviewed - valid

Details

0 / 255

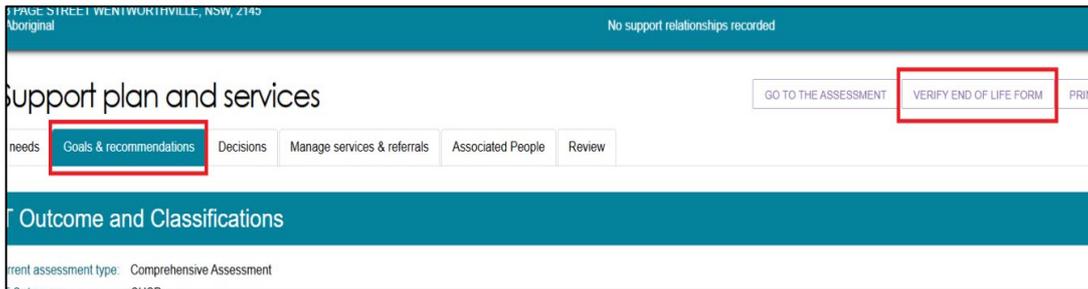
**UPLOAD ATTACHMENT**

Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format. \*

**FLAG AS END OF LIFE** CANCEL



- ! 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).

The 'Add Attachment' pop-up screen has a teal header with the title 'Add Attachment'. Below the header, there is an information icon and a note: 'Please note: Some attachments will be viewable by other people with authorised access to this client record. Please refer to your portal guide for details.' A warning message states: 'All fields marked with an asterisk (\*) are required.' Under the heading 'Attachments', it says 'Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format.\*'. A 'CHOOSE FILE' button is highlighted with a red box, and next to it is the text 'Medical S...ment.docx'. Below this, there is a dropdown menu for 'Attachment type \*', an empty text field for 'Attachment name \*' with a character count of '0 / 150', and an empty text area for 'Attachment description'. At the bottom right, there are 'UPLOAD' and 'CANCEL' buttons.

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

This screenshot shows the 'Add Attachment' pop-up screen with the 'Attachment type \*' dropdown menu open. The dropdown list contains three options: 'Please select...', 'End of Life Form', and 'End of Life - other'. The 'End of Life Form' option is highlighted with a red box. The rest of the screen, including the file selection area, the 'Attachment name \*' field, the 'Attachment description' field, and the 'UPLOAD' and 'CANCEL' buttons, is identical to the previous screenshot.

## 7. Select **UPLOAD**

**Add Attachment**

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

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

**Attachments**  
Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format.\*

CHOOSE FILE Medical S...ment.docx

Attachment type\*  
End of Life Form

Attachment name\*  
Medical Diagnosis Report

Attachment description

24 / 150

UPLOAD CANCEL

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).

**Flag referral as End-of-Life for Barbara KK SMITH**

All fields marked with an asterisk (\*) are required. Referrals flagged for the End-of-Life Pathway are given high priority.

End-of-Life form verification ?  
Document reviewed - valid

Details

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UPLOAD ATTACHMENT

Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format.\*

Medical Diagnosis Report (End of Life Form) [docx 68.49KB] 16 May 2025

FLAG AS END OF LIFE CANCEL

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

**Flag referral as End-of-Life for Barbara KK SMITH**

All fields marked with an asterisk (\*) are required. Referrals flagged for the End-of-Life Pathway are given high priority.

End-of-Life form verification ?  
Document reviewed - valid

Details

0 / 255

UPLOAD ATTACHMENT

Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format.\*

EoL verification document (End of Life Form) [docx 89.99KB] 16 May 2025

Medical Diagnosis Report (End of Life Form) [docx 68.49KB] 16 May 2025

FLAG AS END OF LIFE CANCEL



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.

Started

Barbara KK SMITH

REDBANK, QLD, 4110  
Aged care user ID: AC34125732  
Date accepted: 1 May 2025  
Completed Triage due by: 4 May 2025

96 days overdue

Comprehensive

12 days overdue

Assessment Not Started

High

! 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.

Psychologist  Other social professional  Interpreter

Other professional

Details

Assessor notes

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

Next

GO TO SUPPORT PLAN CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED

2. Record the reason for cancelling the assessment.

## Cancel assessment - no further action required

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

Reason for ending the assessment \*

Select one

Select one

- Client/family/rep unavailable
- Duplicate Client Record
- Interpreter not available
- Unable to contact client
- Outside assessment region
- Assessment no longer required
- ACAT assessment required
- RAS assessment required
- Care approval meets needs
- Client age - alternate options
- Client does not consent
- Clinical staff not available
- Client prefers an FNAO
- Hospital assessment required
- Client prefer later assessment
- Client medically unstable
- Client deceased
- Other

### 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.

## Cancel assessment - no further action required

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

Reason for ending the assessment \*

Client deceased

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

Please supply the following information:

Who, when and how were you informed that this person is deceased? \*

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Date of death  
(if known)

dd/mm/yyyy

### Add Attachments

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

Choose a file...

Comment: \*

0 / 200

CANCEL ASSESSMENT

TAKE ME BACK TO THE ASSESSMENT



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



• Assessment was successfully cancelled

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.