



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

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

! 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). This is available from your Assessment Organisation.

! From 1 November 2025, there are changes to assessment delegations under the *Aged Care Act 2024*, for both Clinical and Non-clinical Assessment Delegates.

To understand **Assessment Delegate changes**, refer to 'Chapter 7: Delegations and Approvals under the Act' of [My Aged Care Assessment Manual](#).

For CHSP only: For guidance on the interim process explaining Manual Delegate Approval for CHSP only for comprehensive and home support assessments, and how it impacts assessors during support plan completion and finalisation from 1 November 2025, refer to *Manual Delegate Approval for CHSP – Standard Operating Procedure* and instructional videos for comprehensive and home support assessments. These are available from your Assessment Organisation.

Note: This process was updated for the 23 February release, the updated approach now applies.

Contents

The Support Plan	4
The Identified needs tab	4
Adding an assessment summary	4
The Goals and Recommendations tab	7
Overriding the IAT Recommendation	7
Types of Recommendations	10
Linking Recommendations to Goals.....	11
Viewing the Recommendation after a delegate decision.....	13
Adding Recommendations	15
General Recommendation.....	15
Service Recommendation.....	16
No Care Type Under the Act	16
Period of Linking Support	18
Period of Reablement	19
Care type for Delegate decision.....	20
Support at Home Recommendations.....	22
Adding Home Support services.....	22
Viewing Recommended SaH services.....	25
Assistive technology and Home modifications (AT-HM) Recommendations	26
Adding a Home modification Recommendation	26
Viewing Home modification Service Recommendation	28
Editing Home modification Recommendation	29
Adding an Assistive technology Recommendation	29
Viewing Assistive technology Service recommendation	31
Editing Assistive technology Recommendation.....	32
Adding Client Concerns and Goals.....	33
Linking goals to Existing Support at Home Recommendations	35
Recording Service Frequency and Intensity.....	37
Support at Home - Restorative Care Pathway	38
Overriding to Restorative Care Pathway.....	39
Recommending Second Unit of Restorative Care Pathway.....	41

End-of-Life Pathway.....	42
Flagging End-Of-Life to an existing SaH Restorative Care Pathway	42
Revert End-Of-Life Flag.....	45
Overriding to End-of-Life for Transitioned Home Care Package (HCP) clients.....	46
Reverting to End-of-Life for Transitioned Home Care Package (HCP) clients	49
Completing the support plan for a home support assessment.....	50
Completing the support plan for a Comprehensive assessment.....	52
Finalising the support plan	54
Finalising a Support Plan for Support at Home classification	56
Ending a period of Reablement or linking support	56
Notice of Decision Letters	59
Generating a NoD Letter	60
Uploading a NoD Letter.....	62
Printing a copy of the support plan	66
Support Plan Reviews.....	67
Viewing a Support Plan Review	67
Starting a Support Plan Review	69
Ad hoc Support Plan Reviews	73
Scheduling an Ad hoc Support Plan Review	73
Transferring a Support Plan Review.....	77
Issuing an assessment referral as a result of a Support Plan Review.....	78
Support Plan Review for Support at Home	80

The Support Plan

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

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

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

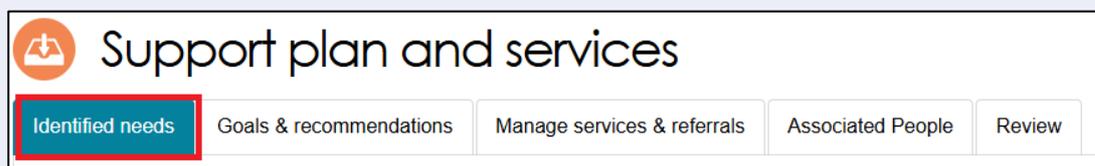
The **SUPPORT PLAN** is made up of several components (tabs):

- [Identified Needs](#)
- [Goals & Recommendations](#)
- Manage Services & referrals (Refer to [My Aged Care – Assessor Portal User Guide 8 – Referring for services | Australian Government Department of Health, Disability and Ageing](#))
- Associated People – showing people associated with the support plan.
- Review – showing a future to review the support plan.

This guide will go into the Goals & recommendations tab in detail.

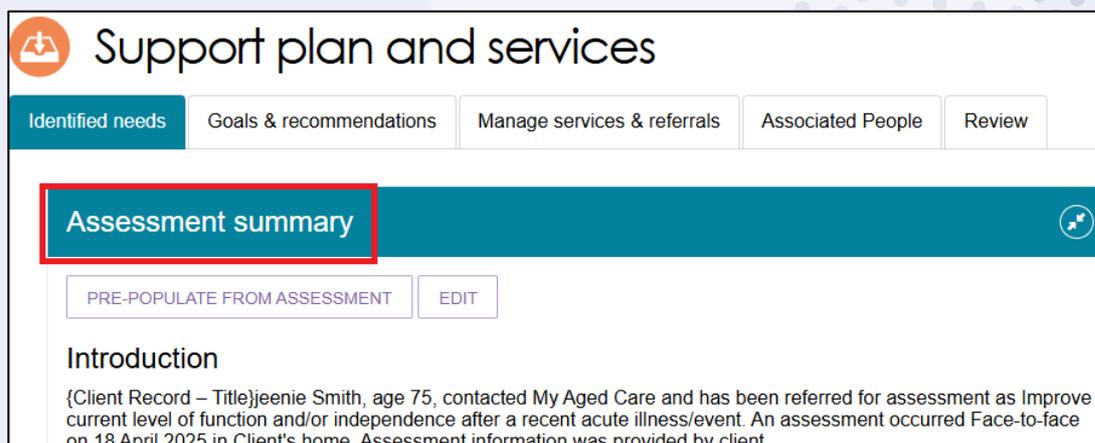
The Identified needs tab

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



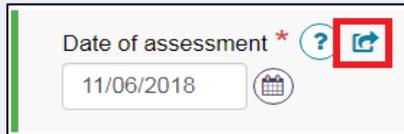
Adding an assessment summary

When completing a support plan, assessors can add an **Assessment summary** within the **Identified needs** tab. The assessor can use **Pre-Populate from Assessment** button to get the assessment summary populated.



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

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



Date of assessment * ? 
11/06/2018 

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

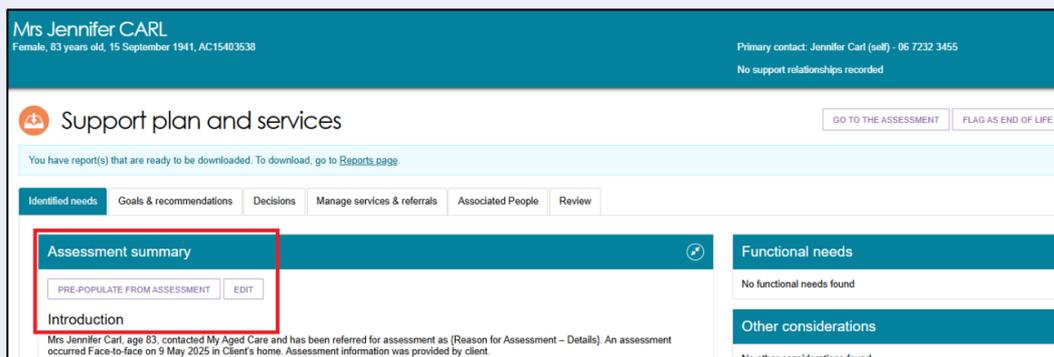
Alternatively, select **EDIT** to edit the assessment summary without any pre-filling. This will open a blank assessment summary.



Assessment summary 
PRE-POPULATE FROM ASSESSMENT **EDIT**

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

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



Mrs Jennifer CARL
Female, 83 years old, 15 September 1941, AC15403538
Primary contact: Jennifer Carl (self) - 06 7232 3455
No support relationships recorded

Support plan and services [GO TO THE ASSESSMENT](#) [FLAG AS END OF LIFE](#)

You have report(s) that are ready to be downloaded. To download, go to [Reports page](#)

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

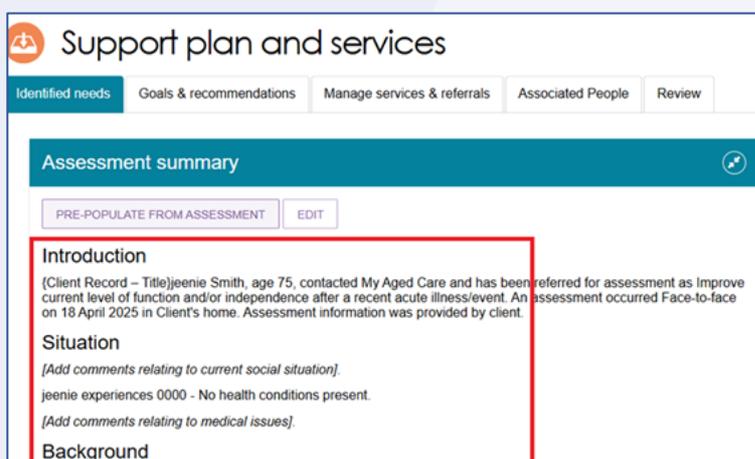
Assessment summary 
PRE-POPULATE FROM ASSESSMENT **EDIT**

Introduction
Mrs Jennifer Carl, age 83, contacted My Aged Care and has been referred for assessment as (Reason for Assessment – Details) An assessment occurred Face-to-face on 9 May 2025 in Client's home. Assessment information was provided by client.

Functional needs
No functional needs found

Other considerations
No other considerations found

Assessors can choose to enter information in the field in the assessment; add relevant information in the assessment summary; or remove the instruction from the assessment summary. Assessors will be prompted to enter additional information that could not be populated from the assessment. This will display as *[example instruction]*.



Support plan and services

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

Assessment summary 
PRE-POPULATE FROM ASSESSMENT **EDIT**

Introduction
(Client Record – Title)Jeenie Smith, age 75, contacted My Aged Care and has been referred for assessment as Improve current level of function and/or independence after a recent acute illness/event. An assessment occurred Face-to-face on 18 April 2025 in Client's home. Assessment information was provided by client.

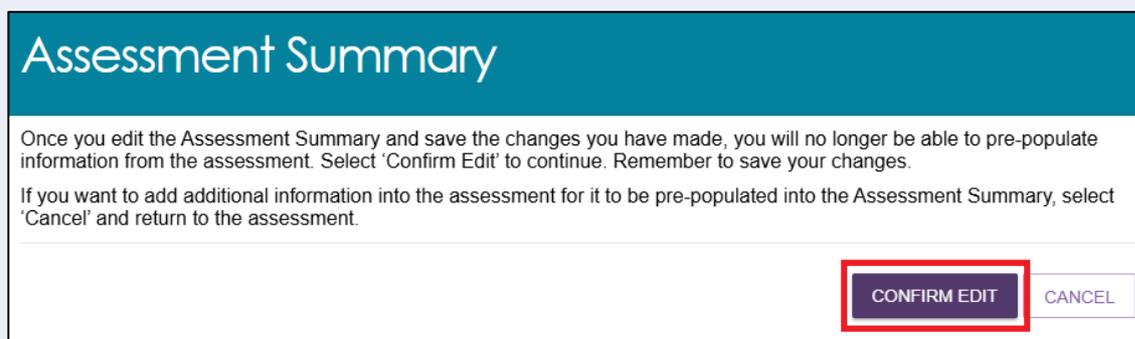
Situation
[Add comments relating to current social situation].
Jeenie experiences 0000 - No health conditions present.
[Add comments relating to medical issues].

Background

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



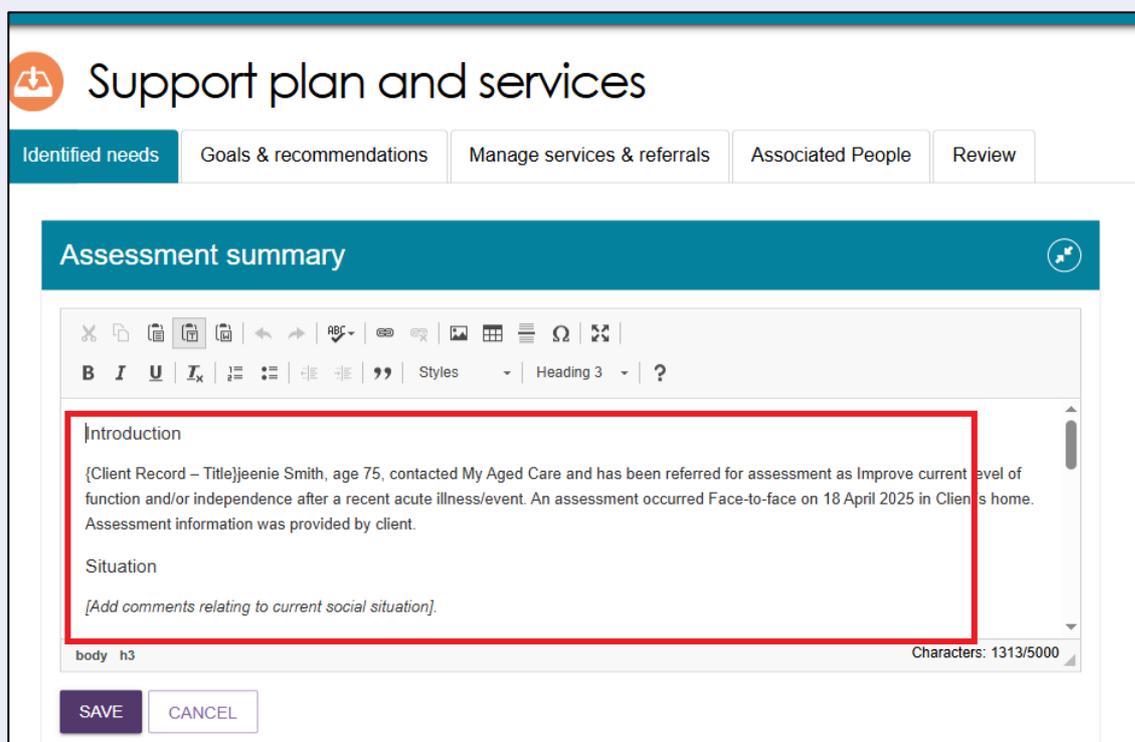
Select **CONFIRM EDIT** to open the editable assessment summary.



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

Once the assessment summary has been edited/updated, select **SAVE** to save changes. Based on the information pre-populated from the assessment, the assessment summary may exceed the 5,000-character limit. Assessors should reduce the assessment summary by removing or summarise old content.

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

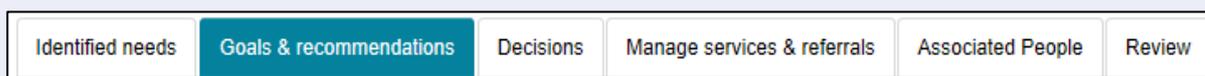


! Ensure changes to the assessment summary are regularly saved, as auto-save does not apply to the assessment summary.

The Goals and Recommendations tab

The **Goals & recommendations** tab is where you will record the client's areas of concerns, goals to address their concerns, and any services or general recommendations. Within the Goals & recommendations tab you will also be able to view the IAT outcome and the recommended classification/s. The recommendation/s is based on inputs from the assessor on the IAT assessment and the client's current care approvals.

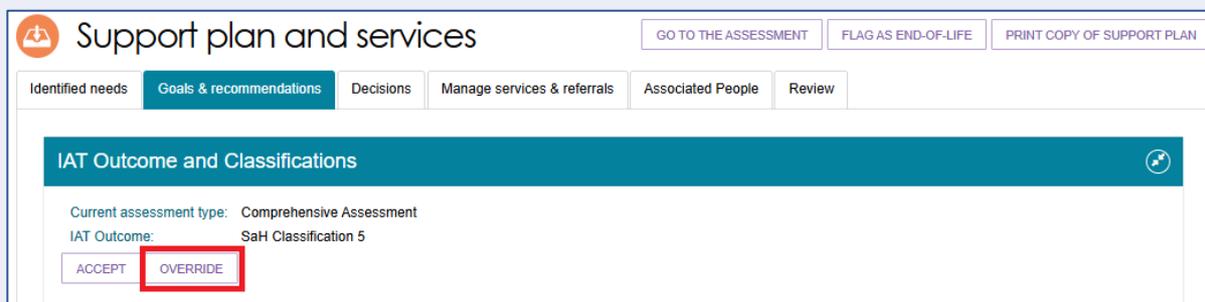
If applicable, more than one active approval can be displayed. For example, when a client has an active Restorative Care Pathway classification approval, and an SaH 1-8 Classification is approved in a reassessment, both the RCP and the SaH classifications will be shown in the Goals & Recommendations tab.



Overriding the IAT Recommendation

! 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).

1. To **OVERRIDE** a recommended classification, select the **OVERRIDE** button located underneath the **IAT Outcome and Classifications** heading.



2. The **Override IAT Outcome** pop up appears, prompting the assessor to input the new classification, the override reason and the override reason description.

The list of classifications that are allowed to be selected will depend on the initial IAT Outcome. Assessors are also only allowed to select classifications in line with the Aged Care Rules. Refer to [My Aged Care Assessment Manual | Australian Government Department of Health, Disability and Ageing](#) for further information.

Select **SAVE TO PLAN** once the fields are completed.

Override IAT outcome

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

IAT outcome: SaH Classification 5
 Classification type: Ongoing

Override IAT outcome to *
 SaH Restorative Care Pathway

Classification type: Short term

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

Override reason *
 Has restorative care goals

Override reason description: * ?
 reason description goes here

28 / 150

SAVE TO PLAN CANCEL

- Once the classification or recommendation is accepted, a new screen will open to input all the services within each service type available for the classification, their frequency and intensity.

The below image shows an example of the Add Home Support Services page. It shows three services within the Allied Health and Therapy service type available to be chosen.

Add Home Support Services

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

Recommended that the client receive: SaH Restorative Care Pathway
 Classification Type: Short-term

Please select services within each service type*

Allied health and therapy

Service	Frequency	Intensity
<input type="checkbox"/> Aboriginal or Torres Strait Islander Health Practitioner assistance	_____	_____
<input type="checkbox"/> Aboriginal or Torres Strait Islander Health Worker assistance	_____	_____
<input type="checkbox"/> Allied health assistance	_____	_____

If Restorative Care Pathway was chosen, this page will display the 'Home support restorative care management' service chosen as default (greyed out).

Restorative care management

Service	Frequency	Intensity
<input checked="" type="checkbox"/> Home support restorative care management	_____	_____ ▾

- Once all the values are entered, Select **SAVE TO PLAN** at the bottom of the page. The following image shows examples of chosen transport services, with frequency and intensity recorded.

Remedial massage _____ ▾

Transport

Service	Frequency	Intensity
<input checked="" type="checkbox"/> Direct transport	5	Days per week ▾
<input checked="" type="checkbox"/> Indirect transport	10	Time(s) per year ▾

SAVE TO PLAN CANCEL

- The updated classification will be displayed on the client's **GOALS AND RECOMMENDATIONS** tab.

Support plan and services FLAG AS END-OF-LIFE PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 5
 Recommended classification: SaH Restorative Care Pathway
 Override reason: Has restorative care goals
 Override reason description: reason description goes here

Client concerns and goals

No client concerns or goals.

Other recommendations

Recommend that the client receive Home support

- The existing classification/s will also display on the right hand side of the updated classification, if applicable.

The below image shows an example of a client with a Transitioned HCP Classification under Support at Home, as per the Aged Care Act 2024. This is displayed in the Existing Classification section.

The screenshot shows a web interface titled "Support plan and services". At the top right, there are two buttons: "REQUEST ASSESSMENT" and "PRINT COPY OF SUPPORT PLAN". Below the title, there are several tabs: "Identified needs", "Goals & recommendations" (which is active), "Decisions", "Manage services & referrals", "Associated People", and "Review". The main content area is titled "IAT Outcome and Classifications" and contains the following information:

Current assessment type:	Comprehensive Assessment	Existing classification:	Transitioned HCP Level 4
IAT Outcome:	SaH Classification 8		

The "Existing classification: Transitioned HCP Level 4" text is enclosed in a red rectangular box.

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

For **clinical aged care needs assessors** (clinical assessors):

- CHSP - refer to *Manual Delegate Approval for CHSP – Standard Operating Procedure* and instructional videos for comprehensive and home support assessments.
- Support at Home Classifications recommendation – refer to [Adding Home Support services for a Support at Home Classification](#).

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

- CHSP – refer to *Manual Delegate Approval for CHSP – Standard Operating Procedure* and instructional videos for comprehensive and home support assessments.
- Support at Home – you should consider converting the assessment to a comprehensive assessment under the supervision of a staff member who holds a clinical assessor role.

Types of Recommendations

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

! For Home Support services under the Support At Home Program, refer to [Adding Home Support services for a Support at Home Classification](#) and [Assistive technology and Home modifications \(AT-HM\) Recommendations](#).

- **General recommendations** are non-Commonwealth funded supports that are identified by the assessor and the client and will be actioned by the client or the assessor rather than a service provider, for example: that the client sees a health practitioner, or that they join a local support group.
- **Service recommendations** are for adding recommendations for services to a clients support plan, such as Commonwealth Home Support Programme (CHSP) services.
- **Assistive technology** under Support at Home program.
- **Home modification** under Support at Home program.
- **Recommended long-term living arrangement** is only applicable to comprehensive assessments. It is the most appropriate long-term living situation identified during a

comprehensive assessment that can be selected from a list of accommodation settings after discussing the goals with the client and/or their supporter. This can only be recommended after a comprehensive assessment has been completed.

- **Care type for Delegate decision recommendations** are applicable only to comprehensive assessments where CHSP is not recommended. These recommendations relate to care types under the [Aged Care Act 2024](#) (the Act) which require approval by a Delegate.
- **Recommendations for a period of linking support** are for where a client's complex circumstances may be a barrier to accessing aged care services, and providing linking support can assist the client to access various services they require.
- **Recommendations for a period of reablement** are for time-limited interventions that are targeted towards a client's specific goal(s) or desired outcome to adapt to some function loss, or regain confidence and capacity to resume their activities, for example: training in a new skill, modification to a client's home environment or having access to equipment or assistive technology.

Linking Recommendations to Goals

Recommendations can be linked to concerns and goals, or they can be added as an **Other Recommendation**. Further information on linking support and reablement is available in the *My Aged Care Assessment Manual* on the [department's website](#).

Recommendations can be associated to more than one goal. When adding your recommendations you can select one or more goals to associate a recommendation, or unlink the recommendation from all goals.

1. You can select the appropriate recommendation from the **Other Recommendations** section of the **Goals & Recommendations** tab. You can then choose to link this recommendation to a relevant goal. If you add a recommendation from the **Other Recommendations** section recommendation will be displayed underneath that heading.

The screenshot displays the 'Goals & Recommendations' interface. At the top, a teal bar shows the concern: 'Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning'. Below this is a goal: 'To be able to perform household tasks'. A section titled 'Other recommendations' is highlighted with a red box and contains several buttons: 'ADD A GENERAL RECOMMENDATION', 'ADD A SERVICE RECOMMENDATION', 'ADD AN ASSISTIVE TECHNOLOGY', 'ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT', 'ADD A CARE TYPE FOR DELEGATE DECISION', 'ADD NO CARE TYPE UNDER THE ACT', 'RECOMMEND A PERIOD OF LINKING SUPPORT', and 'RECOMMEND A PERIOD OF REABLEMENT'. Below these buttons, four recommendation cards are shown, also highlighted with a red box. Each card includes a recommendation icon, the text 'Recommend that the client receive', the recommendation name, and the date '9 May 2025'. The recommendations are: 'Home maintenance and repairs', 'Transport', 'Home Support', and 'Home Modifications'.

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

Goal: To be able to perform household tasks

Most relevant domain that goal area relates to:

- Physical function
- General health
- Personal health
- Home and personal safety

Client's current strengths and abilities in relation to this goal:
Can sit and stand up without help for sometime

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Difficulty with mobility

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)

Motivation to achieve: 8
Status: In Progress

Recommendations

<p>Recommend that the client receive</p> <p>Client Care Coordination</p> <p>9 May 2025</p>	<p>Recommend that the client receive</p> <p>Domestic assistance</p> <p>9 May 2025</p>
<p>Recommend that the client receive</p> <p>Home maintenance and repairs</p> <p>9 May 2025</p>	

Recommendation
Exercise twice per week
Responsibility to action: Client
Recommended by: Sam Myers

Add to this goal:

- To unlink a recommendation from the goal, select the EDIT icon (Blue Pencil) next to the recommended service under the goal and press the **UNLINK THIS RECOMMENDATION FROM ALL GOALS** button and select **SAVE TO PLAN**.

Edit service recommendation

Priority and dates

Priority *
Medium

Recommended service frequency ? Recommended service intensity ?

Recommend a start date
 Yes No

Recommend a review date
 Yes No

Recommend an end date
 Yes No

Responsibility to action
 Assessor Client Other

Comments:
0 / 100

Associated goals
 To be able to perform household tasks

UNLINK THIS RECOMMENDATION FROM ALL GOALS

SAVE TO PLAN CANCEL

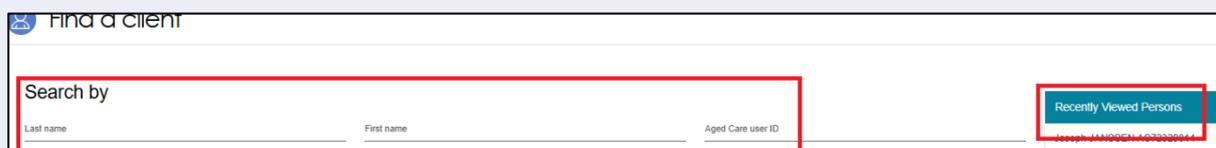


Viewing the Recommendation after a delegate decision

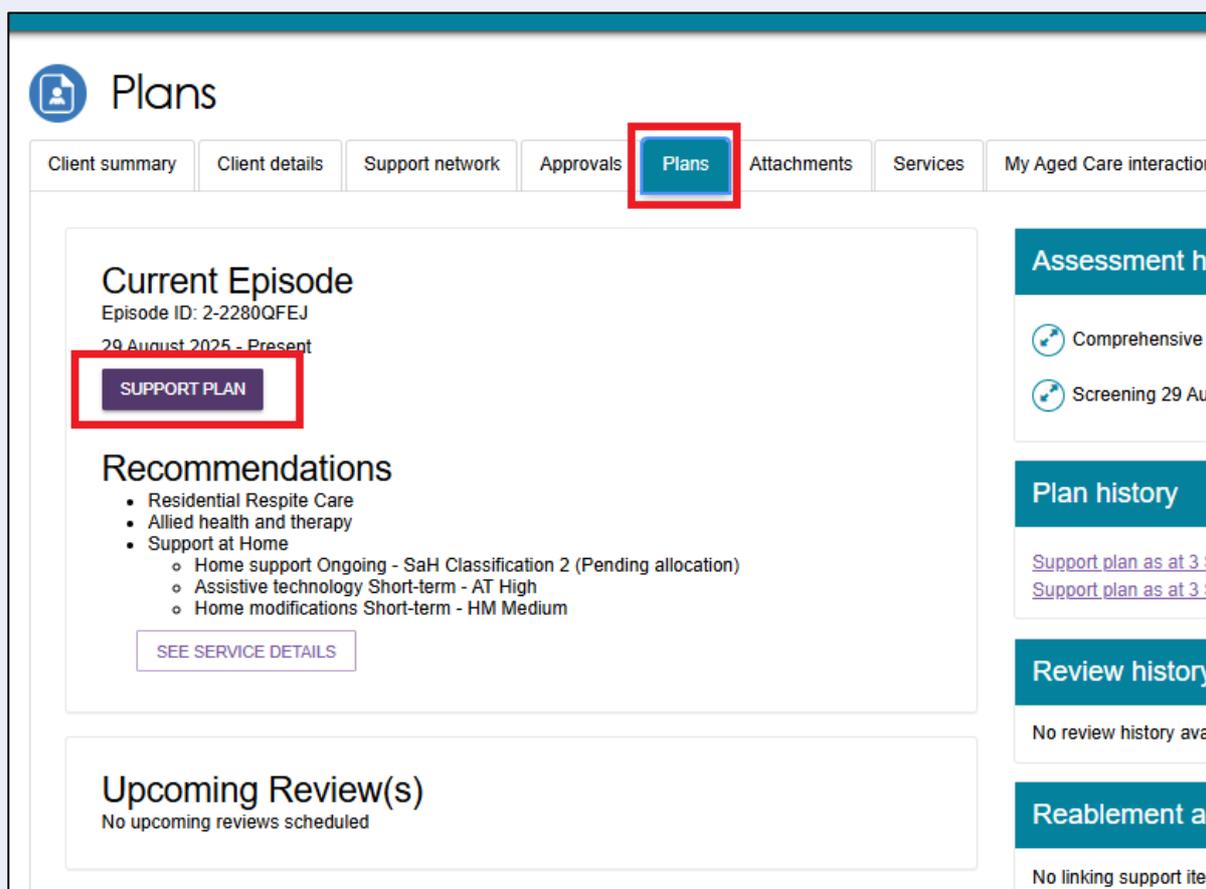
Once the goals and recommendations have been entered, the assessor forwards the referral to the delegate for decision-making. After the delegate completes their review, the assessor can view the outcome, including which recommended services were approved or modified. The assessor can also see if the delegate has added any new services. To access this information, the assessor can locate the client using the [Find a Client](#) link in the Assessor Portal.



You can search for a client in the My Aged Care Assessor Portal by entering their **First Name**, **Last Name**, or **Aged Care User ID** in the search fields. If the client was recently accessed, you can also select them directly from the **Recently Viewed Persons** section for quicker access.



Once you are in the client record, navigate to the **Plans** tab and select **Support Plan**.



Once you are in the client's **Support Plan and Services** screen within the Assessor Portal, navigate to the **Decisions** tab to view the delegate's decision. This section displays the outcome of the delegate's review, including any approved, modified, or newly recommended services.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH Classification 7 (Pending allocation)

IAT Outcome: SaH Classification 7 HM High (Pending allocation)

AT Medium (Pending allocation)

Current care approvals

- Recommend that the client receive **Home support**
- Recommend that the client receive **Assistive technology**
- Recommend that the client receive **Home modifications**

Scroll down to the **Delegate Decisions and Comments** section within the **Decisions** tab to view all decisions made by the delegate regarding the services recommended for the client. This area provides a detailed summary of approved, modified, or newly suggested services, along with any comments or justifications provided by the delegate.

Delegate decisions and comments

Assessment: Submitted on 29 January 2026

Decisions

Recommend that the client receive **Home support**

Classification: SaH Classification 7

Classification type: Ongoing

Home support services: **Care management:** Home support care management
Domestic assistance: General house cleaning, Laundry services, Shopping assistance
Home maintenance and repairs: Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
Home or community general respite: Community and centre-based respite, Flexible respite
Meals: Meal delivery, Meal preparation
Nursing care: Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
Nutrition: Nutrition supports
Personal care: Assistance with self-administration of medications, Assistance with self-care and activities of daily living, Continence management (non-clinical)
Social support and community engagement: Accompanied activities, Assistance to maintain personal affairs, Cultural support, Digital education and support, Expenses to maintain personal affairs, Group social support, Individual social support
Transport: Direct transport, Indirect transport

Approval start: 29 January 2026

Agreed

Recommend that the client receive **Assistive technology**

Assistive technology tier: AT Medium

Classification type: Short-term

Assistive technology services: **Equipment and products:** Assistive technology prescription and clinical support, Communication and information management products, Domestic life products, Managing body functions, Mobility products, Self-care products

Approval start: 29 January 2026

Cease date: 23 April 2027

Agreed

Recommend that the client receive **Home modifications**

Home modifications tier: HM High

Classification type: Short-term

Home modifications services: **Home adjustments:** Home modification products, Home modifications prescription and clinical support

Approval start: 29 January 2026

Cease date: 23 April 2027

Agreed

Decision date (Assessment)
29 January 2026 04:14 PM (Australian Eastern Standard Time)

Adding Recommendations

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

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

To add a Home modification, go to [Add Home modification Recommendation](#).

To add an Assistive technology Service, go to [Add Assistive technology Recommendation](#).

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

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

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

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

General Recommendation

Select **Add a general recommendation**.

Examples of general recommendations include:

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

1. When a pop-up box is displayed, enter information about the general recommendation, check the box if you are linking it to a goal and select **SAVE TO PLAN**. As assessors are completing the assessment, they will be able to add general recommendations to the support plan from the assessment.

Add general recommendation

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

Recommendation: * 0 / 255

Responsibility to action
 Assessor Client Other

Comments: 0 / 100

Associated goals
 To be mobile enough to enjoy gardening and outdoor activities again. To go to the gym twice per week.

[UNLINK THIS RECOMMENDATION FROM ALL GOALS](#)

SAVE TO PLAN [CANCEL](#)

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

Service Recommendation

Select **Add a service recommendation**.

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

For more information on Support at Home Assistive technology services and Home modification services, refer to the [Support at Home - Assistive technology and Home modifications \(AT-HM\) Recommendations](#) section.

The priority for Support at Home service recommendations will default to the priority as calculated by the Integrated Assessment Tool. Assessors should use the comments field to clarify the specific scope of the services that are recommended to be delivered within the Support at Home service type.

The scope of services should be linked to the identified needs from the assessment and goals referred to in the support plan, for example: unable to get to places beyond walking distance; requires transport to health clinic.

No Care Type Under the Act

Where a person is determined as not meeting the eligibility requirements of any care program under the Act, the assessment will result in **No Care Approved** and the client receives a non-approval letter.



! The assessors won't have this option if the Integrated Assessment Tool (IAT) algorithm recommends Support At Home (SAH) classification and the assessor accepts that.

1. Select 'Add No Care Type Under the Act'.

This image shows an example of a client with a comprehensive assessment not eligible for any care programs under the Act, therefore 'Add No Care Type Under the Act' is the only recommendation available to be selected (all other recommendations are greyed out).

The screenshot shows the 'Support plan and services' interface. At the top, there are navigation buttons: 'GO TO THE ASSESSMENT', 'FLAG AS END-OF-LIFE', and 'PRINT COPY OF SUPPORT PLAN'. Below these are tabs for 'Identified needs', 'Goals & recommendations' (selected), 'Decisions', 'Manage services & referrals', 'Associated People', and 'Review'. The main content area is titled 'IAT Outcome and Classifications' and shows 'Current assessment type: Comprehensive Assessment' and 'IAT Outcome: Ineligible for CHSP/SaH'. A yellow warning box states: 'The client is not eligible for ongoing SaH services. If client requires a higher classification or other type of classification, please override the IAT outcome.' Below this are 'ACCEPT' and 'OVERRIDE' buttons. The 'Client concerns and goals' section has an 'ADD AREA OF CONCERN' button and shows 'No client concerns or goals.' The 'Other recommendations' section has several buttons: 'ADD A GENERAL RECOMMENDATION', 'ADD A SERVICE RECOMMENDATION', 'ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT', 'ADD A CARE TYPE FOR DELEGATE DECISION', 'ADD NO CARE TYPE UNDER THE ACT' (highlighted with a red box), 'RECOMMEND A PERIOD OF LINKING SUPPORT', and 'RECOMMEND A PERIOD OF REABLEMENT'. At the bottom, there are buttons for 'COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER' and 'RETURN TO CLIENT'.

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

The screenshot shows a pop-up box titled 'No care type under the Act'. It contains a yellow warning box with the text: 'By selecting this option, you are not recommending the client for any care under the Aged Care Act 2024. This assessment will not be submitted to the Delegate for a decision. You can match and refer the client for Commonwealth Home Support Programme services, if required, and finalise the support plan.' Below this is a note: 'All fields marked with an asterisk (*) are required.' There is a 'Reason: *' dropdown menu with the selected option 'Client hasn't applied for care'. Below the dropdown is a text area for 'Reason or comments (optional)' with a character limit of 'Maximum 255 characters' and a counter showing '0 / 255'. At the bottom right, there are 'SAVE TO PLAN' and 'CANCEL' buttons.

! CHSP, MPS or NATSIFAC in the support plan

If a client already has a CHSP, MPS or NATSIFAC recommendation (including CHSP services added as 'urgent') in their support plan, assessors can complete the client's support plan for a Comprehensive assessment, without needing to add the following recommendations:

- Add a care type for delegate decision, or
- No care approval, or
- No change to existing approval.

Otherwise, an error message will appear:

X No Care Approval' or 'No Change to Existing Care Approvals' cannot be added when CHSP/MPS/NATSIFAC service has been recommended.

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

Support plan and services

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

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT | ADD A CARE TYPE FOR DELEGATE DECISION

Recommend that the client receive
No Care Approval

COMPLETE SUPPORT PLAN | RETURN TO CLIENT

Period of Linking Support

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

During a period of linking support, extension requests for Transition Care and Residential Respite Care services can be requested and granted.

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

Recommend a period of linking support

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

What is linking support ?

Start date *
25/05/2018

Recommended end date *
(e.g. dd/mm/yyyy)

Reason for linking support period *
Short term assistance to access aged care services

Comments
0 / 500

Associated goals
 To be mobile enough to enjoy gardening and outdoor activities again.
 To get eyes checked and new prescription glasses.

[UNLINK THIS RECOMMENDATION FROM ALL GOALS](#)

RECOMMEND CANCEL

Period of Reablement

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

During a period of reablement, extensions requests for Transition Care and Residential Respite Care services can be requested and granted.

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

Recommend a period of reablement

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

What is reablement ?

Start date *
09/02/2023

RecommendedEndDate: *
28/02/2023

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

Comments
Comments go here
16 / 500

RECOMMEND CANCEL



Care type for Delegate decision

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

ADDING A CARE TYPE AS PART OF A GOAL

Goal: To be able to perform their household tasks

Most relevant domain that goal area relates to:

- Physical function
- Home and personal safety

Client's current strengths and abilities in relation to this goal:
Able to move so can perform some duties

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Issue with physical health

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)
- To receive care for a lost or declining function (e.g. can be physical, cognitive or social)

Motivation to achieve: 8
Status: In Progress

Recommendations

Add to this goal:

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD AN ASSISTIVE TECHNOLOGY ADD A HOME MODIFICATION RECOMMEND A PERIOD OF LINKING SUPPORT

RECOMMEND A PERIOD OF REABLEMENT **ADD A CARE TYPE FOR DELEGATE DECISION** LINK TO AN EXISTING RECOMMENDATION LINK TO THE EXISTING SAH RECOMMENDATIONS

ADDING A CARE TYPE SEPARATELY

Client concerns and goals

ADD AREA OF CONCERN

Concern: Unable to perform certain household duties

ADD A GOAL

Goal: To be able to perform their household tasks

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD AN ASSISTIVE TECHNOLOGY ADD A HOME MODIFICATION ADD RECOMMENDED LONG TERM LIVING

ADD A CARE TYPE FOR DELEGATE DECISION ADD 'NO CARE TYPE UNDER THE ACT' RECOMMEND A PERIOD OF LINKING SUPPORT RECOMMEND A PERIOD OF REABLEMENT

2. At the pop-up, select which care type applies, enter the reason and comments, if necessary, then select **SAVE TO PLAN**. The care types available are: No Care Approval, Residential permanent, Residential respite care, and Transition Care. Not all types may be displayed. For example if CHSP, MPS or NATSIFAC was chosen, then 'No Care Approval' will not be available.

Add care type for delegate decision

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

Which care type applies? *

Select one

Select one

No Care Approval

Residential Permanent

Residential Respite Care

Transition Care

0 / 255

SAVE TO PLAN CANCEL

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



3. Once the required care type is selected, the pop-up screen will expand asking for further information. The assessor will be prompted to select the **priority** or **urgency** of the selected care type.

The screenshot shows a form titled "Add care type for delegate decision". At the top, it states "All fields marked with an asterisk (*) are required." Below this, there is a dropdown menu labeled "Which care type applies?*" with "Residential Permanent" selected. Underneath are six checkboxes for room and bathroom configurations: "Shared room + ensuite", "Single room + ensuite", "Shared room + no bathroom or ensuite", "Single room + no bathroom or ensuite", "Shared room + shared bathroom", and "Single room + shared bathroom". There is a date field for "If time-limited, when does the approval stop (optional):" with a calendar icon and a placeholder "(e.g. dd/mm/yyyy)". A second dropdown menu, "What is the urgency of this care type?*" with a question mark icon, is highlighted with a red box. Below it are radio buttons for "Is this emergency care?" with "No" selected. At the bottom, there is a "Reason or comments" text area and two buttons: "SAVE TO PLAN" (highlighted with a red box) and "CANCEL".

For **Residential Permanent** and **Residential Respite Care**, urgency is used.

For Residential Permanent the field is editable and needs to be selected. For Residential Respite Care the field will default to High and cannot be edited. The Aged Care Assessment manual provides guidance on selecting level of urgency.

For Residential Respite Care, ensure that the DEMMI checkbox is ticked, and a valid reason is entered as shown in the image below.

This screenshot shows the same form as above but with "Residential Respite Care" selected in the first dropdown. The "What is the urgency of this care type?*" dropdown is set to "High". The "Is this emergency care?" radio buttons have "No" selected. The "Reason or comments" text area contains a checked checkbox and the text: "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." Below this, there is a sub-label "Reason DEMMI not completed*" and the text "Client has not received a modified DEMMI previously|". At the bottom right, the "SAVE TO PLAN" button is highlighted with a red box.

4. Select **SAVE TO PLAN**.

! If a client's home address is not recorded, you will receive a warning message to update the address while performing the above step.

Add care type for delegate decision

Please update the client record to record a home address. If the home address is not recorded you will be unable to manually capture the MMM classification. You can proceed with a residential aged care recommendation without capturing a client's home address. However, the home address and MMM classification will not be used to determine the client's priority category.

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

Which care type applies? *
Residential Respite Care

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

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

Is this emergency care?
 Yes No

SAVE TO PLAN **CANCEL**

Support at Home Recommendations

Adding Home Support services

1. Once the clinical assessor has accepted the Support at Home classification, the assessor will be prompted to add Home Support services for the client. For each service that is recommended for the client, you will need to tick the tick box, enter a frequency and an intensity.

! If the assessor does not select a service, the Support at Home service provider will not be permitted to provide the service to the client, which may result in a Support Plan Review to add the service to the Support at Home classification.

When assessing for Support at Home, the Support Plan allows assessors to select all relevant service types when making a recommendation. This minimises the number of Support Plan Reviews raised. The only exception is Allied Health and Therapeutic Services for Independent Living, which must be selected manually based on identified goals.



Home | Assessments | Assessment | Bart SAMPSON support plan and services

Master Bart SAMPSON
Male, 81 years old, 1 March 1944, AC01907385

Primary contact: Bart Sampson (self)
No support relationships recorded

REFER THIS CLIENT FOR ASSESSMENT VIEW CLIENT REPORT

Add Home Support services

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

Recommended that the client receive: SaH Classification 5
Classification Type: Ongoing

Please select services within each service type*

Home or community general respite

Service	Frequency	Intensity	Goals
<input checked="" type="checkbox"/> Community and centre-based respite	2	Days per month	
<input checked="" type="checkbox"/> Flexible respite	3	Days per week	

Nutrition

Service	Frequency	Intensity	Goals
<input checked="" type="checkbox"/> Nutrition supports	2	Time(s) per day	

Therapeutic services for independent living

Service	Frequency	Intensity	Goals
<input type="checkbox"/> Art therapy			

- The assessor should review all recommended services to ensure that all the services that are required are either selected or deselected. Then, select the **SAVE TO PLAN** button.

Assessor Portal My Dashboard Find a client Assessment referrals Review requests Assessments Reviews Organisation administration Residential Funding Referrals Find a service provider Reports and documents Aged Care Assessor app Tasks and notifications My Aged Care interactions Logout

Home | Assessments | Assessment | Bart SAMPSON support plan and services

Master Bart SAMPSON
Male, 81 years old, 1 March 1944, AC01907385

Primary contact: Bart Sampson (self)
No support relationships recorded

<input type="checkbox"/> Social work		
<input type="checkbox"/> Speech pathology		
<input type="checkbox"/> Physiotherapy		
<input type="checkbox"/> Psychology		
<input type="checkbox"/> Music therapy		
<input checked="" type="checkbox"/> Diet or nutrition	3	Days per month
<input type="checkbox"/> Allied health assistance		
<input type="checkbox"/> Aboriginal or Torres Strait Islander Health Practitioner assistance		
<input type="checkbox"/> Aboriginal or Torres Strait Islander Health Worker assistance		
<input type="checkbox"/> Exercise physiology		
<input type="checkbox"/> Occupational therapy		
<input type="checkbox"/> Counselling or psychotherapy		

SAVE TO PLAN CANCEL

Accessibility Privacy Disclaimer Terms of use Copyright
Copyright © Commonwealth of Australia ABN 83 605 426 799

myagedcare

- Once saved to the plan you will be redirected to the **Goals & recommendations** tab with a banner stating that the creation of the services to display will take up to 60 seconds to show.

Support plan and services

GO TO THE ASSESSMENT FLAG AS END OF LIFE PRINT COPY OF SUPPORT PLAN

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

i Your request is being processed and may take up to 60 seconds. Once processing finishes you will see the services updated on the screen.

- Once expanded, the assessor will be able to view the Support at Home service recommendation/s. Select the **View (magnifying glass)** icon to view them in detail.



Recommend that the client receive 6 May 2025

Home Support

(not yet in place)

This recommendation requires a delegate decision

Classification: SaH Classification 5

Classification type: Ongoing

Home Support services: **Home or community general respite:** Community and centre-based respite, Flexible respite
Nutrition: Nutrition supports
Domestic assistance: General house cleaning, Laundry services, Shopping assistance
Home maintenance and repairs: Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
Meals: Meal delivery, Meal preparation
Social support and community engagement: Group social support
Transport: Direct transport, Indirect transport
Care management: Home support care management
Personal care: Assistance with self-administration of medications, Assistance with self-care and activities of daily living, Continence management (non-clinical)
Nursing care: Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
Allied health and therapy: Diet or nutrition

Recommended by: Brenna Hale (Assessor) Sunrise Assessments - ACA - VIC 3

COMPLETE SUPPORT PLAN RETURN TO CLIENT

- The detailed view shows the recommended service with frequency. Show more by using the **expand** buttons. To return, select the **CLOSE** button.

Home support services

Classification: SaH Classification 5 Classification Type: Ongoing

Allied health and therapy

- Diet or nutrition: recommended frequency is 3 days per month.

Care management

- Home support care management:

Domestic assistance

Home maintenance and repairs

Home or community general respite

- Community and centre-based respite: recommended frequency is 2 days per month.
- Flexible respite: recommended frequency is 3 days per week.

Meals

Nursing care

Nutrition

CLOSE

- Once the assessor has completed all the required changes, select the **COMPLETE SUPPORT PLAN REVIEW**.



Viewing Recommended SaH services

1. To view details and the statuses of a client's services recommended under their Support at Home classifications, navigate to **OTHER RECOMMENDATIONS** under the **GOALS AND RECOMMENDATIONS** tab. Select the expand icon next to the service, and then select the blue magnifier (View) icon.

Other recommendations

Recommend that the client receive 8 May 2025

Equipment and products

Recommend that the client receive 8 May 2025

Home Support

(not yet in place)

This recommendation requires a delegate decision

Classification: SaH Classification 4
Classification type: Ongoing

Home Support services: **Home or community general respite:** Community and centre-based respite, Flexible respite
Nutrition: Nutrition supports
Domestic assistance: General house cleaning, Laundry services, Shopping assistance
Home maintenance and repairs: Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
Meals: Meal delivery, Meal preparation
Social support and community engagement: Accompanied activities, Assistance to maintain personal affairs, Cultural support, Digital education and support, Expenses to maintain personal affairs, Group social support, Individual social support
Transport: Direct transport, Indirect transport
Care management: Home support care management
Personal care: Assistance with self-administration of medications, Assistance with self-care and activities of daily living, Continence management (non-clinical)
Nursing care: Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
Allied health and therapy: Diet or nutrition

2. A Pop-up screen will open listing all the services recommended.

Home support services

Classification: SaH Classification 4 **Classification Type:** Ongoing

- Expand Allied health and therapy
- Expand Care management
- Expand Domestic assistance
- Expand Home maintenance and repairs
- Expand Home or community general respite
- Expand Meals
- Expand Nursing care
- Expand Nutrition
- Expand Personal care
- Expand Social support and community engagement
- Expand Transport

CLOSE

3. Select the expand card icon to view the details and statuses of all the services associated.



Home support services

Classification: SaH Classification 4

Classification Type: Ongoing

Allied health and therapy

Care management

Domestic assistance

• General house cleaning:

Agreed

• Laundry services:

Agreed

• Shopping assistance:

Agreed

Home maintenance and repairs

Home or community general respite

Meals

• Meal delivery: Linked to goal: Ability to cook

Agreed

CLOSE

Assistive technology and Home modifications (AT-HM) Recommendations

This section outlines how to view, add and edit services offered under the Assistive technology and Home modifications (AT-HM) Services.

Adding a Home modification Recommendation

! When considering adding/editing Home modifications care recommendations, refer to:

- [Support Plan](#) section of [My Aged Care – Integrated Assessment Tool \(IAT\) User Guide](#)
- [Approving AT and HM under Support at Home](#) and [Approving AT and HM under CHSP](#) sections under Chapter 8 of the [My Aged Care Assessment Manual](#)
- [AT-HM Tier Guide](#)
- Assessor workforce training.

If the client's IAT outcome is of any Support at Home Classification, the assessor can add a Home modification recommendation during the assessment.

1. Go to the client's **GOALS AND RECOMMENDATIONS** tab within the Support Plan and Services screen.

Scroll to the **OTHER RECOMMENDATIONS** section.

Select the **ADD A HOME MODIFICATION** button.



Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 4 Agreed
 AT Medium
 Override reason: Higher level service needs
 Override reason description: Require higher level of care

Client concerns and goals

[ADD AREA OF CONCERN](#)

No client concerns or goals.

Other recommendations

[ADD A GENERAL RECOMMENDATION](#) [ADD A SERVICE RECOMMENDATION](#) [ADD AN ASSISTIVE TECHNOLOGY](#) **[ADD A HOME MODIFICATION](#)** [ADD RECOMMENDATION](#)

[RECOMMEND A PERIOD OF LINKING SUPPORT](#) [RECOMMEND A PERIOD OF REABLEMENT](#)

2. The **ADD HOME MODIFICATIONS** screen display.

Select the relevant Home modification Tier from the drop down. (available tiers are HM Low, HM Medium, HM High).

The **SERVICE TYPE** and the linked goals will then be pre-filled.

Then, Select **SAVE TO PLAN**.

Add Home modifications recommendation

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

Home modifications tier *
 HM Medium

Service Type *
 Home adjustments

Home modification products Linked goals

Home modifications prescription and clinical support Linked goals

The client's preference for seeking Home modifications services through the Support at Home program is:*

Seeking services Not seeking services

[SAVE TO PLAN](#) [CANCEL](#)

3. The Home modification recommendation will then display on the client's **GOALS AND RECOMMENDATION** tab under the **OTHER RECOMMENDATIONS** section.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 4 Agreed
 AT Medium
 HM Medium
 Override reason: Higher level service needs
 Override reason description: Require higher level of care

Client concerns and goals

No client concerns or goals.

Other recommendations

Recommend that the client receive Home Support 7 May 2025

Recommend that the client receive Home Modifications

Recommend that the client receive Assistive Technology Your recommendation has been added.

Viewing Home modification Service Recommendation

1. To view the details of the Home modification Service, select the blue expand (pencil) icon next to the Home modification service under the **OTHER RECOMMENDATIONS** section.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 4 Agreed
 AT Medium
 HM Medium
 Override reason: Higher level service needs
 Override reason description: Require higher level of care

Client concerns and goals

No client concerns or goals.

Other recommendations

Recommend that the client receive Home Support 7 May 2025

Recommend that the client receive Home Modifications

2. Details about the recommended Home modification Service will be displayed.

Recommend that the client receive **Home Modifications**

(not yet in place)

This recommendation requires a delegate decision

Home Modification Tier: HM Medium
 Classification type: Short-term
 Home Modification services: **Home adjustments: Home modification products, Home modifications prescription and clinical support**
 Recommended by: UAT.Ford UAT.Lovell (Assessor) Sunrise Assessments - ACA - VIC 3



Editing Home modification Recommendation

1. To edit a Home modification recommendation, select the blue pencil (edit) icon on the top right hand corner of the Home modification service.

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD AN ASSISTIVE TECHNOLOGY | ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT | ADD A CARE TYPE FOR DELEGATE DECISION

ADD 'NO CARE TYPE UNDER THE ACT' | RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive Home Support 7 May 2025 [edit icon]

Recommend that the client receive Home Modifications 7 May 2025 [edit icon]

2. The Editing Home modifications recommendation page displays. Apply the required changes and select **SAVE TO PLAN**.

Editing Home modifications recommendation

! To allocate a new tier at the same tier level, select button 'Allocate new tier'. To change tiers or update linked goals for new

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

Home modifications tier*
HM Medium

Service Type*
Home adjustments

Home modification products Linked goals [edit icon]

Home modifications prescription and clinical support Linked goals [edit icon]

SAVE TO PLAN CANCEL

Adding an Assistive technology Recommendation

- !** When considering adding/editing Assistive technology care recommendations, refer to:
- Support Plan section of [My Aged Care – Integrated Assessment Tool \(IAT\) User Guide](#)
 - Approving AT and HM under Support at Home and Approving AT and HM under CHSP sections under Chapter 8 of the [My Aged Care Assessment Manual](#)
 - [AT-HM Tier Guide](#)
 - Assessor workforce training.

If the client's IAT outcome is of any Support at Home Classification, the assessor can add an Assistive technology recommendation during the assessment.

1. Go to the client's **GOALS AND RECOMMENDATIONS** tab within the Support Plan and Services screen.
Scroll to the **OTHER RECOMMENDATIONS** section.
Select the **ADD AN ASSISTIVE TECHNOLOGY** button.

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 4 Agreed
 AT Medium
 HM Medium

Override reason: Higher level service needs
 Override reason description: Require higher level of care

Client concerns and goals

Concern: Unable to perform certain household duties

Goal: To be able to perform their household tasks

Other recommendations

- The Add Assistive technology recommendation screen displays. Select the Classification Type and the Specified Needs from their drop-downs. Select **SAVE TO PLAN**.

! Services don't display the Linked goals if the service recommendations are from a previous assessment.

Home | Assessments | John KK READ | John KK READ support plan and services | Assistive technology

Add Assistive technology recommendation

The client's preference for seeking Assistive technology services determines whether they are in the AT-HM Priority System.

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

Classification type *
Ongoing

Specified needs *
Specified needs - Assistance Dogs

Service Type *
Equipment and products

- Assistive technology prescription and clinical support Linked goals
- Communication and information management products Linked goals
- Domestic life products Linked goals
- Managing body functions Linked goals
- Mobility products Linked goals
- Self-care products Linked goals

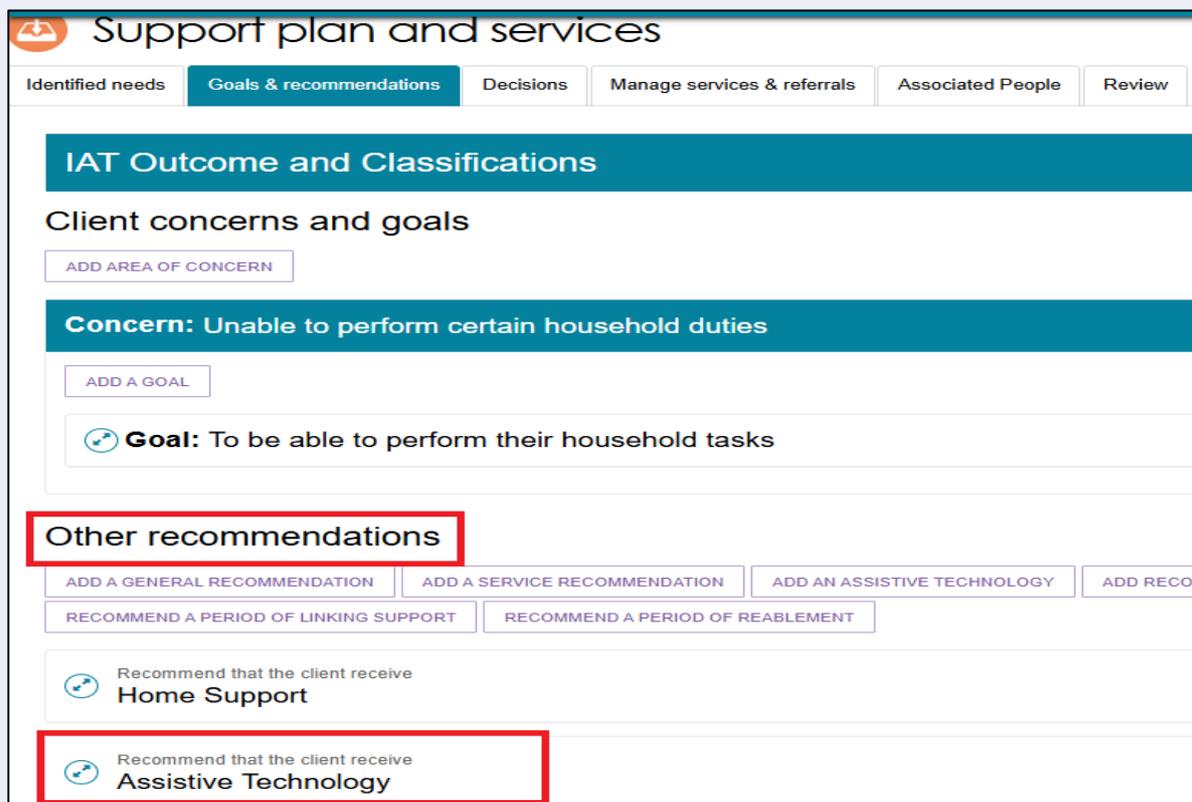
The client's preference for seeking Assistive technology services through the Support at Home program is:*

Seeking services Not seeking services



Viewing Assistive technology Service recommendation

1. [Once the Assistive technology recommendation is added](#), the changes will be displayed on the Client's **GOALS AND RECOMMENDATIONS** tab under the **OTHER RECOMMENDATIONS** section.



Support plan and services

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

IAT Outcome and Classifications

Client concerns and goals

ADD AREA OF CONCERN

Concern: Unable to perform certain household duties

ADD A GOAL

Goal: To be able to perform their household tasks

Other recommendations

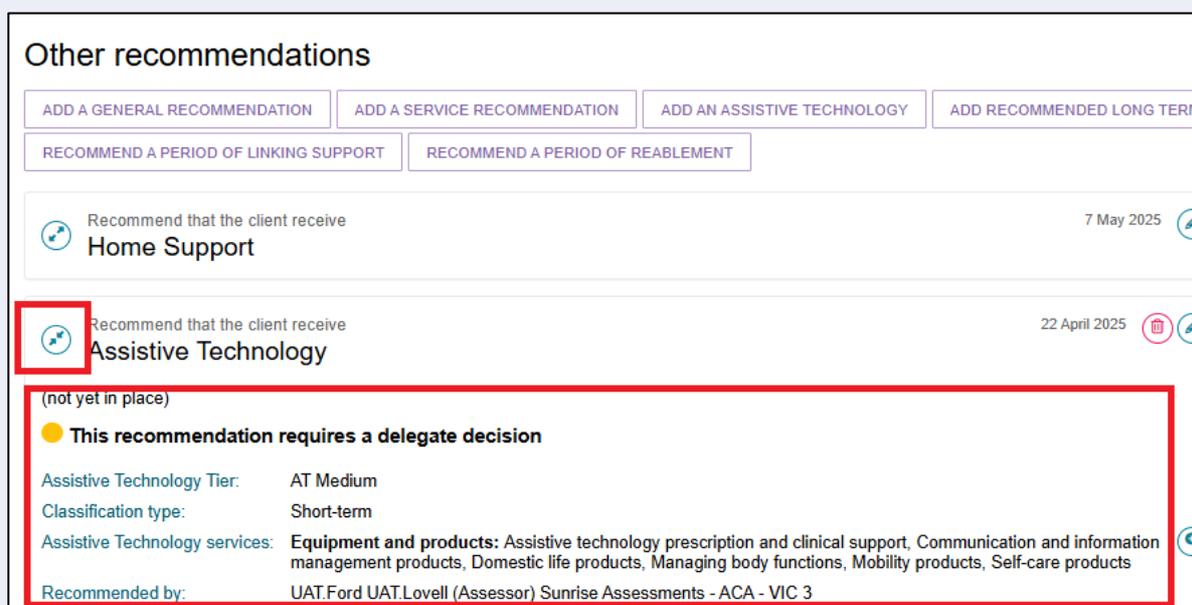
ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD AN ASSISTIVE TECHNOLOGY | ADD RECOM

RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive
Home Support

Recommend that the client receive
Assistive Technology

2. To view the Assistive technology Services recommended, select the blue Expand icon next to **ASSISTIVE TECHNOLOGY**.



Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD AN ASSISTIVE TECHNOLOGY | ADD RECOMMENDED LONG TERM

RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive
Home Support 7 May 2025

Recommend that the client receive
Assistive Technology 22 April 2025

(not yet in place)

This recommendation requires a delegate decision

Assistive Technology Tier: AT Medium
Classification type: Short-term
Assistive Technology services: **Equipment and products:** Assistive technology prescription and clinical support, Communication and information management products, Domestic life products, Managing body functions, Mobility products, Self-care products
Recommended by: UAT.Ford UAT.Lovell (Assessor) Sunrise Assessments - ACA - VIC 3



Editing Assistive technology Recommendation

1. To edit an Assistive technology recommendation, select the blue **Edit (pencil) icon** on the top right hand corner of the Assistive technology service.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT ADD A CARE T...

RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive
Home Support 7 May 2025

Recommend that the client receive
Assistive Technology 7 May 2025

2. The Editing Assistive technology recommendation page appears. Apply the required changes and select **SAVE TO PLAN**.

Editing Assistive technology recommendation

You have report(s) that are ready to be downloaded. To download, go to [Reports page](#).

To allocate a new tier at the same tier level, select button 'Allocate new tier'. To change tiers or update linked goals for new re...

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

Classification type *
Short-term

Assistive technology tier *
AT High

Service Type *
Equipment and products

Assistive technology prescription and clinical support
 Communication and information management products
 Domestic life products
 Managing body functions
 Mobility products
 Self-care products

SAVE TO PLAN CANCEL

Adding Client Concerns and Goals

1. From the support plan and services page select the **Goals & recommendations** tab. Under the Client concerns and goals section, select **ADD AREA OF CONCERN**.

Gender not specified, 56 years old, 25 August 1968, AC84645092
Lot Number 35 1 CELESTE AVENUE CASTLE HILL, NSW, 2154

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
IAT Outcome: SaH Classification 7
Recommended classification: SaH Classification 5
Override reason: Lower level service needs
Override reason description: Change in care needs

Client concerns and goals

ADD AREA OF CONCERN

2. In the pop-up box, record the area of concern, and select **SAVE TO PLAN**.

Add area of concern

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

What is the area of concern? *

Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning

109 / 500

SAVE TO PLAN CANCEL

3. The area of concern will appear under the **Client concerns and goals** section. Select the Bin icon to delete. Select the Pencil icon to edit.

Client concerns and goals

ADD AREA OF CONCERN

Concern: Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning

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

Client concerns and goals

ADD AREA OF CONCERN

Concern: Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning

ADD A GOAL

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

Add goal

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

What is the client's goal? *

To be able to perform household tasks

37 / 500

Most relevant domain that goal area relates to?

Physical function
 Cognitive function
 Social support
 General health
 Personal health
 Home and personal safety
 Other

What are the client's current areas of difficulty or activities where the client needs support in order to achieve this goal? *

Difficulty in lifting light to heavy objects, Difficulty with mobility and long time standing

93 / 500

What are the client's current strengths and abilities in relation to this goal? *

Can sit and stand for a limited period of time

93 / 500

SAVE TO PLAN CANCEL

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

No support relationships recorded

Client concerns and goals

ADD AREA OF CONCERN

Concern: Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning

ADD A GOAL

Goal: To be able to perform household tasks

- Continue to add more concerns and goals by repeating the above step.

! Changing the display order of multiple concerns or goals

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

Client concerns and goals

ADD AREA OF CONCERN

Concern: To be more active in everyday life.

ADD A GOAL

Goal: To go to the gym twice per week.

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

ADD A GOAL

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

6. In the **Goals** section, you can add service recommendations that may be relevant to assisting the client in achieving their goals.

Select the blue expand card icon next to the goal where the service needs to be added and select the relevant button.

Refer to [Adding Recommendations](#) for more information.

Goal: To be able to perform household tasks

Most relevant domain that goal area relates to:

- Physical function
- General health
- Personal health
- Home and personal safety

Client's current strengths and abilities in relation to this goal:
Can sit and stand up without help for sometime

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Difficulty with mobility

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)

Motivation to achieve: 8

Status: In Progress

Recommendations

Add to this goal:

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD AN ASSISTIVE TECHNOLOGY ADD A HOME MODIFICATION RECOMMEND A PERIOD OF LINKING SUPPORT

RECOMMEND A PERIOD OF REABLEMENT ADD A CARE TYPE FOR DELEGATE DECISION LINK TO AN EXISTING RECOMMENDATION LINK TO THE EXISTING SAH RECOMMENDATIONS

Linking goals to Existing Support at Home Recommendations

For clients with recommended Support at Home Classifications, the assessor can link their goals defined in the support plan to the existing Support at Home service recommendations.

1. From the client **SUPPORT PLAN AND SERVICES** screen, go to the **GOALS AND RECOMMENDATIONS** tab. Then go to the **CLIENT CONCERNS AND GOALS** section.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT Outcome: SaH Classification 1

Recommended classification: SaH Classification 4 Agreed

HM Medium

Specified needs - Continence Products

Override reason: Higher level service needs

Override reason description: Require higher level of care

Client concerns and goals

ADD AREA OF CONCERN

Concern: Difficulty in cooking

ADD A GOAL

Goal: Ability to cook

2. View the client **GOAL** by selecting the blue expand card icon. Then, select the **LINK TO THE EXISTING SAH RECOMMENDATIONS** button.

 **Goal: Ability to cook**

Most relevant domain that goal area relates to:

- Physical function
- Social support
- General health
- Personal health

Client's current strengths and abilities in relation to this goal:
Can move and walk

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Lifting objects and cutting vegetables

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)
- To compensate for a declining function (e.g. can be physical, cognitive or social)
- To receive care for a lost or declining function (e.g. can be physical, cognitive or social)

Motivation to achieve: 6
Status: In Progress

Recommendations

Add to this goal:

ADD A GENERAL RECOMMENDATION	ADD A SERVICE RECOMMENDATION	ADD AN ASSISTIVE TECHNOLOGY
LINK TO AN EXISTING RECOMMENDATION	LINK TO THE EXISTING SAH RECOMMENDATIONS	

3. The Link to the existing SaH recommendations screen displays.

Select a recommendation (classification) from the drop down.

Use the expand icon to expand the service type/s to be linked to this goal.

Then, tick the tickboxes next to the desired service/s.

Finally, select the **SAVE TO PLAN** button

Link to the existing SaH recommendations

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

Select a recommendation *
SaH Classification 4

Select the services to be linked to this goal:

-  Care management
-  Domestic assistance
-  Home maintenance and repairs
-  Home or community general respite
-  **Meals**
 - Meal delivery
 - Meal preparation
 - Meal delivery
 - Meal preparation
 - Meal delivery
 - Meal preparation
 - Meal delivery

SAVE TO PLAN CANCEL

4. The linked Support at Home recommendation will be displayed within the relevant client **GOAL** section.

 **Goal: Ability to cook**

Most relevant domain that goal area relates to:

- Physical function
- Social support
- General health
- Personal health

Client's current strengths and abilities in relation to this goal:
Can move and walk

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Lifting objects and cutting vegetables

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)
- To compensate for a declining function (e.g. can be physical, cognitive or social)
- To receive care for a lost or declining function (e.g. can be physical, cognitive or social)

Motivation to achieve: 6

Status: In Progress

Support at Home recommendations:

SaH Classification 4

- **Meals:** Meal delivery
- **Transport:** Indirect transport
- **Personal care:** Assistance with self-care and activities of daily living

Recommendations

Add to this goal:

[ADD A GENERAL RECOMMENDATION](#) [ADD A SERVICE RECOMMENDATION](#) [ADD AN ASSISTIVE TECHNOLOGY RECOMMENDATION](#)

[LINK TO THE EXISTING SAH RECOMMENDATIONS](#)

Recording Service Frequency and Intensity

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

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

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

Add service recommendation

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

Service Type: *

Priority and dates
Priority: *
Low

Recommended service frequency ? Recommended service intensity ?

Recommend a start date
 Yes No

Recommend a review date
 Yes No

Recommend an end date
 Yes No

Responsibility to action
 Assessor Client Other

Comments: 0 / 100

Associated goals
 To be mobile enough to enjoy gardening and outdoor activities again. To go to the gym twice per week.

UNLINK THIS RECOMMENDATION FROM ALL GOALS

SAVE TO PLAN CANCEL

Support at Home - Restorative Care Pathway

Clients approved for the Short-Term Restorative Care (STRC) Program who enter their episode after 1 November 2025 will commence under the Restorative Care Pathway (RCP).

For each transitioned STRC client, they will receive a SaH RCP classification with access to all RCP services. They will also receive an Assistive Technology (AT) Medium, and a Home Modifications (HM) Medium classification.

If a second funding unit is required during a Restorative Care episode, the assessor must determine what funding has already been utilised, including their STRC episode. A client can receive a maximum of two units per year which can be either:

- Two budgets, spaced out over the year or,
- Two budgets within the 16 week period.

Note that an approval for STRC in the system will not reflect as an approval for the Restorative Care Pathway. Assessors will need to determine any previous STRC approvals from the client.

Between 1 November 2025 and 23 February 2026:

- STRC approvals will not be recognised as RCP approvals in the system.
- The system will continue to display them as STRC approvals.
- Assessors will not be able to see whether the client has entered care under STRC/RCP.



From 23 February 2026:

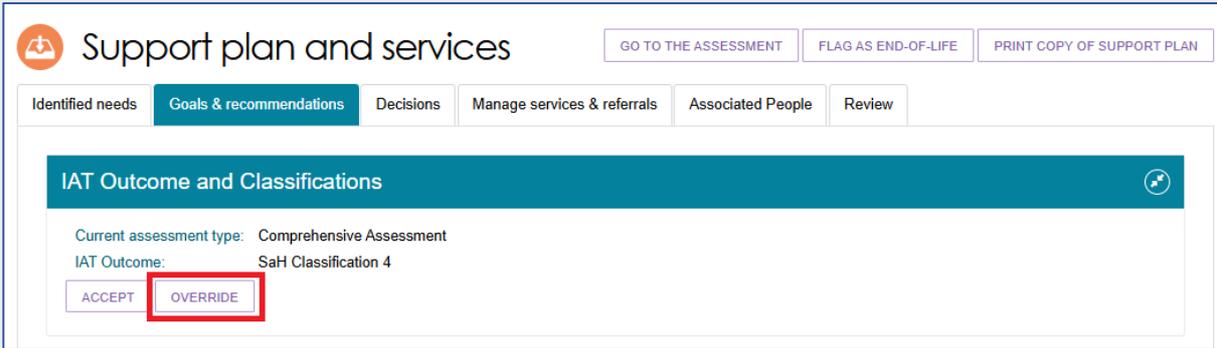
- STRC approvals not commenced before 1 November 2025 will be migrated to RCP approvals in the system.

These migrated approvals will not appear like standard RCP services.

Overriding to Restorative Care Pathway

Once a client receives an IAT outcome, the assessor can override it to Restorative Care Pathway.

1. Go to the client's support plan section and then the Goals & Recommendations tab. Select **OVERRIDE**



Support plan and services

GO TO THE ASSESSMENT FLAG AS END-OF-LIFE PRINT COPY OF SUPPORT PLAN

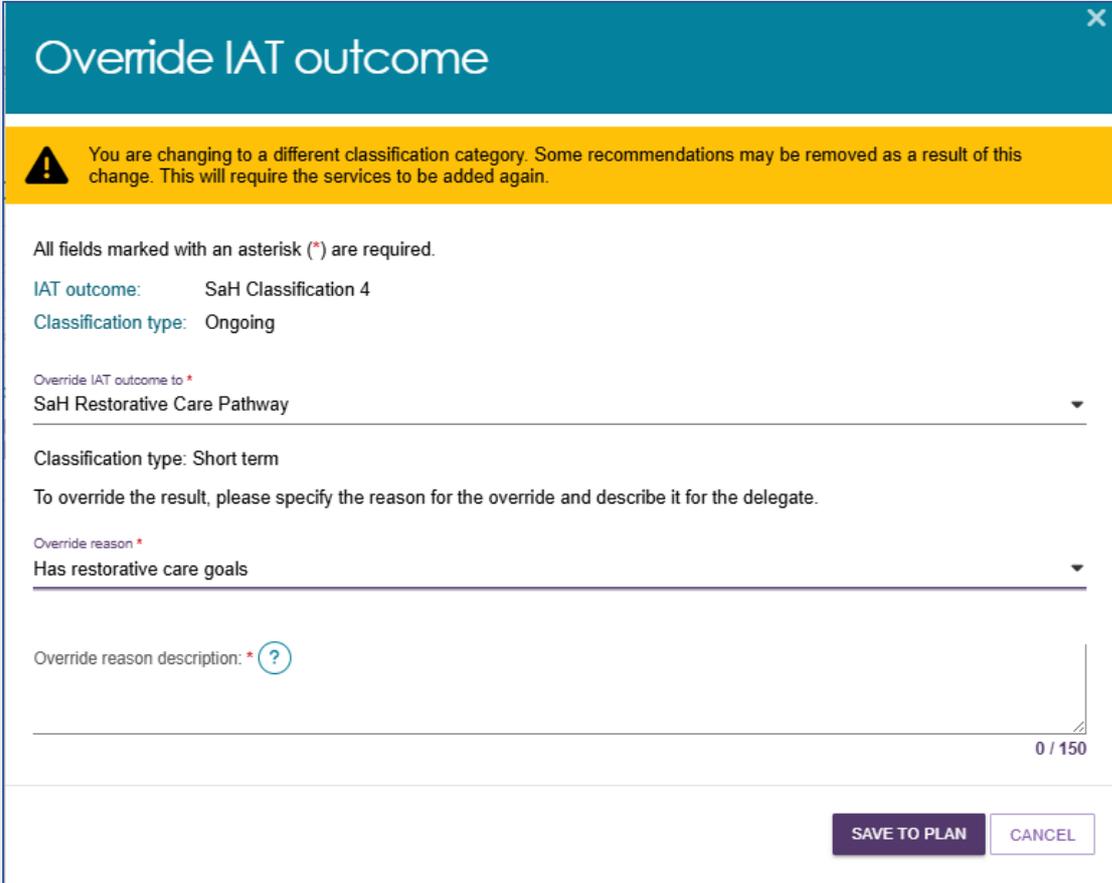
Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

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

ACCEPT **OVERRIDE**

2. The Override IAT Outcome pop up appears. Select 'Override IAT Outcome To' as 'SaH Restorative Care Pathway'. Select an override reason, and enter a description of the reason. Finally, Select **SAVE TO PLAN**.



Override IAT outcome

! You are changing to a different classification category. Some recommendations may be removed as a result of this change. This will require the services to be added again.

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

IAT outcome: SaH Classification 4
Classification type: Ongoing

Override IAT outcome to *
SaH Restorative Care Pathway

Classification type: Short term

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

Override reason *
Has restorative care goals

Override reason description: * ?
0 / 150

SAVE TO PLAN CANCEL

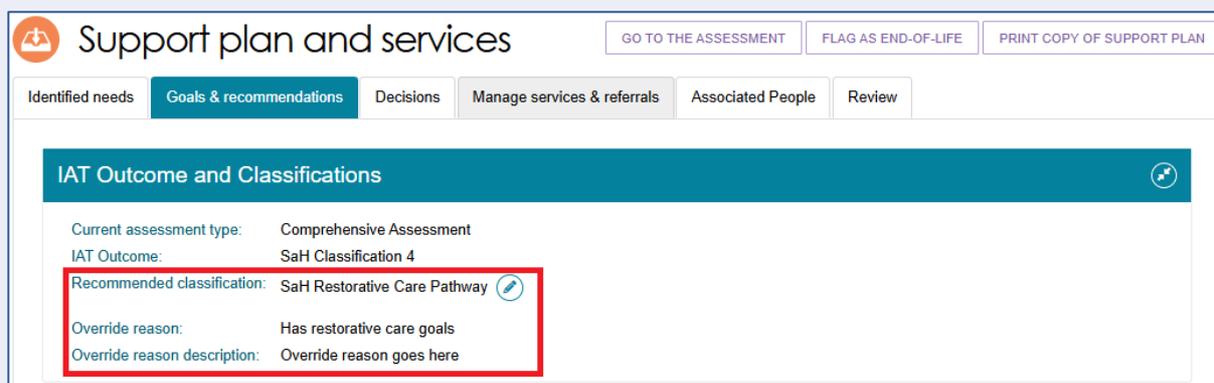


- If the original IAT outcome was a Support at Home classification, you will be asked to review the list of Home Support services. Then, select SAVE TO PLAN.

An information banner may display: 'Your request is being processed and may take up to 60 seconds. Once processing finishes you will see the services updated on the screen.'

 Your request is being processed and may take up to 60 seconds. Once processing finishes you will see the services updated on the screen.

- The Goals & Recommendations page displays again. Go back to the IAT Outcome and Classification heading to view the overridden outcome.



Support plan and services

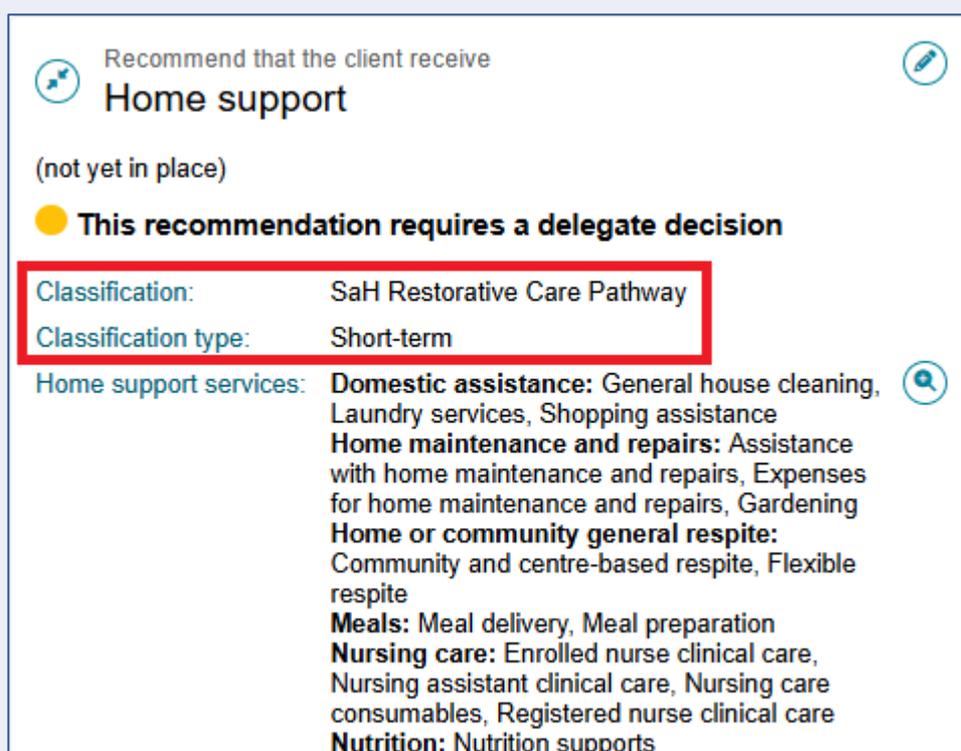
GO TO THE ASSESSMENT FLAG AS END-OF-LIFE PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 4
Recommended classification: SaH Restorative Care Pathway
 Override reason: Has restorative care goals
 Override reason description: Override reason goes here

In case of the Support at Home classification, its classification now displays as 'SaH Restorative Care Pathway'.



Recommend that the client receive Home support
 (not yet in place)

This recommendation requires a delegate decision

Classification: SaH Restorative Care Pathway
Classification type: Short-term

Home support services:

- Domestic assistance:** General house cleaning, Laundry services, Shopping assistance
- Home maintenance and repairs:** Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
- Home or community general respite:** Community and centre-based respite, Flexible respite
- Meals:** Meal delivery, Meal preparation
- Nursing care:** Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
- Nutrition:** Nutrition supports

Recommending Second Unit of Restorative Care Pathway

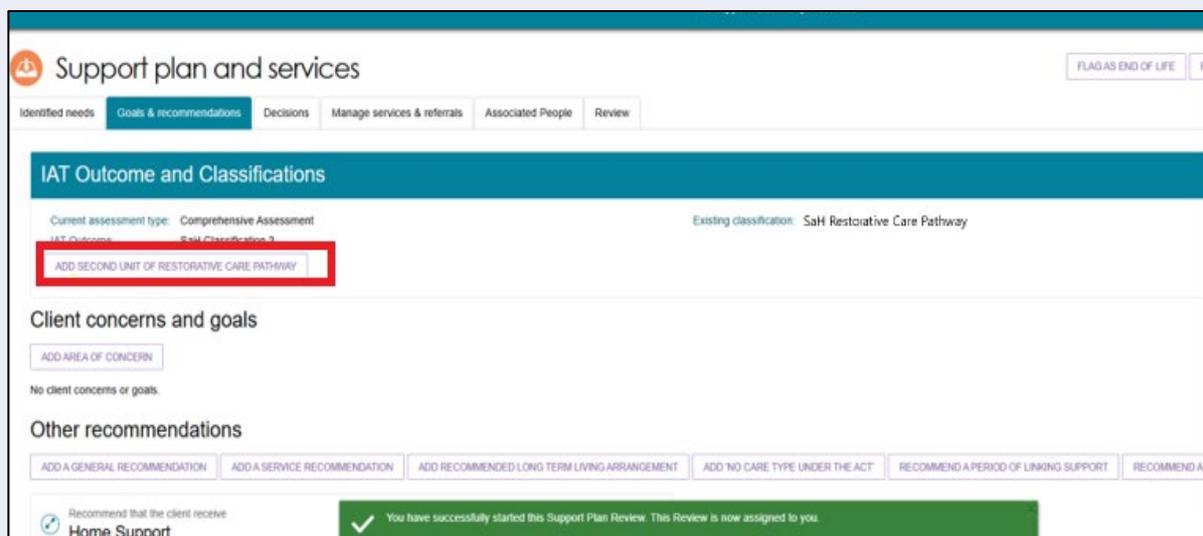
If the client has an approved and active **Support at Home (SaH) Restorative Care Pathway** on the Support Plan, a second unit of Restorative Care Pathway can be requested for a client within sixteen weeks since the commencement of the Restorative Care Pathway (first unit).

Upon delegate approval of the second unit, a new Restorative Care Pathway approval will be created with an approval start date set to the date on which the delegate approved, and the approval end date is set to the same approval end date of the first unit.

Once the second unit is added, the assessor can revert their decision and remove it.

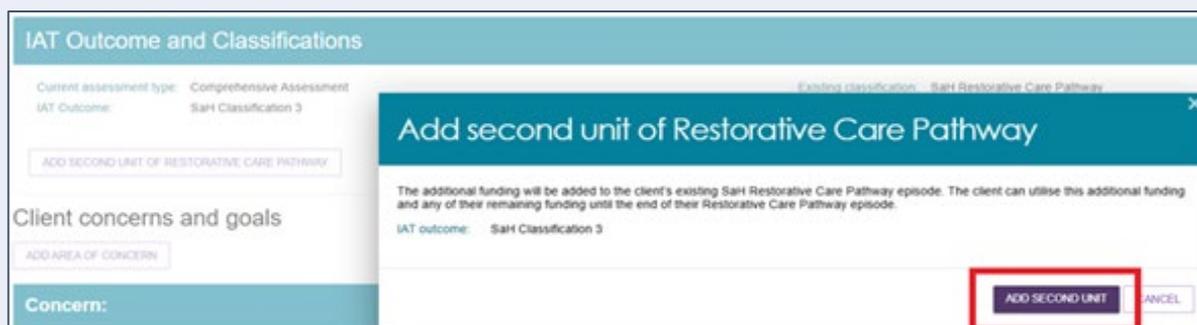
1. Go to the Support Plan and Services section, then to the Goals & Recommendations tab. The Existing classification under the IAT Outcome and Classifications heading should be 'SaH Restorative Care Pathway'.

Then, select **ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY**.



The screenshot shows the 'Support plan and services' interface. The 'Goals & recommendations' tab is active. Under the 'IAT Outcome and Classifications' heading, the current assessment type is 'Comprehensive Assessment' and the existing classification is 'SaH Restorative Care Pathway'. A red box highlights the 'ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY' button. Below this, there are sections for 'Client concerns and goals' and 'Other recommendations'.

2. Once the **ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY** button is selected, a new window will open with **ADD SECOND UNIT** button to confirm the selection.



The screenshot shows a confirmation window titled 'Add second unit of Restorative Care Pathway'. The window contains the text: 'The additional funding will be added to the client's existing SaH Restorative Care Pathway episode. The client can utilise this additional funding and any of their remaining funding until the end of their Restorative Care Pathway episode.' Below this text, there is a red box highlighting the 'ADD SECOND UNIT' button. The background shows a blurred view of the 'Support plan and services' interface.

3. The assessor has the option to revert their decision to recommend a second unit of restorative care pathway if the circumstances change by selecting the **REMOVE SECOND UNIT OF RESTORATIVE CARE** button.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment | Existing classification: SaH Rest

IAT Outcome: SaH Classification 3

REMOVE SECOND UNIT OF RESTORATIVE CARE

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT | ADD NO CARE TYPE UNDER THE

Recommend that the client receive **Home Support** | 8 May 2025

SAVE AND SUBMIT FOR DELEGATE DECISION | RETURN TO CLI | **Successfully added second unit of Restorative Care Pathway.**

4. Select **Remove** at the confirmation pop up.

Remove second unit of Restorative Care Pathway

Remove second unit of Restorative Care Pathway for Sergio MAY.

REMOVE | CANCEL

End-of-Life Pathway

Flagging End-Of-Life to an existing SaH Restorative Care Pathway

If the review is flagged as End of Life, the assessor can set the classification to **SaH End-of-Life Pathway** when:

- existing classification is **SaH Restorative Care Pathway**
- end-of life documents are verified
- before submitting the Support Plan Review for delegate decision.

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage service & referrals | Associat

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT outcome: SaH Classification 3

Recommended classification: SaH Restorative Care Pathway

OVERRIDE TO END OF LIFE | **ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY**

1. At the client's Goals and Recommendations tab, go to the IAT Outcome and Classifications section, and select the **OVERRIDE TO END OF LIFE** button.

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT outcome: SaH Classification 3

Recommended classification: SaH Restorative Care Pathway

OVERRIDE TO END OF LIFE | ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY

2. check for the information in the recommendations section and select **COMPLETE AND FINALISE SUPPORT PLAN REVIEW** button.

- **Nursing care:** Enrolled nurse clinical care
- **Personal care:** Continence management (non-clinical)

Recommended by **Damien Wayne**

COMPLETE AND FINALISE SUPPORT PLAN REVIEW | RETURN TO CLIENT

3. The IAT Outcome and Classifications section will now display the recommendation classification as SaH End-Of-Life Pathway.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT outcome: SaH Classification 3

Recommended classification: SaH End-of-Life Pathway

Existing classification: SaH Restorative Care Pathway

REVERT TO RESTORATIVE CARE

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

4. Then, select **Save and Submit for Delegate Decision**.

- **Transport:** Direct transport
- **Nursing care:** Enrolled nurse clinical care
- **Personal care:** Continence management (non-clinical)

Recommended by **Damien Wayne**

SAVE AND SUBMIT FOR DELEGATE DECISION | RETURN TO CLIENT

! If there is a change of mind from the client or their support guardian that they do not want their assessment to be flagged as **END OF LIFE**, the assessor will have the ability to [Revert to the ongoing classification](#).

5. Enter the outcome of the Support Plan Review from the drop-down menu selection alongside who the plan was conducted with.

Select **COMPLETE AND FINALISE SUPPORT PLAN REVIEW** to finalise the Support Plan Review. The outcome details entered above cannot be edited once the Support Plan Review is complete and will appear on the client's support plan.

Complete & finalise support plan review for Natalie HOLLAND

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

Outcome of support plan review *

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

Support plan conducted with *

COMPLETE & FINALISE SUPPORT PLAN REVIEW CANCEL

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

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

6. The Support Plan Review will be visible under the **PLANS** tab in the client record.

View support network

Plans

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

Current Episode
Episode ID: 1-1AP86BY2
16 August 2023 - Present
SUPPORT PLAN

Recommendations

- Home Care Package Level 1
- Social support and community engagement
- Meals

Upcoming Review(s)
No upcoming reviews scheduled

Assessment history

- 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

- Review 2 May 2025

Reablement and linking support history

Revert End-Of-Life Flag

If there is a change of mind from the client or their support guardian that they do not want their assessment to be flagged as **END OF LIFE**, the assessor will have the ability to **Revert** to the ongoing classification.

1. Go to the client's profile and go to the **Goals and Recommendations** tab.
2. The IAT Outcome and Classifications page displays. It says that the recommended classification is SaH End-Of-Life Pathway. Select the button underneath to revert to the previous recommendation. The below example shows **Revert to Restorative Care**.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH

IAT outcome: SaH Classification 3

Recommended classification: SaH End-of-Life Pathway

REVERT TO RESTORATIVE CARE

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

3. Select Revert at the confirmation pop up.

Revert to Restorative Care Pathway

Revert SaH End-of-Life Pathway for Sergio MAY back to Restorative Care Pathway.

REVERT CANCEL

4. Once confirmed, the assessor will be taken back to the reverted screen, which is the client's **GOALS AND RECOMMENDATIONS** tab as shown below.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH Restorative Care Pathway

IAT outcome: SaH Classification 3

Recommended classification: SaH Restorative Care Pathway

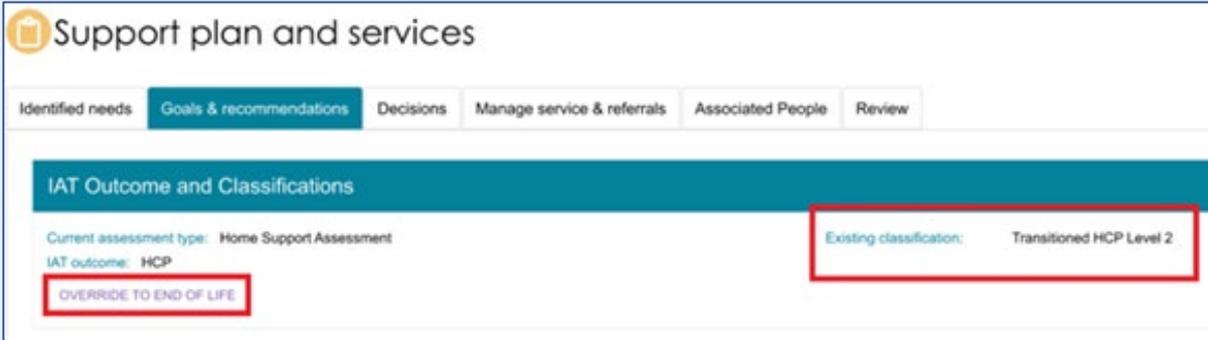
OVERWRITE TO END OF LIFE ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY

Client concerns and goals

Overriding to End-of-Life for Transitioned Home Care Package (HCP) clients

Assessors can override a client's classification from **Transitioned HCP Level 1–4** to **SaH End-of-Life Pathway** during a Support Plan Review, once end-of-life documentation has been verified. This is necessary because Transitioned clients do not have pre-created services, and tailored Home Support services must be added to meet their end-of-life care needs.

1. Select the Goals & recommendation tab from the client's profile. The Existing classification will display at the IAT Outcome and Classifications section as **Transitioned HCP Level 1–4**. Select the **OVERRIDE TO END OF LIFE** button.



Support plan and services

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

IAT Outcome and Classifications

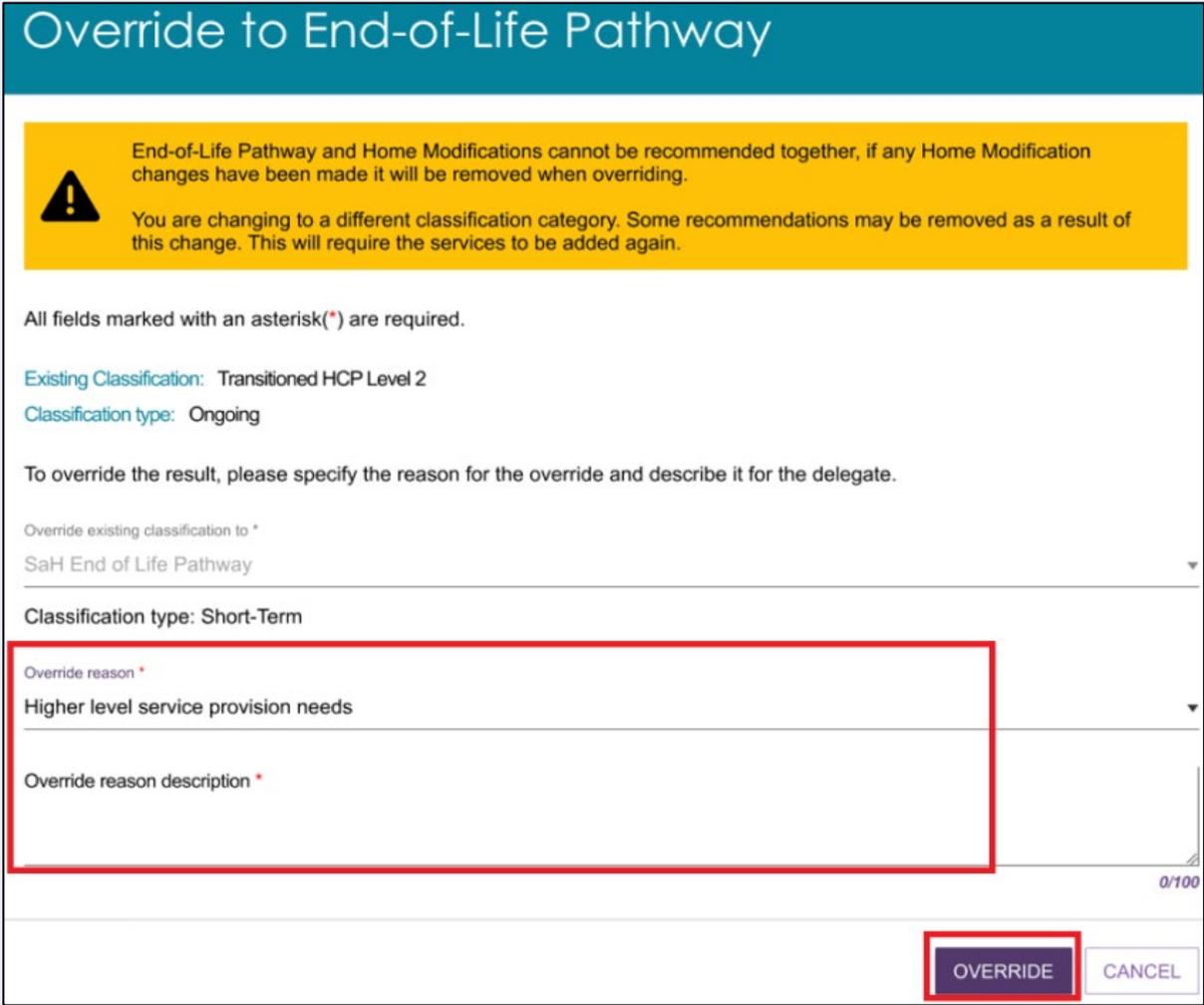
Current assessment type: Home Support Assessment

IAT outcome: HCP

Existing classification: Transitioned HCP Level 2

OVERRIDE TO END OF LIFE

2. A pop-up screen **OVERRIDE TO END-OF-LIFE PATHWAY** will appear prompting to enter relevant information. Upon entering the information select **OVERRIDE**.



Override to End-of-Life Pathway

! End-of-Life Pathway and Home Modifications cannot be recommended together, if any Home Modification changes have been made it will be removed when overriding.

You are changing to a different classification category. Some recommendations may be removed as a result of this change. This will require the services to be added again.

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

Existing Classification: Transitioned HCP Level 2

Classification type: Ongoing

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

Override existing classification to *

SaH End of Life Pathway

Classification type: Short-Term

Override reason *

Higher level service provision needs

Override reason description *

0/100

OVERRIDE CANCEL

3. You will be taken to the **ADD HOME SUPPORT SERVICES** page prompting to add the

services as required.

Tick the desired service/s, add a Frequency and Intensity, and link any goals.

Prefers to speak Chinese [View support network](#)

Add Home Support services

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

Recommended that the client receive: SaH End-of-Life Pathway
Classification type: Short term

Linked goals

Please select services within each service type *

Domestic Assistance

Services	Frequency	Intensity	Goals
<input checked="" type="checkbox"/> General House Cleaning	Frequency	Intensity	Linked goals
<input checked="" type="checkbox"/> Laundry Services	Frequency	Intensity	Linked goals
<input checked="" type="checkbox"/> Shopping Assistance	Frequency	Intensity	Linked goals
<input checked="" type="checkbox"/> Shopping Assistance	Frequency	Intensity	Linked goals
<input checked="" type="checkbox"/> Shopping Assistance	Frequency	Intensity	Linked goals

Home maintenance and repairs

Services	Frequency	Intensity	Goals
----------	-----------	-----------	-------

4. Select **SAVE TO PLAN**.

Nursing care consumables

Services	Frequency	Intensity	Goals
<input type="checkbox"/> Allied health assistance	Frequency	Intensity	Linked
<input type="checkbox"/> Podiatry	Frequency	Intensity	Linked
<input type="checkbox"/> Social work	Frequency	Intensity	Linked
<input type="checkbox"/> Speech pathology	Frequency	Intensity	Linked
<input type="checkbox"/> Diet or nutrition	Frequency	Intensity	Linked
<input type="checkbox"/> Aboriginal or Torres Strait Islander Health Practitioner assistance	Frequency	Intensity	Linked
<input type="checkbox"/> Aboriginal or Torres Strait Islander Health Worker assistance	Frequency	Intensity	Linked
<input type="checkbox"/> Physiotherapy	Frequency	Intensity	Linked
<input type="checkbox"/> Psychology	Frequency	Intensity	Linked
<input type="checkbox"/> Exercise physiology	Frequency	Intensity	Linked
<input type="checkbox"/> Occupational therapy	Frequency	Intensity	Linked
<input type="checkbox"/> Counselling or psychotherapy	Frequency	Intensity	Linked
<input type="checkbox"/> Music therapy	Frequency	Intensity	Linked

SAVE TO PLAN

5. You will be taken to the **GOALS & RECOMMENDATIONS** page.

At this stage you can **REVERT** to the transitioned classification if required.

Select **SAVE AND SUBMIT FOR DELEGATE DECISION**.



Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: Transitioned HCP Level 2
 IAT outcome: HCP
 Recommended classification: SaH End-of-Life Pathway
 REVERT TO TRANSITIONED CLASSIFICATION

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | RECOMMEND AN ASSISTIVE TECHNOLOGY
 RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT | ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT

Recommended that the client receive
Home Support
 (Not yet in place)
 This recommendation requires a delegate decision
 Classification: SaH End-of-Life Pathway Classification type: Short term
 Home support services: [Search icon]
 Recommended by: Damien Wayne

SAVE AND SUBMIT FOR DELEGATE DECISION | RETURN TO CLIENT

! If a client's existing classification is **SaH End-of-Life Pathway**, the Assessor can [override back to Transitioned HCP Level 1-4](#) prior to submitting the Support Plan for delegate decision. After overriding, the assessor can also [revert to SaH End-of-Life Pathway](#) if required.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Home Support Assessment Existing classification: SaH End-of-Life Pathway
 IAT outcome: HCP
 OVERRIDE TO TRANSITIONED CLASSIFICATION

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION

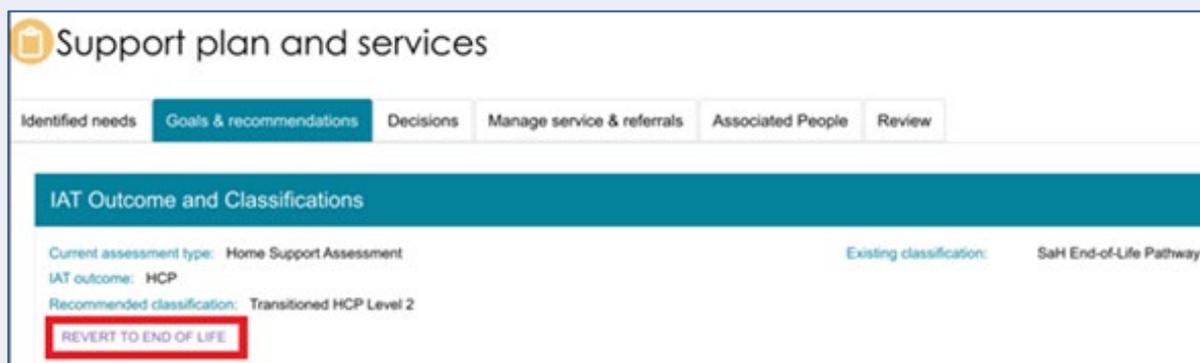


Reverting to End-of-Life for Transitioned Home Care Package (HCP) clients

Assessors will have the option to revert the Transitioned HCP classification back to **End of Life**, after overriding the End of Life to the Transitioned classification.

1. Go to the client's **GOALS & RECOMMENDATIONS** screen. The existing classification is SaH End-of-Life Pathway.

Select **REVERT TO END OF LIFE**.



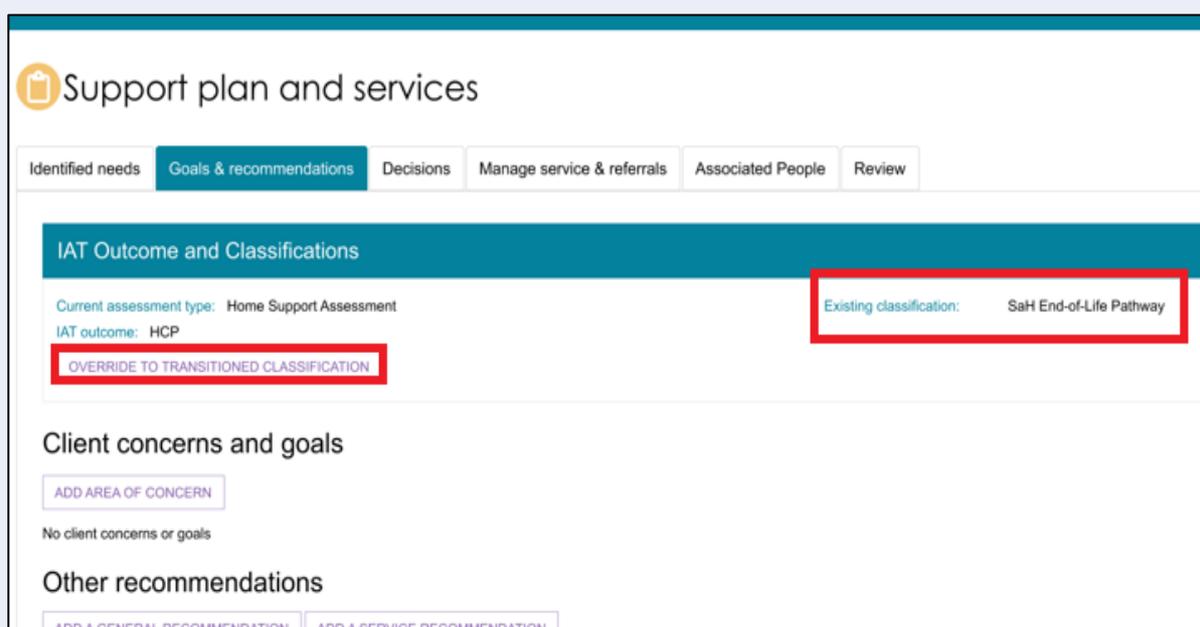
The screenshot shows the 'Support plan and services' interface. The 'Goals & recommendations' tab is active. Under 'IAT Outcome and Classifications', the following information is displayed: Current assessment type: Home Support Assessment; Existing classification: SaH End-of-Life Pathway; IAT outcome: HCP; Recommended classification: Transitioned HCP Level 2. A red box highlights the 'REVERT TO END OF LIFE' button.

2. A pop-up screen will appear prompting the user to confirm the action. Select **REVERT**.



The screenshot shows a confirmation pop-up titled 'Revert to End-of-Life Pathway'. The text reads: 'Revert to End-of-Life Pathway for Claire Louise:'. At the bottom right, there are two buttons: 'REVERT' (highlighted with a red box) and 'CANCEL'.

3. You will be directed to the **GOALS & RECOMMENDATIONS** screen.



The screenshot shows the 'Support plan and services' interface. The 'Goals & recommendations' tab is active. Under 'IAT Outcome and Classifications', the following information is displayed: Current assessment type: Home Support Assessment; Existing classification: SaH End-of-Life Pathway; IAT outcome: HCP. A red box highlights the 'OVERRIDE TO TRANSITIONED CLASSIFICATION' button. Below this section, there are sections for 'Client concerns and goals' (with an 'ADD AREA OF CONCERN' button) and 'Other recommendations' (with 'ADD A GENERAL RECOMMENDATION' and 'ADD A SERVICE RECOMMENDATION' buttons).

Completing the support plan for a home support assessment

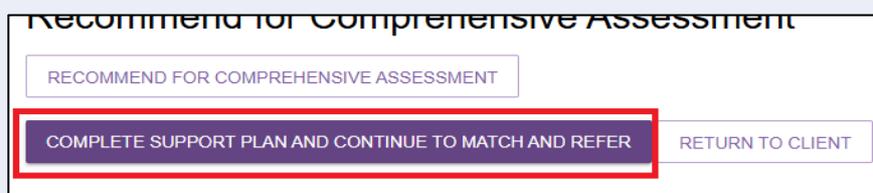
! From 1 November 2025, assessors should not issue CHSP referral codes until after the Assessment Delegate has approved the recommendation.

For more information on how to issue referral codes for CHSP only, please refer to *Chapter 9: Finalising the Assessment and Service Referral* of [My Aged Care Assessment Manual](#), and instructional videos for **home support assessments**.

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

Follow these steps to complete the support plan for a Home Support assessment:

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



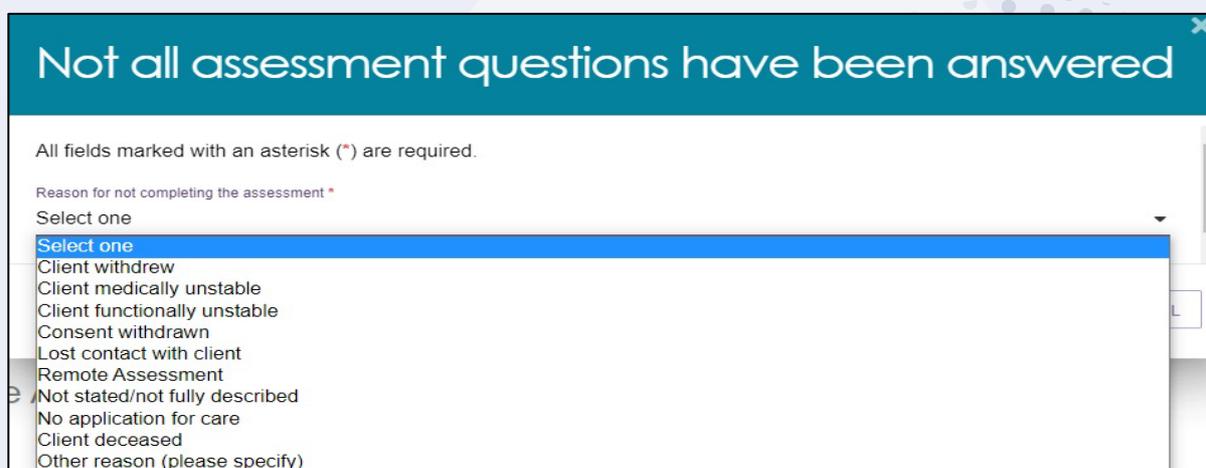
Recommend for Comprehensive Assessment

RECOMMEND FOR COMPREHENSIVE ASSESSMENT

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER

RETURN TO CLIENT

3. Review the assessment summary and support plan carefully for consistency and accuracy before completing the support plan. Once you select **COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER**, you will not be able to make any changes to the assessment or support plan. However, you will still be able to issue referrals, generate referral codes and action rejected referrals, for recommendations after you have finalised support plan, where appropriate.
4. If you have not answered all the mandatory questions in the assessment, a pop-up box will be displayed. You will be required to provide a reason for not completing all the mandatory questions before you can **Complete assessment**.



Not all assessment questions have been answered

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

Reason for not completing the assessment *

Select one

Select one

- Client withdrew
- Client medically unstable
- Client functionally unstable
- Consent withdrawn
- Lost contact with client
- Remote Assessment
- Not stated/not fully described
- No application for care
- Client deceased
- Other reason (please specify)

! If your reason for ending an assessment without answering all mandatory questions is **Client deceased**, this will change the client's status to **Deceased** and make the client record read only. Any unaccepted service referrals will be recalled, services in place will be ceased, assessments will be cancelled and the client's access to the client portal will be revoked. My Aged Care will not send correspondence to the client or their support network after the status is changed to **Deceased**.

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

The **Manage Services & Referrals** tab enables assessors to connect clients with appropriate aged care services following an assessment. It allows users to search for service providers based on client needs and preferences, issue referral codes and manage referral modes such as sequential or broadcast.

The screenshot shows the 'Support plan and services' interface. At the top, there are tabs for 'Identified needs', 'Goals & recommendations', 'Manage services & referrals' (highlighted with a red box), 'Associated People', and 'Review'. Below the tabs, the 'Services not yet in place' section is highlighted with a red box. It contains a 'Help at Home' section and an 'Allied health and therapy' section. The 'Allied health and therapy' section shows a status of 'Low' (green dot) and 'Not actioned' (red dot). It also displays 'No associated goals', 'Recommended By: Louie Hinson', and 'User Type: Assessor'. At the bottom of this section are three buttons: 'FIND PROVIDERS', 'ISSUE REFERRAL CODE', and 'REMOVE THIS SERVICE RECOMMENDATION'. At the bottom of the entire interface are two buttons: 'FINALISE SUPPORT PLAN' and 'RETURN TO CLIENT'.

6. Perform the required function and Select **FINALISE SUPPORT PLAN**. (In the below example, a referral code has been issued.)

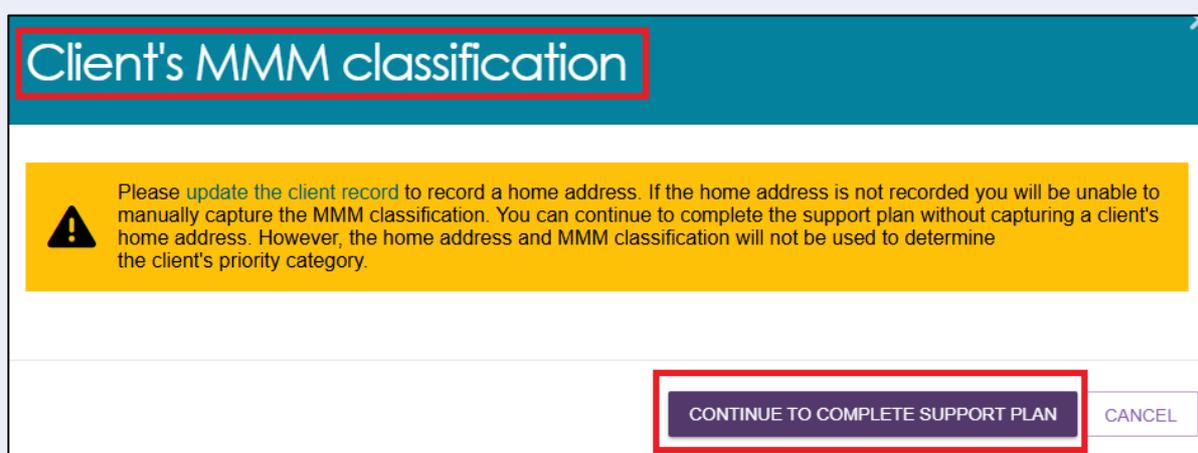
The screenshot shows the 'Support plan and services' interface. At the top, there are tabs for 'Identified needs', 'Goals & recommendations', 'Manage services & referrals' (highlighted with a red box), 'Associated People', and 'Review'. Below the tabs, the 'Services not yet in place' section is highlighted with a red box. It contains a 'Help at Home' section and an 'Allied health and therapy' section. The 'Allied health and therapy' section shows a status of 'Low' (green dot) and 'Referral Code Generated' (orange dot). It also displays 'No associated goals', 'Recommended By: Louie Hinson', and 'User Type: Assessor'. Below this section, a 'Manual referral code 2-161567175246' is shown, followed by a 'FIND PROVIDERS' button. At the bottom of this section are two buttons: 'GENERATE REFERRAL CODE LETTER' and 'FINALISE SUPPORT PLAN' (highlighted with a red box). At the bottom of the entire interface are two buttons: 'FINALISE SUPPORT PLAN' and 'RETURN TO CLIENT'. A green notification bar at the bottom of the interface displays a checkmark and the text 'Referral code successfully generated.'

Completing the support plan for a Comprehensive assessment

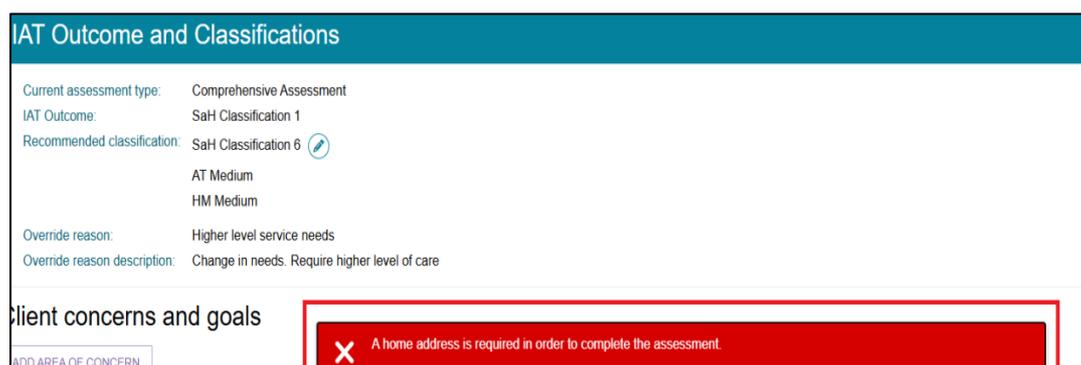
Follow these steps to complete the support plan for a Comprehensive assessment:

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

If the client has a Support at Home classification (ongoing or short-term) but no home address or MMM (Modified Monash Model) classification, a pop-up screen will appear while performing this step prompting or reminding the assessor to record the client's home address. The assessor can continue to complete the support plan without recording the address at this stage. Select **CONTINUE TO COMPLETE SUPPORT PLAN**.



- ! The following banner will be displayed if you continue to complete support plan without recording the client's address. "A home address is required in order to complete the assessment."



3. If the client's address is recorded but their location does not belong to any of Australia's **MMM classifications (MMM1 - MMM7)**, the system will prompt you to update client's MMM classification prior to completing the support plan. If the MMM Classification is not known, Select **UNKNOWN** from the dropdown menu.

Update client's MMM classification

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



The client's MMM classification cannot be derived. Please verify that the client's home address is Lot Number 27 SEENEY Street ORLANDO NT 0115. If this address is incorrect please [update the client record](#). If this address is correct, please manually select the client's MMM classification below.

MMMClassification: * (?)

Unknown

Select one

MM1 Metropolitan areas

MM2 Regional centres

MM3 Large rural towns

MM4 Medium rural towns

MM5 Small rural towns

MM6 Remote communities

MM7 Very Remote communities

Unknown

4. Select **SAVE TO PLAN** to proceed.

Update client's MMM classification

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



The client's MMM classification cannot be derived. Please verify that the client's home address is Lot Number 27 SEENEY Street ORLANDO NT 0115. If this address is incorrect please [update the client record](#). If this address is correct, please manually select the client's MMM classification below.

MMMClassification: * (?)

Unknown

SAVE TO PLAN

CANCEL

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

SAVE AND SUBMIT FOR DELEGATE DECISION

RETURN TO CLIENT

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

Submit for Delegate decision

You are about to send this assessment and support plan to the Delegate for their decision.

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

Client applied for care under the Aged Care Act 2024 *

SUBMIT

CANCEL

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



The assessment and support plan has been sent to the Delegate for their decision



Finalising the support plan

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

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

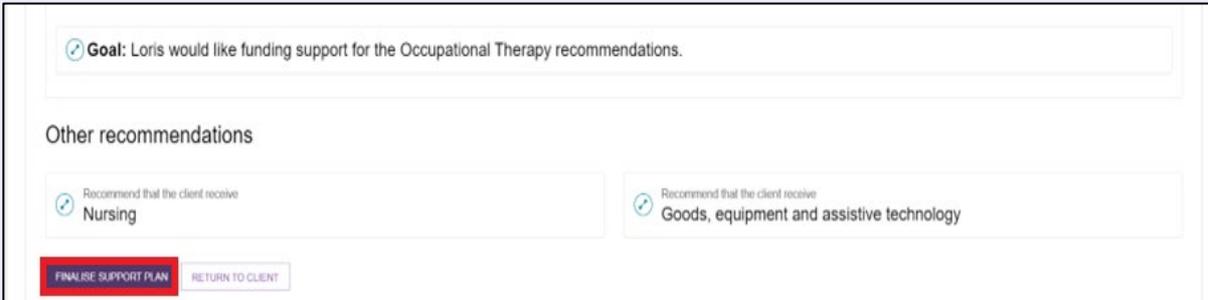
! The client's support plan should be finalised once an effective referral(s) has been made or where the client chose not to proceed with aged care services or to manage their own referrals. An effective referral is where:

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

! From 1 November 2025, assessors should not issue CHSP referral codes until after the Assessment Delegate has approved the recommendation.

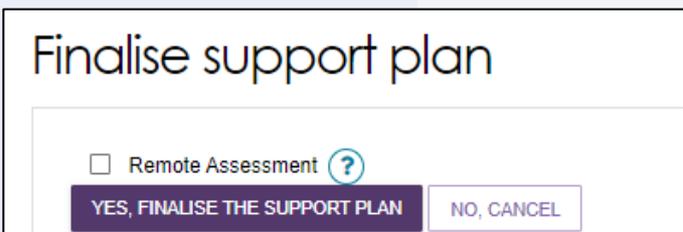
For more information on how to issue referral codes for CHSP only, please refer to *Chapter 9: Finalising the Assessment and Service Referral* of [My Aged Care Assessment Manual](#), and instructional videos for **comprehensive** and **home support assessments**.

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



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

2. A pop-up box will display, and the referral status for each recommended service type will be pre-populated. Where a referral is **Not Actioned**, you will need to record a reason.
3. If the face-to-face assessment was conducted in a remote location, you should ensure that the **Remote Assessment indicator** is selected before the support plan is finalised.



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

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

Finalise support plan

Are you sure you want to finalise this support plan?
You will not be able to make any changes to the support plan once finalised.

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

Remote Assessment ?

Service Recommendations

Meals
Outcome
Referral Code Generated

Comments

0 / 500

Domestic Assistance
Outcome
Referral Code Generated

- General House Cleaning

Comments

0 / 500

Goods, equipment and assistive technology
Outcome
Referral Code Generated

- Support and mobility aids

YES, FINALISE THE SUPPORT PLAN NO, CANCEL

! If you are choosing outcomes to support a client located remotely, you can choose **Community-based care**.

Outcome comments are required if you have chosen **Not actioned** or **Community-based care** following a remote assessment. Please provide detailed comments to support your outcome reasons.

Finalise support plan

Are you sure you want to finalise this support plan?
You will not be able to make any changes to the support plan once finalised.

! If you are choosing outcomes to support a remote access client, please supply detailed comments to support your reasoning against the appropriate outcome below.

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

Service Recommendations

Allied Health and Therapy Services
Outcome
Not actioned

Outcome Reason *

Select one

- Funded services unavailable
- To seek nonfunded services
- Client accepted to waitlist
- Client declined services
- Undergoing support
- Community-based care**

YES, FINALISE THE SUPPORT PLAN NO, CANCEL

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

✓ You have successfully finalised Support Plan for Joseph Franklin



Finalising a Support Plan for Support at Home classification

Unlike other recommendations, the screen for finalising the Support Plan for clients' recommended Support At Home classification will not include the individual services to record the outcome. It will be displayed as Support at Home.

Select **YES, FINALISE THE SUPPORT PLAN**.

Finalise support plan

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

Remote Assessment ?

Service Recommendations

Support at Home

Outcome
Not actioned

Outcome Reason *

Comments

YES, FINALISE THE SUPPORT PLAN NO, CANCEL

Ending a period of Reablement or linking support

Assessors can end the period of reablement or linking support, in either one of two ways.

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

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

There are no service recommendations for this client

Recommend that the client receive **END LINKING SUPPORT PERIOD** ?

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

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

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT outcome ?

IAT outcome: CHSP
Current assessment type: Home SupportAssessment

Client concerns and goals
No client concerns or goals.

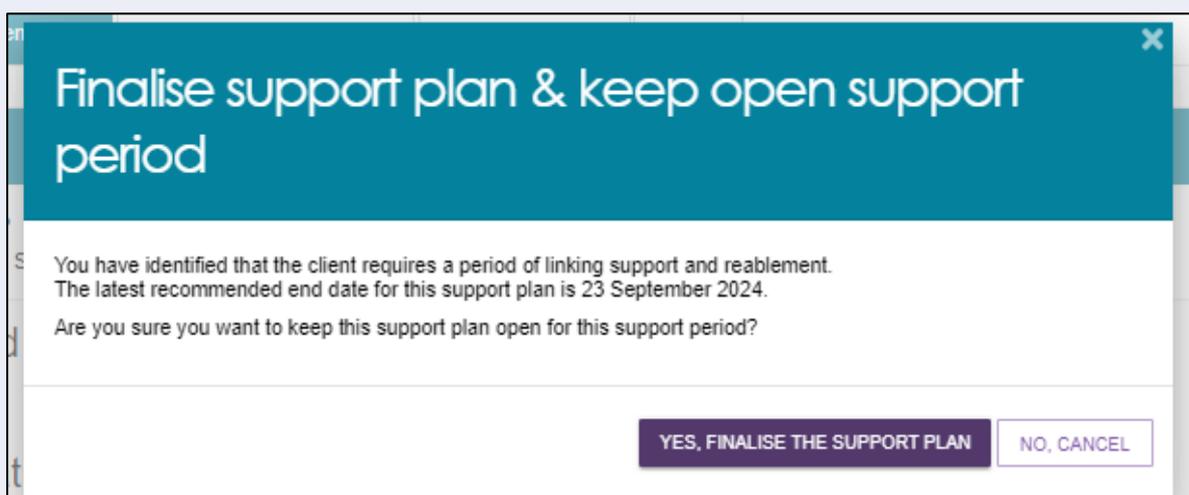
Other recommendations
There are no service recommendations for this client

Recommend that the client receive Linking Support

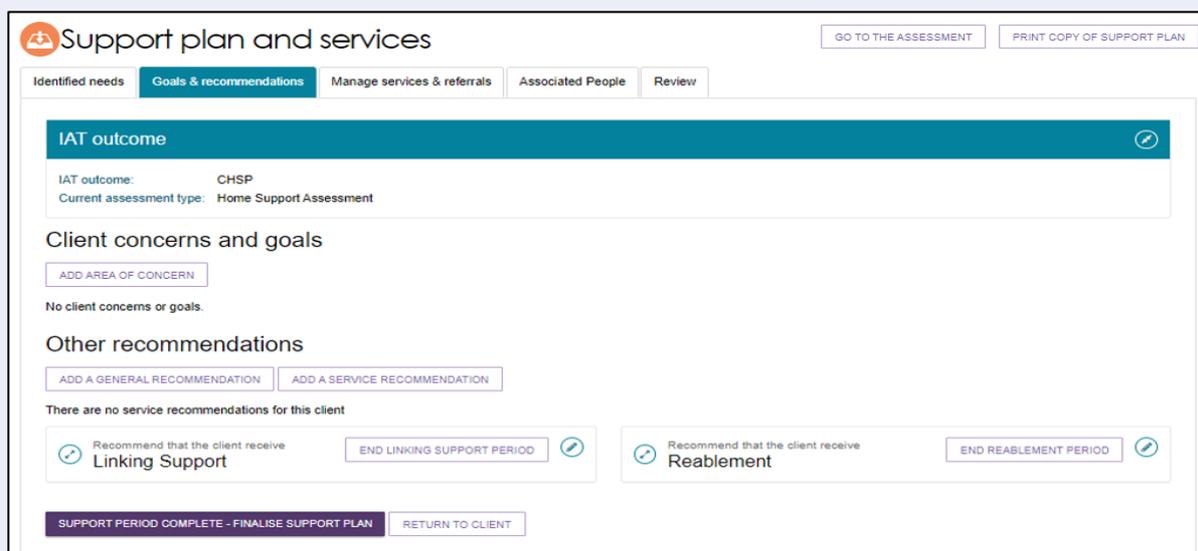
Recommend that the client receive Reablement

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

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



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



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



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

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

End period of reablement ✕

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

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

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

The end date for this reablement period is *

04/12/2018 📅

Were the client's goals met? *

Goals partially met ▼

Outcome of this reablement period *

Incomplete ▼

Comments *

Client entered hospital

23 / 500

END PERIOD OF REABLEMENT
CANCEL

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

Notice of Decision Letters

Assessors can generate and upload Notice of Decision (NoD) Letters (Approval or Non-approval letters) under limited circumstances, at the end of an assessment or during support plan review. Home Support Assessors can generate and upload all NoD Letters that are available in a Home Support setting. Comprehensive assessors can only generate and upload some comprehensive assessment NoD letters, with the Delegate being able to process the rest, including Support at Home.

The below tables show which assessment recommendation NoD letters a comprehensive assessor and a delegate can generate and upload, and which NoD letters they can generate and upload during the support plan review phase. For more information on the Delegate's role refer to [My Aged Care – Assessor Portal User Guide 10 – Assessment delegate processes | Australian Government Department of Health, Disability and Ageing](#).

Generating and Uploading NoD Letters with the following Assessment Recommendation	Comprehensive Assessor	Delegate
CHSP only	✓	N/A
MPS	✓	N/A
NATSIFAC	✓	N/A
Support at Home	×	✓
Residential	×	✓
Transition Care	×	✓
Support at Home with CHSP	×	✓
No Care Approval, No Change to Existing Care Approvals	×	✓

Generating and Uploading NoD Letters during Support Plan Review	Comprehensive Assessor	Delegate
CHSP only	✓	N/A
MPS only	✓	N/A
NATSIFAC only	✓	N/A
Support at Home only	×	✓
Support at Home with CHSP	×	✓
Support at Home with MPS	×	✓
Support at Home with NATSIFAC	×	✓

Generating a NoD Letter

For a Home Support or Comprehensive assessment recommending CHSP only:

1. Go to the client's Support Plan from the Plans tab, then select the Goals & recommendations tab.
2. Select **GENERATE APPROVAL LETTER** or **GENERATE NON-APPROVAL LETTER**. Note that these buttons only appear for assessments or support plan reviews that you have done.



Support plan and services REQUEST ASSESSMENT PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

Current assessment type: Home Support Assessment
IAT Outcome: CHSP

Client concerns and goals
No client concerns or goals.

Other recommendations

Recommend that the client receive **Meals** 4 February 2026

Recommend that the client receive **Transport** 4 February 2026

Recommend that the client receive **National ATSI Aged Care Program** 4 February 2026

Recommend that the client receive **Multi-Purpose Service - Residential** 4 February 2026

GENERATE APPROVAL LETTER **GENERATE NON-APPROVAL LETTER** UPLOAD APPROVAL OR NON-APPROVAL LETTER

RETURN TO CLIENT

For Comprehensive assessments, you can also generate NoD letters from the **Decisions** tab. The actual button displayed will depend on the recommendation.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

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

Current care approvals

Transition Care
• After Hospital Care
Priority for this care type: Medium
Approval starts: 5 February 2026
Entry period end date: 5 March 2026
Source system: Gateway

Delegate decisions and comments

Assessment: Submitted on 5 February 2026

Decisions

Transition Care
• After Hospital Care
Priority for this care type: Medium
Approval starts: 5 February 2026
Entry period end date: 5 March 2026
Source system: Gateway
● Agreed

Recommend that the client receive **Home support**

Decision date (Assessment)
5 February 2026 12:00 AM (Australian Eastern Standard Time)

GENERATE APPROVAL LETTER UPLOAD APPROVAL LETTER

- For approval letters, double check you have the correct client before selecting **GENERATE APPROVAL LETTER**. Non-Approval letters are automatically generated.

Generate approval letter

You are generating the approval letter for Caroline CHISHOLM

GENERATE APPROVAL LETTER CANCEL



4. **The Reports and Documents** page appears. The NoD Letter's name, requested date and status appears under the My Reports section of the Reports tab. When ready, select the **View** link. You will be able to save a copy onto your computer.

! NoD Letters are defaulted to the Rich Text Format (.rtf). This format is not accepted when uploading. Ensure your letters are saved as one of the acceptable formats prior to uploading - .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt.

Reports and documents

Reports Forms Links

My Reports

Name	Requested Date	Status
Caroline Chisholm Delegate Approval Letter Template 5 February 2026	5 February 2026	Ready - View

Uploading a NoD Letter

You can upload a NoD letter from the client's Goals & recommendations tab, Decisions tab or from the Attachments tab.

1. Go to the client's Support Plan from the Plans tab, then select the Goals & recommendations tab.
2. Select **UPLOAD APPROVAL OR NON-APPROVAL LETTER**.

Support plan and services

REQUEST ASSESSMENT PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

Current assessment type: Home Support Assessment
IAT Outcome: CHSP

Client concerns and goals

No client concerns or goals.

Other recommendations

Recommend that the client receive **Meals** 4 February 2026

Recommend that the client receive **Transport** 4 February 2026

Recommend that the client receive **National ATSI Aged Care Program** 4 February 2026

Recommend that the client receive **Multi-Purpose Service - Residential** 4 February 2026

GENERATE APPROVAL LETTER GENERATE NON-APPROVAL LETTER **UPLOAD APPROVAL OR NON-APPROVAL LETTER**

RETURN TO CLIENT

For Comprehensive assessments, you can also upload NoD letters from the **Decisions** tab. The actual button displayed will depend on the recommendation.

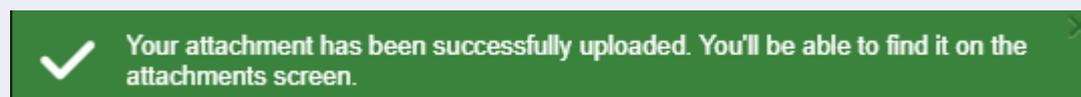
3. The **Upload approval or non-approval letter** pop up appears.

Choose the NoD letter. Name the attachment. Select the type of attachment – either ‘Approval letter sent to client’ or ‘Non-approval letter sent to client’. Optionally include a description of the attachment (such as assessment date and time).

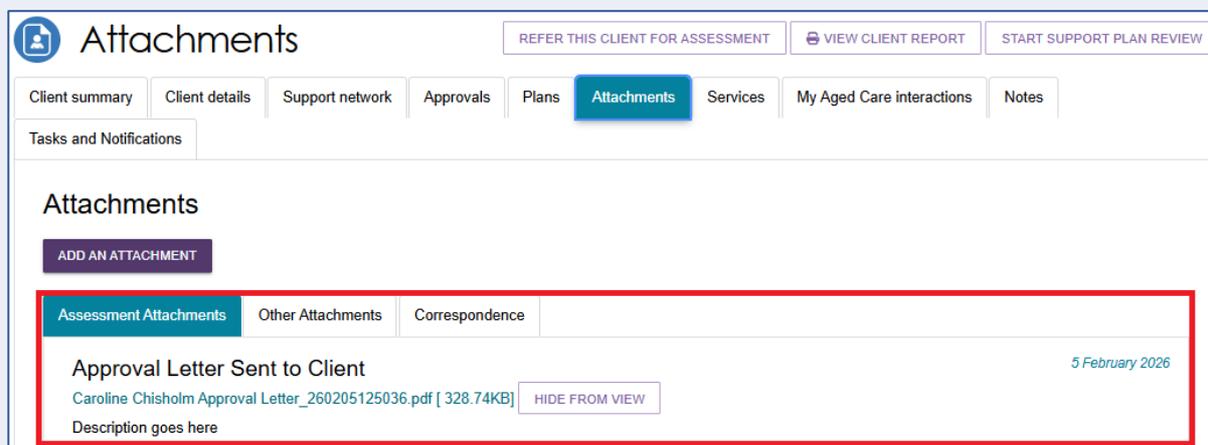
Finally, select **Upload**.

! NoD Letters are defaulted to the Rich Text Format (.rtf) when being generated. This format is not accepted when uploading. Ensure your letters are saved as one of the acceptable formats prior to uploading - .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt.

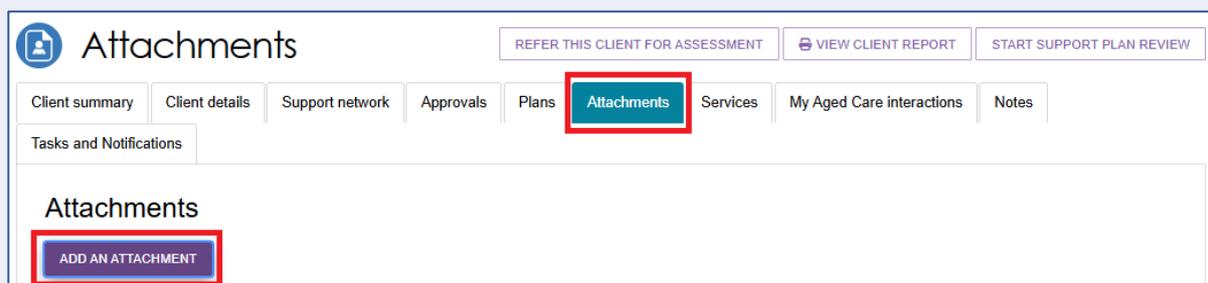
- When upload is successful, a green success message displays: 'Your attachment has been successfully uploaded. You'll be able to find it on the attachments screen.'



- Go to the client's Attachment tab from the Client Summary. The NoD letter is viewable from the Assessment Attachments tab.



You can also upload NoD letters by selecting **ADD AN ATTACHMENT** from the Attachments section.



The **Add An Attachment** pop up appears.

Choose the NoD letter. Name the attachment. Select the type of attachment – either 'Approval letter sent to client' or 'Non-approval letter sent to client'. Optionally include a description of the attachment (such as assessment date and time).

Finally, select **Upload**.

! NoD Letters are defaulted to the Rich Text Format (.rtf) when being generated. This format is not accepted when uploading. Ensure your letters are saved as one of the acceptable formats prior to uploading - .jpeg, .jpg, .bmp, .png, .docx, .slsx, .pdf, or .txt.

Add an attachment X



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,

(250 characters)

Type of attachment *

Select one

Appointment of Support form

Approval Letter Sent to Client

Assessment Tool

AT prescription

AT quote

Care Plan

Clinical Notes

Discharge Summary

End-of-Life - other

End-of-Life Form

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

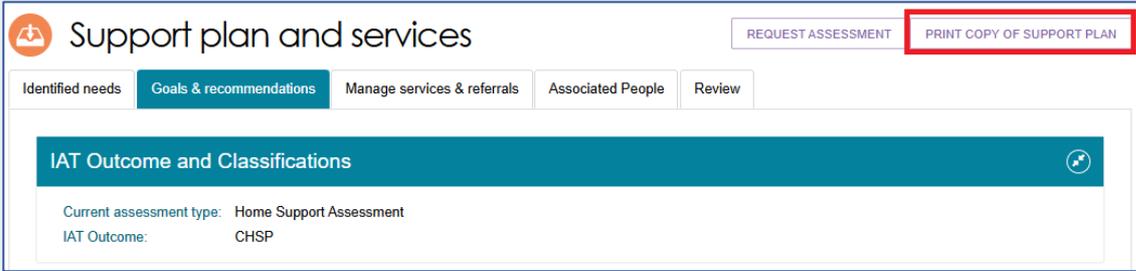
Offline Notes



Printing a copy of the support plan

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

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



Support plan and services

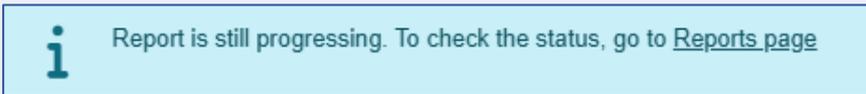
REQUEST ASSESSMENT **PRINT COPY OF SUPPORT PLAN**

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

IAT Outcome and Classifications

Current assessment type: Home Support Assessment
IAT Outcome: CHSP

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



i Report is still progressing. To check the status, go to [Reports page](#)

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



Reports and documents

Reports **Forms** Links

My Reports

Name	Requested Date	Status
Caroline Chisholm Support Plan 5 February 2026	5 February 2026	Ready - View

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



Australian Government | myagedcare | SUPPORT PLAN

Support plan

Mrs Caroline CHISHOLM
Aged Care ID: AC43611987 Date of Birth: 30/05/1928 Age: 97 years

About your most recent (support plan review)

Review Date: 04/02/2026
Conducted by: Nasirc Schroederx (UAT SAH Automation Outlet)
Conducted with: Client
Outcome of Review: Updates to the existing plan
Outcome Details:



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



SUPPORT PLAN

Support plan

Mr Sly Stallone
Aged Care ID: AC76808781 **Date of Birth:** 09/12/1956 **Age:** 69 years

Support Plan Review (first completed)

Review Date: 10/02/2026
Conducted by: Elnaq Gibsone (UAT SAH Automation Outlet)
Conducted with: Client
Outcome of Review: Updates to the existing plan
Outcome Details:

Your goals and recommendations

No current concerns, goals or recommendations

General recommendations

No current general recommendations

Your recommended service

Your current care approvals

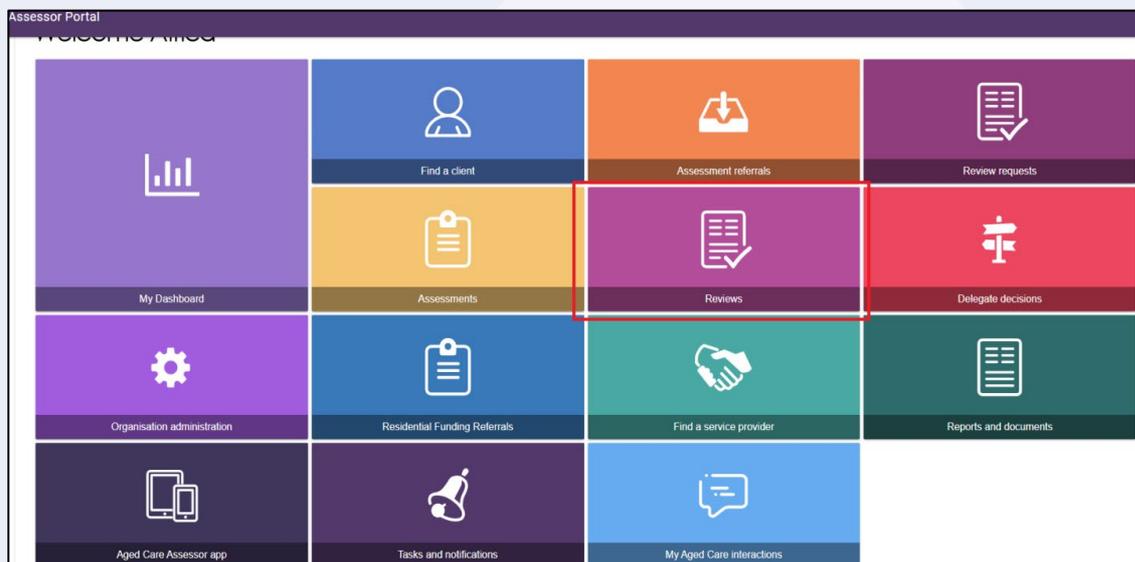
Home support
 SaH End-of-Life Pathway - Short-term – Care management

Service:	Approved from:	Approved to:	Emergency approval:	No care reason:
Home support care management	10/02/2026	25/08/2026		

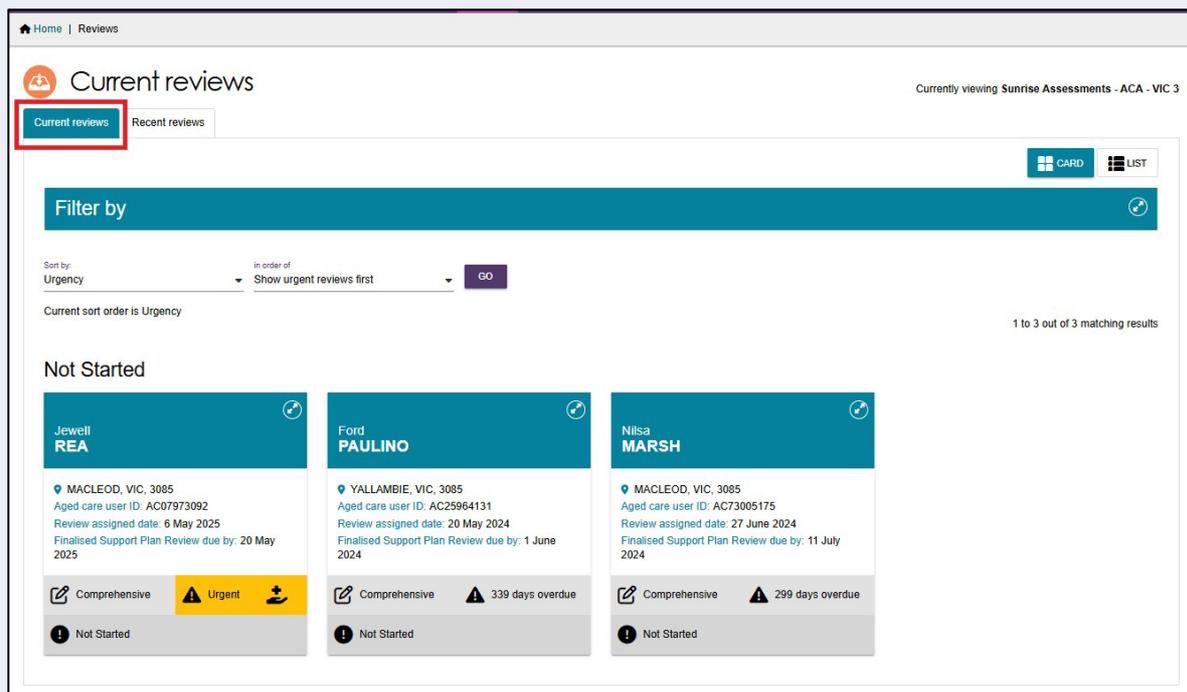
Support Plan Reviews

Viewing a Support Plan Review

1. Select the **Reviews** tile from the homepage to view all Support Plan Reviews assigned to you.



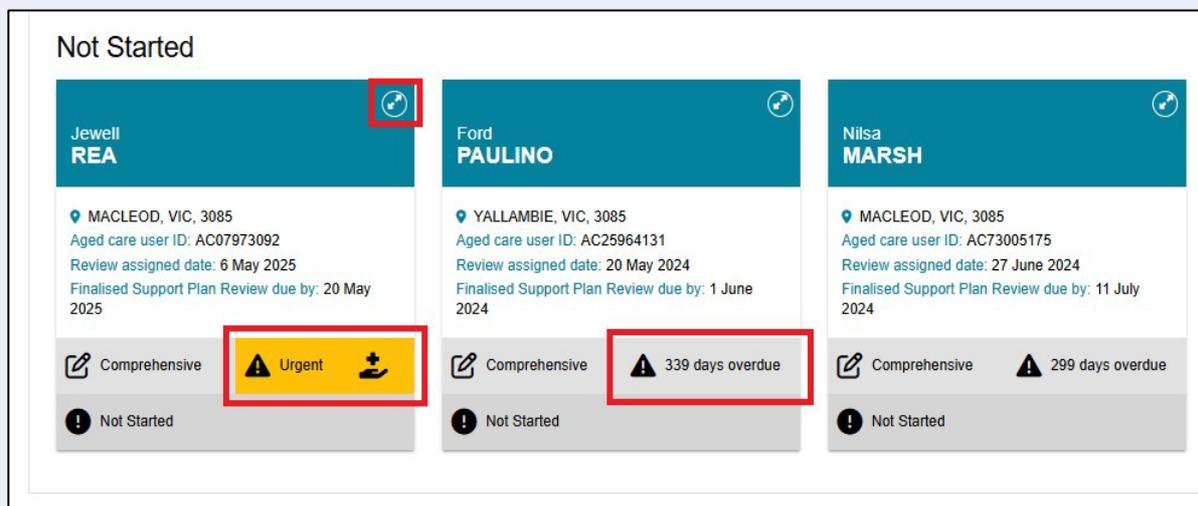
2. Go to the **Current reviews** tab to view Support Plan Reviews assigned to you.



3. Select the expand button on the top of the review card to see further information.

The card will also display the assessment type, urgency for the Support Plan Review to be completed and if it is currently overdue.

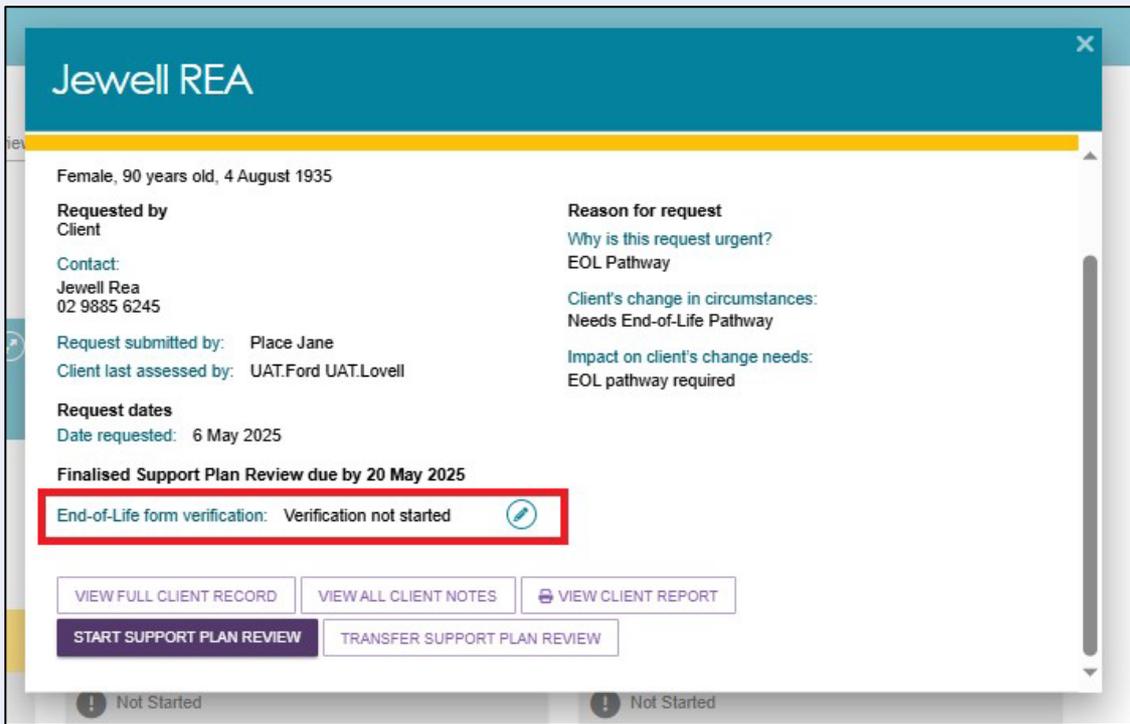
The below example also contains the End-of-Life Pathway symbol.



4. If the request is for the End-of-Life Pathway services, select the edit (pencil) button to start verifying or adding the End-of-Life Pathway Form.

Further information on how to verify the End-of-Life Pathway Form can be found in the [My Aged Care Assessment Manual](#).

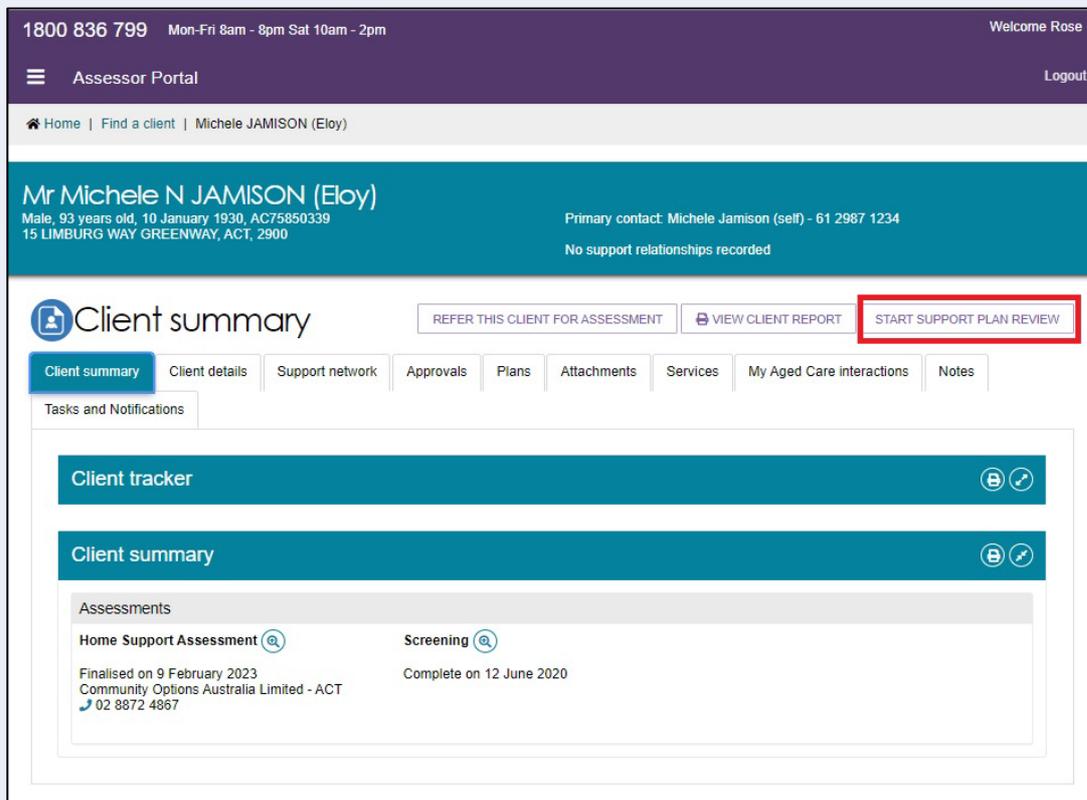




Starting a Support Plan Review

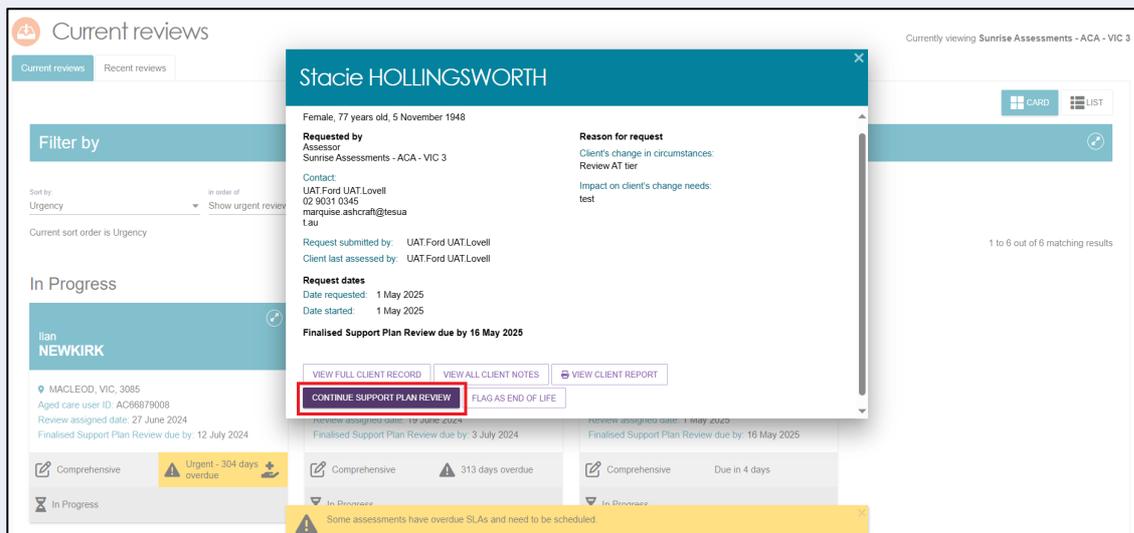
Follow these steps to start a Support Plan Review that has been assigned to you:

1. Expand the client card in either card or list view. The Client Summary page displays. Select **START SUPPORT PLAN REVIEW**.

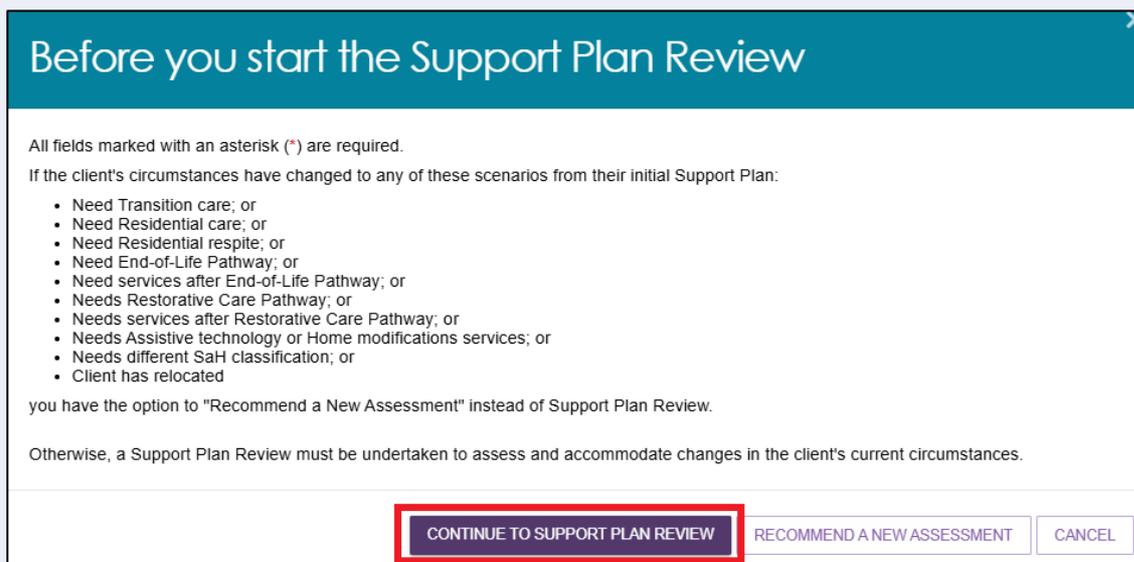


Alternatively, from the Current reviews page you can also expand the client card and select **START SUPPORT PLAN REVIEW**.





- From the **Before you start the Support Plan Review** pop-up select either **CONTINUE TO SUPPORT PLAN REVIEW** or **RECOMMEND A NEW ASSESSMENT**.
Select **CONTINUE TO SUPPORT PLAN REVIEW** to start the Support Plan Review for the client. If the client's circumstances have changed and it is more appropriate to issue a referral directly for a new assessment rather than completing a Support Plan Review, select **RECOMMEND A NEW ASSESSMENT**.



- You will be prompted to enter the outcome of the review and reason for the new assessment referral, then select an organisation of which to issue the referral. This can only be done in circumstances where a client requires one or more of the following:
 - Transition Care
 - Residential Care
 - Residential Respite
 - End-of-life Pathway
 - Services after End-of-Life Pathway
 - Restorative Care Pathway
 - Services after Restorative Care Pathway
 - Assistive technology or Home modifications services.

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

If consent is provided by a supporter guardian, then their first name must be entered before proceeding.

Consent to share information with My Health Record

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

Information

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Chapter 7, Part 2 of the Aged Care Act 2024. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

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

No Yes

Consent decision by *

Decision made by

Decision made by

Client

Supporter Guardian

0 / 255

CONTINUE TO SUPPORT PLAN REVIEW CANCEL

5. If the client does not consent to share their support plan with My Health Record you will also be required to enter a consent denial reason before selecting **CONTINUE TO SUPPORT PLAN REVIEW**. If the consent is not provided by the client's supporter guardian, their first name must be entered along with the denial reason before proceeding.

Consent to share information with My Health Record

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Chapter 7, Part 2 of the Aged Care Act 2024. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

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

No Yes

Consent decision by *

Client

Consent denial reason *

Please select a reason for not providing the consent

Please select a reason for not providing the consent

Do not wish to disclose

Other

Privacy concerns

CONTINUE TO SUPPORT PLAN REVIEW CANCEL



6. Select **CONTINUE TO SUPPORT PLAN REVIEW**.

Consent to share information with My Health Record

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Chapter 7, Part 2 of the Aged Care Act 2024. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

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

No Yes

Consent decision by *
Supporter Guardian

Supporter Details

First name: *
Roger

Last name:
Yeast

Comments:
0 / 255

CONTINUE TO SUPPORT PLAN REVIEW CANCEL

7. Once a Support Plan Review has been started, an assessor will be able to make changes to information in the following sections of the client's support plan:

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

! Previously recommended CHSP, MPS or NATSIFAC services

From 23 February 2026, CHSP, MPS and NATSIFAC recommendations and delegate approval will continue to be a manual process. For guidance on the interim process explaining Manual Delegate Approval for CHSP only for comprehensive and home support assessments, and how it impacts assessors during support plan completion and finalisation refer to *Manual Delegate Approval for CHSP – Standard Operating Procedure*

This means that for clients who had these services recommended before 23 February 2026, assessors cannot delete these services in the client's IAT assessment during the support plan review or when the support plan is 'Undergoing Support'.

The below image shows the Goals & Recommendations section of a client's support plan. Historical CHSP, MPS or NATSIFAC services do not have the Delete button available.



Ad hoc Support Plan Reviews

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

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

Scheduling an Ad hoc Support Plan Review

An **ad hoc** Support Plan Review can be scheduled by the assessor outside the usual review schedule, typically when there is a significant change in the client's needs, health, or circumstances that affect the level or type of care they require.

1. To schedule an ad hoc Support Plan Review, navigate to the **REVIEW** tab under **SUPPORT PLAN AND SERVICES** screen.



2. Select the **CALENDAR** icon under **SCHEDULE A REVIEW**, pick a future date for review and select the **SAVE CHANGES** button.

Mrs Mary LAMB
Female, 87 years old, 15 April 1938, AC41287954
7 BICENTENNIAL DRIVE JERRABOMBERRA, NSW, 2619
refers to speak Croatian

Support plan and services

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

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

Schedule a review

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

Review Date: * 

(e.g. dd/mm/yyyy)

SAVE CHANGES

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

3. Select **COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER**.

Support plan and services

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

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

Schedule a review

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

Review Date: * 

(e.g. dd/mm/yyyy)

SAVE CHANGES

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

4. You will notice the **START SUPPORT PLAN REVIEW** button on the top right hand side of the client's **PLANS** tab. Select **START SUPPORT PLAN REVIEW**.

REFER THIS CLIENT FOR ASSESSMENT VIEW CLIENT REPORT **START SUPPORT PLAN REVIEW**

Approvals **Plans** Attachments Services My Aged Care interactions Notes Tasks and Notifications

Assessment history 

 Comprehensive Assessment 9 May 2025

5. Select **CONTINUE TO SUPPORT PLAN REVIEW** button on the next screen.

Before you start the Support Plan Review

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

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

- Need Transition care; or
- Need Residential care; or
- Need Residential respite; or
- Need End-of-Life Pathway; or
- Need services after End-of-Life Pathway; or
- Needs Restorative Care Pathway; or
- Needs services after Restorative Care Pathway; or
- Needs Assistive Technology or Home Modification services; or
- Client has relocated

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

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

CONTINUE TO SUPPORT PLAN REVIEW

RECOMMEND A NEW ASSESSMENT

CANCEL

6. This will take you to the **CONSENT** screen. Complete the required fields and select **CONTINUE TO SUPPORT PLAN REVIEW**.

Consent to share information with My Health Record

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

Information

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Chapter 7, Part 2 of the Aged Care Act 2024. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

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

No Yes

Consent decision by *

Client

Comments:

CONTINUE TO SUPPORT PLAN REVIEW

CANCEL

7. A pop-up window will open to input the client's change in circumstance. Select the relevant reason.



Start support plan review for Freddy FLINT

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

What circumstances have changed for the client? *

Please select...

- Hospital Discharge
- Fall(s) or risk of falling
- Change in medical condition
- Change in cognitive status
- Change in care needs
- Increasing frailty
- Change in caring arrangements
- Change in living arrangements
- Review service recommendations
- Vulnerable client
- Needs Transition Care
- Needs Residential Care
- Needs Residential Respite
- Client has relocated
- Needs End-of-Life Pathway
- Review End-of-Life Pathway
- Review HM tier
- Review AT tier
- Needs Restorative Care

0 / 1000

.jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, .txt

START SUPPORT PLAN REVIEW CANCEL

8. Continue to input all the relevant information, **UPLOAD** any supporting documentation (such as a letter from qualified health professionals) as required and select **START SUPPORT PLAN REVIEW**.

Start support plan review for Freddy FLINT

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

What circumstances have changed for the client? *

Change in care needs

How has this affected the client's need? * (?)

Client's day to day routine is impacted due to declining health condition

73 / 1000

Add additional information to support your request? (?)

UPLOAD ADDITIONAL INFORMATION1

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

START SUPPORT PLAN REVIEW CANCEL



Transferring a Support Plan Review

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

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

The screenshot shows the 'Current reviews' page. On the left, there are filters for 'Filter by' and 'Sort by' (set to 'Urgency'). A client card for 'Melina RAMSEY' is displayed, showing her location (WODONGA, VIC, 3690), aged care user ID (AC32746497), and review assigned date (7 June 2024). The card details include: 'Female, 84 years old, 30 July 1940', 'Requested by: Health Professional/Admin', 'Contact: Brayden Jeanbaptiste', 'Request submitted by: Denese Mahaffey', 'Client last assessed by: Abbey Redman', 'Request dates: Date requested: 3 March 2023', and 'Reason for request: Client's change in circumstances: Hospital Discharge'. The 'Impact on client's change needs' section states: 'Harley is requesting Domestic Assistance, Meals, Personal Care & Transport for Milena, because Increasing functional decline, back pain and falls at home.' At the bottom of the card, there are buttons for 'VIEW FULL CLIENT RECORD', 'VIEW ALL CLIENT NOTES', 'VIEW CLIENT REPORT', 'START SUPPORT PLAN REVIEW', and 'TRANSFER SUPPORT PLAN REVIEW' (highlighted with a red box).

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

The screenshot shows the 'Transfer this support plan review for Melina Ramsey' form. It includes a note: 'All fields marked with an asterisk (*) are required.' The form has a dropdown for 'What is the reason for transfer? *', a 'Comments:' text area, and a 'Search for Assessment Organisation: *' section. Under 'Search for Assessment Organisation: *', there are two radio buttons: 'Use the client's address' (selected) and 'Enter an alternative assessment address'. The 'Client address' is listed as '11 7 NICOLE Crescent WODONGA VIC 3690'. There are 'SEARCH', 'TRANSFER' (highlighted with a red box), and 'CANCEL' buttons. At the bottom, a banner reads: 'Before making the transfer, please contact the Assessment Organisation you want to refer the client to and provide as much information as possible in the comments box to assist the receiving organisation. Please note, a review can only be transferred once. Please ensure that you have client consent before transferring.' The banner also includes the Australian Government Department of Health and myagedcare logos.

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

! Support Plan Reviews can only be transferred once.

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

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

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

Complete & finalise support plan review for Lilly Field

All fields marked with an asterisk (*) must be completed before submission
Reason for this support plan review started on 5 March 2021
Change in medical condition

Outcome of support plan review *
A new assessment required

Not selected
No changes to support plan
Updates to the existing plan
A new assessment required
SPR cancelled
Other

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

Assign this referral to:*

Myself
 My Organisation
 Another Organisation

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

Support plan conducted with *
Client

Assign this referral to:*

Myself
 My Organisation
 Another Organisation

Please select the assessment type: *
Comprehensive Assessment

Please select outlet for this referral *
GRAZIER AGED CARE Outlet ACAT-RAS

Assessment setting: * ?
 Hospital
 Non-Hospital

Priority * ?

Comments:

COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT CANCEL

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

Assign this referral to:*

Myself

My Organisation

Another Organisation

Please select the assessment type:*

Comprehensive Assessment

Assessment setting: ?

Hospital

Non-Hospital

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

Search for Assessment Organisation: *

Use the client's address

Client address

142 John Lane NOMANS LAKE WA 6312

Enter an alternative assessment address

SEARCH

Select Assessment Organisation*

Wheatbelt ACAT, NORTHAM, Ph 02 8011 6544

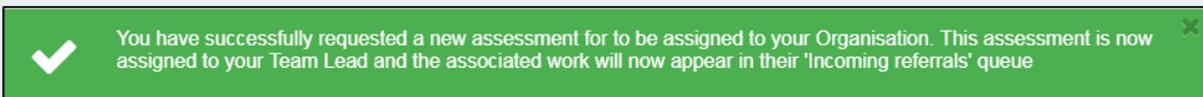
Priority ?

Medium

Comments:

COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT CANCEL

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



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

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

Support Plan Review for Support at Home

A Support Plan Review for Support at Home is conducted when there is a need to reassess a client's current Support at Home services due to changes in their circumstances, goals, or care needs. This review ensures that the services being provided remain appropriate, effective, and aligned with the client's preferences and situation.

The **Goals & recommendations** tab is where you will record the clients:

- areas of concern,
- goals to address their concerns,
- any services or general recommendations, and
- any care type recommendations.



Support at Home care types are delivered under the *Aged Care Act 2024* (the Act). If they need a delegate decision, this can be done at [Add a care type for delegate decision](#).

