



## Assessor Portal User Guide 6 - Completing an Assessment

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

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

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

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

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

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

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

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

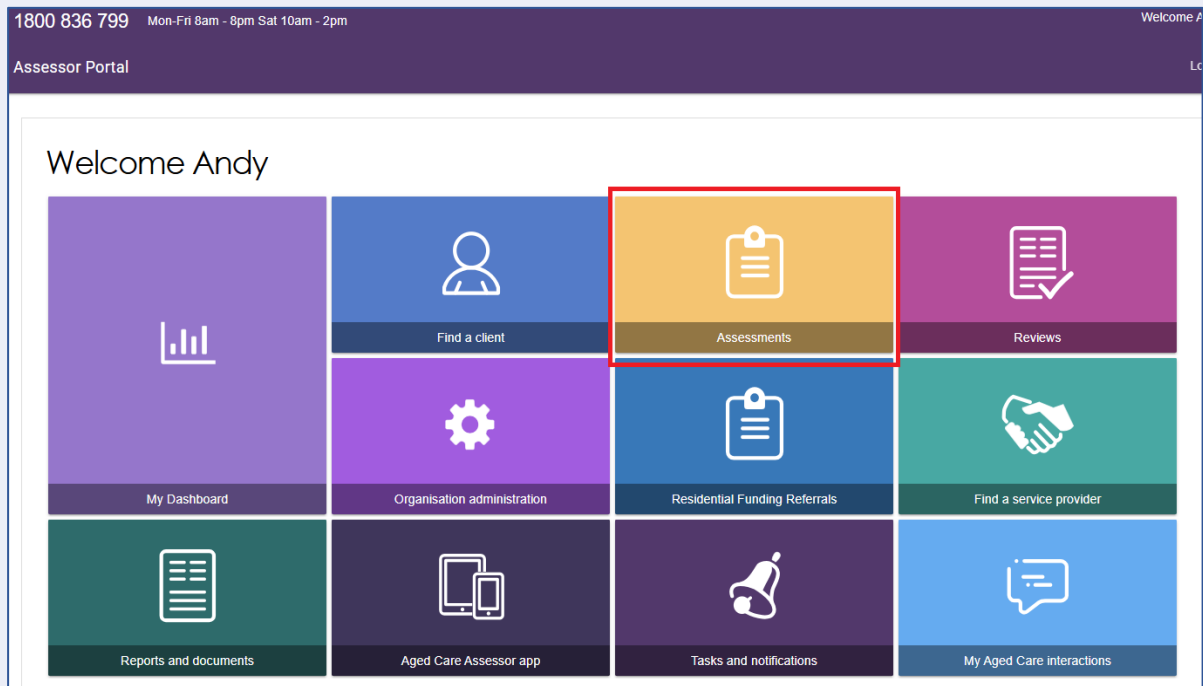
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## Viewing assessments

Follow these steps to view an assessment:

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



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

- Triage not started
- Assessment not started
- Assessment in progress
- Assessment completed but not yet finalised
- Assessment awaiting delegate decision (not applicable for reviews)
- Delegate decision completed but not finalised (not applicable for reviews).
- Assessments returned to the assessor from the delegate.

Name	Aged care user ID	Locality	Assessment type	Accepted date	Status	Date due	Priority
GLENN Bobbi	AC12345678		Comprehensive	02/10/2025	Assessment Not Started (Completed Triage)	▲ 05/10/2025 (228 days overdue)	High
SNIDER Edson	AC23456789	SCARBOROUGH, QLD, 4020	Comprehensive	20/11/2025	Assessment In Progress (Completed Support Plan)	▲ 30/11/2025 (172 days overdue)	High
PURCELL Eloise	AC34567890	BRISBANE CITY, QLD, 4000	Comprehensive	13/04/2026	Assessment Complete (Delegate Decision)	▲ 22/04/2026 (29 days overdue)	High

For more information about assessments returned to the assessor from the delegate, refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#).

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

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

Recent assessments

Currently viewing ABC Outlet

Current assessments **Recent assessments**

Filter by

1 to 20 out of 20 matching results

Name	Aged care user ID	Locality	Assessment type	Completed/cancelled date	Status	Priority
SHARP Jane	AC12345678	BRISBANE CITY, QLD, 4000	Home Support	15 April 2026	Finalised	High
SMITH Libby	AC23456789	BRISBANE CITY, QLD, 4000	Home Support	14 April 2026	Finalised	Medium
SMITH Jane	AC34567890	MACGREGOR, ACT, 2615	Comprehensive	13 February 2026	Finalised	Low
SMITH Tony	AC45678901	MACGREGOR, ACT, 2615	Comprehensive	18 February 2026	Finalised	Low

! Further information about using the sort and advanced filter functions can be found in the [My Aged Care – Assessor Portal User Guide 3 – Managing referrals for assessment and support plan reviews](#).

## Starting an assessment

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

Current assessments

Currently viewing ABC Outlet

Current assessments **Recent assessments**

Filter by

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

Current sort order is Assessment Priority

1 to 42 out of 42 matching results

### Assessment Not Started

<b>Bobbi GLENN</b> Aged care user ID: AC65392276 Date accepted: 2 October 2025 Completed Triage due by: 5 October 2025 Comprehensive 228 days overdue Assessment Not Started <b>High</b>	<b>Mark YELLOW</b> GOOGONG, NSW, 2620 Aged care user ID: AC78063402 Date accepted: 29 April 2026 Completed Triage due by: 2 May 2026 Comprehensive 19 days overdue Assessment Not Started <b>High</b>	<b>Maple MAY</b> Aged care user ID: AC04723284 Date accepted: 11 May 2026 Completed Triage due by: 14 May 2026 Comprehensive 7 days overdue Assessment Not Started <b>High</b>	<b>David ATTENBOROUGH</b> Aged care user ID: AC74234634 Date accepted: 21 May 2026 Completed Triage due by: 24 May 2026 Home Support Due in 3 days Assessment Not Started <b>Medium</b>
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2. The client's card or listing displays, which includes a summary of client information. Assessors can access read-only versions of previous screening, triage and assessments, attachments relevant to the client's referral, and the client's support plan, if available.

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

For comprehensive assessments, clinical assessors will be able to indicate the assessment setting before starting the assessment.

**Jeenie SMITH**

Please confirm that jeenie SMITH, 29 April 1950, 74 Years, AC33505270 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

Aged 74 ( 29 April 1950 ), Female

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



**Preferences**  
No preference was recorded

**Assessment details**  
FNAO-preference No  
Assessment type Home Support  
Assessment reason Self-Referral  
Assessor Louie Hinson  
Triage conducted by Elissa Mazur

Completed Triage due by 7 February 2025

**Client story**  
No client story was recorded

**Comments**

Support plan ● Triage Completed   
Home Support Assessment ● Triage Completed 

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

**Bobbi GLENN**

Please confirm that Bobbi GLENN, 3 September 1965, 60 Years, AC65392276 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.



Aged 60 ( 3 September 1965 ), Female


Referred from Aged Care Gateway on 25 September 2025  
Accepted on 2 October 2025

**Preferences**  
No preference was recorded


**Assessment details**  
Assessment type Comprehensive  
Assessment reason

Completed Triage due by 5 October 2025

**Client story**  
03/10/2025   
02/10/2025 

**Assessment setting** Non-Hospital 

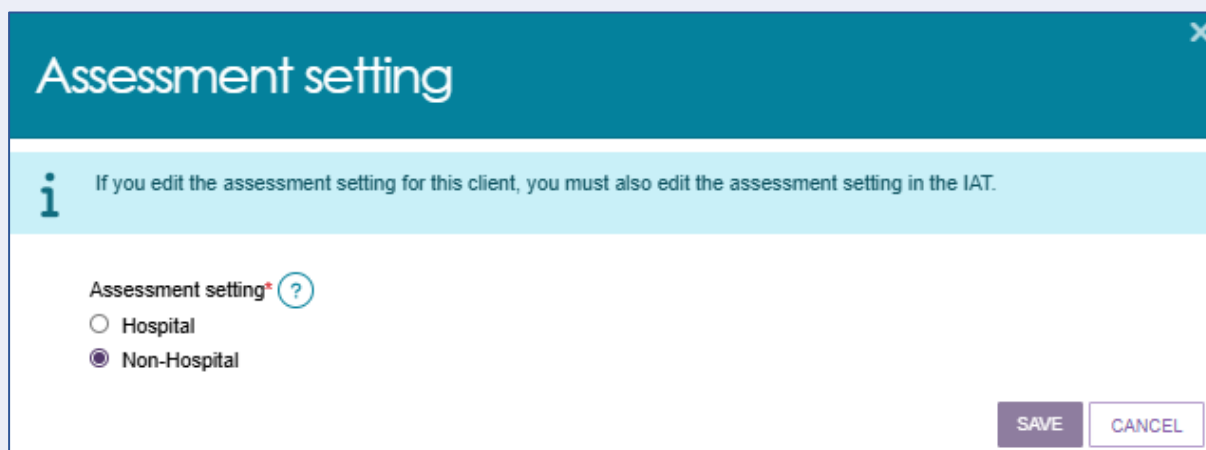
Assessor Africa Green  
Triage conducted by Lowell Elliott

Support plan ● Triage Completed 

[VIEW ALL 4 CLIENT NOTES](#)

**Comments**

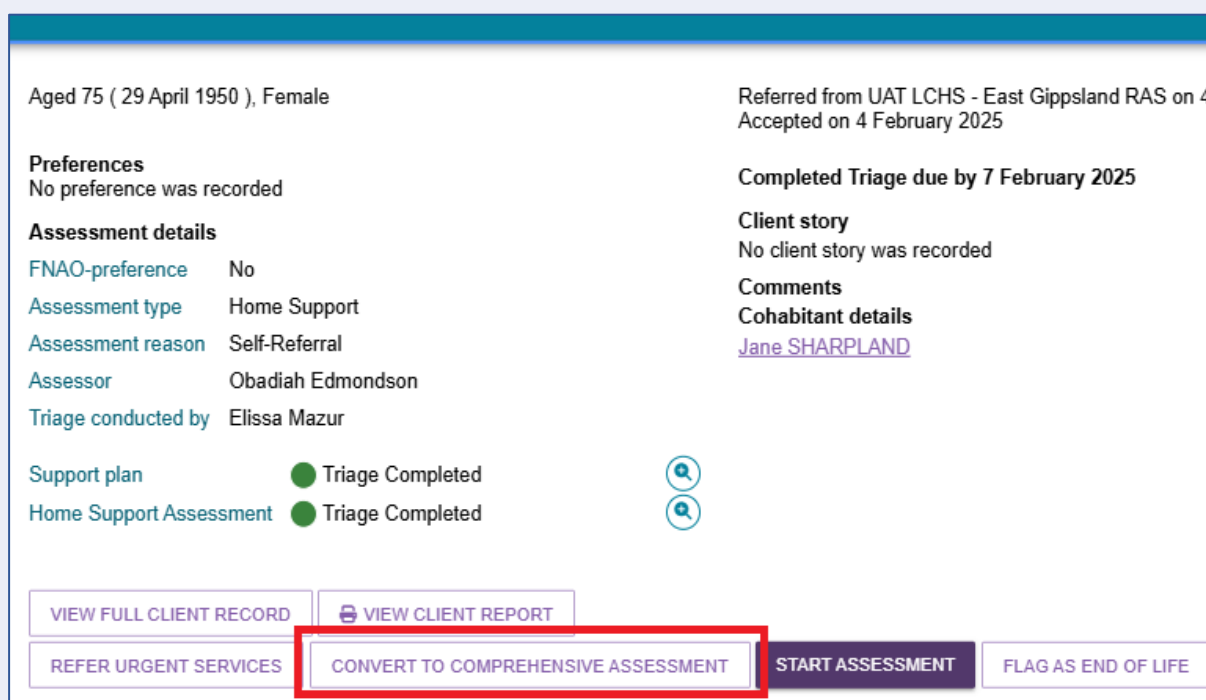
- The **Assessment setting** pop up appears. Select **Hospital** or **Non-Hospital** and select **Save**.



- The **Assessment setting** that is filled out here must match the value recorded in the Integrated Assessment Tool ([IAT](#)). Clinical assessors must ensure that both fields are manually updated to reflect the same value if one is changed.

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

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



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

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

**Convert to comprehensive assessment**

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

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

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

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

Reason for change \*  
High level care needs

Reason or comments: \*  
0 / 255

Supervising assessor \*

**YES, CONVERT ASSESSMENT** NO, CANCEL

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

**Convert to comprehensive assessment**

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

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

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

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

Reason for change \*  
High level care needs

Reason or comments: \*  
0 / 255

Supervising assessor \*

**YES, CONVERT ASSESSMENT** NO, CANCEL

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

**Maple MAY**

Please confirm that Maple MAY, 1 February 1950, 76 Years, AC04723284 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

Aged 76 ( 1 February 1950 ), Female      Referred from **ABC Outlet** on 11 May 2026  
Accepted on 11 May 2026

**Preferences**  
No preference was recorded      Completed Triage due by **14 May 2026**

**Assessment details**  
**Assessment type** **Comprehensive**  
 Assessment reason Self-Referral      **Client story**  
 No client story was recorded  
 Assessment setting Non-Hospital      **Comments**  
 Assessor Africa Green  
 Triage conducted by Africa Green

**Support plan**      ● Triage Completed  
**Comprehensive Assessment**      ● Triage Completed

VIEW FULL CLIENT RECORD      VIEW CLIENT REPORT

REFER URGENT SERVICES      **START ASSESSMENT**      FLAG AS END-OF-LIFE

- You will then be asked to record client consent.

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

If there is a suggestion that the client lacks capacity for consent, complete this form with the client's confirmed supporter-guardian in My Aged Care.

The **My Aged Care Assessment Consent Form** is available for download from the **Reports & Documents** tile of the assessor portal.

**Reports and documents**

Reports      **Forms**      Links

**Forms**

- Self-Service Form - Abbey Pain Scale [pdf 221.46KB]
- Self-Service Form - Alcohol Use Disorders Identification Test [pdf 287.27KB]
- Self-Service Form - Application for Care - October 2020 [pdf 354.04KB]
- Self-Service Form - Barthel Index of Activities of Daily Living [pdf 216.67KB]
- Self-Service Form - Brief Pain Inventory [pdf 256.86KB]
- Self-Service Form - Caregiver Strain Index [pdf 148.48KB]
- Self-Service Form - Client Record Details [pdf 364.25KB]
- Self-Service Form - NSAF Comprehensive Assessment and Support Plan 20221027 [PDF]
- Self-Service Form - Geriatric Depression Scale [pdf 217.58KB]
- Self-Service Form - Home Support Assessment and Support Plan - October 2018 [pdf 48]
- Self-Service Form - Informant Questionnaire on Cognitive Decline in the Elderly (IQ COD)
- Self-Service Form - Integrated Assessment Tool - Offline Form [pdf 1.28MB]
- Self-Service Form - K-10 [pdf 942.84KB]
- Self-Service Form - KICA-COG images [pdf 539.52KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - ADL [PDF 148.59KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Carer [pdf 695.20KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Cognitive Assessment
- Downloads - Mini Nutritional Assessment [pdf 81.38KB]
- Self-Service Form - Modified Caregiver Strain Index [pdf 216.96KB]
- Self-Service Form - My Aged Care Assessment Consent Form v2.1 [pdf 316.19KB]**
- Template - Template notice of priority for home care service - not vary v1.0 [rtr 10.27KB]
- Template - Template notice of priority for home care service - not vary v2.0 [rtr 10.27KB]

10. If consent is given, select the applicable consent options and then select **CONTINUE**.

A signed copy of the Aged Care Assessment Consent form should be obtained during this step.

## Consent for Assessment

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

### Information

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

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

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

### When and how to seek consent?

Assessors must seek and gain informed consent from the client (or supporter, decision-making supporter or guardian) either prior to or when commencing the assessment or reassessment.

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

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

### Does client have capacity to give informed consent?

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

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

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

For more information, please see the [My Aged Care Assessment Manual](#)

### Script to be read.

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

- The assessor<sup>1</sup> will collect information that allows them to assess your eligibility for aged care services.
- For your assessment, the assessor will collect personal information about you, such as information about your name and address, and information about your health and care needs.
- The information you provide will be recorded in your My Aged Care client record and will be used and disclosed by the assessment organisation, the Department of Health and Aged Care as well as any aged care providers while providing aged care services to you.
- If it is required for your assessment, the assessor may need to collect information from your General Practitioner, other health professionals, your family or carers.
- As part of your assessment, if you provide the assessor with personal information about other people such as your family or your support person, you confirm that you have obtained the other person's consent and that you have brought the contents of the privacy notice which is set out at [privacy notice web address](#) to their attention. Information about these other people will be included in your My Aged Care client record and will be handled in the same way as your own personal information - being for the purpose of providing aged care services to you.
- The information you provide may also be recorded in the assessment organisation's IT systems and will be used and disclosed by the assessment organisation for the purpose of determining your eligibility for aged care services.
- The assessor may share your personal information with other organisations to manage the support you need, for example, the Department of Health and Aged Care, aged care or health providers, Services Australia and state and territory services.
- As we go through the assessment, please tell me if you do not want any of your information to be recorded. We can discuss how to manage this further.
- You can change your mind and withdraw your consent to participate in the assessment at any time. However, this will mean the assessor cannot complete your assessment for aged care services. You will need to arrange your own aged care services.
- You can view the privacy notice which is set out at [privacy notice web address](#) as well as the My Aged Care privacy policy on the My Aged Care website at [myagedcare.gov.au](#) for more information on how we handle your personal information.
- Do we have your consent to assess the eligibility of Patricia THOMPSON for aged care services?

Supporter Consent Form

Select one

Select one

The client

The client with support person

Consent was not given

The supporter/guardian

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

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

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

care services.

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

Consent Obtained From \*

Consent was not given

Please select a reason for not providing the consent \*

Client unable to consent

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

**SAVE AND CLOSE** CANCEL

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

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

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

Once you have selected the relevant pre-population options, select **CONFIRM SELECTION**.

### Pre-populate or start a blank assessment

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

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

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

Please select\*

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

Blank Assessment

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

**CONFIRM SELECTION** CANCEL

If you do not wish to pre-populate the IAT select **Blank Assessment**.

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

## Pre-populate or start a blank assessment

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

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

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

Please select\*

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

Blank Assessment

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

CONFIRM SELECTION

CANCEL

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

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

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

## Demographic details

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

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

Remote Assessment ?

### Personal details & Identification

First name \*

Shonna

Middle name

Last name \*

Herrington

Address:

Unit 2 28 4 DWYER Street MACLEOD VIC 3085

Contact details:

0219582129

Medicare number:

31777511631

To change the above details,

[view the full client record.](#)

### Background

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

Date of birth

16/01/1946

or

Estimated age

79

Gender \*

Female

Country of birth \*

Philippines

Ethnicity \*

Filipino

SAVE AND CONTINUE TO ASSESSMENT

CANCEL



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

**Demographic details**

Filipino

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

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

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

**Government ID references**

Department of Veterans' Affairs (DVA) card number

Medicare card number

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

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

8 BRUCE HIGHWAY, SARINA QLD 4737  
was classified as:

**Summary**    Classifications

**District of Workforce Shortage for Specialists**

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

Catchment: Mackay (31202)

**Distribution Priority Area for GPs**

IMGs / FGAMS	Yes
Bonded doctors	Yes

Catchment: Sarina

**Modified Monash Model**

2015	MM 5
2019	MM 5
2023	MM 5

**ASGS Remoteness Areas**

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

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

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

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

The screenshot shows the 'Plans' tab for Mrs Shonna HERRINGTON. The navigation bar includes: Client summary, Client details, Support network, Approvals, Plans (highlighted with a red box), Attachments, Services, My Aged Care interactions, Notes, Tasks and Notifications, and Residential Funding Classifications. The main content area is divided into two columns. The left column contains 'Current Episode' (Episode ID: 1-1AP86BY2, 14 May 2025 - Present, with a SUPPORT PLAN button) and 'Upcoming Review(s)' (No upcoming reviews scheduled). The right column contains 'Assessment history' (highlighted with a red box), 'Plan history', 'Review history', and 'Reablement and linking support history'. The 'Assessment history' section lists four items: Comprehensive Assessment 14 May 2025, Comprehensive Assessment 16 August 2023, Home Support Assessment 28 September 2020, and Screening 18 September 2020. The 'Plan history' section lists four support plans: Support plan as at 29 September 2020, Support plan as at 17 July 2023, Support plan as at 18 August 2023, and Support plan as at 6 May 2025. The 'Review history' section states 'No review history available'. The 'Reablement and linking support history' section states 'No linking support items available'.

## Completing an assessment

**!** The IAT contains an algorithm to ensure consistent client outcomes based on their needs. The algorithm will draw on assessment responses and the client's current care approvals and recommend an aged care service. This will display in the **SUPPORT PLAN AND SERVICES PAGE** under the **GOALS AND RECOMMENDATIONS** tab after an assessor finalises the IAT. When certain conditions are met, there may also be information messages suggesting that a client may be suitable for Restorative Care Pathway, Support at Home (including Assistive technology and/or Home modifications).

1. Once you have commenced an assessment, the client's Demographic details page displays. Some details may have been pre-filled from an earlier triage, screening or assessment. Ensure all mandatory information is complete and up to date, then select **SAVE AND CONTINUE TO ASSESSMENT**.

Demographic details

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

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

Remote Assessment ?

**Personal details & Identification**

First name \*  
David

Middle name

Last name \*  
Attenborough

Address:  
Contact details:  
not specified  
Medicare number:  
To change the above details,  
view the full client record.

**Background**

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

Date of birth  
08/05/1926

or

SAVE AND CONTINUE TO ASSESSMENT CANCEL

2. The **ASSESSMENT DETAILS** page will display. Key client information will be displayed at the top of each page of the assessment.

Home | Assessments | Assessment

Mr David ATTENBOROUGH

Male, 100 years old, 8 May 1926, AC74234634

Save Assessment

Triage

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

Physical, Personal Health & Frailty

Social

Cognition

Behaviour

Psychological

Home & Personal Safety

Financial or Legal

Support Considerations

**Assessment Details**

Clear Page Information

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

Date of assessment \* 21/05/2026

Participants consulted prior to the assessment \*  
 Yes  No

Mode of assessment \*  
 Face-to-face  Over-the-phone  Via tele-health

Assessment setting \*  
Please select...

Details

0 / 500



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

The screenshot shows the 'Assessment Details' page. On the left, a navigation bar has 'Triage' selected and highlighted with a red box. Other options include 'Assessment Details', 'Reason for Assessment', and 'Carer Profile'. The main content area is titled 'Assessment Details' and includes a 'Save Assessment' button at the top left and a 'Clear Page Information' button at the top right. Below the title, a note states 'All fields marked with an asterisk ( \* ) are required.' A form field for 'Date of assessment \*' is visible, containing the date '21/05/2026' and a calendar icon.

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

This close-up shows the navigation bar with 'Assessment Details' selected. A green checkmark is visible to the right of the text, indicating that the selection is confirmed. Other options like 'Reason for Assessment' and 'Carer Profile' are visible below it.

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

## Assessment features

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


This screenshot shows the 'Assessment Details' page with the 'Clear Page Information' button highlighted with a red box. The navigation bar on the left now shows 'Assessment Details' with a green checkmark, and 'Medical and Medications' is added as a new option. The main content area remains the same as in the previous screenshot.

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

The screenshot shows a purple 'Clear page information' dialog box. It contains the text: 'Select 'Yes, clear page information' to clear information on this page. Select 'Cancel' to go back to the questionnaire.' At the bottom, there are two buttons: 'Cancel' and 'Yes, clear page Information', with the latter highlighted by a red box.

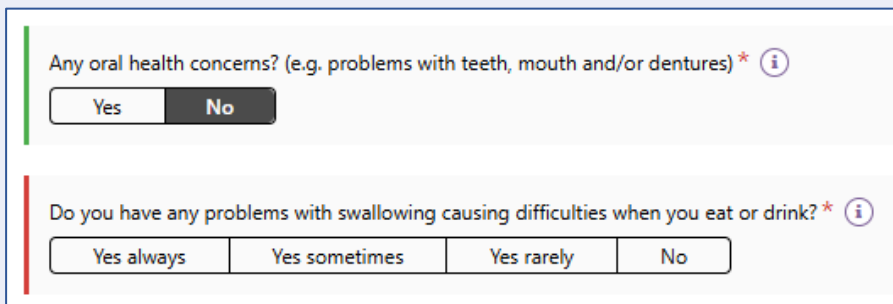
**!** Pages that do not contain Validated Assessment Tool triggering questions will only have the option to **Yes, clear page** and **cancel**. However, pages with Validated Assessment Tools trigger questions, will have a fourth option to **Clear all**.

Selecting **Clear page** will trigger an in-action symbol which demonstrates that the clearing

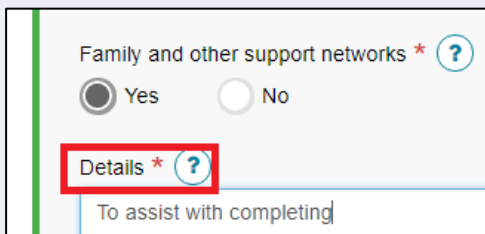
is in progress. Selecting **Clear page information** will also remove the check box  that triggers the display of Validated Assessment Tools.

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


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

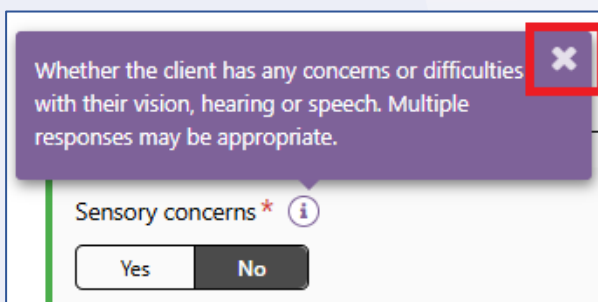


4. Some questions will require additional mandatory details depending on the answer. In these cases, an asterisk will appear next to the details section to indicate that it is now mandatory to complete.



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

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



7. Two mandatory tick boxes must be filled at the bottom of each page.
- 'I have reviewed the information on this page and I confirm that it is correct.'
  - 'I have confirmed that any required goals are added to the Support Plan.'

Then, you can navigate to the next assessment page by selecting the **NEXT** button at the bottom right-hand corner or by selecting the relevant section from the navigation bar. Assessment information will also be saved.

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

**!** Please confirm you have completed the clients' goals before you finalise the IAT. Once you finalise the IAT, the IAT outcome and any recommendation prompts will be generated.

Before you confirm, please select 'Save Questionnaire And Continue to Support Plan' and in 'Goals & Recommendations' take the following actions:

- Add any goals that you may have identified are required for the client.
- Review any pre-existing goals.

If you have identified there are no goals required for the client, you can confirm and finalise the IAT.

I have confirmed that any required goals are added to the Support Plan.\*

Next

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

Save Assessment

Triage

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

### Clinical attendance (for non-clinical assessors)

Threshold questions are also used throughout the IAT to trigger moving the assessment into clinical/comprehensive areas. These questions are identified by a blue banner.

For example, if you answer **No** to the question 'is the client managing urinary incontinence issue?' then additional question/s will be displayed that require clinical attendance to complete.

Toileting – Bladder\* ⓘ

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

Is the client managing urinary incontinence issue? \*

Yes No

! This section of IAT must be completed under your organisation's clinical governance

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

Yes No

For non-clinical assessors, these questions can only be completed under the **clinical attendance process** which is supported by an assessment organisation's clinical governance framework. To proceed in answering these questions, you must:

1. Confirm that you are completing this section of the IAT under your organisation's clinical governance by selecting **YES**.
2. Select your clinical supervisor's (supervising clinical assessor) name from the text box. This person must have provided clinical attendance.
3. Select **SAVE DETAILS**.

Clinical Declaration and Supervisor details

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

Yes No

Please select the supervising assessor

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

Clinical Declaration and Supervisor details

Clinical Declaration: Provided    Supervising Assessor: Africa Green   

! This section of IAT must be completed under your organisation's clinical governance

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


Yes No





## Health Conditions

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

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


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






Health condition(s)   Add as Other Consideration

Health Condition * 	Health Condition Description *	Diagnosis Status * 	Primary Health Condition * 
1004	Other diseases of upper respiratory tract (includes respiratory allergies (excluding allergic asthma), chronic rhinitis & sinusitis, chronic diseases of tonsils & adenoids)	<input type="text" value=""/> <ul style="list-style-type: none"> <li>Client reported</li> <li style="background-color: #ccc;">GP confirmed</li> <li>Hospital confirmed</li> <li>Other health practitioner confirmed</li> </ul>	Primary Health Condition 

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

Assessors must also indicate the **Primary Health Condition**, and can add health conditions as an **Other Consideration** in the client's Support Plan.

Health condition(s)   Add as Other Consideration

Health Condition * 	Health Condition Description *	Diagnosis Status * 	Primary Health Condition * 
1004	Other diseases of upper respiratory tract (includes respiratory allergies (excluding allergic asthma), chronic rhinitis & sinusitis, chronic diseases of tonsils & adenoids)	GP confirmed <input type="text" value=""/>	Primary Health Condition 
1307	Osteoarthritis	Hospital confirmed <input type="text" value=""/>	Primary Health Condition 

**+ Add Health Condition**

## Adding Identified Needs

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

These will appear as tickable checkboxes when applicable, on the far right side of each of the IAT questions.

- Add as recommendation
- Add as Other Consideration
- Add as Functional Need
- Add as Complexity Indicator

*Add As Functional Need example*

Get to places out of walking distance\* Add as Functional Need

Without help   **With some help**   Completely unable

Who helps?\*

Informal carer(s)    Aged care service provider(s)    Other

*Add As Other Consideration and Add as Recommendation examples*

Home safety equipment client has

Smoke alarm(s)

Personal alarm

Personal emergency plan

Other technology

- Add as Other Consideration
- Add as Recommendation
- Add as Recommendation
- Add as Recommendation

Sometimes the checkboxes will be automatically added if qualifying questions are answered.

For example if the client has an assistance dog, eligible for and able to access the Physical Assistance Dogs program, and the assistance dog meets the definition used by HealthDirect.

Then, the **Assistive technology – Assistance dog** category will be automatically added as an Other Consideration Assistance Dog as Other Consideration example

Does the client have any vision, hearing, speech or somato related concerns or difficulties?\*

Vision\*

Low vision   Monocular blindness   Binocular blindness

Does the client have an assistance dog?\*

Yes   No

Is the client eligible for and able to access the Federal Government funded Physical Assistance Dogs Program?\*

Yes   No

Does the client's assistance dog meet the definition of an assistance dog used by Health Direct?\*

Yes   No   Add as Other Consideration

**Assistive technology** and **Home modifications** are also able to be added as an **Other Consideration**.

This question appears at the bottom of seven assessment topics, to allow assessors to consider funding required for Medications, Function, Physical Personal Health and Frailty, Social, Cognition, Psychological, and Home and Personal Safety.

Once selected, the checkbox next to 'Add as Other Consideration' is automatically ticked (and greyed out).

In relation to function, this client would benefit from funding for:

Assistive technology       Home modifications

Add as Other Consideration

Upon selecting the checkbox/es, the above considerations will appear on the **Other Considerations** tab of the **Support Plan**, in their own sections on the right hand side of the Assessment summary.

Recommendations will appear in the **Goals & recommendations** tab.

**!** Remember to add any Assistive technology and Home modifications considerations to the client's support plan. Refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#).

The screenshot displays the 'Support plan and services' interface. At the top, there are navigation tabs: 'Identified needs', 'Goals & recommendations', 'Decisions', 'Manage services & referrals', 'Associated People', and 'Review'. The 'Assessment summary' tab is active, showing an 'EDIT' button and an introduction for Mr Bruce Wayne. Below the introduction are sections for 'Situation', 'Background', 'Assessment', and 'Recommendation'. On the right side, there are three panels: 'Functional needs' (listing Transport, Light Housework, Shopping, and Meals preparation), 'Other considerations' (highlighted with a red box, listing Assistive technology consideration - Function, Home modifications consideration - Function, Assistive technology consideration - Physical personal health and frailty, Home modifications - Physical personal health and frailty, and AT-Ongoing consideration - Assistance Dog), and 'Complexity indicators'. At the bottom right, there are 'PRE-POPULATE FROM ASSESSMENT' and 'EDIT' buttons.

## Viewing and adding carers in the assessment

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

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

Mr Tom Farah TANCOCO

Male, 81 years old, 15 September 1944, AC39652359  
Lot Number 159 1 OLD BAY ROAD DECEPTION BAY, QLD, 4508

VIEW/ADD CARERS

Save Assessment

Triage

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

### Carer Profile

Clear Page Information

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

How many people excluding the client live in the same household as the client? \*

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

### Carers

Current carers

Add a carer

ADD A CARER

SAVE

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

### Find a carer

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

First name \*

Last name \*

Date of birth

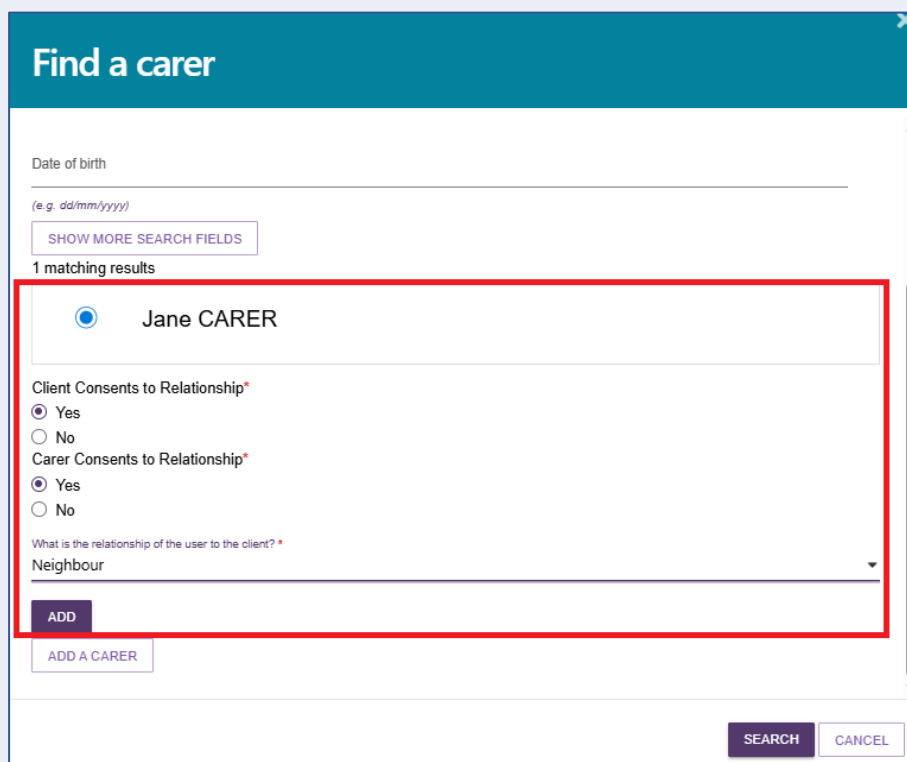
(e.g. dd/mm/yyyy)

SHOW MORE SEARCH FIELDS

SEARCH CANCEL

4. If there is already a record for the person, they will be displayed in matching results.

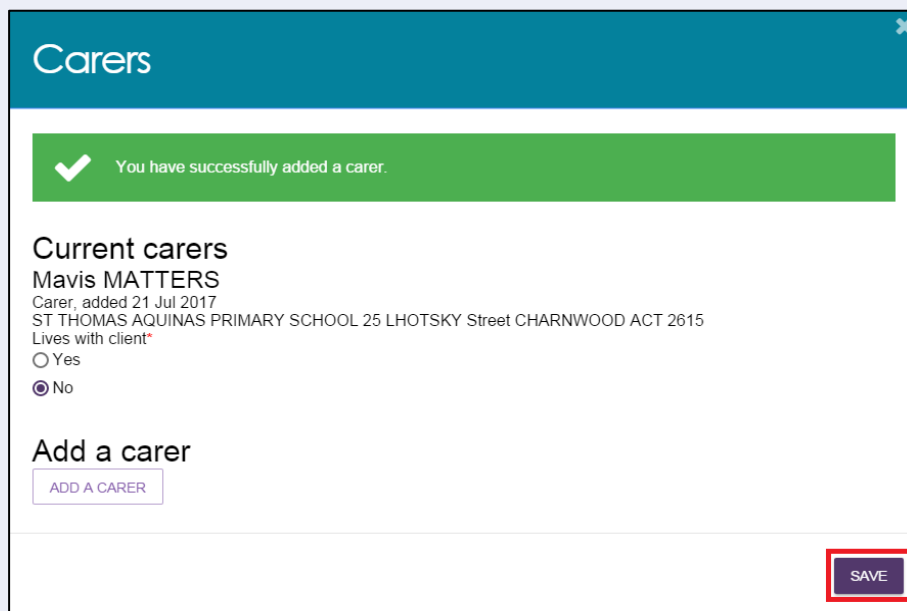
By selecting the radio button next to the person's name, it will open more fields including both client and carer consent to the relationship, and the relationship of the user to the client. Select **ADD**.



The screenshot shows a 'Find a carer' form with a teal header. Below the header is a search field for 'Date of birth' with a placeholder '(e.g. dd/mm/yyyy)' and a 'SHOW MORE SEARCH FIELDS' button. Below this, it says '1 matching results'. A red box highlights a result for 'Jane CARER'. Underneath the name are three sections: 'Client Consents to Relationship\*' with 'Yes' selected, 'Carer Consents to Relationship\*' with 'Yes' selected, and 'What is the relationship of the user to the client?\*' with 'Neighbour' selected. At the bottom of the red box is an 'ADD' button. Below the red box is an 'ADD A CARER' button. At the bottom right of the form are 'SEARCH' and 'CANCEL' buttons.

5. You will receive a confirmation message on screen, notifying that **You have successfully added a Carer.**

Select **SAVE** to save changes.



The screenshot shows a 'Carers' form with a teal header. Below the header is a green confirmation message: 'You have successfully added a carer.' Below this is a section titled 'Current carers' with the following details: 'Mavis MATTERS', 'Carer, added 21 Jul 2017', 'ST THOMAS AQUINAS PRIMARY SCHOOL 25 LHOTSKY Street CHARNWOOD ACT 2615', and 'Lives with client\*' with 'No' selected. Below this is an 'Add a carer' section with an 'ADD A CARER' button. At the bottom right of the form is a 'SAVE' button highlighted with a red box.

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

Find a carer

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

First name \*  
Jane

Last name \*  
Carer

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

SHOW MORE SEARCH FIELDS

1 matching results

Jane CARER

ADD

ADD A CARER

SEARCH CANCEL

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

The consent for registration during this stage is solely to create the client-carer relationship within the My Aged Care system.

By creating this relationship, the carer will display in the client's support network and also appear as an option to be added to the client's support plan at a later stage.

Consent will be sought for any changes to this carer relationship throughout the process.

For information on how to capture a client and carer's consent for call-backs from the [Carer Gateway](#) and/or National Dementia Helpline, go to [Assessor Portal User Guide 2 – Registering support people and adding relationships](#).

## Add a person

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

First name: \*  
Jack

Last name: \*  
Carer

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

Gender \*  
Male

Lives with client\*  
 Yes  
 No

Client Consents to Relationship\*  
 Yes  
 No


Carer Consents to Relationship\*  
 Yes  
 No

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

**SAVE** CANCEL

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

## Carers

 You have successfully added a carer.

### Current carers

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

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

### Add a carer

ADD A CARER

**SAVE**

## Adding a Sensitive Attachment in the assessment

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

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

Mr Zoe FORSTER

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

Financial or Legal

**Support Considerations**

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

Yes No

Risk client may cause harm to themselves or others  Add

Yes No

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

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

Assessor Portal

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

## Reports and documents

Reports **Forms** Links

### Forms

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

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

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

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

*Support Considerations page of the IAT assessment*

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

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

Financial or Legal

Support Considerations

Any evidence that the client is self-neglecting of personal care, nutrition or safety?  
 Yes  No

Risk client may cause harm to themselves or others  
 Yes  No

*Attachments Page*

**Attachments**

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

**ADD AN ATTACHMENT**

Assessment Attachments   Other Attachments   Correspondence

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

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

Upload sensitive attachment pop up

## Upload sensitive attachment

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

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

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

**CHOOSE FILE** No file chosen

Name of the attachment: \*

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

0 / 250

**UPLOAD** **CANCEL**

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

## Add an attachment

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

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

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

**CHOOSE FILE** No file chosen

Name of the attachment: \*  
(150 characters)

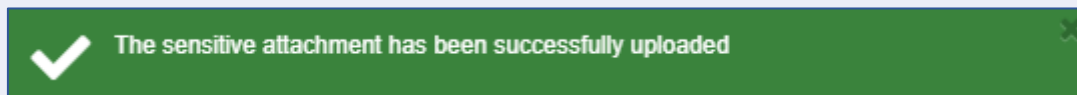
Please provide a short description about the contents of the attachment, e  
(250 characters)

Type of attachment \*  
Select one

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



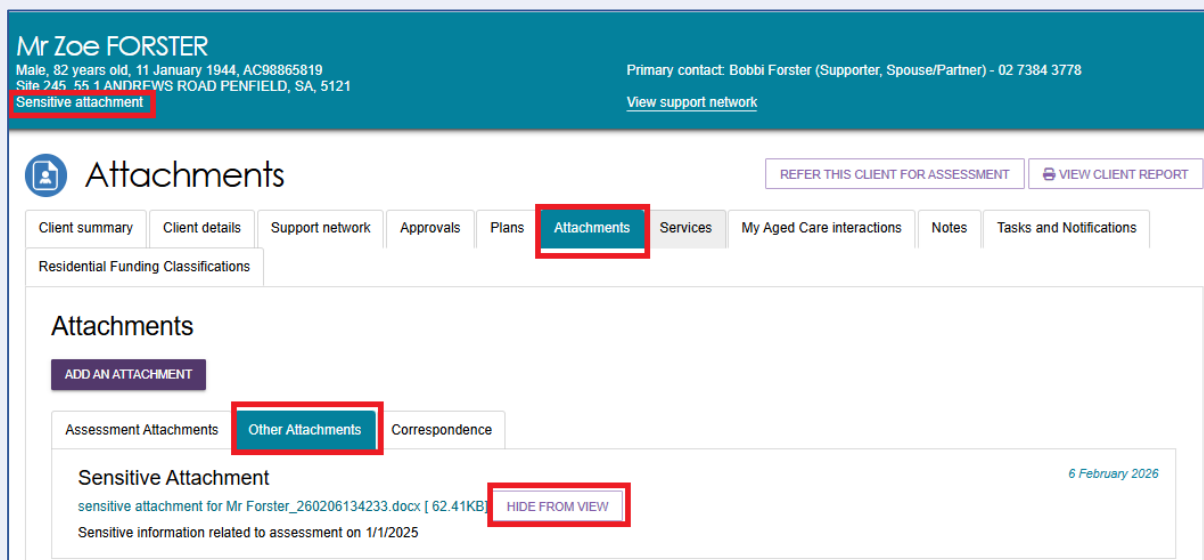
5. Once successfully uploaded, a green banner will display at the bottom of the screen.



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

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

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



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

Primary contact: Bobbi Forster (Supporter, Spouse/Partner) - 02 7384 3778  
View support network

Attachments

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

Residential Funding Classifications

Attachments

ADD AN ATTACHMENT

Assessment Attachments Other Attachments Correspondence

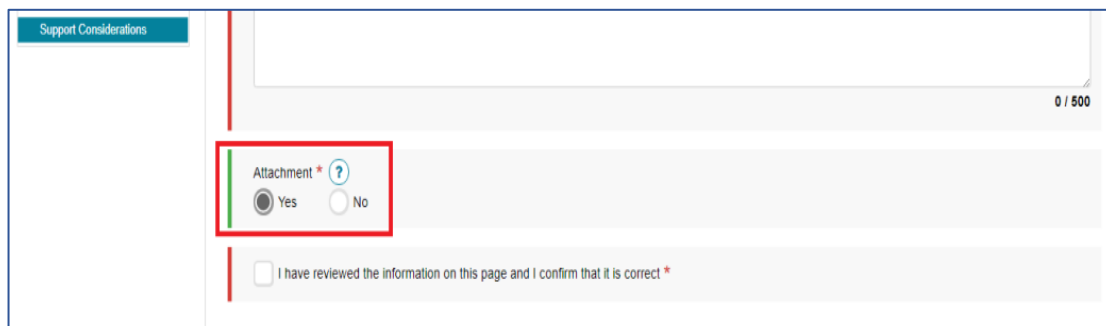
Sensitive Attachment  
sensitive attachment for Mr Forster\_260206134233.docx [ 62.41KB] HIDE FROM VIEW  
Sensitive information related to assessment on 1/1/2025

6 February 2026

- ! If you have added a Sensitive Attachment as part of the assessment, you should record this in the **Support Considerations** page.

Sensitive attachments will not display to providers or to clients viewing their information through the My Aged Care online account.

The My Aged Care contact centre and assessors will be able to view this attachment. Service providers who have accepted a client's referral will receive an alert notifying them that sensitive information is available and are advised to contact the client's assessor or My Aged Care contact centre to access this information.



Support Considerations

Attachment \* ?  
 Yes  No

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

## Navigating the Validated Assessment Tools

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

### Duke Social Support Index - Social Interaction Subscale

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

None	1-2 people	More than 2 people
------	------------	--------------------

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

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

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

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

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

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

Total score Total score cannot be calculated until all questions have been answered

Landerman alternative models stress buffering 1989

2. Other Validated Assessment Tools within the IAT will only display if required and agreed to by the client. For example the **Revised Urinary Incontinence Scale** appears as a result of answers indicating urinary incontinence, and that the client is able or willing to complete the tool.

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

Yes	No
-----	----

### Revised Urinary Incontinence Scale (RUIS) i

Urine leakage related to the feeling of urgency

Not at all	Slightly	Moderately	Greatly
------------	----------	------------	---------

Urine leakage related to physical activity, coughing or sneezing

Not at all	Slightly	Moderately	Greatly
------------	----------	------------	---------

Small amounts of urine leakage (drops)

Not at all	Slightly	Moderately	Greatly
------------	----------	------------	---------

How often do you experience urine leakage?

Never	Less than once a month	A few times a month	A few times a week
-------	------------------------	---------------------	--------------------

How much urine do you lose each time?


None	Drops	Small splashes	More
------	-------	----------------	------

Total score i Total score cannot be calculated until all questions have been answered

Sansoni J, Hawthorne G, Fleming G, Owen E and Marosszeky N (2015) Technical Manual and Instructions: Revised incontinence and Patient Satisfaction Tools, Version 2, Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong. Used by permission.

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

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

None	1-2 people	More than 2 people	
------	------------	--------------------	---

**!** Assessors must complete all and any screening tools in the Cognition section.

If the client do not have a confirmed dementia diagnosis and answered NO to completing the Step 1 GP Cog and the Step 2 GP Cog, then the assessor must provide a reason for the client not completing the cognitive screening tool.

## Cognition

[Clear Page Information](#)

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

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

Yes  No

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

Yes  No

Is there an informant available to complete GPCog - Step 2? \*

Yes  No

Please provide a reason for the client not completing the cognitive screening tool \*

Client displays cognitive issues but declines to complete cognitive questions	Client does not display cognitive issues but declines to complete cognitive questions	Unsure if Client displays cognitive issues but declines to complete cognitive questions
---	---	---

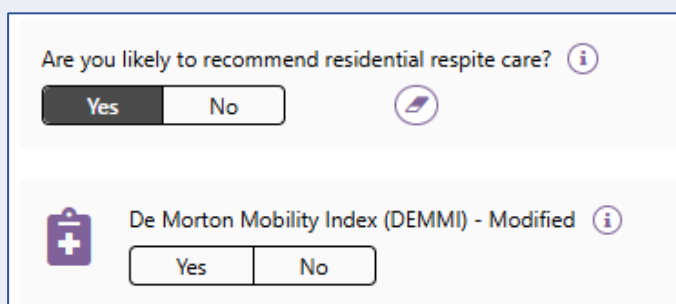
## Modified de Morton Mobility Index (DEMMI) and Residential Respite Care (Clinical assessor)

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


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


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

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



Are you likely to recommend residential respite care? i

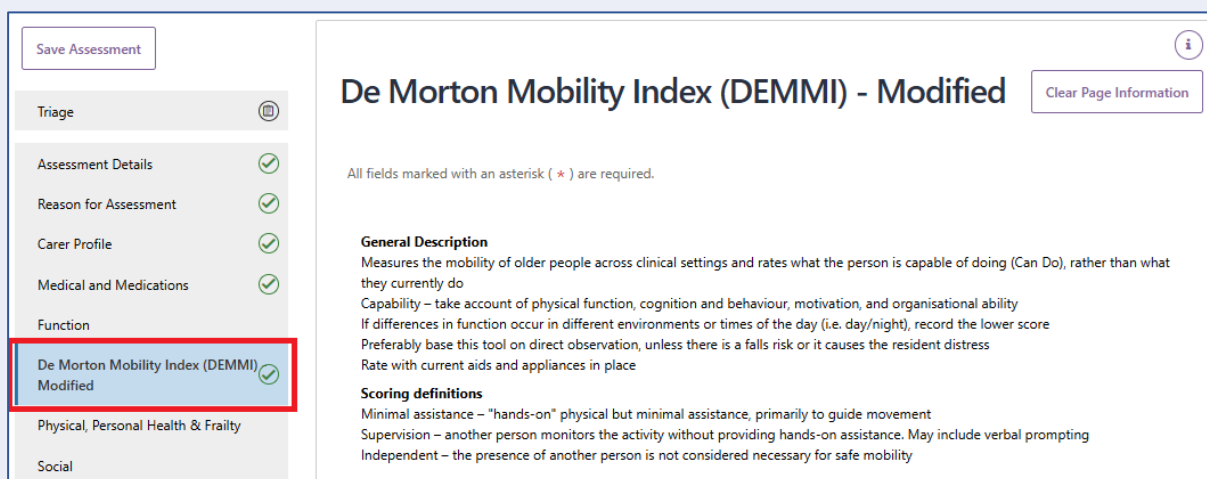
Yes No 

 De Morton Mobility Index (DEMMI) - Modified i


Yes No


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


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





Save Assessment

Triage 


Assessment Details 

Reason for Assessment 

Carer Profile 

Medical and Medications 

Function

**De Morton Mobility Index (DEMMI) Modified** 

Physical, Personal Health & Frailty

Social

De Morton Mobility Index (DEMMI) - Modified i Clear Page Information

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

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

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

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

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

**Bed**

Bridge ⓘ

Unable | Able

Roll onto side ⓘ

Unable | Able

Lying to sitting ⓘ

Unable | Minimal assistance | Supervision | Independent

4. Select the Help icon ⓘ to reveal help text.

Bridge ⓘ

Person is lying supine and is asked to bend their knees and lift their bottom clear of the bed.


Bridge ⓘ

Unable | Able

5. Select the Eraser icon  to clear your answer.

Sit unsupported in chair ⓘ

Unable | 10 seconds



6. Once you have completed the required sections, confirm the information on the page is correct, confirm that any required goals are added to the support plan, and select **NEXT**.

Walking independence ⓘ

Unable | Minimal assistance | **Supervision** | Independent with gait aid

Independent without gait aid

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

**!** Please confirm you have completed the clients' goals before you finalise the IAT. Once you finalise the IAT, the IAT outcome and any recommendation prompts will be generated.

Before you confirm, please select 'Save Questionnaire And Continue to Support Plan' and in 'Goals & Recommendations' take the following actions:

- Add any goals that you may have identified are required for the client.
- Review any pre-existing goals.

If you have identified there are no goals required for the client, you can confirm and finalise the IAT.

I have confirmed that any required goals are added to the Support Plan

**Next**

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

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

Are you likely to recommend residential respite care? i

Yes  No ↻

De Morton Mobility Index (DEMMI) - Modified i

Yes  No ↻

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

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

**Add care type for delegate decision** ✕

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

Reason or comments  
0 / 255

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

Reason DEMMI not completed \*  
Enter the reason the Modified DEMMI was not completed here|  
58 / 500

## Saving an assessment

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

**Ms Bobbi GLENN**  
Female, 60 years old, 3 September 1965, AC65392276  
Requires French translator, prefers to speak French

**Save Assessment**

Triage

Assessment Details

### Assessment Details

Clear Page Information

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

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

**Denzel WASHINGTON**  
Male, 71 years old, 28 December 1954, AC59482423  
Lot Number 60 BICENTENNIAL DRIVE JERRABOMBERRA, NSW, 2619

**Save Assessment**

Triage

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

Physical, Personal Health & Frailty

### Reason for Assessment

Clear Page Information

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

What is the key circumstance that has triggered client/supporter seeking assessment for aged care services? \* *i*

Referral from a health professional

Hospital discharge

Fall(s)

Medical condition(s)

Difficulties with activities of daily living

Change in caring arrangements

Assessment successfully saved

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Australian Government  
Department of Health and Aged Care

myagedcare

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

FINALISE IAT AND GO TO SUPPORT PLAN

**SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN**

CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED

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



**Current assessments** Currently viewing **ABC Outlet**

**Current assessments** Recent assessments

CARD LIST

**Filter by**

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

Current sort order is Assessment Priority 1 to 42 out of 42 matching results

### Assessment In Progress

<b>Bobbi GLENN</b>	<b>Edson SNIDER</b>	<b>Denzel WASHINGTON</b>
Aged care user ID: AC65392276 Date accepted: 2 October 2025 Completed Support Plan due by: 12 October 2025	SCARBOROUGH, QLD, 4020 Aged care user ID: AC20740221 Date accepted: 20 November 2025 Completed Support Plan due by: 30 November 2025	JERRABOMBERRA, NSW, 2619 Aged care user ID: AC58482423 Date accepted: 16 April 2026 Completed Support Plan due by: 26 May 2026
Comprehensive <span style="margin-left: 20px;">⚠️ 224 days overdue</span>	Comprehensive <span style="margin-left: 20px;">⚠️ 175 days overdue</span>	Comprehensive <span style="margin-left: 20px;">Due in 2 days</span>
Assessment In Progress <span style="float: right; background-color: red; color: white; padding: 2px 5px;">! High</span>	Assessment In Progress <span style="float: right; background-color: red; color: white; padding: 2px 5px;">! High</span>	Assessment In Progress <span style="float: right; background-color: green; color: white; padding: 2px 5px;">Low</span>

## Finalising the IAT

- Remember to confirm that you have completed the client's goals before finalising the IAT.

For more information about goals, refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#)

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

**⚠️ Please confirm you have completed the clients' goals before you finalise the IAT. Once you finalise the IAT, the IAT outcome and any recommendation prompts will be generated.**

Before you confirm, please select 'Save Questionnaire And Continue to Support Plan' and in 'Goals & Recommendations' take the following actions:

- Add any goals that you may have identified are required for the client.
- Review any pre-existing goals.

If you have identified there are no goals required for the client, you can confirm and finalise the IAT.

I have confirmed that any required goals are added to the Support Plan\*

Next

- Once you have completed the assessment, select **FINALISE IAT AND GO TO SUPPORT PLAN** located at the bottom of the Assessment page. This option only appears when all mandatory questions have been answered.

3. A pop-up will then display asking for consent to share their support plan via their My Health Record. It contains the following sections:
  - Information
  - When and how to seek consent? Does client have capacity to give informed consent?
  - Script to be read
  - Consent to service referrals, and consent to share support plan to My Health Record.



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

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

### Information

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

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

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

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

## When and how to seek consent?

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

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

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

## Does client have capacity to give informed consent?

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

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

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

For more information, please see the consent section of [My Aged Care Assessment Manual](#)

## Script to be read.

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

- Your service referrals will contain personal information about your assessed care needs and circumstances that have been obtained from your My Aged Care client record, including your name, address, contact details and care needs.
- Information about your service referrals will be recorded in your My Aged Care client record and will be used and disclosed by service providers and the department in the course of providing aged care services to you.
- The service providers will use the referral information to decide if they can offer you the services.
- The service referral may also be recorded in the service providers' IT systems for the purposes of determining whether they can provide you with the relevant services and providing those services.
- Service providers may share your personal information with other organisations to manage the support you need, for example, the Department of Health and Aged Care, aged care or health providers, Services Australia and state and territory services.
- Services for which you are eligible are recorded in your support plan. You can consent to have your support plan uploaded to your My Health Record, if you have one. This will allow it to be viewed by yourself as well as people or entities who you have given permission to view your records, like healthcare providers and your supporter or guardian.
- As we go through the service referral process, please tell me if you do not want any of your information to be recorded. We can discuss how to manage this further.
- You can change your mind and withdraw your consent to participate in the service referral process at any time. However, this will mean the assessor cannot issue further service referrals. You will need to arrange your own aged care services.
- You are agreeing to select one (or more) of three ways to send a My Aged Care service referral to the provider:
  1. **Referral code:** The assessor will give you a referral code/s to take to your chosen provider. The provider will enter your referral code into My Aged Care and will be able to see your information and accept your referral. [Please do not disclose your referral code to a provider until you are ready to engage their service/s as your provider of choice.]
  2. **Sequential:** The assessor will send your referral to your chosen provider/s in the order of your preference. You can limit your preference to one or more providers. If your first preference is not available, the referral is automatically sent to your next preference.
  3. **Broadcast:** The assessor will send your referral to all available providers. In agreeing to a broadcast referral, multiple providers could contact you to see if they can provide you with the service/s. If a provider accepts your referral, the other provider/s will no longer see your information.
- You can view the privacy notice which is set out at [privacy notice web address](#) as well as the My Aged Care privacy policy on the My Aged Care website at [myagedcare.gov.au](#) for more information on how we handle your personal information.
- Do we have your consent to refer David ATTENBOROUGH to one or more service providers?
- Do we have your consent to upload the support plan of David ATTENBOROUGH to their My Health Record?

### Consent to service referrals

Consent obtained from \*

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

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

No  Yes

Consent decision by \*

Comments:

CONTINUE

CANCEL

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

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

**Consent to service referrals**

Consent obtained from \*

Select one

Select one

The client

The client with support person

Consent was not given

The supporter guardian

5. Select **No** or **Yes** to **Consent to share Support Plan to My Health Record (MHR)**.

If consent is provided select **Yes**, choose who made the decision, and then select **CONTINUE**.

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

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

No  Yes

Consent decision by \*

Decision made by

Decision made by

Client

Supporter Guardian

0 / 255

**CONTINUE** CANCEL

If consent has not been provided, select **No**. Choose who made the decision, then select a reason for the decision not to provide consent from the drop-down menu. Select **CONTINUE**.

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

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

No  Yes

Consent decision by \*

Please select a valid response from consent decision by

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

0 / 255

**CONTINUE** CANCEL

6. If the consent decision has been made by a Supporter guardian, then the Supporter guardian's **first name** must be entered before selecting **CONTINUE**. Optionally the **last name** and any **comments** can be entered.

Consent decision by \*  
Supporter Guardian

Supporter Details

First name: \*  
Last name:

Comments:  
0 / 255

CONTINUE CANCEL

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

! Once the IAT has been finalised it cannot be edited unless the Assessment Delegate returns the IAT for an assessor to make an amendment. Therefore, it is important to ensure all information has been correctly captured before selecting **FINALISE IAT**.

For more information about assessments returned to the assessor from the delegate, refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#).

## Finalise IAT and go to support plan

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

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

FINALISE IAT

TAKE ME BACK TO THE ASSESSMENT

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

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

9. You will then be re-directed to the client's **Support plan and services** page to complete the client's support plan.

If the client consented to sharing their support plan via their My Health Record, a green banner will display at the bottom of the **Support plan and services** page if this was successfully linked.

**Support plan and services**

GO TO THE ASSESSMENT   FLAG AS END-OF-LIFE   HOME SUPPORT ASSESSMENT 21 MAY 2026   PRINT COPY OF SUPPORT PLAN

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

**Assessment summary**

PRE-POPULATE FROM ASSESSMENT   EDIT

**Latest completed support plan review**

No completed review found

**Functional needs**

Transport

**Other considerations**

Health conditions  
Home safety  
Sensory concerns  
HM consideration - Home and Personal Safety  
Client is living in a rural or remote area.

**Complexity indicators**

No complexity indicators found

COMPLETE SUPPORT PLAN   RETURN TO CLIENT

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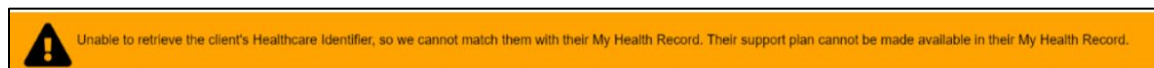
Consents for Service Referrals and My Health Record were updated successfully.

Australian Government  
Department of Health and Aged Care   myagedcare

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



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



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

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

Mr David **ATTENBOROUGH**  
Male, 100 years old, 8 May 1926, AC74234634

Primary contact: David Attenborough (self)  
No support relationships recorded

**Support plan and services**

GO TO THE ASSESSMENT   FLAG AS END-OF-LIFE   HOME SUPPORT ASSESSMENT 21 MAY 2026   PRINT COPY OF SUPPORT PLAN

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

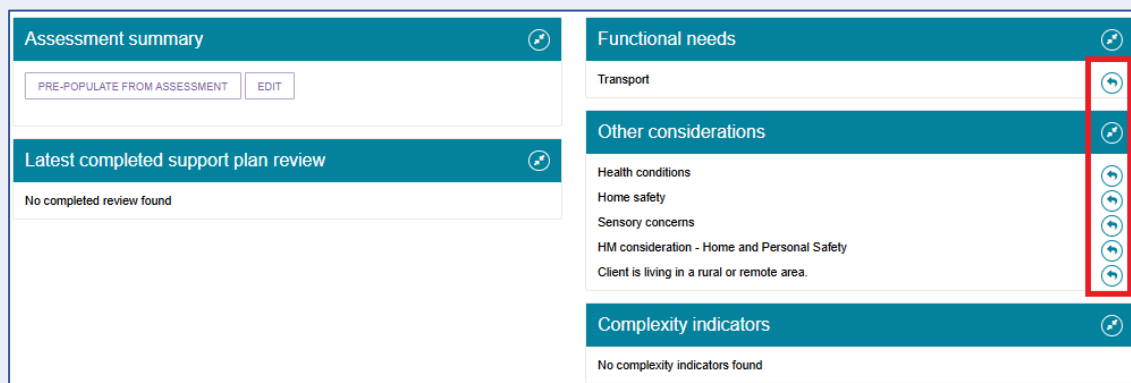
**Assessment summary**

PRE-POPULATE FROM ASSESSMENT   EDIT

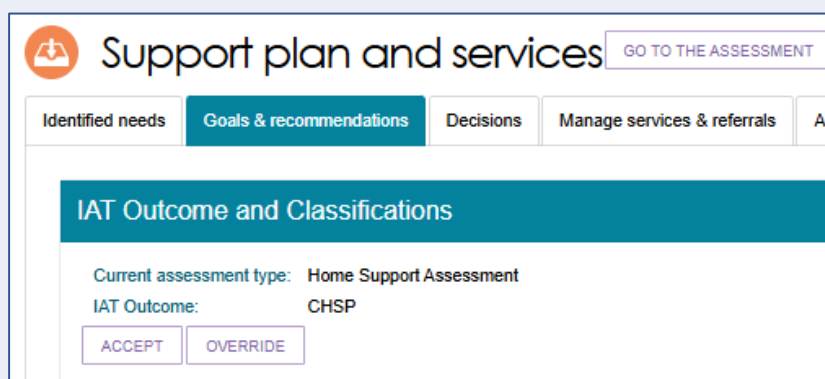
**Functional needs**

Transport

11. You can also re-open the **Functional needs**, **other considerations**, and **complexity indicators** from the Support plan and Services page by selecting the return arrow. Any Assistive technology (AT) and/or Home modifications (HM) considerations that were identified by the assessor during the assessment will also be listed here.

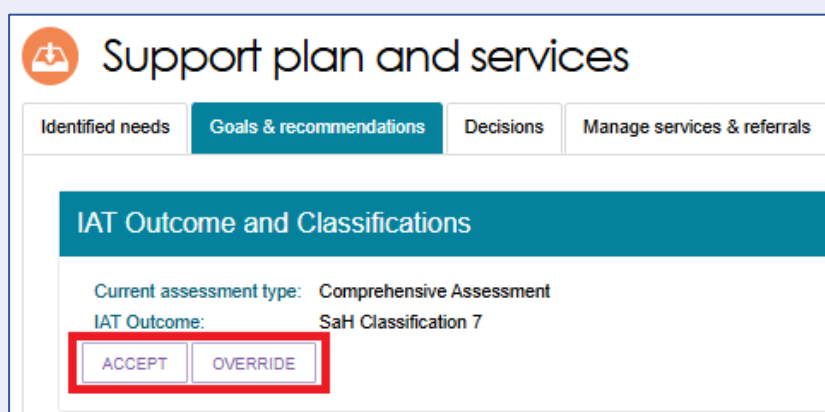


12. The IAT outcome will be displayed in the **GOALS AND RECOMMENDATIONS** tab.



### Accepting or Overriding an Assessment

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

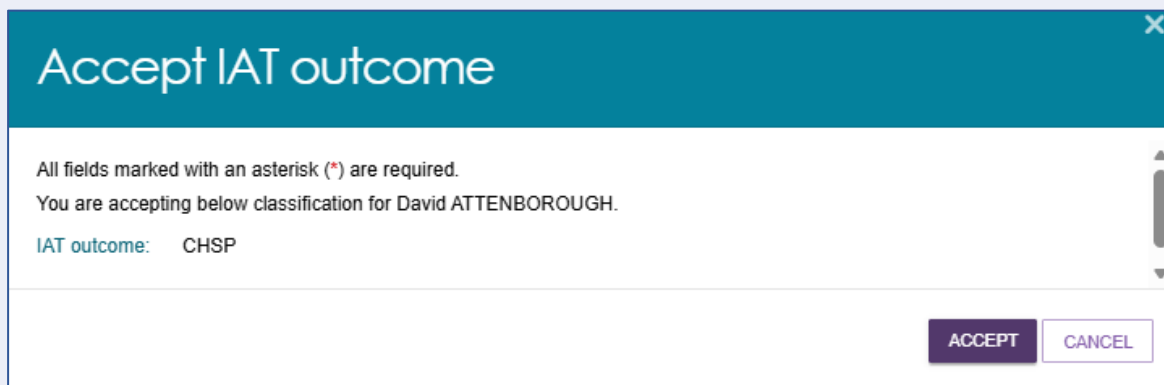


! The IAT will allow an ongoing Support at Home Classification to be overridden to a different ongoing classification level. However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs.

An ongoing SaH classification outcome cannot be overridden to an ongoing lower or higher SaH classification outcome (in line with section 81-10 of the Aged Care Rules).

## Accepting IAT Outcome

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

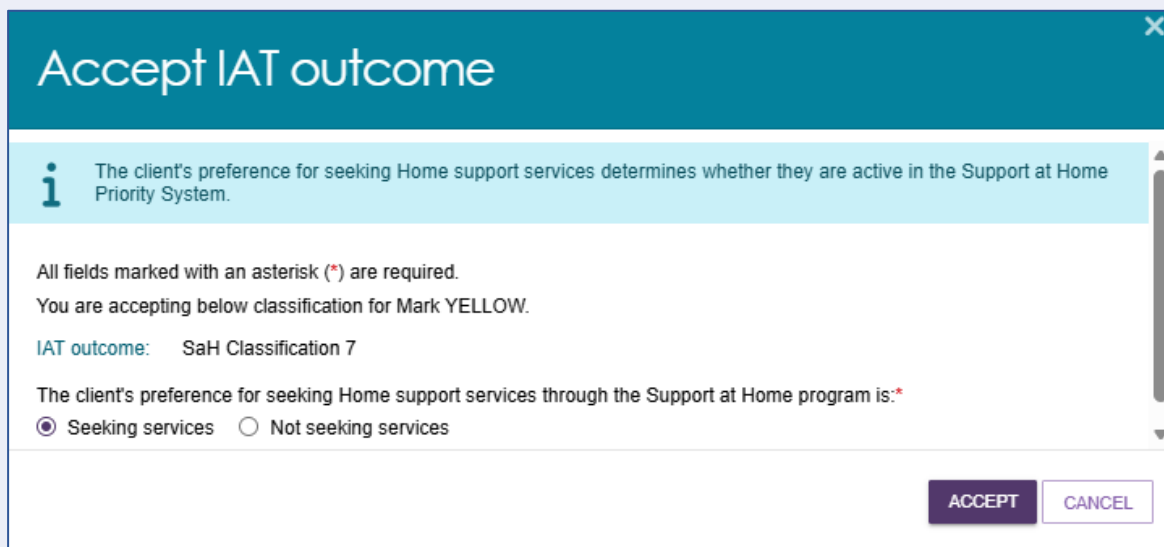


The screenshot shows a pop-up window titled "Accept IAT outcome" with a close button (X) in the top right corner. The window contains the following text: "All fields marked with an asterisk (\*) are required." followed by "You are accepting below classification for David ATTENBOROUGH." Below this, it says "IAT outcome: CHSP". At the bottom right, there are two buttons: "ACCEPT" (highlighted in purple) and "CANCEL".

If the client receives a **Support at Home (SaH) classification**, an information banner appears: 'The client's preference for seeking Home support services determines whether they are active in the Support at Home Priority System'.

You will also be asked to select whether the client's preference for seeking Home support services through the Support at Home program is **Seeking services** or **Not seeking services**.

If they seek Home support services, select **Seeking Services**, then select **ACCEPT**.



The screenshot shows a pop-up window titled "Accept IAT outcome" with a close button (X) in the top right corner. It features an information banner at the top: "The client's preference for seeking Home support services determines whether they are active in the Support at Home Priority System." Below the banner, it says "All fields marked with an asterisk (\*) are required." followed by "You are accepting below classification for Mark YELLOW." Below this, it says "IAT outcome: SaH Classification 7". Then, it asks "The client's preference for seeking Home support services through the Support at Home program is:" with two radio button options: "Seeking services" (which is selected) and "Not seeking services". At the bottom right, there are two buttons: "ACCEPT" (highlighted in purple) and "CANCEL".

If the client receives a **Support at Home (SaH) classification** and is not seeking Home support services, select **Not seeking services**. Then select a reason at the drop down:

- Deceased
- Care needs reduced
- Permanent residential care
- Other care arrangements
- Means testing
- Does not want Restorative care
- Did not wish to specify
- Returned mail
- Other. Please specify

## Accept IAT outcome



The client's preference for seeking Home support services determines whether they are active in the Support at Home Priority System.



The client is no longer seeking services. On save, any existing request(s) for Home support services will be removed.

On approval of this recommendation, no Home support services will be requested. If Home support services are required, you must change the client's Home support services preference to seeking services.

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

You are accepting below classification for Mark YELLOW.

IAT outcome: SaH Classification 7

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

Seeking services  Not seeking services

What is the reason for not seeking Home support services preference? \*

Select one

Select one

Deceased

Care Needs Reduced

Permanent Residential Care

Other Care Arrangements

Means Testing

Does not want Restorative Care

Did Not Wish to Specify

Returned Mail

Other. Please Specify

ACCEPT

CANCEL

If **Other. Please specify** is selected, enter the reason in the text box below.

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

Seeking services  Not seeking services

What is the reason for not seeking Home support services preference? \*

Other. Please Specify

Please specify \*

Other reason for not seeking Home support services here

Finally, select **ACCEPT**.

The client will have any existing requests for Home support services removed, and no Home support services requested.



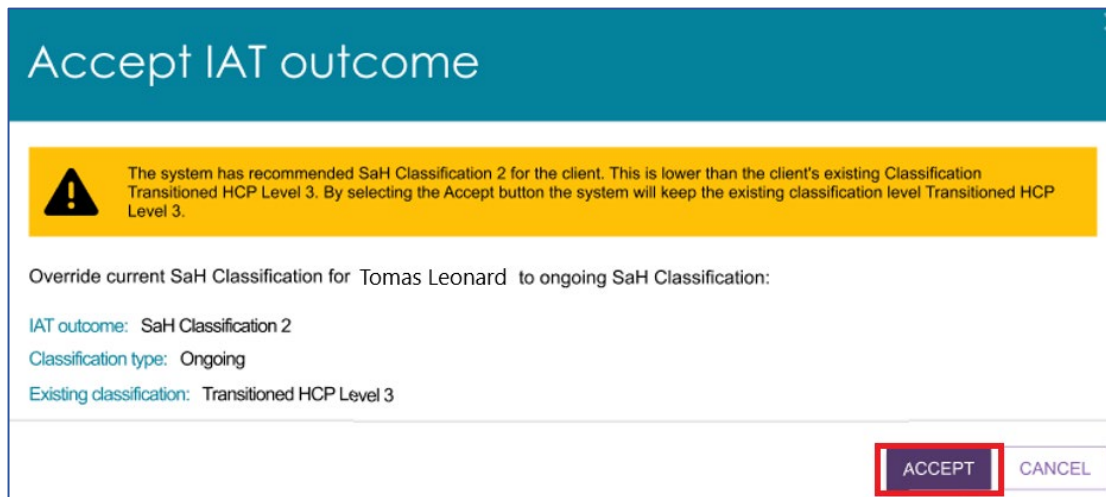
The client is no longer seeking services. On save, any existing request(s) for Home support services will be removed.

On approval of this recommendation, no Home support services will be requested. If Home support services are required, you must change the client's Home support services preference to seeking services.



## ! Transitioned Home Care Package (HCP) clients

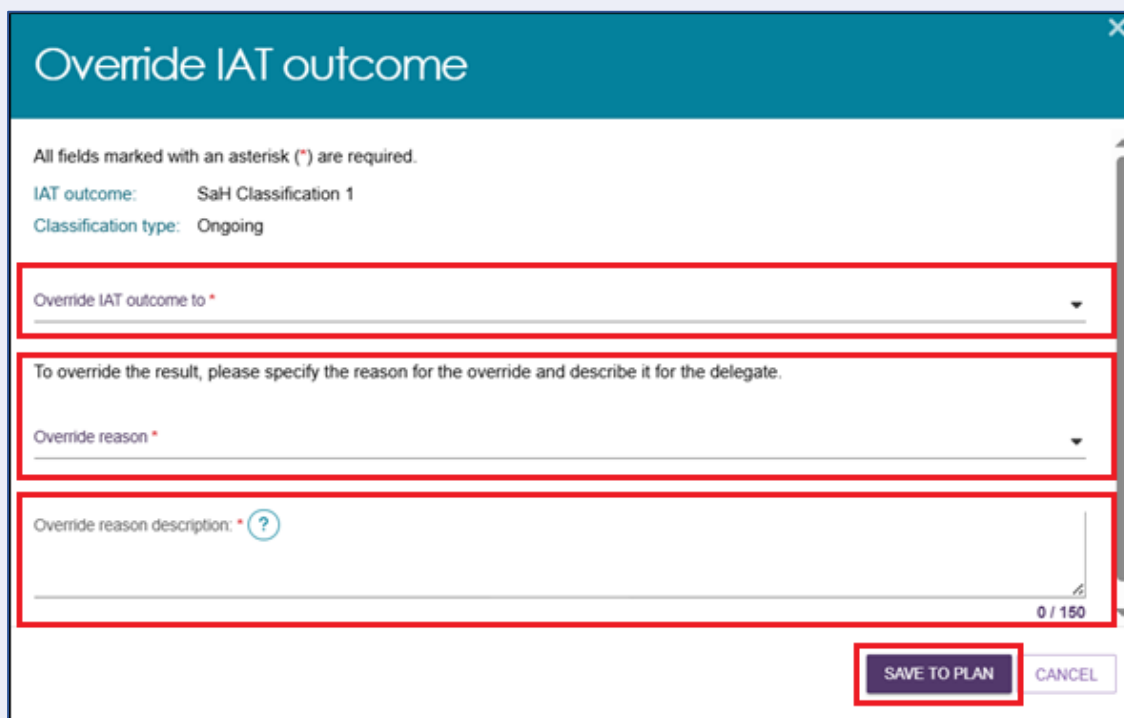
When completing a reassessment for a Transitioned client, if the IAT (Integrated Assessment Tool) outcome recommends a classification of **Transitioned HCP Level 1-4** a warning message will appear in the **Accept IAT Outcome** screen.



The screenshot shows a window titled "Accept IAT outcome". At the top, there is a yellow warning banner with a black exclamation mark icon. The text in the banner reads: "The system has recommended SaH Classification 2 for the client. This is lower than the client's existing Classification Transitioned HCP Level 3. By selecting the Accept button the system will keep the existing classification level Transitioned HCP Level 3." Below the banner, the text says "Override current SaH Classification for Tomas Leonard to ongoing SaH Classification:". Underneath, there are three lines of information: "IAT outcome: SaH Classification 2", "Classification type: Ongoing", and "Existing classification: Transitioned HCP Level 3". At the bottom right, there are two buttons: "ACCEPT" (highlighted with a red box) and "CANCEL".

## Overriding IAT Outcome

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



The screenshot shows a pop-up window titled "Override IAT outcome". At the top left, it says "All fields marked with an asterisk (\*) are required." Below this, there are two lines of information: "IAT outcome: SaH Classification 1" and "Classification type: Ongoing". There are three main input fields, each highlighted with a red box: 1. "Override IAT outcome to \*" is a dropdown menu. 2. "Override reason \*" is a dropdown menu with the instruction "To override the result, please specify the reason for the override and describe it for the delegate." above it. 3. "Override reason description: \*" is a text area with a question mark icon and a character count "0 / 150" at the bottom right. At the bottom right, there are two buttons: "SAVE TO PLAN" (highlighted with a red box) and "CANCEL".

If the recommended classification is Support at Home Classification, End of Life or a Residential Care Program you will be navigated to the **Add Home support services** page to then select on the services you wish to accept or override. Refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#) for information on how to add Home support services.

## ! Legislation and Overriding IAT Outcomes

In line with legislation, you are not permitted to:

- recommend a different ongoing Home Support classification level.
- override 'Ineligible for CHSP/SaH' to any ongoing Home Support services.

You are permitted to recommend short-term pathways and Residential Care according to the rules of the [My Aged Care Assessment Manual](#).

### Recommending ongoing Home Support services via Support at Home or CHSP

- Ensure the recommended classification aligns with the IAT outcome.
- If after an IAT review, the IAT outcome shows a lower classification than the client's current classification, ensure the recommended classification is equivalent to the client's existing classification.



In line with legislation, you are not permitted to override the IAT Outcome to recommend a different ongoing home support classification level (e.g., CHSP or SaH class 1-8) nor can you override the IAT Outcome of 'ineligible for CHSP/SaH' to recommend ongoing home support services. If your intent is to recommend ongoing home support services through Support at Home or CHSP, please ensure the recommended classification aligns with the IAT outcome. You can override the IAT outcome to recommend other care types, such as short-term pathways and residential care, in line with guidance provided in the Aged Care Assessment Manual.

Note: If through the IAT review process, the IAT outcome results in a lower classification than the client's current existing classification, please ensure the Recommended Classification is equivalent to the client's existing Classification level when recommending ongoing home support services through Support at Home or CHSP.

## Recommending SaH Restorative Care Pathway

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

When you override the IAT outcome to SaH Restorative Care Pathway (RCP), the Assistive technology **AT Medium** and Home modifications **HM Medium** classifications are also automatically added, and you can edit or remove these recommendations if needed.



Adding SaH Restorative Care Pathway automatically includes AT Medium and HM Medium. You can edit or remove these recommendations if needed.

Overriding to RCP means that there may be some recommendations removed so you will need to add these services again.



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.

1. Select 'SaH Restorative Care Pathway' at the **Override IAT Outcome to** drop-down.
2. Select an override reason at the **Override reason** drop-down

The override reasons available for this pathway are:

- Has restorative care goals
- Delay/prevent ongoing services
- Needs early intervention care
- Other.

## Override IAT outcome ✕

**i** Adding SaH Restorative Care Pathway automatically includes AT Medium and HM Medium. You can edit or remove these recommendations if needed.

**!** 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.

**!** In line with legislation, you are not permitted to override the IAT Outcome to recommend a different ongoing home support classification level (e.g., CHSP or SaH class 1-8) nor can you override the IAT Outcome of 'ineligible for CHSP/SaH' to recommend ongoing home support services. If your intent is to recommend ongoing home support services through Support at Home or CHSP, please ensure the recommended classification aligns with the IAT outcome. You can override the IAT outcome to recommend other care types, such as short-term pathways and residential care, in line with guidance provided in the Aged Care Assessment Manual.

Note: If through the IAT review process, the IAT outcome results in a lower classification than the client's current existing classification, please ensure the Recommended Classification is equivalent to the client's existing Classification level when recommending ongoing home support services through Support at Home or CHSP.

**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 \*  
 Please select...

Please select...

Has restorative care goals

Delay/prevent ongoing services

Needs early intervention care

Other

SAVE TO PLAN
CANCEL

3. Enter the override reason description in the text box below the drop-down.

Override reason \*  
 Other

---

Override reason description: \* ?  
 Override reason description

28 / 150

4. Finally, select **SAVE TO PLAN**.

### ! Recommending RCP From Ongoing SaH Classification only

The IAT also allows a CHSP classification to be overridden to RCP during a comprehensive assessment. However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs.

Where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules).

An ongoing SaH classification must be generated to override and recommend RCP for approval.

### Overriding for transitioned clients undergoing reassessment

For transitioned clients undergoing reassessment:

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

### Overriding to the SaH End-of-life Pathway

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

**Assistive technology (AT) Medium** will automatically be selected as well.

The screenshot shows the 'Support plan and services' interface. At the top, there is a navigation bar with tabs: 'Identified needs', 'Goals & recommendations' (selected), 'Decisions', 'Manage services & referrals', 'Associated People', and 'Review'. A 'GO TO THE ASSESSMENT' button is in the top right. Below the tabs is a section titled 'IAT Outcome and Classifications'. It displays the following information:

Current assessment type:	Comprehensive Assessment
IAT Outcome:	SaH Classification 2
Recommended classification:	SaH End-of-Life Pathway
	AT Medium
Override reason:	Higher level service needs
Override reason description:	EOL

### Converting to Comprehensive Assessment

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

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

Mr David ATTENBOROUGH  
Male, 100 years old, 8 May 1926, AC74234634

Primary contact: David Attenborough (self)  
No support relationships recorded

## Support plan and services

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

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

### IAT Outcome and Classifications

Current assessment type: Home Support Assessment  
IAT Outcome: CHSP

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

## Convert to comprehensive assessment

You are about to convert the assessment type from Home Support to Comprehensive for David ATTENBOROUGH.

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

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

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

Reason for change \*  
**High level care needs**

Reason or comments: \*  
Enter reason or comments here

29 / 255

**YES, CONVERT ASSESSMENT**   NO, CANCEL

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

Mr David ATTENBOROUGH  
Male, 100 years old, 8 May 1926, AC74234634

Primary contact: David Attenborough (self)  
No support relationships recorded

## 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: CHSP

Accessibility   Privacy   Disclaimer   Terms of use  
Copyright © Commonwealth of Australia ABN: 61 609 000 000


Assessment type has been changed

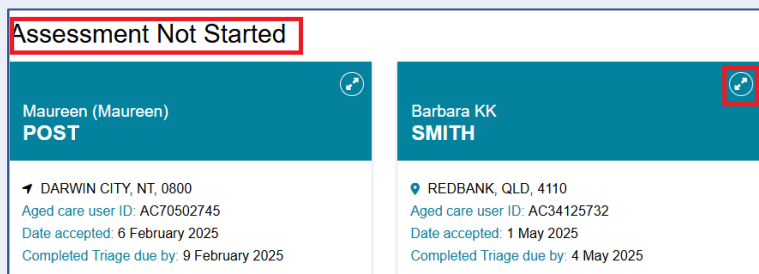
myagedcare

## Flagging an Assessment as End of Life

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

1. From the **CURRENT ASSESSMENTS** tab, under Assessment Not Started section select the

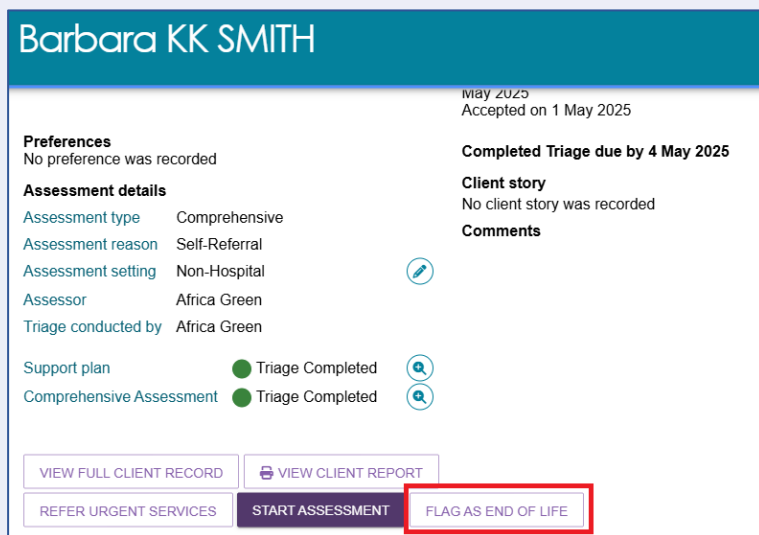
expand card icon  of the client to the flagged as End of Life.



**Assessment Not Started**

<b>Maureen (Maureen) POST</b> DARWIN CITY, NT, 0800 Aged care user ID: AC70502745 Date accepted: 6 February 2025 Completed Triage due by: 9 February 2025	<b>Barbara KK SMITH</b> REDBANK, QLD, 4110 Aged care user ID: AC34125732 Date accepted: 1 May 2025 Completed Triage due by: 4 May 2025
---	--

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



**Barbara KK SMITH**

may 2025  
Accepted on 1 May 2025

**Preferences**  
No preference was recorded

**Assessment details**

Assessment type	Comprehensive
Assessment reason	Self-Referral
Assessment setting	Non-Hospital
Assessor	Africa Green
Triage conducted by	Africa Green

**Support plan**

Support plan	Triage Completed
Comprehensive Assessment	Triage Completed

**Completed Triage due by 4 May 2025**

**Client story**  
No client story was recorded

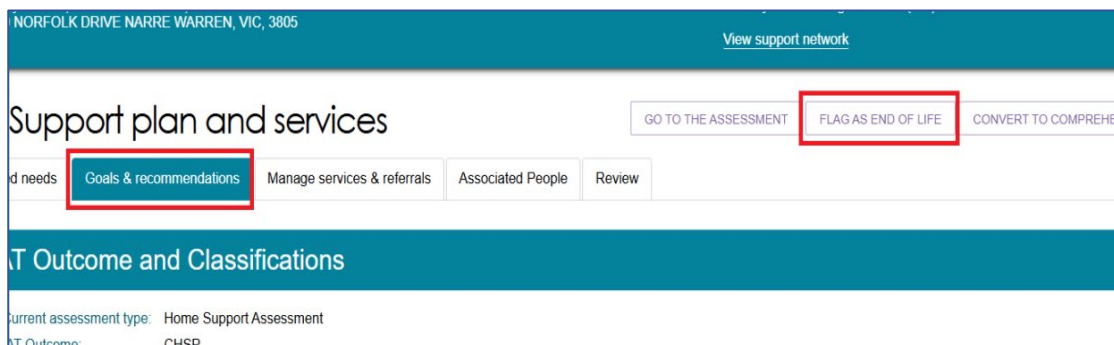
**Comments**

VIEW FULL CLIENT RECORD | VIEW CLIENT REPORT

REFER URGENT SERVICES | START ASSESSMENT | **FLAG AS END OF LIFE**

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

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



NORFOLK DRIVE NARRE WARREN, VIC, 3805

View support network

**Support plan and services**

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

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

**AT Outcome and Classifications**

Current assessment type: Home Support Assessment

AT Outcome: CHSP

3. A pop-up screen will open prompting **END OF LIFE VERIFICATION**.

Based on the documents verified, chose the relevant selection from the dropdown list.

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

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

End-of-Life form verification ?  
No selection made

No selection made  
Document reviewed - valid  
Document reviewed - pending  
Document reviewed - not valid

FLAG AS END OF LIFE CANCEL

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

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

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

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

Details

0 / 255

UPLOAD ATTACHMENT

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

FLAG AS END OF LIFE CANCEL

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

1 PRAISE STREET | WENTWORTHVILLE, NSW, 2145  
Aboriginal No support relationships recorded

Support plan and services

GO TO THE ASSESSMENT VERIFY END OF LIFE FORM PRINT

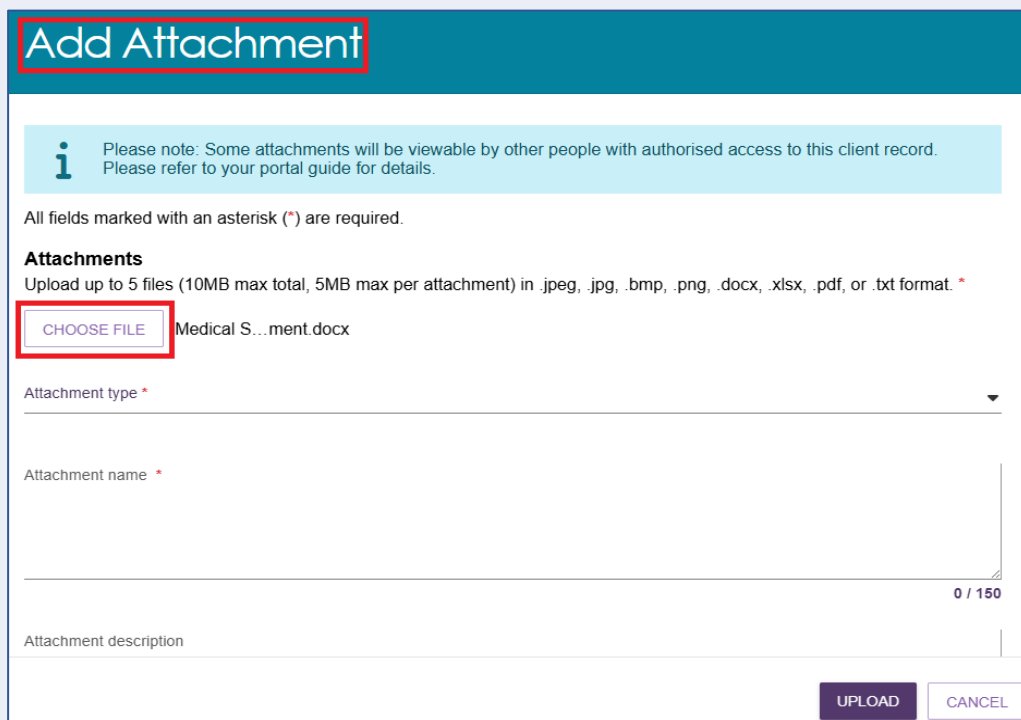
needs Goals & recommendations Decisions Manage services & referrals Associated People Review

Outcome and Classifications

Current assessment type: Comprehensive Assessment

5. A Pop-up screen **ADD ATTACHMENT** will appear to add the relevant documentation supporting the Client's diagnosis by a qualified medical professional.

Select **CHOOSE FILE** button to attach the documentations (Please ensure the document meets all the criteria described on the screen).



**Add Attachment**

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

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

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

**CHOOSE FILE** Medical S...ment.docx

Attachment type \*

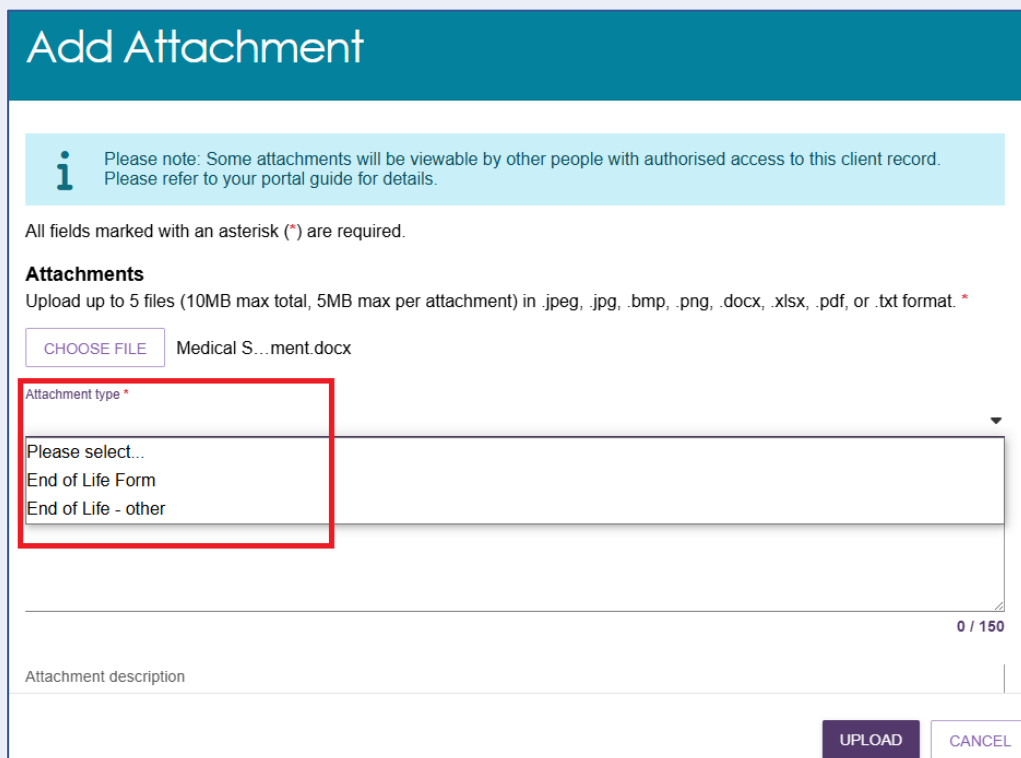
Attachment name \*

0 / 150

Attachment description

**UPLOAD** **CANCEL**

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



**Add Attachment**

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

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

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

**CHOOSE FILE** Medical S...ment.docx

Attachment type \*

Please select...

End of Life Form

End of Life - other

0 / 150

Attachment description

**UPLOAD** **CANCEL**

## 7. Select **UPLOAD**

### Add Attachment

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

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

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

Medical S...ment.docx

Attachment type \*  
End of Life Form

Attachment name \*  
Medical Diagnosis Report

24 / 150

Attachment description

## 8. A pop-up screen will appear with the document attached.

To attach more documentation, select **UPLOAD ATTACHMENT** (up to 5 files can be attached. Please ensure the attachments meets all the required criteria).

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

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

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

Details

0 / 255

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


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



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

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

Referrals flagged for the End of Life pathway are given high priority.



End-of-Life form verification   
Document reviewed - valid

Details

0 / 255

UPLOAD ATTACHMENT

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


EoL verification document (End of Life Form) [docx 89.99KB]	16 May 2025	
Medical Diagnosis Report (End of Life Form) [docx 68.49KB]	16 May 2025	

FLAG AS END OF LIFE CANCEL

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


### Started



745  
025  
February 2025



 96 days overdue


Medium

#### Barbara KK SMITH

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

 Comprehensive  12 days overdue

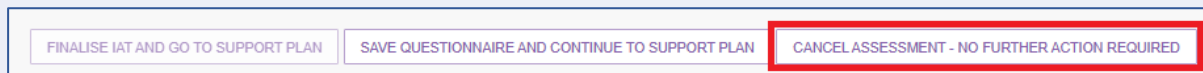
Assessment Not Started  High 

 More information on flagging a referral as End of Life can be found in [Assessor Portal – User Guide 7 – Completing a support plan and support plan review](#).

## Cancelling an assessment

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

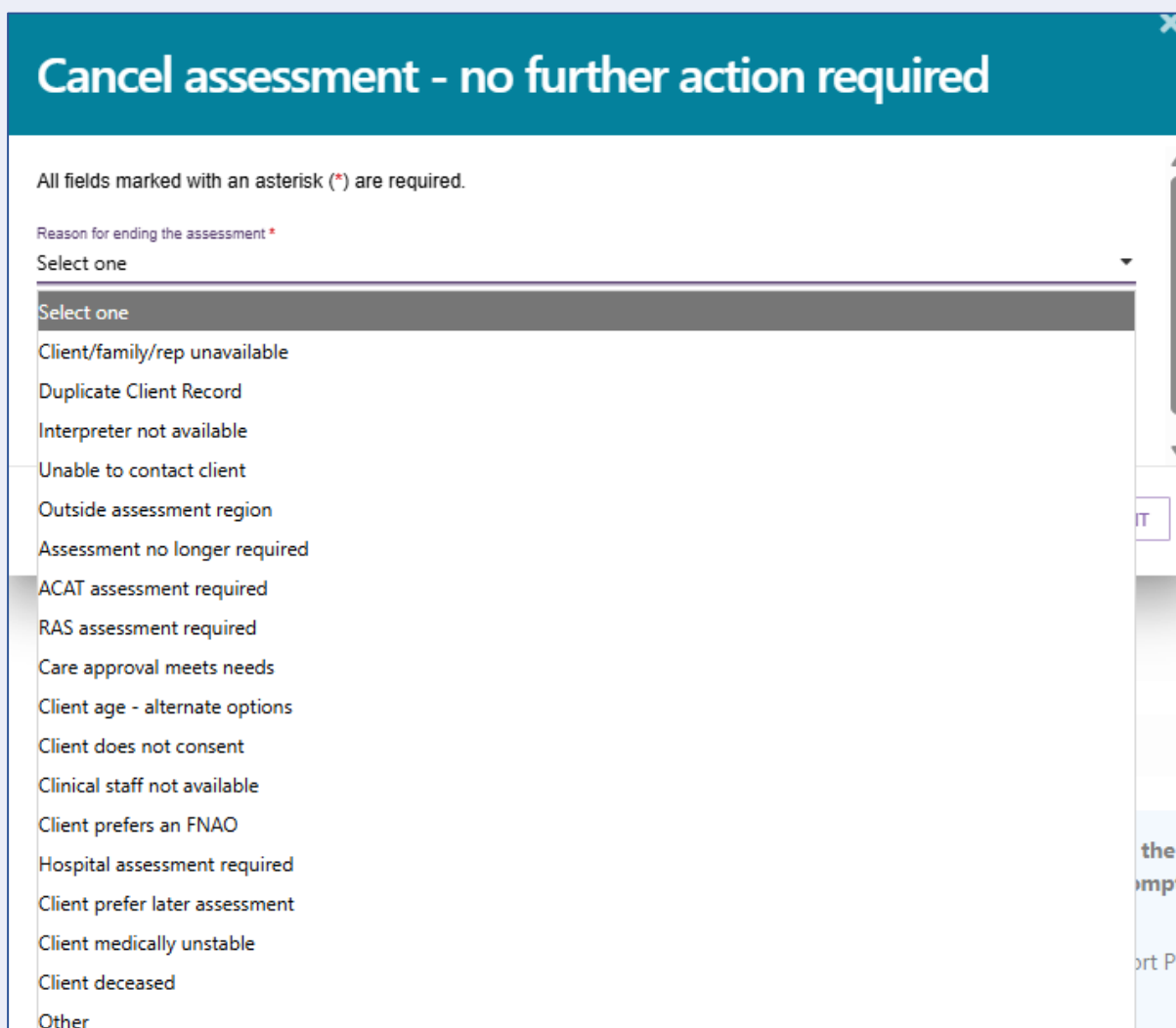
1. To cancel an assessment, Select **CANCEL ASSESSMENT- NO FURTHER ACTION REQUIRED** at the bottom of the assessment page.



A screenshot of the assessment page showing three buttons at the bottom. The buttons are: 'FINALISE IAT AND GO TO SUPPORT PLAN', 'SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN', and 'CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED'. The third button is highlighted with a red border.

2. Select the reason for cancelling the assessment at the **Reason for ending the assessment** drop-down.

If you select **Client deceased**, go to Step 4.



A screenshot of the 'Cancel assessment - no further action required' form. The form has a teal header with the title 'Cancel assessment - no further action required'. Below the header, it says 'All fields marked with an asterisk (\*) are required.' The main section is titled 'Reason for ending the assessment \*' and 'Select one'. A dropdown menu is open, showing a list of reasons: 'Select one', 'Client/family/rep unavailable', 'Duplicate Client Record', 'Interpreter not available', 'Unable to contact client', 'Outside assessment region', 'Assessment no longer required', 'ACAT assessment required', 'RAS assessment required', 'Care approval meets needs', 'Client age - alternate options', 'Client does not consent', 'Clinical staff not available', 'Client prefers an FNAO', 'Hospital assessment required', 'Client prefer later assessment', 'Client medically unstable', 'Client deceased', and 'Other'. The 'Client deceased' option is highlighted.

3. Enter comments for the reason for ending the assessment. Then, select **CANCEL ASSESSMENT**.

**Cancel assessment - no further action required**

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

Reason for ending the assessment \*  
Assessment no longer required

Comment: \*  
Comment here

12 / 200

**CANCEL ASSESSMENT** TAKE ME BACK TO THE ASSESSMENT

4. If you cancel an assessment because a client is deceased, you will need to enter the following information, then select **CANCEL ASSESSMENT**:
- Who, when and how were you informed that this person is deceased. For example, “Mrs. Smith rang to inform us that Mr. Smith has passed away on Saturday.”
  - Date of Death (if known)
  - Any Attachments such as Death Certificate, Hospital Discharge documents.

**Cancel assessment - no further action required**

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

Reason for ending the assessment \*  
Client deceased

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

Please supply the following information:

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

0 / 500

Date of death (if known) ?

dd/mm/yyyy

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

Choose a file...

Comment: \*

0 / 200

**CANCEL ASSESSMENT** TAKE ME BACK TO THE ASSESSMENT

! Cancelling an assessment with the reason of **Client deceased** will change the client's status to **Deceased** and make the client record read-only.

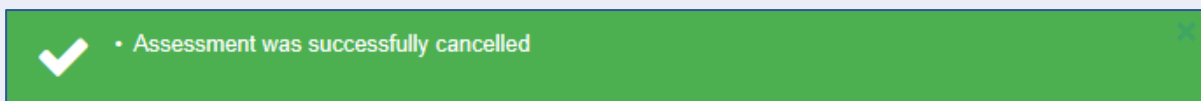
Any unaccepted service referrals will be recalled, services in place will be ceased and the client's access to the client portal will be revoked.

My Aged Care will not send correspondence to the client or their supporters after the status is changed to **Deceased**.

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

5. A confirmation message will be displayed on screen that the assessment has been cancelled.

You will then be taken to the Client summary page which will confirm the cancelled status.



6. After cancelling an assessment, the client information will appear in the assessor's recent assessments tab.

Assessors will still be able to search for the client using the Find a client functionality.

Recent assessments Currently viewing ABC Outlet

Current assessments **Recent assessments**

CARD LIST

Filter by

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

Current sort order is Assessment Priority 1 to 21 out of 21 matching results

**Assessment Cancelled**

Client Name	Location	Assessment Status	Priority
Maple MAY	JERRABOMBERRA, NSW, 2619	Assessment Cancelled	High
Micah TURNER	JERRABOMBERRA, NSW, 2619	Assessment Cancelled	Low
Gideon (Misti) LUSTER YALA DATA	MANGO HILL, QLD, 4509	Assessment Cancelled	Low