Australian Government
Department of Health, Disability and Ageing

Aged Care Assessment Manual

Version 8.2

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IMPORTANT

The *Aged Care Act 2024* governs the delivery of funded aged care services by registered providers. The information in this manual helps assessment teams to understand the laws around the government-funded aged care system and specifies mandatory and best practice guidance for aged care needs assessment teams to deliver high-quality assessment services.

Parts of this manual summarise multiple legal documents in accessible, simple language, so it doesn't contain every detail of the law. It is not intended as legal or professional advice on interpretation of the legislation or how it applies in individual circumstances.

Additional information and resources that may further support you to understand your responsibilities and obligations are available through the following Australian Government resources:

- Department of Health, Disability and Ageing https://www.health.gov.au
- My Aged Care www.myagedcare.gov.au
- Aged Care Quality and Safety Commission www.agedcarequality.gov.au
- Services Australia http://www.servicesaustralia.gov.au

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Document purpose

This Aged Care Assessment Manual specifies mandatory and best practice guidance for aged care needs assessment teams including assessors, team leaders, triage delegates and assessment delegates. To achieve the delivery of high-quality assessment services, assessment organisations are required to follow the guidance in this manual in the assessment of older people's support and aged care needs and eligibility for government funded aged care services under the *Aged Care Act 2024* (Cth).

In addition to the guidance in this manual, assessors are expected to also use the Aged Care Assessment Quality Framework to deliver a high-quality assessment experience and service for every older person. All assessors, delegates and team leaders are also required to complete the mandatory training outlined in the My Aged Care Workforce Learning Strategy.

The Department of Health, Disability and Ageing will regularly review and update this Manual as required to ensure it remains up to date in the context of system changes and enhancements to the My Aged Care operating model.

Guidance for undertaking residential aged care (RAC) funding assessments is provided in the Australian National Aged Care Classification (AN-ACC) RAC Funding Assessor Training Manual.

Key sources of information to complement this manual include:

- IAT User Guide
- Aged Care Assessment Quality Framework
- Aged Care Act 2024
- Aged Care Rules 2025
- My Aged Care website
- Fact sheets for Assessors
- My Aged Care Assessor Portal resources
- My Aged Care Workforce Learning Strategy
- Assessment Hub SharePoint Site
- Support at Home Program Manual
- Commonwealth Home Support Program (CHSP) Manual 2025-2027
- Multi-Purpose Service Program (MPSP) Fact Sheets
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) Manual
- Aboriginal and Torres Strait Islander Aged Care Framework
- Support at Home Assistive Technology and Home Modifications (AT-HM) scheme Fact Sheet
- Transition Care Program (TCP) Guidelines
- Support at Home Pricing Resources

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Terminology

Throughout this document:

- The terms 'individual,' 'older person', ‘client’, ‘care recipient’ and 'participant' are used interchangeably to refer to a person who meets the eligibility criteria for an aged care assessment and government funded aged care services under the *Aged Care Act 2024 (the Act)*.
- The term ‘reassessment’ is used throughout this document to describe an assessment that occurs after an older person has already been assessed at least once.
- The terms ‘provider’ or ‘service provider’ are used throughout this document to refer to a ‘registered provider’ as outlined in the *Act*.
- The term ‘assessor’ or ‘needs assessor’ are used interchangeably throughout this document to refer to a person who conducts aged care assessments, for home support and comprehensive assessments.

This symbol displays throughout the document and denotes significant change in information and the assessment process from version 8.1 of the Aged Care Assessment Manual.

This symbol displays where there are links to further information and resources.

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Document Structure

Chapter	What you'll find in this chapter	Key Changes from v8.1 to v8.2
Chapter 1 Aged Care Act 2024	Key concepts under the *Aged Care Act 2024* that are important to understand. Eligibility requirements to access aged care services • Service list and structure under *Aged Care Rules 2025* • Approvals under *Aged Care Act 2024* • Transition arrangements	• Removal of instructions to assessors to self-refer and reassess STRC clients for a second unit of RCP funding. System functionality now exists to use the SPR pathway. • Eligibility considerations for people aged between 50-64 experiencing homelessness or risk of homelessness • Inclusion of definitions of homelessness and at risk of homelessness
Chapter 2 Overview of My Aged Care and Single Assessment System	Provides information about My Aged Care and the Single Assessment System including: • Introduction of pilot of Aboriginal and Torres Strait Islander Assessment Organisations from August 2025 • Assessment Organisation roles and responsibilities • Assessment types • The Integrated Assessment Tool (IAT)	• Additional information on delivering culturally safe assessments. • Updated table to include more information about the Validated Assessment Tools
Chapter 3 Referral, Registration and Screening	Details the referral, registration and screening stages of the assessment journey. Information includes: • Registered supporters • Entry into My Aged Care • Registering with my aged care • Screening • Alternative entry (urgent services pathway) • Application for Care form	• New information about support decision making • New information about exceptional circumstances and approving a service without an assessment.

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Chapter	What you'll find in this chapter	Key Changes from v8.1 to v8.2
Chapter 4 Referral for Assessment	Details the assessment referral process in the My Aged Care assessor portal including: • Managing and actioning referrals and assigning referral priority, • Managing preference for Aboriginal and Torres Strait Islander assessments • Explaining how priority categories are assigned to different assessments including Home Support, Comprehensive and Hospital Assessments • Using the End-of-Life Pathway 'high priority' referrals in the system • Explaining how assessors can self-refer for eligible and (likely) ineligible individuals. • SPRs and reassessment requests	• End-of-Life Pathway (EoL) – information about identification of urgent EoL Support Plan Reviews for team leaders
Chapter 5 Assessment Activities	Includes important information about how to undertake an aged care needs assessment and complete a support plan for an older person. This chapter includes: • Consent for triage and assessment • Triaging Assessments and Triage Delegate role • Triage for SPRs • Revocation of Eligibility • Undertaking a needs assessment using the IAT • Assessment settings • Clinical attendance • IAT outcome • Recommending service types and services • Converting a home support assessment to comprehensive • Support Plan	• Eligibility considerations for people aged between 50-64 experiencing homelessness or risk of homelessness • Additional information about obtaining consent for people being triaged for a reassessment after a support plan review • End-of-Life (EoL) Pathway – information about submission of EoL Pathway Forms for individuals undergoing telehealth assessments • Additional advice about assessing a person who is not in their usual accommodation setting • Additional information about building rapport and trust with older Aboriginal and Torres Strait islander people • Revised guidance on undertaking an assessment including tools and techniques for assessing an older person and recording assessment information

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Chapter	What you'll find in this chapter	Key Changes from v8.1 to v8.2
	• Wellness & Reablement • Linking Supports • Assessment wrap-up	• Updated information for Aboriginal and Torres Strait Islander Assessment Organisations • New criteria to determine whether an older person needs urgent service provision, which relates to requiring care to enable discharge from hospital • Updated information and guidance on the IAT Outcome • Additional guidance for recording concerns, goals and recommendations • Additional guidance on converting a home support assessment to a comprehensive assessment. • Updated guidance on completing the assessment summary • Updated information on dementia specific information and supports
Chapter 6 Aged Care Programs	Includes important information about the aged care programs recommended by assessors to meet an older person's needs and goals.	• New information on Support at Home funding and finding a provider • CHSP – minor clarifications relating to eligibility, hoarding and squalor and CHSP interaction with AT-HM; inclusion of information relating to grandfathered CHSP clients; and inclusion of a fifth CHSP support that can be assessed alongside Support at Home (section 6.5) changes…. • RCP – call out box advising RCP should not be recommended for individuals in hospital • RCP – removed information about approvals of ongoing Support at Home classifications ceasing active RCP episodes • End-of-Life (EoL) Pathway – additional information about submission of EoL Pathway Forms for individuals undergoing telehealth assessments • New information about when CHSP AT and/or HM can be accessed while waiting for AT-HM scheme funding • Substantive changes to CHSP section. • Updated information on accessing ongoing home support services alongside TCP

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Chapter	What you'll find in this chapter	Key Changes from v8.1 to v8.2
		• Additional information on exiting residential care
Chapter 7 Delegations and approvals under the Act	Includes information about: • The powers under the Aged Care Act 2024 that are delegated to Triage Delegates and Clinical and Non-Clinical Assessment Delegates. • How approvals work under the *Aged Care Act 2024*, and the decisions that delegates make.	• Updated wording for potential applicable reasons under section 67
Chapter 8 Delegate decisions in practice	Includes guidance for assessment delegates covering: • How to make sound, evidence-based decisions • step-by-step processes for approving aged care services across the service groups • Other approvals (including giving approvals after a service has commenced and approving a service without an assessment).	• RCP – removed information about approvals of ongoing Support at Home classifications ceasing active RCP episodes • Text removed about an offline Notice of Decision for CHSP approvals- this can now be generated on system.
Chapter 9 Finalising the Assessment and Service Referral	Includes guidance about: • Finalising the assessment • Recording and communicating the assessment outcome • Referring the older person for services, • The single provider model for Support at Home (which includes a single referral code for all services/pathways) • Completing the Notice of Decision (approval/non-approval letter).	Substantial changes have been made to this chapter. • CHSP – added information about generating service referrals for grandfathered CHSP clients with existing referrals • Updated information on generating a Notice of Decision. • CHSP – added information about generating service referrals for CHSP clients who accessed urgent CHSP services).
Chapter 10 SPRs and Reassessments	Includes guidance on the circumstances for conducting a support plan review (SPR) or a reassessment for each aged care program.	• RCP – removed information about approvals of ongoing Support at Home classifications ceasing active RCP episodes • RCP - removal of instructions to assessors to self-refer and reassess

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Chapter	What you'll find in this chapter	Key Changes from v8.1 to v8.2
		STRC clients for a second unit of RCP funding. System functionality now exists to use the SPR pathway. • Additional information about a person's position on the SaH priority queue when they are reassessed to a higher classification level while awaiting SaH funding.
Chapter 11 Reviewable Decisions, Revocations and Complaints	Provides information on assessment related reviewable decisions in accordance with the *Aged Care Act 2024*. It also details: • The Review of Decisions process • Options for reviews and revocations • The complaints process.	• New information on the role of Internal Decision Reviewer in relation to Support at Home Reviewable Decisions
Chapter 12 Supporting Diverse Experiences and Needs	Outlines the ways in which the aged care system supports an older person's diverse needs by ensuring they have access to person-centered aged care assessments and services. This includes valuing older people, their identities, cultures, abilities, diversity, beliefs and life experiences.	• Updated information about people living with dementia • Additional guidance about assessing older people in a prison setting
Chapter 13 Operating Procedures	Includes information on privacy, information management and relevant legislation. Also included in this chapter is information about: • Applying to be a delegate • Clinical governance • Separation of assessment services and delivery of aged care services • Information management and privacy under the *Aged Care Act 2024* • Framework for governance of Indigenous data • Branding	• Updated information on the Delegates on/off form for non-clinical assessment delegates • New information about Conflict of Interest in assessment delivery

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Chapter	What you'll find in this chapter	Key Changes from v8.1 to v8.2
	• Resources for consumers • Reporting and performance	
Chapter 14 Fees and Payments	Provides guidance on fees, payments and participant contributions for funded aged care services.	No substantive changes have been made to this chapter.
Appendices	Appendices include: • Glossary • Contact Details • Clinical Governance Guidance for Aged Care Needs Assessment Organisations • Clinical attendance • Wellness and Reablement • Restorative Care Case Studies • Aged Care Assessment Workforce Credentials • Case studies of individuals experiencing homelessness or at risk of homelessness	• Inclusion of case studies of individuals experiencing homelessness and being at risk of homelessness

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1. Chapter 1: Aged Care Act 2024

What you'll find in this chapter

This chapter introduces some key concepts under the *Aged Care Act 2024* (the Act) that are important to understand. They include:

- The structure of the Act
- Statement of Rights and Principles
- Dignity of Risk
- Eligibility requirements to access government funded aged care services
- Service List and structure under the *Aged Care Rules 2025*
- Transition Arrangements for 1 November 2025

1.1. About the Aged Care Act 2024

The *Aged Care Act 2024* (the Act) is rights-based legislation designed to put older people at the heart of the aged care system. It includes a Statement of Rights and a Statement of Principles to ensure the focus remains on the needs and well-being of older people. The Act provides a framework to deliver high-quality, safe, and respectful funded aged care services while empowering those who receive them.

The Act upholds these rights through:

- **Strong Legal Foundations**: The Act establishes a person-centred aged care system, and the objects of the Act give effect to Australia's obligations under international human rights treaties, ensuring a robust legal basis.
- **Independent Oversight**: The Act introduces mechanisms for independent system oversight, promoting accountability and fairness within the aged care system.
- **Equitable Access**: It ensures that all individuals are assessed against a culturally safe and appropriate single assessment framework, facilitating fair access to aged care services.

This structure is designed to ensure that aged care services are fair, accessible, and centred on the dignity and rights of older people.

The Act is structured into eight chapters, each focusing on different aspects of the aged care system. These are summarised below.

The most relevant areas of the Act for assessment organisations are in Chapter 2 which explains eligibility and assessment processes, and Chapter 8 which covers reconsiderations, decision reviews, and delegation provisions.

Chapter 1 – Introduction
This Chapter establishes the purpose, objectives, and scope of the Act. It introduces the key principles that underpin the Act, including the Statement of Rights and the Statement of Principles, which recognise the rights, dignity, and autonomy of older Australians. The Chapter also defines important concepts and terminology used throughout the Act, ensuring consistency in interpretation and application. This Chapter also includes the aged care service list (Prescribed in the Aged Care Rules 2025 in Part 3).

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Chapter 2 – Entry to the Australian Aged Care System

This Chapter includes the requirements for an individual to access government-funded aged care services. It details the eligibility criteria for aged care needs assessments, the aged care needs assessment process, and how individuals are approved for services. Additionally, it covers the approach to classifying the level of funding required, how priority for services is established, and the allocation of available aged care places to individuals and providers.

Chapter 3 – Registered providers, aged care workers, and digital platform operators

This Chapter focuses on aged care service providers, aged care workers, and the digital platforms that support aged care services. It sets out the registration process for providers, the approval process for residential care homes, and the conditions and obligations that registered providers must meet. It also outlines requirements for aged care workers, governance structures, and compliance responsibilities, ensuring service quality and accountability.

Chapter 4 – Funding of aged care services

This Chapter details how the Commonwealth funds aged care services, including whether that funding is through subsidies or grant based. This Chapter also sets out the individual fees and contributions that are payable for funded aged care services. It explains the funding structures for home support, assistive technology, home modifications, and residential care services. It also outlines means-testing rules, financial obligations of individuals accessing services, and mechanisms for subsidy payments to registered providers. This ensures a fair and sustainable funding model that aligns with individuals' financial circumstances.

Chapter 5 – Governance of the aged care system

This Chapter establishes the underlying governance of the broader aged care system. It establishes roles such as the System Governor, Aged Care Quality and Safety Commissioner, and Complaints Commissioner, detailing their responsibilities in ensuring compliance, investigating concerns, and enforcing the Aged Care Quality Standards. It also establishes the Aged Care Quality and Safety Advisory Council, who provides expert advice to improve aged care services and regulatory approaches.

Chapter 6 – Regulatory mechanisms

This Chapter outlines the enforcement measures in place to ensure aged care providers comply with legal and quality standards. It details the monitoring and investigation processes, including the use of compliance notices, banning orders, civil penalties, and enforceable undertakings. The Chapter also covers whistleblower protections and the legal mechanisms available to investigate and address regulatory breaches, ensuring transparency and accountability in the sector.

Chapter 7 – Information management

This Chapter establishes the rules for handling aged care data, privacy, and information sharing. It sets out record-keeping requirements for providers and government agencies and outlines protections against the misuse of sensitive personal information. The Chapter also introduces whistleblower protections and mechanisms for publishing key information about aged care providers and services, ensuring transparency and public trust in the system.

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Chapter 8 – Miscellaneous

The final Chapter covers additional provisions, including the reconsideration (review) and appeal processes available to individuals and providers regarding decisions made under the *Aged Care Act 2024 (the Act*). It details delegation powers, administrative automation, financial provisions, and the Minister's authority to make rules under the Act. This Chapter also mandates periodic reviews of the legislation to ensure it remains effective and responsive to the evolving needs of the aged care sector.

Subordinate legislation

The Act is supported by subordinate legislation the *Aged Care Rules 2025 (the Rules)*. The Rules sit underneath the Act and provide further detail and instruction on how the Act operates. There are two distinct bodies of Rules which will support the Act. Transitional Rules which deal with transitional matters not already addressed by the *Aged Care (Consequential Amendments and Transitional Provision) Act 2024* and the *Aged Care Rules 2025.*

About the new rights-based Aged Care Act | Australian Government Department of Health, Disability and Ageing

1.2. Statement of Rights and Principles

The Statement of Rights and the Statement of Principles support a person-centred aged care system, ensuring older people receive equitable, safe and quality care.

The Statement of Rights and the Statement of Principles are a reference point for the standard of conduct, duties and obligations for when assessment staff, registered providers and aged care workers deliver funded aged care services.

Figure 1 – Aged Care Act 2024 (Cth) Statement of Rights and Principles

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1.2.1. The Statement of Rights

The Statement of Rights (section 23 of the *Aged Care Act 2024 (the Act)*) is a fundamental part of the person-centred Act and promotes the older person's right to receive safe, high-quality care in the Commonwealth aged care system.

All assessment staff should perform their functions and duties in a way that is compatible with the rights. Of importance, assessment organisations and their assessment staff should ensure that an individual's need for funded aged care services is assessed, or reassessed, in a way that is:

- culturally safe, culturally appropriate, trauma-aware and healing-informed, and
- accessible and suitable for individuals living with dementia or other cognitive impairment.

1.2.2. The Statement of Principles

The Statement of Principles (section 25 of the Act) provide guidance on how the aged care system should operate. It should be used to guide the decisions, actions and behaviours of everyone operating in the aged care system, including assessors, providers, aged care workers, registered supporters and government agencies.

The Statement of Principles also aims to guide government agencies and bodies to ensure that the whole aged care system is directed towards the safety, health, wellbeing, and quality of life of individuals accessing funded aged care services.

1.3. Dignity of risk

During an aged care needs assessment, assessors should work with older people to balance their responsibility for an individual's right to make choices, even if their choices include some risk to themselves. This right is known as 'dignity of risk' which involves:

- Assessors considering the older person's rights mentioned in the Statement of Rights when undertaking an assessment.
- Ensuring older people during an assessment can, where possible, make informed decisions for themselves, including in the setting of goals, including if those decisions involve risk
- The new role of a registered supporter under the *Aged Care Act 2024 (the Act)*, who can support an older person to make and communicate their own decisions regarding their care and preferences.

1.4. Eligibility requirements to access government funded aged care services

From 1 November 2025, all government funded aged care services can only be provided once an older person has been found eligible to undergo an aged care needs assessment by the System Governor (a Triage Delegate) and it has been decided that the individual requires access to aged care services by the System Governor (an Assessment Delegate) following an aged care needs assessment.

This means that all services are Act-based services under the Act from 1 November 2025, including services that an older person accesses through a specialist aged care program

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(e.g. Commonwealth Home Support Program, Multi-purpose Service Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Transition Care Program).

1.4.1. Age eligibility requirements

Under the *Aged Care Act 2024*, there are clear eligibility requirements that an individual will need to meet to have an aged care needs assessment. Section 58 of the Act outlines these eligibility requirements.

Note:

To be eligible for an aged care needs assessment an individual must be:

-aged 65 or over; or

-an Aboriginal or Torres Strait Islander person and is aged at least 50; or

-homeless, or at risk of homelessness, and is aged at least 50; and

Each of the above individuals must also provide information relating to the individual's care needs. Care needs are defined under the Act as one or both of the following:

-the individual has difficulty (whether physically, mentally or socially) undertaking any daily living activities;

-the individual needs help from another person, or the assistance of an aid, to maintain their physical, mental or social capacity to function independently.

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1.4.2. Informing the eligible younger person of other services

There are limited circumstances in which people under the age of 65 can access Australian government aged care services. Under subparagraph 58(c) if the individual is under the age of 65 and falls into one or more of the eligible cohorts, they must:

(i) be informed of any other services that may be available to meet their care needs (noting that it is not a requirement for a person under the age of 65 to take up other services in place of aged care services).
(ii) elect, in the approved form, to be provided with government funded aged care services before they turn 65.

For eligible younger people who make an application via the My Aged Care contact centre, they will be informed of other services at this stage. However, for all other registration pathways, the Triage Delegate will need to inform the eligible younger person of other services. Further information about this process is at section 5.3.2 of this Manual.

Note:

The Principles and Guidelines for a younger person's access to Commonwealth funded aged care services is no longer relevant under the Aged Care Act 2024.

Definitions for 'homeless' and 'at risk of homelessness'

A person aged 50 years or older who is homeless or at risk of homelessness may be eligible for an aged care needs assessment and access funded aged care services. For Triage Delegates to determine if an individual aged 50 to 64 meets the eligibility criteria for a needs assessment under the homeless or risk of homelessness provision in the *Aged Care Act 2024*, the following definitions apply:

Homeless definition

The term 'homeless' in the context of aged care and for the purposes of receiving a needs assessment and funded aged care services refers to an individual who:

- is aged 50 or older, **and**
- has prematurely aged and requires services for their aged care needs, **and**
- has the following living arrangements:
    - lacks any adequate roof over their head, **or**
    - has no security of tenure, or moves between various forms of temporary or medium-term shelter, **or**
    - stays in accommodation that falls below minimum community standards, **and**
- does not have the means to change their living arrangements.

At risk of homelessness definition

The term 'at risk of homelessness' in the context of aged care and for the purposes of receiving a needs assessment and funded aged care services refers to an individual who:

- is aged 50 or older, **and**
- has prematurely aged and requires services for their aged care needs, **and**
- is at risk of experiencing the following living arrangements:
    - lacks any adequate roof over their head, **or**
    - has no security of tenure, or moves between various forms of temporary or medium-term shelter, **or**
    - stays in accommodation that falls below minimum community standards, **and**
- does not have the means to change their living arrangements.

Once an aged care needs assessment is undertaken, the assessment delegate must ensure that all eligibility requirements are met before approving any service group, service type, or specific funded aged care service.

This means that the older person's situation must meet the conditions outlined in sections 66 to 68 of the *Aged Care Act 2024 (the Act)*, and any additional eligibility criteria set by the relevant *Aged Care Rules 2025* must be satisfied. If these requirements are not met, the assessment delegate cannot approve the provision of aged care services.

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Any younger individual[1] who were already accessing services on 1 November will not be required to have a reassessment. Younger individuals currently accessing services will be able to continue to access these, even if they are below the minimum age requirements for the Act, subject to any actions required for that individual to transition to the Act.

1.5. Transition arrangements to the *Aged Care Act 2024*

As part of the commencement of the *Aged Care Act 2024 (the Act)* on 1 November 2025, different transitional arrangements have been put in place for existing clients and new clients being assessed as eligible for government funded aged care services.

Assessment staff should follow the procedures outlined in Table 1 when managing approvals for older people who transitioned from the *Aged Care Act 1997* to the *Aged Care Act 2024*.

Table 1: Transitional Arrangements from 1 November 2025

Cohort	Transitional Arrangements from 1 November 2025
Home Care Package (HCP)	• All HCP recipients transitioned to Support at Home. - Assigned one of four Transitioned HCP classifications based on their current HCP level. • No Support at Home classification (Levels 1–8) assigned at transition. • Transitional classification can be retained indefinitely, even after reassessment, if more beneficial.
Multi-Purpose Services Program (MPSP)	• Home/community services recipients (or those starting within 3 months) automatically approved for: - Ongoing/short-term home support - Assistive Technology (AT) - Home Modifications (HM) • Residential aged care recipients (or those starting within 3 months) approved for ongoing/short-term residential care.

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[1] A younger individual is a person who is under 50 years old for Aboriginal and Torres Strait Islander people or people who are homeless or at risk of homelessness or under 65 years old for all other persons.

Cohort	Transitional Arrangements from 1 November 2025
NATSIFACP	• Individuals receiving NATSIFACP services in the 12 months before 1 Nov 2025 are automatically eligible under the Act. • No new assessment required unless care needs change. • All new clients post 1 November are required to make an application for funded aged care services by registering with MAC, undergo a needs assessment and obtain an access approval for one or more service groups in place to access services delivered under NATSIFACP. • However, they can receive NATSIFACP services before assessment if they meet the criteria for alternative entry.
Commonwealth Home Support Program (CHSP)	• Registered and assessed clients automatically transition and continue accessing services. • Unregistered and unassessed clients must have been assessed by 31 October 2025 to continue accessing services. • Grandfathered clients (from pre-2015 programs) who have never been assessed must undergo an assessment. • Under the transitional arrangements and under section 71 of the Act, CHSP clients who have accessed a CHSP service by 31 October 2025 and are awaiting assessment on or after 1 November can have their service approval backdated to 1 November if they are found eligible at assessment
Short-Term Restorative Care (STRC) ***(now known as RCP)***	• The STRC Programme changed to the 'Restorative Care Pathway' under Support at Home from 1 November 2025. • STRC clients who commenced their care episode before 1 November 2025, and were still in flight on 1 November, have had their care continue under transitional arrangements. • Those approved for STRC that commenced their care episode after 1 November 2025 will have their STRC approval converted into an approval for the Restorative Care Pathway. They will also receive approval for assistive technology medium tier and home modifications medium tier. • They have six months from their STRC approval to accept the Restorative Care Pathway/AT-HM place. • After this, they will need to be reassessed to access restorative care or AT-HM under the Support at Home program, if eligible.
Younger People	• Younger people already accessing services on 1 November did not require a reassessment.

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Cohort	Transitional Arrangements from 1 November 2025
	• Younger people currently accessing services will be able to continue to access these services and also be eligible to be assessed for other aged care services in the future. • Younger people, who were in the process of applying for aged care services on 1 November, will be eligible to be assessed under relevant criteria within the *Approval of Care Recipients Principles 2014*.
Transition Care Program (TCP)	• Transition Care Program clients who continued to receive care across the transition from the Aged Care Act 1997 to the Aged Care Act 2024 had their eligibility and approval deemed across. • All new clients post 1 November will be required to have a comprehensive assessment and receive delegate approval, before they are discharged from hospital, to be referred to a transition care service provider.
Residential Care	• Existing residents in care on 1 November 2025 were allocated a place to ensure no payment or continuity of care issues for the provider or older Australian. This cohort of older Australians did not need to do anything to facilitate this allocation. It happened as part of the transition to the Act. • Older Australians who were assessed and approved as requiring residential care, prior to 1 November 2025, were automatically allocated a place and can enter care when they choose to.

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1.5.1. Transitioned Home Care Package

All individuals who were receiving a Home Care Package (HCP) on 1 November 2025 were transitioned to the Support at Home program. At the point of transition, they were not assigned a Support at Home classification level (Levels 1–8). Instead, each person was allocated one of four Transitioned Home Care Package classifications, based on their HCP level prior to 1 November 2025.

Clients can remain on these transitional classifications indefinitely, unless assessed and approved for a Support at Home classification at a higher level. A transitional classification can be retained even if the client has a new assessment and the IAT outcome results in a Support at Home classification level that would reduce their funding compared to their transitional level. When reassessing transitioned clients, assessors must ensure the transitional classification is retained when it is more beneficial to the client.

Table 2: Transitioned levels and recommended outcomes

Transition level	IAT Outcome	Recommended outcome
Transitioned HCP 1	CHSP Support at Home Classification 1	Retain Transitioned HCP 1
	Support at Home Classification 2-8	Use Support at Home 2-8 Class aligning with IAT outcome.
Transitioned HCP 2	CHSP Support at Home Classification 1-2	Retain Transitioned HCP 2
	Support at Home Classification 3-8	Use Support at Home 3-8 Class aligning with IAT outcome.
Transitioned HCP 3	CHSP Support at Home Classification 1-5	Retain Transitioned HCP 3
	Support at Home Classification 6-8	Use Support at Home 6-8 Class aligning with IAT outcome.
Transitioned HCP 4	CHSP Support at Home Classification 1-7	Retain Transitioned HCP 4
	Support at Home Classification 8	Use Support at Home 8 Class aligning with IAT outcome.

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Section 6.7 Classification of the Support at Home Manual.

1.5.2. Support plan reviews for transitioned Home Care Package (HCP) clients

Transitioned HCP clients will continue to be eligible for support plan reviews (SPRs) under the same process currently in place. However, in line with existing procedures, if it is determined that a client's circumstances have changed significantly, a reassessment will be required.

Under Support at Home a higher Support at Home classification level cannot be approved through an SPR — this can only occur following a reassessment and the IAT outcome generates a higher classification level. When reassessing transitioned clients, assessors will need to ensure that they maintain the transitional classification where it is more beneficial for the older person. This will be flagged in the system on reassessment. If the IAT outcome is a lower classification than the existing active ongoing classification, then a warning message will display to inform the assessor that they can retain the existing classification by clicking the accept button.

When completing an SPR to transition a client to the End-of-Life Pathway, assessors will have the option to convert the client's Transitioned HCP level to End-of-Life once the End-of-Life form has been uploaded and validated. Clients receiving services on the End-of-Life Pathway can also return to their Transitioned HCP level, just as clients in the Support at Home program can return to their previous classification level.

1.5.3. Transitioned Home Care Package recipients and access to the Assistive Technology and Home Modifications scheme

All Home Care Package (HCP) recipients transitioned over to Support at Home with approval for Assistive Technology (AT) transitional and Home Modifications (HM) transitional classifications. These approvals enable a transitioned HCP recipient who has not undergone a reassessment and does not have AT-HM funding, to use their HCP unspent funds to purchase equipment, products and home modifications from the AT-HM list. Providers must document and justify the need and reasoning for the purchase and retain all evidence to support the claim.

If a transitioned HCP recipient has no HCP unspent funds and requires AT-HM, the provider can, with consent from the participant, refer them for a support plan review.

Where a transitioned HCP recipient has been reassessed under Support at Home and receives approved AT-HM funding, the purchase of assistive technology and home modifications must be first drawn from any HCP unspent funds before the provider can claim from the AT-HM funding account.

All purchases of AT-HM items must align with the participant's needs, be agreed with the participant, be documented in their care plan and meet any prescription requirements, where applicable.

AT-HM List

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1.5.4. Multi-Purpose Service Program (MPSP)

Existing MPSP clients on 1 November 2025

Transitional arrangements were put in place for individuals already accessing services under the MPSP on 1 November 2025 to provide for service continuity.

Individuals assessed as falling within the transitional cohorts outlined in the transitional legislation (based on previous needs assessments and/or information collected from their providers) will be deemed to have relevant service group approvals, and related decisions, in place, as required in order to access funded aged care services under the *Aged Care Act 2024.*

An individual accessing aged care services in a home or community setting through a MPSP provider at transition time, or who has an agreement in place to commence these services within 3 months of the transition time, will be approved for ongoing and short-term home support, as well as short-term AT and HM.

An individual accessing residential care services in a Multi-Purpose Service facility at transition time, or who has been approved to commence services within 3 months of the transition time, will be approved for ongoing and/or short-term residential care.

Note:

An individual's transitional status is confirmed via a notice given to their provider. This letter is also attached to their My Aged Care Client Record. By June 2026, relevant approvals and referrals will also be retrospectively added to Department of Health, Disability and Ageing systems to facilitate these individuals moving between MPSP and mainstream services in future.

If an older person in one of the transitional cohorts above wants to access mainstream aged care services (outside the MPSP):

if they plan to access mainstream services under a home and community setting: they will need to call My Aged Care and either:

-seek to undergo a re-assessment if they only have a MPSP classification level provided at transition time, or

-where they already have a transitional HCP classification level, indicate that they are now seeking mainstream services, where they already have a transitional HCP classification level, at which point they will be placed in the Support at Home Priority System's queue based on their priority category and approval date.

If they plan to access mainstream services in a residential care home, they can commence services with their new provider but will then need to undergo a Residential Aged Care funding assessment (i.e. a classification re-assessment).

Information is available for people leaving the MPSP to access other services, to ensure they are aware they might need to wait for services to become available and could pay higher fees. The fact sheet also provides more information on the process for people leaving the MPSP, particularly in the interim until their My Aged Care client records are updated in mid-2026.

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Leaving the MPSP Consumer Fact Sheet

1.5.5. New Multi-Purpose Service Program (MPSP) Clients post 1 November 2025

Since 1 November 2025, all new clients are required to make an application for funded aged care services, undergo a needs assessment and obtain an access approval for one or more service groups in place to access services delivered under the MPSP.

There is also a specific workflow assessors need to follow to ensure they can generate a referral to an MPSP provider - that is, a service recommendation must be added in addition to recommendations for residential care, home support, AT and/or HM services. The one referral code will cover all services delivered at or through a MPS facility.

Note:

For clients who have been assessed and want to leave their MPSP provider and access mainstream aged care services:

-If they plan to access mainstream services under a home and community setting: they will need to call My Aged Care and indicate that they are now seeking mainstream services at which point they will be placed in the Support at Home Priority System's queue based on their priority category and approval date (a reassessment may also be required if they have had a significant change in circumstances).

- If they plan to access mainstream services in a residential care home: they can commence accessing services through the new home but will then need to undergo a Residential Aged Care funding assessment (i.e. a classification re-assessment).

Fact sheet: Leaving the Multi-Purpose Service Program (MPSP) – Consumer fact sheet | Australian Government Department of Health, Disability and Ageing

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1.5.6. National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)

Existing NATSIFACP clients

There are transitional arrangements in place for individuals who accessed services under the NATSIFACP in the 12 months leading up to 1 November 2025 to ensure service continuity with the commencement of the Aged Care Act 2024 (the Act).

Individuals assessed as falling within the transitional cohorts outlined in the transitional legislation (based on previous needs assessments or information collected from their providers via the six-monthly Service Activity Reports) were deemed to have relevant service

group approvals, and related decisions, in place, as required in order to access funded aged care services under the Act.

If transitioned clients move to a different provider or a different location where NATSIFACP services are not available, they may require an aged care needs assessment. It will depend on whether they only have a National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) default classification level, the service types they require and the range of programs available at their new location.

> Note:
>
> Individuals will be notified of their status post 1 November 2025 in writing via a notice given to their provider. This letter was updated to their My Aged Care Client Record in late 2025. Relevant service recommendations and referrals have been added to Department of Health, Disability and Ageing's systems.
>
> If an older person in one of the transitional cohorts above wants to access mainstream aged care services:
>
> -if they plan to access mainstream services under a home and community setting: they will need to call My Aged Care and either:
>
> -seek to undergo an aged care needs assessment if they only have a default NATSIFACP classification level provided at transition time, or
>
> -indicate that they are now seeking mainstream services, where they already have a transitional HCP classification level, at which point they will be placed in the Support at Home Priority System's queue based on their priority category and approval date.
>
> -if they plan to access mainstream services in a residential care home: they will need to undergo a Residential Aged Care funding assessment (i.e. a classification re-assessment) and an aged care assessment if they have not had one previously.

New National Aboriginal and Torres Strait Islander Flexible Aged Care Program Clients post 1 November 2025

All new clients are required to make an application for funded aged care services, by registering with My Aged Care, undergo a needs assessment and obtain an access approval for one or more service groups in place to access services delivered under NATSIFACP. However, they can receive NATSIFACP services before assessment if they meet the criteria under alternative entry provisions.

1.5.7. Commonwealth Home Support Program (CHSP)

Registered and assessed Commonwealth Home Support Program (CHSP) clients automatically transitioned under the Act on 1 November 2025. These clients can continue accessing their current CHSP services in line with their assessed need, without taking any action.

Unregistered and unassessed CHSP clients must register with My Aged Care and be assessed as eligible for the CHSP to continue accessing government funded aged care services.

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Note:

Assessment approvals can be backdated for eligible CHSP clients under Section 71 of the Act.

Transitional rules allow CHSP clients who applied for an assessment by 31 October to have approvals backdated to 1 November if they are assessed as eligible after the Act commenced.

Grandfathered clients (clients receiving services through a previous program who were grandfathered into the CHSP) that have not since undergone an assessment will need to do so to continue receiving services.

1.5.8. Short-Term Restorative Care (STRC) Programme

The Short-Term Restorative Care (STRC) Programme has changed to the 'Restorative Care Pathway' under Support at Home. Transition arrangements for people accessing STRC or who hold an active approval for STRC apply to two cohorts including:

- STRC Programme participants who commence their care episode before 1 November 2025 and are still in flight on 1 November. These participants will have their care continued under transitional arrangements.
- Participants approved for the STRC Programme but who have commenced their care episode after 1 November 2025. These participants have had their STRC approval converted into an approval for the Restorative Care Pathway.
    - They have also received approval for an assistive technology low, medium or high tier and home modifications low or medium tier. They will have six months from their STRC approval to accept the Restorative Care Pathway/AT-HM place.
    - After this, they will need to be reassessed to access restorative care or AT-HM under the Support at Home program, if eligible. A second unit of funding to use within a single Restorative Care Pathway episode can be requested via a support plan review request.
    - An assessor will no longer need to self-refer and undertake a reassessment to grant access to a second unit of funding. The SPR pathway can now be used.
    - Requests for higher levels of AT funding will also need to follow this process. Please note, a request for high-tier AT will require recommendation and also approval for a Support at Home classification. Approval for RCP will result in a second unit of RCP funding being given and all evidence requirements must be met.

Guide for Short-Term Restorative Care providers transitioning to the Restorative Care Pathway | Australian Government Department of Health, Disability and Ageing

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1.5.9. Transition Care Program (TCP)

TCP clients receiving transition care on 1 November 2025

Transition Care Program clients in care on 1 November 2025 had their eligibility and approval for the program deemed across.

New TCP clients post 1 November 2025

All new clients are required to have a comprehensive assessment and receive delegate approval, before they are discharged from hospital, to be referred to a transition care service provider.

1.5.10. Residential Care

Residential care clients in residential care on 1 November 2025

Residents in care on 1 November 2025 were allocated a place to ensure no payment or continuity of care issues for the provider or older Australian. This cohort of older Australians did not need to do anything to facilitate this allocation.

Prospective residents with a residential care approval but not in care on 1 November 2025

Older Australians who were assessed and approved as requiring residential care, prior to 1 November 2025, were automatically allocated a place on commencement of the Aged Care Act 2024 and can enter care when they choose to.

1.5.11. Younger People

Younger people receiving existing aged care services

On commencement of the Aged Care Act 2024 (the Act) on 1 November 2025, any younger individual[2] already accessing services are not required to have a reassessment. Younger individuals will be able to continue to access services, even if they are below the minimum age requirements for the Act, subject to any actions required for that individual to transition to the Act.

If the care needs of younger individuals, who transitioned from the *Aged Care Act 1997*, have changed, they will be eligible for reassessment to access residential aged care. These individuals may be eligible for reassessment for other aged care services based on program level transition rules.

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[2] A younger individual is a person who is under 50 years old for Aboriginal and Torres Strait Islander people or people who are homeless or at risk of homelessness or under 65 years old for all other persons.

Younger people with 'In-flight assessments'

Younger individuals who are applying for residential aged care and have provided enough information in My Aged Care to show they began the process before 1 November 2025 will be 'Reviewed and Approved' based on the eligibility criteria under the *Aged Care Act 1997*.

Ability First Australia (AFA) (for younger people who are not NDIS participants) or the NDIA YPIRAC team (for NDIS participants) helps younger people explore age-appropriate options before they seek access to residential aged care – as per section 11A of the *Approval of Care Recipients Principles 2014* (the requirement of specified evidence).

A younger person who has registered with these services on or before 31 October but is yet to register with My Aged Care is still considered to have commenced an assessment process so will still be eligible to receive an assessment. The AFA and NDIA reports will clearly document the date on which the younger person commenced registration with the service.

Younger people who are new aged care clients as of 1 November 2025

Since 1 November 2025, if a person aged under 65 (who is not Aboriginal and Torres Strait Islander, homeless or at risk of homelessness and aged 50+) has not commenced the process of applying for aged care services (including registering with AFA or the NDIA YPIRAC team), they are not eligible for an assessment for aged care services.

1.6. Aged Care Service List

The Act provides for the delivery of funded aged care services to individuals under the Australian aged care system. Section 8 of the Act states the *Aged Care Rules 2025* must prescribe a list of services for which funding may be payable under the Act.

The *Aged Care Rules 2025* lists and describes each service and specifies the service group and the service type it is in.

The Aged Care Service List divides the funded aged care services into a variety of **service types**. The **services** within a service type are to be delivered by registered providers through **service groups**.

The Aged Care Service List provides a clear reference for registered providers, funding authorities, and regulatory bodies, ensuring consistency and transparency in aged care service delivery.

The Aged Care Service List serves several key functions:

- **Defining Funded Services:** The list specifies which aged care services qualify for government funding, ensuring clarity for registered providers and older people.
- **Service Categorisation:** Services are grouped under various service types and are delivered under the different service groups.
- **Regulatory Compliance:** The list supports oversight by ensuring that only registered providers (or associated providers of those registered providers) can deliver funded aged care services listed under the service list, in alignment with the Act's broader regulatory framework.

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It is important for assessment delegates to understand the different types of funded aged care services that require approval under the Act, as well as the specific responsibilities and limitations involved in approving each service, service type and service group.

1.7. Service groups

Funded aged care services are categorised into **four service groups**, which specify the setting and nature of care an individual can access.

Table 3: Detail of the four service groups for funded aged care services

Service Group	Setting and nature
Home Support	• Designed to assist older people in remaining independent at home. • Includes service types such as personal care, domestic assistance, social support, meals. • Must be delivered in a home or community setting.
Residential Care	• Provides 24-hour support for individuals with high or complex care needs. • Includes ongoing (permanent) and short-term (respite) classification types • Includes: Personal Care: Assistance with daily activities like bathing, dressing, eating, and mobility. Health Care: Access to nursing care, medication management, and sometimes allied health services. Social Support: Opportunities for social interaction, recreational activities, and community engagement. Safety and Supervision: Staff are available around the clock to ensure residents' safety and respond to emergencies. • Must be delivered in an approved residential care home.
Assistive technology	• Covers equipment and products that enable or enhance independence.

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Service Group	Setting and nature
	• Examples include walking frames, personal alarms, and communication devices. • Must be delivered in a home or community setting.
Home modifications	• Adjustments made to a person's home environment to enhance safety and accessibility. • Includes ramps, handrails, bathroom modifications, and similar adaptations. • Must be delivered in a home or community setting

Note:

Section 10 of the Act gives more information about the settings where care can be provided, including what *a residential care home* and a *home or community setting* mean.

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1.8. Approvals under the *Aged Care Act 2024*

Approvals under the *Aged Care Act 2024* revolve around three primary components that, when combined, are comparable to 'being approved for a program' under the *Aged Care Act 1997*. The components are 'Service group', 'Classification type' and 'Classification level' (sometimes simply referred to as 'Classification'). A priority category is also applied in some circumstances.

- **Service groups** specify the setting and nature of care an individual can access. There are four service groups: **home support**, **assistive technology**, **home modifications** and **residential care**.
- **Classification types** differentiate the time period that services are delivered for under the service group. There are three classification types: **ongoing**, **short-term** and **hospital transition**. Each classification type has a different purpose in meeting the needs of an individual and so are funded and timed accordingly.
- **Classification levels** determine the amount of funding available to deliver the aged care services that an individual has been approved to access under a service group.

The table below compares some examples before and after the introduction of *Aged Care Act 2024*.

Table 4: Comparison of program approval structure between Aged Care Act 1997 and Aged Care Act 2024

Before the introduction of the *Aged Care Act 2024*	**After the introduction of the *Aged Care Act 2024*, the older person is approved for…**
Home Care Package Level (1-4)	Service group: Home support Classification type: Ongoing Classification level: SAH (Support at Home) Class (1-8)
Commonwealth Home Support Package (CHSP)	Service group: Home support Classification type: Ongoing Classification level: CHSP Class
Goods Assistive Technology (GEAT) and Home Modifications (CHSP)	Service group: Assistive technology, Home modifications Classification type: Short-term Classification level: AT CHSP, HM CHSP
Residential Respite Care	Service group: Residential care Classification type: Short-term Classification level: Respite Class (1-3)
Short-Term Restorative Care Programme	Service group: Home support Classification type: Short-term Classification level: SAH Restorative Care Pathway

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The following sections show the possible combinations of classification type and classification level a person can be approved for under each service group.

Decisions for service group and classification type are made under section 65(2) of the Act. Decisions for classification level are made under section 78 of the Act.

Table 5: Service group: Home support

Service group	Classification type	Classification level
Home support	Ongoing	CHSP class Support at Home (SAH) class 1 to 8
	Short-term	SAH restorative care pathway SAH end-of-life pathway
	Hospital transition	Home Support Hospital Transition class (HS HT class)

Table 6: Service group: Assistive technology

Service group	Classification type	Classification level
Assistive technology	Ongoing	Assistance dogs
	Short-term	AT CHSP AT low AT medium AT high
	Hospital transition	AT HT class

Note: classification levels are also referred to as 'funding tiers' in the Support at Home program.

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Table 7: Service group: Home modifications

Service group	Classification type	Classification level
Home modifications	Short-term	HM CHSP HM low HM medium HM high

Note: classification levels are also referred to as 'funding tiers' in the Support at Home program.

Table 8: Service group: Residential care

Service group	Classification type	Classification level
Residential Care	Ongoing	Class 0 Class 1 to Class 13
	Short-term	Class 0 Respite class 1 (101), Respite class 2 (102) and Respite class 3 (103)
	Hospital transition	RC HT class

Note: 'Class 0' is a default classification applied before the client has been assessed for their classification level.

1.9. Deciding if the older person requires aged care services

After an individual has been determined as eligible for an aged care needs assessment, an assessment delegate determines whether the assessed individual requires access to funded aged care services, and which service groups, and in some cases service types and services they require. This requirement is set out in subsection 65(2) of the Act.

This decision is made based on:

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- An assessment report (referred to in practice as the Support Plan),
- In the case of reassessments in accordance with subparagraph 64(1)(c)(ii) of the Act, any relevant information relating to the individual provided.

The table below summarises the sections of the Act that relate to eligibility for access to services. These sections of the Act, and how they apply to an Assessment Delegate's decision-making, are explained in detail in Chapters 7 and 8.

Table 9: Approval to access funded aged care services under section 65

Section of the Act	Criteria	Available Service Group/s	Available classification type/s	Relevant program/s
66	Individual must be an Aboriginal or Torres Strait Islander person The individual must meet any eligibility requirements prescribed by the rules for the relevant service group.	• Residential Care • Home support • Assistive technology • Home modifications	All classification types	All programs, but in particular NATSIFACP*
67	Individual must have an impairment; **and** There must be a specific reason why the individual requires access to the service type/s or services. The individual must meet any eligibility requirements prescribed by the rules for the relevant service group.	• Home support • Assistive technology • Home modifications	All classification types	• Support at Home • CHSP • TCP • MPSP • NATSIFACP

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Section of the Act	Criteria	Available Service Group/s	Available classification type/s	Relevant program/s
68	Individual must have a continuing need for residential care because they are 'sick' The individual must meet the eligibility requirements prescribed by the rules for the service group residential care.	• Residential care	All classification types	• Residential care (ongoing or short-term) • TCP • MPSP • NATSIFACP

Important:

If the older person is an Aboriginal or Torres Strait Islander person, an assessment delegate only needs to approve them for one or more service groups. They are automatically approved for all the service types and services in any service group they are approved for.

1.9.1. Approvals for service types and services

A service is defined in the Aged Care Service List defined in the Aged Care Rules 2025. It lists the four service groups, and the service types and services within them.

See Chapter 7 for further information on service approvals.

1.9.2. Approvals for priority categories

The priority categories assigned to individuals under section 86 of the Act determine when certain services are allocated under section 92 of the Act. These categories are based on the assessed urgency of need, complexity of care requirements, and potential risks associated with delayed support.

See Chapter 7 for further information on priority category decisions.

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1.9.3. Period of effect of approvals

Each access approval, classification level, and priority category has a period of effect that is prescribed under the Act. This means that these approvals remain in effect for the period of time specified by the Act, unless the approval is revoked or a reassessment occurs resulting in a new approval.

In addition to the other legislative requirements described above, for an older person to receive funded aged care services, they need both:

- an access approval that is in effect (or 'active'), and
- a classification level that is in effect.

Periods of effect for an approval for decisions are detailed in sections 71, 80 and 89 of the Act.

See Chapter 7 for further information on period of effect of approvals.

1.10. Accessing funded aged care services

Under the Act, older people will access funded aged care services through the following:

- **Commonwealth Home Support Program (CHSP)**: Offers entry-level in-home care services to assist older people with daily tasks, promoting independence and community connection.
- **Support at Home program**: Assists older people in maintaining independence by providing in-home care services, assistive technology and home modifications, enabling them to live safely and comfortably in their own homes.
- **Residential Care**: Provides accommodation and 24-hour support in aged care facilities for individuals requiring continuous care on either a permanent or short-term basis.
- **Transition Care Program (TCP)**: Offers short-term goal-oriented therapy focused care for older people after a hospital stay, aiming to improve their independence and confidence.
- **Multi-Purpose Service Program (MPSP)**: Provides integrated health and aged care services for older people in small rural and remote communities, allowing them to stay close to family and friends while receiving necessary support.
- **National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)**: Funds organisations to provide culturally safe aged care services for older Aboriginal and Torres Strait Islander people, allowing them to be cared for close to home and community.

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> Note:
>
> CHSP, TCP, MPSP, NATSIFACP are defined as a specialist aged care program under the Act.

Older people do not need to be separately approved under the Act to access services through MPSP or NATSIFACP. Rather these service pathways are added as a service recommendation in the client's Support Plan to accompany the access approval for a service group and classification type.

1.11. Where approvals can be used

Some approvals can be taken to more than one type of program or provider. This is part of how the Act gives more flexibility to tailor the response to the individual.

For example, some people may choose to access their approved services through MPSP or NATSIFACP. Where this is recommended, a referral to a relevant provider will be made alongside the approval.

> Note:
>
> If an older person accesses services through MPSP or NATSIFACP, the classification level will not restrict the type or amount of services that can be provided to the person.

The table below shows where the different approval combinations can be used.

The systems, tools and templates assessors and assessment delegates use will take these into account and/or prompt when needed.

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Table 10. Service group, classification type and classification level approval combinations

Program	Service group – Classification type - Classification level
Commonwealth Home Support Program (CHSP)	Home support – ongoing - CHSP class Assistive technology – short-term – AT CHSP Home modifications – short-term – HM CHSP
Support at Home program	Home support – ongoing – SAH class 1 to 8 Home support – short-term – SAH restorative care pathway Home support – short-term – SAH end-of-life pathway Assistive technology – ongoing – assistance dogs Assistive technology – short-term – AT low, AT medium, AT high Home modifications – short-term – HM low, HM medium, HM high
Residential Aged Care	Residential care – ongoing – Class 0 to 13* Residential care – short-term – Class 0 to 3
Transition Care Program (TCP)	Home support – hospital transition – HS HT class Assistive technology – hospital transition – AT HT class Residential care – hospital transition – RC HT class

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Program	Service group – Classification type - Classification level
Multi-Purpose Service Program (MPSP)	Home support – ongoing - CHSP class Home support – ongoing – SAH class 1 to 8
National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)	Home support – short-term – SAH restorative care pathway Home support – short-term – SAH end-of-life pathway Assistive technology – short-term – AT CHSP Assistive technology – short-term – AT low, AT medium, AT high Home modifications – short-term – HM CHSP Home modifications – short-term – HM low, HM medium, HM high Residential care – short-term – Class 0 to 3 Residential care – ongoing – Class 0 to 13

* Following a client's admission to permanent residential care, a residential aged care funding assessor will conduct an assessment using the Australian National Aged Care Classification (AN-ACC) assessment tool, which will result in a classification level determined by a proprietary algorithm.

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2. Chapter 2: Overview of My Aged Care and the Single Assessment System

What you'll find in this chapter

This chapter provides information on the Single Assessment System including:

- My Aged Care
- Single Assessment System
- Aboriginal and Torres Strait Islander Assessment Organisations
- Assessment Organisation roles and responsibilities
- Home Support Assessments
- Comprehensive Assessments
- The Integrated Assessment Tool (IAT)

2.1. My Aged Care

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

The key elements of My Aged Care include:

- Access to My Aged Care for older people, their families, registered supporters or carers by:
    - calling My Aged Care on 1800 200 422 (FreeCall*) from 8am to 8pm Monday to Friday or 10am to 2pm Saturday (local time).
    - visiting the My Aged Care website (www.myagedcare.gov.au)
    - booking a face-to-face appointment with an Aged Care Specialist Officer (ACSO), located in some Services Australia service centres by calling 1800 227 475
    - contacting a Care Finder or Elder Care Support Worker who will assist them to navigate the aged care system.
- a My Aged Care Service Provider and Assessor Helpline (1800 836 799)
- An aged care needs assessment to identify an older person's needs using the IAT and an access approval to access government funded aged care services.

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

- a central older person record that will include each older person's current aged care requirements and associated history and services provided through My Aged Care

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- ability to request, register and end registered supporter relationships
- a referral capability that enables the contact centre, ACSOs and assessors to find appropriate assessment, home support, residential and community support services or resources for older people
- web-based portals for older people (My Aged Care Online Account), assessors, service providers and support organisations.

Assessment organisations can use the My Aged Care assessor portal to:

- manage their assessment organisation contact details and set up individual staff members with access to the My Aged Care assessor portal
- manage referrals for assessment
- submit and action requests to create to register or end supporter relationships and create organisation agent relationships
- complete triage and determine eligibility for an aged care needs assessment
- undertake assessments using the IAT and develop a Support Plan
- make delegate decisions for access to government-funded aged care services
- conduct support plan reviews (SPRs) and reassessments
- refer older people for aged care services
- recommend a period of reablement or for linking support on the Support Plan
- review and update older person records consistent with the assessment and Support Plan outcomes.

My Aged Care is committed to supporting older Aboriginal and Torres Strait Islander people and their carers by making it easier to access aged care assessment services that are respectful of culture, community, and connection to Country. All assessment organisations, including those participating in the Aboriginal and Torres Strait Islander assessment organisations pilot, recognise the importance of cultural safety, trust, and relationships. Embedding cultural safety into the assessment process will help improve the experience of older Aboriginal and Torres Strait Islander people, as well as their families and carers. Information, assessment and support will be delivered in ways that uphold dignity and promote wellbeing.

In addition to the standard ways that older Aboriginal and Torres Strait Islander people, their families and carers can access My Aged Care, Aboriginal and Torres Strait Islander led support such as Elder Care Support Program, can also help facilitate access to My Aged Care services and assessments. This will help to ensure that older Aboriginal and Torres Strait Islander people and their carers receive support in a trusted and culturally safe environment.

Older Aboriginal and Torres Strait Islander people can indicate their preference to have their assessment delivered by an Aboriginal and Torres Strait Islander assessment organisation.

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A client's preference to be assessed by an Aboriginal and Torres Strait Islander organisation can be captured at multiple points along the aged care journey. It may be captured when registering a client in the My Aged Care system, confirmed when completing demographic details during the triage stage of an assessment. It may also be noted by an assessor during an assessment. Once recorded, the preference will display in the client's profile and on the client's card.

It is acknowledged that establishing trust may require time, particularly for older Aboriginal and Torres Strait Islander people. Assessors should ensure clients feel culturally safe, respected, and comfortable before they request personal or sensitive information. To support this, assessors should consider if assessments should be conducted over multiple sittings to allow the process to proceed at a pace that respects the older person's readiness and preferences. During this period, assessors are expected to maintain regular contact with the older person to ensure continuity while the assessment remains active. This ongoing engagement helps foster trust and continuity and ensures that the older person feels supported throughout the process.

> Note:
>
> My Aged Care assessor portal users are reminded that they are subject to several obligations when handling information in the Portals. This includes obligations under the Privacy Act 1988 (Cth) and where relevant the Aged Care Act 2024 (Cth).

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2.2. Single Assessment System

The Single Assessment System came into effect in July 2024, with the IAT introduced on 1 July and the Single Assessment System workforce introduced in December 2024. It provides a single aged care assessment pathway for older people to access aged care services. This included the phased implementation of Aboriginal and Torres Strait Islander assessment organisations from August 2025. The system has been established to respond to Recommendations 28 and 48.2(b) of the Royal Commission into Aged Care Quality and Safety to make it easier for older people to access culturally safe aged care assessments and adapt services as their needs change.

The Australian Government delivers aged care assessments through the Single Assessment System workforce. Aged care assessments are delivered by a mix of state and territory governments, for-profit organisations, not-for-profit organisations, Aboriginal Community Controlled Health Organisations (ACCHOs) and private sector providers.

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

Assessment organisations are responsible for the day-to-day operation of the Single Assessment System including the timely delivery of assessments under the *Aged Care Act 2024* (the Act), as well as the management, training, and performance of individual assessors and delegates.

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The department has responsibility for the Single Assessment System, including providing advice on Australian Government policy, the monitoring and reporting of performance against agreed service levels, and the management of regulatory and other administrative processes relating to the Act.

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

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

2.3. Aboriginal and Torres Strait Islander assessment organisations

Older Aboriginal and Torres Strait Islander people experience barriers to accessing aged care services, which can prevent them from receiving the care they need.

Aboriginal and Torres Strait Islander assessment organisations are being established in response to Royal Commission Recommendation 28 and 48.2(b) to *'ensure, wherever possible, that aged care assessments of Aboriginal and Torres Strait Islander people are conducted by assessors who are Aboriginal or Torres Strait Islander people, or others who have undertaken training in cultural safety and trauma-informed approaches'.*

The vision for Aboriginal and Torres Strait Islander assessment organisations is to create a culturally safe and empowering environment. This pathway aims to make it easier for older people to access clear and relevant information about aged care assessment; have their needs assessed in a responsive and respectful manner; and, be supported in locating and accessing aged care services that align with their aged care needs and preferences. This will support clients to maintain their independence at home for longer.

Since August 2025, a small number of Aboriginal and Torres Strait Islander aged care assessment organisations started delivering culturally safe, trauma aware and healing informed aged care assessments. This pilot is part of a phased rollout and over time, future phases will cover more areas across Australia.

These organisations provide older Aboriginal and Torres Strait Islander people:

- an improved assessment experience
- options to stay at home for longer.
- more choice when seeking culturally safe aged care assessment.

Aboriginal and Torres Strait Islander assessment organisations work closely with local community organisations and support networks including Aboriginal Community

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Controlled Organisations, Aboriginal Community Controlled Health Organisations, and the Elder Care Support program. Together, they work to support, empower, educate and encourage the older Aboriginal and Torres Strait Islander people and their communities to identify their needs and explore how aged care can help them age well, remain connected to community, and support them to stay at home and on Country for longer.

Older Aboriginal and Torres Strait Islander people can access aged care needs assessments through the existing assessment organisations, or once established, through an Aboriginal and Torres Strait Islander assessment organisation if available in their area.

Aboriginal and Torres Strait Islander assessment organisations are responsible for equipping their workforce to deliver culturally safe, trauma aware and healing informed assessments in communities that are covered in their service regions. This may include training on local customs, protocols and kinship obligations.

Aboriginal and Torres Strait Islander assessment organisations are expected to:

- conduct culturally safe, trauma aware and healing informed assessments using yarning and flexible approaches to build trust with the older Aboriginal and Torres Strait Islander person. Assessments may be delivered at a location that the older person feel most at ease and comfortable,
- undertake face-to-face assessments, where possible. This could be in the older person's home, at a community centre, or outdoors at a place of the older person's choosing.
- allow for multiple visits, if required, to build trust and develop a relationship.
- with client's consent, involve the client's family members, advocates, registered supporter/s or other people who support the client in the assessment process with the client's consent and/or in line with the client's will and preferences,
- connect with the older person's GP, service provider and support networks to help inform an assessment, to gain a comprehensive understanding of the client's health and wellbeing, minimising the older person having to tell their story multiple times,
- be embedded within the local community. Connecting with the local community with their knowledge of local services, customs and protocols will allow them to support matching appropriate assessors to the older people preferences and needs,
- maintain a connection with the older person for the whole journey through to receiving services via assessors and/or Elder Care Support workers. This will help to manage any uncertainty or questions throughout the process,
- work with organisations that support stolen generation survivors and their families,
- provide interpreting services, when needed, and
- support clients to access services they need (where this cannot be provided by ECS workers or care finders)

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- Single Assessment System for aged care | Australian Government Department of Health, Disability and Ageing
- Aboriginal and Torres Strait Islander Assessment Organisations
- Interactive map of available services
- Fact Sheet for assessors

2.4. Overview of assessment organisation roles and responsibilities

Contract and operational managers lead and manage the assessment organisation's outputs and performance according to their agreements with the Commonwealth. Assessment organisations cover geographical assessment regions across Australia.

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

The department understands that, for Aboriginal and Torres Strait Islander assessment organisations, where assessment services may be one of the many services that they provide to older Aboriginal and Torres Strait Islander people, the assessment workforce may be able to leverage expertise and skills within the broader organisation to inform the delivery of holistic aged care assessments under the clinical governance framework described in Appendix C.

For further information on the qualifications required to hold the roles in the below table, please refer to Appendix F. Refer to the My Aged Care Workforce Learning Strategy for the training requirements for the roles specified below.

Table 11. Assessment organisational roles and responsibilities (excluding some roles in RAC)

Role Title	Role type	Role Description
Contract manager	Business	Contract Managers, manage and report the assessment services and performance specified in the organisation's agreement with the Commonwealth. Contact point for the department for contract management.
Assessment Organisation Operational Manager	Business and System	Assessment Organisation Operational Managers, manage the delivery of assessment services specified in the organisation's agreement with the Commonwealth at an operational level.

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Role Title	Role type	Role Description
		Operational managers may also hold organisational or outlet administration roles in the My Aged Care assessor portal. They can initiate and submit delegate applications for others in their organisation.
Organisational and/or outlet administrator	Business and System	Organisational and/or outlet administers coordinate the operations of assessment organisations and their outlets. The administrator at an organisation level can view and manage information for the entire organisation in the portal. They are also responsible for updating service information as required.
Team leader	Business and System	A team leader oversees assessment teams, including delegates and assessors, and manages assessment activities including but not limited to the management of referrals detailed in Chapter 4 of this Aged Care Assessment Manual. Team leaders provide ongoing support to assessment staff, including clinical support to assessors and delegates. Additionally, team leaders undertake regular reviews of quality management processes to support continuous improvement of assessment related services.
Triage delegate	Business and system	A triage delegate performs functions and powers of the System Governor delegated to their role as detailed in Chapter 5 and 7 of the Aged Care Assessment Manual, including but not limited to determining an individual's eligibility for an aged care needs assessment.

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Role Title	Role type	Role Description
Clinical assessor	Business and System	A clinical aged care needs assessor undertakes home support and comprehensive assessments in accordance with Chapter 5 of the Aged Care Assessment Manual. A clinical aged care needs assessor also holds the role of non-clinical assessment delegate.
Non-clinical assessor	Business and System	A non-clinical needs assessor undertakes home support assessments in accordance with Chapter 5 of the Aged Care Assessment Manual. A non-clinical aged care needs assessor also holds the role of non-clinical assessment delegate.
Clinical assessment delegate	Business and System	A clinical assessment delegate performs functions and powers of the System Governor delegated to their role as detailed in Chapter 7-8 of the Aged Care Assessment Manual, including but not limited to approving an individual for funded aged care services.
Non-clinical assessment delegate	Business and System	A non-clinical assessment delegate performs functions and powers of the System Governor delegated to their role as detailed in Chapter 7-8 of the Aged Care Assessment Manual, including but not limited to approving an individual for funded aged care services under the Commonwealth Home Support Program. Non-clinical assessors and Clinical assessors hold this role.

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Role Title	Role type	Role Description
Workplace trainer	Business	A workplace trainer provides and coordinates the mandatory training required to be undertaken by staff within of an assessment organisation in accordance with the Aged Care Workforce Learning Strategy and Chapter 2 of the Aged Care Assessment Manual.
Administration officer	Business	An Administration Officer provides support to the Team Leader and delegates, by performing the day-to-day work of phoning and booking appointments, assigning the booking to assessors, rescheduling and reassigning an assessment should any changes need to occur (assessor on unplanned leave, older person needs to change the appointment) and assigning SPRs. Administration officers may hold the team leader system role to manage and assign, un-assign and reassign referrals or transfer referrals for triage and assessment(s) and assign SPRs to an assessor.
Delegate support officer	Business and System	Delegate Support provide support to the assessment delegate with administrative tasks associated with delegation such as printing and sending letters.

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My Aged Care Assessor Portal - Organisational Administrator User Guide

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2.5. Supporting Community Engagement through the Aboriginal and Torres Strait Islander assessment pathway

Culturally safe assessments are everyone's responsibility. All organisations within the Single Assessment System are accountable for ensuring assessments are culturally safe.

As Aboriginal and Torres Strait Islander assessment organisations are embedded within communities, these organisations are well placed as trusted intermediaries to inform their communities about the Aboriginal and Torres Strait Islander Assessment pathway through communication channels that best suit the community.

To support all assessment organisations communications products developed by the Department can be adapted to suit community. Products could include:

- A website with more information about Aboriginal and Torres Strait Islander assessment to refer to
- Scripts that can be turned into radio content, or videos using local leaders
- Social media tiles that can be shared on organisations platform
- Printed products that can be used to generate interest in the service

2.5.1. Supporting the broader roll out of Aboriginal and Torres Strait Islander Assessment Organisations

Aboriginal and Torres Strait Islander assessment organisations participating in the first phase of the implementation of the workforce will assist and inform the department's planning for future phases of the implementation.

These organisations and broader community engagement will provide advice, input and feedback regarding the cultural appropriateness of the aged care needs assessment process, including time dedicated to community engagement and case management for assisting older Aboriginal and Torres Strait Islander people in their aged care assessment journey.

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2.6. Training requirements for assessment teams

The My Aged Care Workforce Learning Strategy (Workforce Learning Strategy), defines and sets the mandatory, minimum training requirement for the Single Assessment System workforce and the My Aged Care workforce, including timeframes for completion. Training occurs as part of the staff members induction into the assessment organisation. Some roles have mandatory credential requirements. Details of these qualification requirements are provided in Appendix F. The assessment organisation is responsible for validating that each person has the required qualifications for their role before requesting registration for training.

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The department and assessment organisations are jointly responsible for training assessment organisation staff. The Workforce Learning Strategy explains the blended approach to mandatory training requirements including on-line training, on-the-job learning and learner appraisal. This approach also acknowledges existing knowledge and skills of the workforce, and that learning is ongoing.

To complement the Workforce Learning Strategy, a My Aged Care Quality Learning Framework establishes processes by which the My Aged Care workforce can attain and maintain the capabilities they require, including the mechanisms by which capabilities are verified through on-line learning, on-the-job training, and learner appraisals. It defines the learning quality standards and guidelines that govern the implementation of the minimum training requirements through a blended model of learning and training.

2.6.1. Training delivery

Assessment organisations are responsible for ensuring their workforce undertake relevant minimum mandatory training requirements. Learners must complete the training that is relevant to their role, and all roles held (if multiple). Training is only available to people who are working in an assessment organisation that delivers that service. The department will consider exceptions for operational requirements. To find out more email myagedcare.capability@health.gov.au

The department delivers learning and supports training through a learning management system called MAClearning. The MAClearning platform supports delivery of minimum training requirements described in the Workforce Learning Strategy, supported by guides that outline the requirements for successful completion.

Access to MAClearning is provided by the department. Workplace trainers and operational managers are responsible for providing the details of new learners to the department for registration on MAClearning. Registration requests should be sent to maclearninghelp@Health.gov.au.

Delegates are also required to complete specified delegate training through the MAClearning system.

From time to time, the department may require assessors to undertake additional training when changes are made to programs, policies or processes. Generally, this training will be provided through MAClearning.

- My Aged Care Workforce Learning Strategy
- My Aged Care Quality Learning Framework
- New training and learning system for My Aged Care workforce

2.7. The single assessment pathway

On entry into My Aged Care, an assessment referral is made (following screening) to an assessment organisation for the older person. Once an assessment referral has been accepted by an assessment organisation, older people's care needs will be triaged by a clinically trained Triage Delegate who will make a decision on a person's eligibility for an aged care needs assessment and, if eligible, ensure that the assessment type they are referred to is proportionate to their needs and level of complexity.

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Upon accepting an assessment referral, assessment organisations are expected to actively engage with the older person as well as their support networks. This may include, but is not limited to, Elder Care Support staff, care finders, aged care providers, GPs, Aboriginal Community Controlled Health Organisations, social workers, and other relevant parties who may have facilitated the older person to access the aged care system. This engagement aims to develop a comprehensive understanding of the needs of the older Aboriginal and Torres Strait Islander person. Assessment organisations are expected to maintain regular contact with the client while the assessment remains active to maintain continuity and build rapport. The Aboriginal and Torres Strait Islander Aged Care Framework highlights that aged care assessment should be delivered in a culturally safe manner while also empowering older people to engage with the aged care system and receive services that commensurate with their needs. This ongoing engagement helps foster trust, ensures the client feels supported throughout the process, and contributes to a more accurate and respectful assessment outcome.

Establishing these connections will help build a more comprehensive understanding of the older person's needs. This also minimises the need for the client to repeat their story or answer common questions multiple times which helps to reduce stress, thereby improving the overall assessment experience.

Older people with entry level needs are assigned for a home support assessment and those with more complex needs are assigned for a comprehensive assessment.

All assessment organisations may deliver assessments through subcontracting arrangements subject to approval from the department.

2.7.1. Home support assessments

Non-clinical assessors undertake home support assessments of an older person's care needs under the *Aged Care Act 2024*. Non-clinical assessors use the IAT to enable nationally consistent assessment services. Home support assessments are appropriate for older people who have entry level care needs.

A home support assessment builds on the information collected during registration, screening, and triage to determine an older person's eligibility to receive aged care services. Home support assessments are conducted face-to-face when safe to do so in the older person's usual home setting. This will assist with the environmental, physical, and social components of the assessment as the assessor could observe the client's level of independence, functioning, and existing support arrangements. After the assessment, the assessor will develop a Support Plan that summarises the assessment findings, individualised goals, and service recommendations. The Support Plan will be submitted for approval to a non-clinical assessment delegate, and a Notice of Decision will be generated and sent to the older person and any of their registered supporters who are entitled to receive this information.

There may be occasions where, during a home support assessment, questions will be triggered in the IAT that will require clinical judgement. To reduce the need for an assessment to be reassigned to a clinical assessor, the non-clinical assessor will be required to seek the attendance of a clinical assessor to ask the clinical questions at the time of the assessment via video or phone, or at a later time via phone (see Chapter 5).

At the end of the assessment, the IAT outcome may result in a Support at Home classification level, or the assessor may determine that the older person has intensive and complex care needs. In these circumstances the assessment must be converted to a comprehensive assessment in the IAT before Support at Home or Residential Aged Care

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can be added to the support plan (see Chapter 5). If this conversion is initiated by a non-clinical assessor, they will need to seek the supervision of a clinical assessor in accordance with their organisation's clinical governance framework and standard operating procedures. The Support Plan will be submitted for approval by a clinical assessment delegate, and a Notice of Decision will be generated and sent to the older person and any of their registered supporters who are entitled to receive this information.

2.7.2. Comprehensive assessments

A comprehensive assessment is an assessment of aged care needs for older people, undertaken by clinical assessors, who use the IAT to enable nationally consistent assessment services. Comprehensive assessments are appropriate for older people who have more complex needs and who may require a higher level of care.

A comprehensive assessment builds on the information collected during registration, screening and at triage, to determine an older person's eligibility to receive aged care services. A comprehensive assessment is usually conducted in a suitable face-to-face context when safe to do so, to determine an older person's eligibility for aged care services. Optimally, an aged care assessment is undertaken in an older person's home. In some circumstances a comprehensive assessment may be undertaken in a clinical setting, such as a hospital. A support person (e.g. family, friend, registered supporter, Elder Care Supporter, Care Finder etc.) may also be in attendance.

After completion of the IAT the assessor develops a Support Plan that summarises the assessment findings, individualised goals, and recommendations. The Support Plan will be submitted for approval by a clinical Assessment Delegate, and a Notice of Decision will be generated and sent to the older person and any registered supporters who are entitled to receive this information.

Comprehensive assessments often require a longer time to complete due to the complexity of needs. Assessors and assessment organisations are expected to maintain regular contact with the client while the assessment remains active to maintain continuity and build rapport.

The Aboriginal and Torres Strait Islander Aged Care Framework highlights that aged care assessments should be delivered in a cultural safe manner while also empowering older people to engage with the aged care system and receive services that address their needs. Assessors are expected to maintain regular contact with an older Aboriginal and Torres Strait Islander person while the assessment remains active to maintain continuity and build rapport. This ongoing engagement helps foster trust, ensures the older person feels supported throughout the process, and contributes to a more accurate and respectful assessment outcome.

2.8. Other assessment activities

2.8.1. Support plan reviews (SPR)

Assessors conduct SPRs for older people who have previously had an assessment where their needs and circumstances have changed or when finalising a period of reablement and the Support Plan is updated. Where there is a significant change in an older person's circumstances a reassessment is undertaken (see Chapter 10 Support plan review and reassessments').

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2.8.2. Wellness and reablement

The provision of wellness and reablement approaches are embedded in the aged care assessment. These approaches build on people's strengths and goals to promote greater independence and autonomy in daily living tasks. They avoid 'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves without needing on-going service delivery, or with a reduced need for services. Reablement involves supporting participants to maintain or regain skills, improving functional capacity, improving confidence and enhancing capability so an older person can resume everyday activities. All assessors should adopt wellness and reablement approaches during the assessment and consider whether a recommendation for time-limited reablement under the CHSP is appropriate. Time-limited reablement services tend to be delivered within a 12-week period with the aim to wrap up services when the older person has met their goal or specific outcome. This involves the older person and reablement providers working together to plan how they will address specific barriers to independence and achieve the client's goal.

2.8.3. Linking support

An assessment includes the provision of linking support activities to vulnerable older people where areas of vulnerability pose barriers to receiving mainstream aged care supports or care. Issues leading to vulnerability could include experiencing homelessness, mental health concerns, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage, cognitive decline and/or living in a remote locality, and previous traumatic events. The provision of linking support will assist in linking the older person to one or more services they require to live with dignity, and independence.

Assessors may work with Elder Care Support staff to provide guidance to older Aboriginal and Torres Strait Islander people to assist them to engage with the aged care system.

2.8.4. Assessment delegation

The Secretary of the department as the System Governor plays a key role in the governance of the aged care system. Under the *Aged Care Act 2024* the System Governor is afforded a range of powers and functions. These powers and functions include but are not limited to determining an individual's eligibility for an aged care needs assessment and their need for Commonwealth subsidised aged care services. The System Governor will delegate some of their powers and functions to internal delegations (departmental staff) and to some roles within assessment organisations. There are three roles within assessment organisations, that are delegated certain functions or powers of the System Governor:

- Triage Delegates
- Non-clinical Assessment Delegates
- Clinical Assessment Delegates

For further information about delegate roles, their functions and responsibilities refer to Chapter 7 of this manual

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2.8.5. Multi-disciplinary approach

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

A multidisciplinary approach to aged care assessment for older Aboriginal and Torres Strait Islander people should go beyond a clinical assessment and must consider the client's social, emotional, and cultural wellbeing. It may involve collaboration with other professionals, social workers, community members, as part of the assessment and guided by the client. This is to ensure the assessment is holistic, culturally safe and responsive to the person's needs. Respect and care for Aboriginal and Torres Strait Islander peoples' ways of working is critical to building reciprocal trust and the client's ageing well outcomes.

This approach should also be applied to other people who have experienced trauma such as people from diverse backgrounds and life experiences. Assessors need to apply trauma-aware, culturally safe and rights-based approaches to assessment, consistent with the Statement of Rights under the Aged Care Act 2024, to uphold older people's dignity, autonomy, safety, informed choice and control, and to minimise the risk of re-traumatisation. For further information see Chapter 12.

2.9. Aims and key features of assessment

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

- deliver timely, safe, and nationally consistent aged care assessments of a high quality guided by the Aged Care Assessment Quality Framework, facilitating access to Commonwealth government aged care services which best meet the current needs of the older person.
- conduct assessments in accordance with privacy obligations, and with the consent of the older person (or their appointed decision maker), optimally in a face-to-face setting when safe to do so.
- value and support an older person's identity, culture, and diversity.
- involve older people and their carers, support network and other service providers, such as Care Finders and Elder Care Support workers (where they are registered as an Agent supporting the client) as appropriate in assessment and care support planning processes.
- ensure assessments of older people are independent, holistic, and older person-focused, incorporating assessment of physical, medical, psychological, cultural, social, environmental and wellness dimensions which are separate from service provision.
- deliver tailored Support Plans incorporating an older person's choice, improving the health and wellbeing of older people, which are based on their goals and current care needs, embedding wellness and reablement approaches where appropriate (see Chapter 5).

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- ensure older people from diverse backgrounds have equitable access to assessment services.

- provide a choice for older Aboriginal and Torres Strait Islander people to access culturally safe, trauma aware and healing informed aged care assessments from Aboriginal and Torres Strait Islander assessment organisations.

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

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

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

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

2.10. Assessment quality

Assessment organisations are required to undertake aged care needs assessments using the IAT in a manner that focuses on the older person and contributes to delivering timely, safe and nationally consistent high-quality assessments, guided by the Aged Care Assessment Quality Framework (the Framework).

The Framework describes essential organisational skills required to support assessors to reach and maintain a high-quality assessment experience for every older person. It also incorporates the three-tiers of quality management, focusing on assuring quality assessments including those in relation to younger people (existing aged care recipients needing a reassessment for other aged care services), older Aboriginal and Torres Strait Islander people and those from diverse backgrounds.

The Framework aligns with the consumer-focused principles of the Aged Care Quality Standards from the Aged Care Quality and Safety Commission (ACQSC).

These Aged Care Quality Standards identify a high-quality assessment as one that meets the following four quality goals:

1. **Personal** –the assessment process is conducted as a respectful conversation and is responsive to the person's individual situation, context, goals, and aspirations – it includes and respects the role of carers and family and ascertains the sustainability of this support. Further, the support plan accurately reflects the older person's personal and unique circumstances (i.e., physical, medical, psychological, cultural, social, and personal) and the older person's specific goals and aspirations reflective of their assessed care needs.
2. **Effective** – the older person feels that the assessment process culminates in them being able to exercise choice and control in accessing the right services (as available

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and as eligible) to assist them to remain in a setting most appropriate to their needs. There is a reduced need for the older person to tell their story more than once.

3. **Connected** – the older person feels connected to their My Aged Care pathway to services; understands how and why the assessment process contributes to their journey and what the likely timeframes are for approval decisions and access to services.
4. **Safe** – the older person is provided a physically, emotionally and culturally safe assessment where their unique experiences are respected and factored into the way they are assessed for aged care. All assessments are delivered in a safe environment and free from harm.

The Framework provides detail of the key components and elements that must be in place to achieve high-quality assessment for every older person.

Detailed measures and performance targets against the four quality goals are described in Section 5 of the Framework. The tools used to manage a quality assessment align to a three-tiered approach to managing quality.

Assessment organisations are required to comply with the guidance set out in the Framework and this Manual. Assessment organisation managers play an important role in providing program support, training and information to their assessment staff to enable them to undertake quality assessments. Operational managers are required to distribute documents and products relating the Aged Care Assessment Quality Framework to their assessment workforce.

2.11. Integrated Assessment Tool (IAT)

The IAT was developed as part of the aged care reforms undertaken in accordance with the Australian Government's response to recommendations from the Royal Commission into Aged Care Quality and Safety.

The IAT and its Validated Assessment Tools is the prescribed tool that assessors must use under s62-5 of the Aged Care Act 2024. The IAT is essential for capturing a comprehensive profile of an older person's needs, ensuring accuracy and consistency in decision-making. The IAT consolidates key information about an older person's needs across a number of domains, providing a holistic view of their health and circumstances. Additionally, embedded validated tools assess abilities and capacity, forming a solid evidence base for determining care needs.

The IAT is divided into 12 sections. Some of the sections contain nested questions to tailor assessments, only diving deeper into areas where needed.

The IAT Offline Form is also available for assessors who are undertaking assessments remotely or who do not have any available internet access at the time of the assessment.

IAT Offline Form

IAT User Guide

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2.11.1. Validated Assessment Tools

Where appropriate, assessors should consider using culturally appropriate validated tools within the IAT to deliver culturally safe, trauma aware and healing informed assessments. These tools are detailed in Table 12

Table 12. Validated culturally appropriate assessment tools

Validated culturally appropriate tool	Short description
Good Spirit Good Life (GSGL):	The GSGL addresses gaps in health and aged care by providing a culturally-informed approach to measuring, understanding and meeting the quality of life of older First Nations people. The tool measures wellbeing using 12 interconnected factors which are important to the First Nations people, such as family and friends, connection to Country, community, culture, health, respect, their role as an Elder, support services, safety and security, spirituality, future wishes and basic needs being met. Guidance on Good Spirit Good Life is available at: https://www.aboriginalageingwellresearch.com/gsgl-resources (registration required to view) This tool is available in the Integrated Assessment Tool (IAT).
De Morton Mobility Index modified	The DEMMI modified 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. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions • The completion of Departmental training on the DEMMI modified is required before it can be used in a client assessment. • AN-ACC Assessor Manual for guidance on responding to questions in the DEMMI-modified validated tool.
Duke Social Support Index – Social Interaction Subscale	The Duke Social Support Index (DSSI) intends to capture essential components of social support related to mental health outcomes and the use of health services in treating older individuals with non-psychiatric medical illnesses.

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Validated culturally appropriate tool	Short description
	Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer this validated tool with a client at an assessment. • Guidance on the DSSI is available at https://alswh.org.au/wp-content/uploads/2020/08/DDSSection2.7DSSI.pdf
Step 1 GP Cog and Step 2 GP Cog	The GP-Cog is a reliable, valid, and efficient instrument to screen for dementia. The GP-Cog score is not influenced by the cultural and linguistic background of a person making it an invaluable screening tool especially in multicultural patient settings. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer this validated tool with a client at an assessment. • Guidance on the GP-Cog is available at gpcog.com.au.
Patient Health Questionnaire-4 (PHQ-4)	The purpose of the PHQ-4 is to allow for ultra-brief and accurate measurement of core symptoms/signs of depression and anxiety by combining the two-item measure (PHQ–2), consisting of core criteria for depression, as well as a two-item measure for anxiety (GAD–2), both of which have independently been shown to be good brief screening tools Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Some guidance on PHQ-4 is available at: Anxiety & Depression (PHQ-4) | The WELL Office – McGill University
Geriatric Depression Scale	The Geriatric Depression Scale (GDS) (15 point version) is a depression assessment tool specifically designed for older people. The GDS can be filled out by the client or administered by an interviewer. It comprises 15

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Validated culturally appropriate tool	Short description
	questions about how the client has felt over the past week. Questions require yes/no answers. Some items in the GDS may not be appropriate at all times for all cultural groups. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer this validated tool with a client at an assessment.
KICA Cog	A validated cognitive assessment tool for older Indigenous Australians, aged 45 years and older, in remote settings for whom other dementia assessments are not suitable. • Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. Please review the MAClearning element **Validated Assessment Tools in Practice** for further guidance on how and when to administer this validated tool with a client at an assessment. • KICA COG (Remote) • Instruction Booklet This tool is available in the Integrated Assessment Tool (IAT).
KICA Cog Urban Regional	KICA was modified for use with Aboriginal people in regional and urban settings. The regional and urban KICA is an instrument to assess dementia in older Aboriginal people in regional and urban settings. **Additional information and training resources:** Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element **Validated Assessment Tools in Practice** for further guidance on how and when to administer this validated tool with a client at an assessment.

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Validated culturally appropriate tool	Short description
	• Guidance on the KIKA Cog Urban Regional is available at Indigenous Cognitive Assessment: Regional and Urban KICA | National Ageing Research Institute Limited (nari.net.au) This tool is available in the Integrated Assessment Tool (IAT).
KICA Carer	The KICA-Carer is an informant questionnaire given by the interviewer. It is the informant cognitive subsection of the KICA that was developed and validated in the Kimberley region of WA. • Kimberley Indigenous Cognitive Assessment – KICA-Carer This tool is available in the Integrated Assessment Tool (IAT).
Revised Urinary Incontinence Scale	The Revised Urinary Incontinence Scale (RUIS) is a validated tool to assess the severity and impact of urinary incontinence in adults. The RUIS consists of 10 items that assess the frequency, amount, and impact of urinary incontinence, as well as the patient's level of concern related to incontinence. Each item is scored on a scale from 0 to 3, with higher scores indicating a greater severity and impact of urinary incontinence. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Revised Incontinence and Patient Satisfaction Tools Version 2 – Technical Manual and Instructions • RUIS Brochure – Summary for assessing and monitoring urinary incontinence. • International Continence Society (ICS)- RUIS - study findings • Please review the MAClearning element **Validated Assessment Tools in Practice** for further guidance on how and when to administer the RUIS with a client at an assessment.
Revised Faecal Incontinence Scale	The Revised Faecal Incontinence Scale (RFIS), is a validated assessment tool used to assess the severity and impact of fecal incontinence in adults. The RFIS is

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Validated culturally appropriate tool	Short description
	designed to be simple and effective and can be completed by a trained healthcare professional. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Revised Incontinence and Patient Satisfaction Tools Version 2 – Technical Manual and Instructions • RUIS Brochure – Summary of assessing and monitoring faecal incontinence. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer the RFIS with a client at an assessment.

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3. Chapter 3: Referral, registration and screening

What you'll find in this chapter

This chapter details the referral, registration and screening stages of the assessment journey. Information includes:

- Entry into My Aged Care
- Registered supporters
- Screening
- Alternative entry
- Emergency Residential Care – Application for Care form (for residential care or residential respite)

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3.1. Entry into My Aged Care

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

An older person's need for aged care services may also be identified by their family and carers, social worker, Elder Care Support connectors, care finders, or service providers.

These entry points to access Australian Government-funded aged care services comprise the 'approved form' under section 56 of the Aged Care Act 2024 for new applicants and section 64 for those older people or eligible younger people who are making an application for a reassessment (noting the 'request a support plan review' pathway also constitutes an approved form for section 64). These entry points also comprise the approved form for the purposes of section 71 (alternative entry).

Note:

Older Aboriginal and Torres Strait Islander people will be able to indicate their preference for their assessment to be conducted by an Aboriginal and Torres Strait Islander assessment organisation at any of the below stages, or referral points.

3.1.1. Modes of entry into My Aged Care

Phone

Older people can call the My Aged Care Contact Centre on 1800 200 422, 8am to 8pm Monday to Friday or 10am-2pm Saturday, local time (FreeCall*).

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The My Aged Care Contact Centre receives inbound calls and referrals, creates records for older people, progresses the registration and cancellation of supporter and agent relationships, raises SPR requests, screens for needs and refers older people to assessment organisations and service providers and/or provides information to older people.

Online

Apply for an assessment online

The Apply for an Assessment Online process can be used as an alternative to contacting the My Aged Care Contact Centre or seeing an ACSO. The online form enables consumers to register with My Aged Care and apply for their first assessment online or on behalf of a family member or friend. The My Aged Care system automatically processes the online form. A request to register a supporter for the older person can also be submitted using this tool.

> Note: some older people may have had a previous assessment but were found ineligible, which would also result in them having an existing record.

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

Web referrals (Make a Referral form)

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

Web referrals contain decision support to guide the home support or comprehensive assessment pathway; however, the triage delegate can accept the recommended assessment pathway or recommend (with justification) the other assessment option.

Where the referral is submitted by a GP or health professional, for the first assessment referral (e.g., where no previous assessment exists), the system will automatically process the referral where all information is correctly entered and attachments supplied. Where automated processing is successful, a referral for assessment will be automatically issued to an appropriate assessment organisation.

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

GP e-Referral

GPs may also choose to use GP e-Referrals which can be accessed from their practice management system. The form will pre-populate the patient's information with the GP then adding any additional information and attachments as required. It is then submitted

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safely and securely to My Aged Care for processing and will follow a similar process to that outlined for the Make a Referral form.

GPs will be able to record a client's preference for an Aboriginal and Torres Strait Islander assessment organisation.

Face to face access through an Aged Care Specialist Officer (ACSO)

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

ACSOs will be able to help older Aboriginal and Torres Strait Islander people indicate their preference for an Aboriginal and Torres Strait Islander assessment organisation.

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

Services Australia website: Aged Care Specialist Officer

3.1.2. My Aged Care Online Account

Create account and registration

Once registered with My Aged Care, an older person can set up access to their My Aged Care Online Account by linking it to their myGov account. Confirmation of the type of account, identification and contact details are required. Registered supporters for an older person can also set up their own Online Account. If they have authority to access the older person's information, they can navigate from their own account to the account of the person they support.

An older person's Online Account contains important information about the older person, their registered supporter(s), organisation agent relationship details, aged care assessments, services, and interactions with My Aged Care. Further information about accessing and using a My Aged Care Online Account is available on the My Aged Care website.

3.2. Alternative entry

Section 71 of the Act provides 'alternative entry' pathways that allow an older person in certain circumstances to begin receiving care before being assessed and approved for funded aged care services.

Subsection 71(4) of the Act outlines the three different circumstances when an individual may access care before undergoing an assessment or receiving approval. These circumstances are outlined as the following:

- **Urgent services**: The individual was in urgent need of access to funded aged care services and there was a significant risk of harm to the individual if services were not provided before an approval was given.

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- **Lack of availability of culturally safe assessments**: The individual is an Aboriginal and Torres Strait Islander person and at the time the individual sought access to funded aged care services, there was a lack of availability to access a culturally safe assessment.
- **Services commenced through a specialist aged care program and there is a significant delay in assessment**: The individual started to receive care from a specialist aged care program (such as CHSP, MPSP or NATSIFACP) before approval was given, and at the time the individual sought funded aged care services there was a significant delay in the availability to undertake a needs assessment.

This pathway is available for individuals who commenced accessing specialist aged care services before an approval was given. Specialist aged care programs include:

- Multi-Purpose Service Program (MPSP)
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP); and
- Commonwealth Home Support Program (CHSP).

Note that, because eligibility criteria for the Transition Care Program (TCP) requires the individual to have an assessment in a hospital setting before they are recommended TCP, TCP cannot be accessed through alternative entry.

To access any of the alternative entry pathways, an individual (often with the support of their provider) must make an application to the System Governor in an 'approved form' within the time period specified in the Aged Care Act 2024 (the Act) and *Aged Care Rules 2025*.

An application can be lodged for access to Commonwealth subsidised services under the Act's alternative entry provisions via any of the available application pathways (e.g. Contact Centre, online referral or self-referral through an Assessment Organisation). In this context, an 'application' under section 71 refers to the initial registration process undertaken by contacting My Aged Care Contact Centre.

This pathway is also available for individuals to access residential care or residential respite care under the Act's alternative entry provisions via any of the available application pathways or by submitting the Emergency Residential Care - Application for Care Form. For further information on the form see section 3.6, Chapter 3).

Individuals (often with the support of their provider) have a period of **5 days** after the day on which services commenced to make an application under section 71 of the Act

In most cases, individuals who have accessed a service prior to an assessment would have accessed this service through contacting the My Aged Care Contact Centre and referred at the point of screening. In a small minority of cases, individuals may receive urgent services directly through a CHSP provider prior to applying through My Aged Care, in which case the provider would support the older person to register through My Aged Care within the 5-day timeframe.

The *Aged Care Rules 2025* specify one exception, if the registered provider delivering services is a NATSIFACP or MPSP provider. In this instance, the individual has **30 days** after the day care commenced to make an application. Providers should support the individual to go through the application process within this timeframe.

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If the System Governor is satisfied one of the circumstances outlined in the Act applies to the individual and any other requirements under section 71 have been met, the Act allows for the date care began to be recorded as the date of effect of approval. Further information is available in Chapter 9 of the Manual to assist Assessment Delegates to give backdated approval after care has commenced via the Notice of Decision.

Alternative Entry is also applicable for older people new to the aged care system or those individuals *already* eligible and accessing services, but whose needs have changed and a re-assessment of their needs is required.

3.2.1. Alternative Entry – CHSP Direct-to-Provider Referrals

If an individual is eligible for the alternative entry pathway under subsection 71(4) of the Act, they can be issued a CHSP direct-to-provider referral prior to being assessed.

These referrals are issued by triage delegates and, in some circumstances, My Aged Care Contact Centre staff or ACSOs during screening.

Older people who may require CHSP referrals prior to being assessed include:

- New individuals who are applying for an aged care needs assessment
- Current CHSP clients who are waiting for a support plan review or reassessment
- Support at Home participants who have a fully allocated budget or are waiting for a budget allocation and have an urgent need for services.

Screening

The My Aged Care Contact Centre and ACSOs can only issue CHSP urgent service referrals in limited circumstances if there is an immediate health or safety need.

These services are:

- nursing
- transport
- meal delivery
- personal care
- other support services due to the absence of a carer, such as flexible respite.

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

Triage

Triage delegates are responsible for determining whether individuals require direct-to-provider referrals through the CHSP prior to being assessed.

Triage delegates should:

- Issue direct-to-provider referrals for CHSP services if the client requires the service and meets the criteria in subsection 71(4) of the Act

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- Review any urgent service referrals that have been issued by the My Aged Care Contact Centre or ACSO and extend 'recommended end dates' if required
- Check all clients with an immediate health or safety need for services have a 'high' assessment priority.

If the client accessed or is accessing funded aged care services prior to assessment through the alternative entry pathway, but is refusing to have an assessment, the Triage delegate or assessor will need to explain that it is a requirement under the *Aged Care Act 2024* to complete an assessment to keep receiving services, otherwise their government-funded services will cease. Alternatively, the client may enter a full fee-paying arrangement with the service provider. The assessor should also remind the client of the benefits of undergoing a full assessment, for example:

- It does not cost anything to receive an assessment
- An assessment will provide the client with a more fulsome evaluation of their needs and may result in different services being recommended that they were not previously eligible for.

Assessment

Even if the services are no longer required, individuals who have accessed CHSP urgent services **must undergo an assessment**.

Assessors must contact an older person within two weeks if they have been issued urgent service referrals to ensure:

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

Where an assessor determines the client requires ongoing CHSP services after a period of urgent services, they **must generate new CHSP service referrals**. For more information see Chapter 9.4.5.

3.2.2. Residential care or residential respite care in urgent circumstances

Alternative entry pathways are available for individuals who require urgent residential care or residential respite care. To be eligible, at the time care is accessed there must be a significant risk of harm to the individual if those services were not delivered before approval to access funded aged care services was given. An application can be lodged by providers or individuals for access to residential care or residential respite care under the Act's alternative entry provisions via any of the available application pathways or by submitting the Emergency Residential Care - Application for Care Form. Individuals have 5 days after the day on which services commenced to lodge an application. For further information on the use of the form to apply urgent residential care or residential respite care, refer to section 3.6 of this Manual.

In urgent cases, the person is already receiving care, but this does not mean they are permanently entering aged care or will remain at the current facility.

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3.3. Screening

My Aged Care Contact Centre staff and ACSOs complete screening after a person registers with My Aged Care and has a My Aged Care older person record and identification number assigned. Older people can opt in to receive SMS notifications prior to the call, which helps build trust by alerting them that My Aged Care will be calling from a private number.

Alternatively, screening is built into the online inbound referral, such as when a health professional conducts a web-referral and applies for an older person's assessment online.

Under the *Aged Care Act 2024* screening **no longer decides** if a client is eligible for an aged care needs assessment. Instead, this responsibility now rests with Triage Delegates within assessment organisations.

The screening outcome is intended only as a recommendation on an individual's **likely eligibility** for an aged care needs assessment.

Under the *Aged Care Act 2024*, individuals maintain the right to make an application for funded aged care services even if they are not initially considered to meet the eligibility criteria for an aged care needs assessment. However, the final eligibility determination rests with the Triage Delegate in an assessment organisation, who evaluates the referral according to the requirements outlined in section 58 of the *Aged Care Act 2024*. See section 1.4 for eligibility requirements to access funded aged care.

An individual's eligibility to access services once they have been assessed will be determined by an Assessment Delegate. The Assessment Delegate will consider the 'assessment report', which comprises the support plan and any other relevant information. If an Assessment Delegate is satisfied an individual requires access, they will make a decision under section 65 to approve access to one or more funded aged care services.

3.3.1. Outcomes of screening

On completion of the screening:

- Assign referral priority to indicate the timing of the assessment and the urgency in which services are delivered to an older person, which is based on an older person's level of function, the level of risk in relation to the care situation and any other relevant concerns.
- Send the referral to an appropriate assessment organisation with the older person's consent.
- For urgent referrals for the End-of-Life Pathway, ensure the referral is marked as 'End-of-Life'.
- Send urgent service referrals to a CHSP provider with the older person's consent and **send an assessment referral at the same time**. If urgent services are approved, Assessment delegates can backdate approvals for the urgent services after an assessment, see Section 3.4.1

Note:
Where a referral is issued to the organisation in error, the My Aged Care Contact Centre can recall the referral (see Chapter 4 Referral for assessment).

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3.4. Support networks for an older person

Where an older person is registered with My Aged Care, there may also be a network of registered supporters and/or agent organisations on the older person's record.

3.4.1. Registered supporters

Supported decision-making in aged care legislation

Everyone has the right to make decisions about their life, including the support and services they receive from aged care.

The *Aged Care Act 2024* (the Act) puts the rights of older people first. It aims to ensure aged care services are safe and older people are treated with respect.

A key change under the Act is that every older person is presumed to have the ability to make decisions. Some older people may want or need support to make these decisions. Supported decision-making is the process of providing support to help older people make and communicate their own decisions, rather than having decisions made for them. This allows older people to remain in control of their lives.

Supported decision-making in assessments

Under the Act, assessors should promote an older person's right to make decisions, engage with registered supporters in line with the older person's will and preferences, and embed supported decision-making in assessment delivery.

It is important to remember that supported decision-making principles and practices are not just about engaging with registered supporters. Supported decision-making is about supporting an older person to make their own decisions, in the ways they want or need.

This might look like:

- Asking the older person to make decisions about their aged care services and needs (rather than deferring to their family, registered supporters or their active, appointed decision-maker),
- Checking whether an older person has a registered supporter, and whether the older person wants that person to provide support. Remember that having a registered supporter does not mean that the older person needs to include them in discussions and their decision-making processes. It is always up to the older person. A registered supporter can only act in line with the older person's will and preferences, and
- Considering how supported decision-making principles can be embedded into an assessment process. This could be:
    - more time for the older person to explore options and only asking them to make one decision at a time,
    - presenting the older person with options in ways the older person prefers, such as visually, and
    - encouraging and supporting the older person to make decisions at a time and place most comfortable for the older person.

Role of registered supporters

Chapter 1, Part 4 of the Act establishes the role of a registered supporter. The registered supporter role is one of the changes under the Act that aim to promote each older

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persons' right to be supported to make their own decisions. The registered supporter role commenced on 1 November 2025 and replaced existing regular and authorised representative relationships in My Aged Care.

Under the Act, older people can still choose who can support them to make decisions, if they want or need support. These people can be – but don't always have to be – registered supporters. A registered supporter may be a trusted family member or friend or anyone else of an older person's choosing, who can help them to request, access and understand information and communicate their wishes.

There are benefits to registering a supporter. Registered supporters can:

- help older people to make and communicate their own decisions about aged care. This might include speaking to My Aged Care, aged care assessors, aged care providers and workers, and the Aged Care Quality and Safety Commission, and
- request, access and receive information about the older person they support.

All registered supporters have duties under the Act they must comply with. These duties are intended to promote an older person's safety, rights, will, and preferences.

Having a registered supporter does not stop an older person from being able to receive information, make decisions, or communicate directly with others including their aged care provider, My Aged Care and assessors. Older people can continue to request, receive and communicate information and make their own decisions.

An older person does not have to register a supporter. Some older people might feel they are already supported by their carers and other significant people in their lives, without needing any of them to become a registered supporter. These people can continue to play an important role in supporting an older person, regardless of whether they are a registered supporter. This means, with the older person's consent, someone who is not a registered supporter may continue supporting an older person during their assessment. The older person may provide their consent for another person to communicate their decisions and wishes, but this consent is not enduring and is limited to the interaction at the time.

Assessors must ensure that the older person has provided their consent each time someone who is not their registered supporter is communicating the decisions of, or information for, the older person. Guidance for assessors when engaging with someone seeking to make a decision on behalf of an older person is provided in the sections on appointed decision makers.

Wherever possible, aged care providers and assessment organisations must continue to ask the older person to make decisions about their aged care services and needs, even where there is a registered supporter. An older person's ability to make decisions and communicate their will and preferences may change from day to day, or over time, so understanding who their registered supporters are and the role they can perform is essential in respecting the older person's rights.

The System Governor plays a role in regulating registered supporters. This includes registration, suspension and cancellation.

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Active, appointed decision makers

Some registered supporters may also have guardianship, enduring power of attorney or similar legal authority recognised under the Act. These people are appointed decision makers for the older person and can make decisions on behalf of the older person under Commonwealth, state or territory arrangements. They can only make decisions in line with their active, legal authority.

Decision-making arrangements differ across Commonwealth, state and territory jurisdictions. As such, the authority a person may have to make decisions for an older person may be subject to different requirements and conditions. In some circumstances, a person's authority to make decisions for an older person is not enlivened until the older person is found to have lost, or be experiencing a loss, in their decision-making ability, for some or all decisions. Before actioning a request or decision made by a person other than an older person, assessors need to consider the person's decision-making authority for an older person, including when it becomes active, on a case-by-case basis. This may involve sighting medical evidence about the older person.

If a registered supporter who is also an appointed decision maker is supporting the older person to make a decision that falls outside the scope of their Commonwealth, state or territory arrangement, they must not make the decision on the older person's behalf. For example, where an active, appointed decision maker has financial decision-making authority only, they cannot make personal decisions for the older person - they should instead support the older person to make that decision. If the older person wants support, the registered supporter should adopt principles of supported decision-making in line with the duties of a registered supporter.

Becoming a registered supporter does **not** provide a person with decision-making authority for the older person. A registered supporter's role is to support the older person to make and communicate their own decisions.

There is no requirement to register a supporter, including where that person is also an appointed decision-maker under a Commonwealth, state or territory arrangement. An active, appointed decision-maker can continue to exercise their legal authority, without being registered as a supporter.

Where there is no appointed decision maker

My Aged Care understands that there may be times where an older person is no longer able to make decisions and has no one in place with legal authority to make decisions for them.

While My Aged Care cannot give anyone decision-making powers to act on an older person's behalf, there are steps that those supporting them can take to enable an older person to receive the care and support they need.

One option is to submit an application for a guardianship and/or administration order with a state or territory court, board, panel or tribunal. They can conduct a hearing and decide if a person requires a legal decision maker. They can also decide who this person will be and what decisions they may make. Some state and territory processes also include emergency options to appoint a decision maker quickly if necessary.

Further information about appointed decision makers can be found on the My Aged Care website at appointed decision makers.

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Consent and registered supporter types

In most cases, both the older person and their prospective supporter must consent to the relationship being registered. As part of obtaining consent, the older person will be asked: (1) if they would like to register a supporter; and (2) if they would like that supporter to be automatically given certain information and documents about them. This is information that may or must be provided to the older person under the Act. An older person should not feel pressured to register a supporter relationship.

Active, appointed decision makers can seek to register as an older person's supporter without the consent of the older person.

This means there are three types under the umbrella term of 'registered supporter':

- **Supporter** – a person who the older person consented to registering as a supporter **and** to be automatically given information and documents that may or must be given to the older person under the Act.
- **Supporter lite** – a person who the older person consented to registering as a supporter but **not** to be automatically given information and documents that may or must be given to the older person under the Act.
- **Supporter guardian** – a person who is registered by the System Governor as a supporter and who also has active decision-making authority for the older person by virtue of a Commonwealth, state or territory arrangement.

The following table summarises these types and the consent requirements:

Table 13. Supporter relationships and consent requirements

	Two party consent		One party consent
	Supporter	**Supporter lite**	**Supporter guardian**
Can help an older person make and communicate their own aged care decisions	✓	✓	✓
Must comply with the duties of a registered supporter, including to avoid or manage conflicts of interest	✓	✓	✓
Will be given certain aged care information about the older person automatically	✓	✗	✓
Can request aged care information about the older person	✓	✓	✓
Can make decisions on behalf of the older person, in line with their active, authority under Commonwealth, state or territory arrangements	✗	✗	✓

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The labels ‘supporter’, ‘supporter lite’ and ‘supporter guardian’ may be referred to in the My Aged Care Assessor Portal and App during the supporter registration process. For example, if an older person indicates they consent to registering a supporter, but not to that supporter automatically being given certain information about them, the My Aged Care Assessor Portal or App will note that a supporter lite relationship is being progressed. These labels will also be visible in the My Aged Care Assessor Portal or App to indicate the type of relationship that was registered.

An active, appointed decision-maker may choose not to register as a supporter, but to otherwise make themselves known to My Aged Care. Requests to do so should be escalated to the departmental delegate responsible for supporters, with proof that demonstrates the appointed decision maker has decision-making authority for the older person under a Commonwealth, state or territory arrangement and that their authority is active.

Duties

All registered supporters have duties under the new Act that they must comply with. Registered supporters must act honestly, diligently, and in good faith when undertaking these duties. These duties are intended to promote an older person’s safety, rights and will and preferences.

The duties include that registered supporters must:

- Act in a way that promotes the will, preferences, and personal, cultural, and social wellbeing of the older person they are supporting.
- Act honestly, diligently and in good faith.
- Support the older person only to the extent necessary for the older person to do the thing themselves.
- Apply their best endeavours to maintain the ability of the older person to make their own decisions.
- Declare, and avoid or manage, conflicts of interest.

These duties apply when a person is acting as a registered supporter, including when they are requesting, accessing, receiving or communicating information for the older person to support the older person to make or communicate an aged care decision.

Registered supporter Conflicts of interest

Registered supporters have a duty to avoid or manage conflicts of interest they have in their role as a registered supporter, and to inform the System Governor of conflicts as they arise.

A conflict of interest arises if a registered supporter’s personal or professional interests or obligations interfere with, could compromise, or may influence the supporter’s ability to carry out their role under the new Act. This could include a conflict between the older person’s interests and the registered supporter’s interests. A conflict of interest can be real, potential or perceived. A conflict of interest that cannot be avoided or managed can call into question the registered supporter’s ability to be impartial, selfless and perform their role under the Act.

The Conflicts of Interest policy

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Conflicts of interest policy | Australian Government Department of Health, Disability and Ageing

Acting in line with the older person's known will and preferences

A registered supporter must act in line with an older person's known will and preferences. This includes when a registered supporter is:

- requesting, accessing, or receiving information or documents, and
- communicating information, including the will, preferences and decisions of the older person.

The role of a registered supporter is not to make decisions on behalf of an older person, even if that decision is based on the older person's known or likely will and preferences.

An older person's known will and preferences are what the older person currently wants, now or in the future. The only way to know an older person's will and preferences is to communicate with them. This means that a registered supporter needs to communicate with the older person about how they want to be supported with their decision-making and what their current will and preferences are.

If a registered supporter seeks to make a decision on behalf of an older person, they can only do so as an active, appointed decision maker (if that decision is within the scope of their active, legal authority), not as a registered supporter. Active, appointed decision makers must act in accordance with the conditions and requirements under their relevant Commonwealth, state or territory arrangement. These arrangements will have specific requirements relating to how and when decision-making authority can be exercised.

Suspension and cancellation of a registered supporter

Suspension and cancellation are new relationship statuses for registered supporters. While suspended, a supporter's registration has no effect. This means that an assessor cannot engage with that person as a registered supporter. Cancellation can follow suspension or can occur without a prior suspension, depending on the circumstances. If cancelled, a supporter's registration has no effect, and an assessor cannot engage with that person as a registered supporter.

The processes of suspension and cancellation are detailed in the Act and intend to promote the safety and wishes of an older person. More information on these processes can be found on the department's website.

While assessors cannot suspend the registration of a supporter, assessors do have a role in raising or handling complaints. If an assessor believes that a registered supporter is not acting in compliance with their duties under the Act, or is otherwise concerned about the basis for which a person was registered by the System Governor, they are encouraged to raise this with the System Governor team responsible for registered supporters. This can be done using the online form for making a submission to the System Governor responsible for supporters.

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No requirement to register a supporter

Not every older person will want or need a registered supporter. Carers and other significant people in an older person's life continue to play an important role in supporting an older person, without needing to be registered supporters.

Transitioning to the registered supporter role

Most representative relationships in My Aged Care went through changes to come under the Act. If an older person had a regular or authorised representative active in My Aged Care on 31 October 2025, they became a registered supporter under the Act on 1 November 2025. This ensured that older people seeking or receiving aged care services continued to have decision-making support available to them.

Since 1 November 2025, representative relationships that were active in My Aged Care and had not opted out transitioned to supporter relationships. If older people and their supporters did not want to transition to a supporter relationship and did not opt out by 31 October, they can still request to end their supporter relationship at any time in their My Aged Care Online Account or by calling My Aged Care.

Representative arrangements made under the Quality of Care Principles 2014 no longer exist under the Act. Further, these arrangements did not automatically transition to the Act. These representatives were encouraged to become registered supporters under the Act.

- Key information and pathways to request to register a supporter: www.myagedcare.gov.au/registering-supporter
- Information on appointed decision makers: www.myagedcare.gov.au/registering-supporter/appointed-decision-makers
- Registered supporter policy library: https://www.health.gov.au/resources/collections/registered-supporter-resources
- Guide to using the Assessor Portal: My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships
- Information about transitional arrangements in place for My Aged Care representatives before 1 November 2025: Transition arrangements for the new registered supporter role | Australian Government Department of Health, Disability and Ageing
- My Aged Care – Registration of a Supporter form
- My Aged Care – translated resources

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3.4.2. Agent organisations

An older person will no longer be able to create their own agent organisation relationships on the My Aged Care website or in their online account. These relationships will need to be created by the agent organisations' staff or My Aged Care staff, including assessors, through the Service and Support Portal.

Getting support to navigate aged care | My Aged Care

My Aged Care Service and Support Portal | Australian Government Department of Health, Disability and Ageing

3.5. Exceptional Circumstances – approving a service without an assessment

In some circumstances, under section 65(4) of the *Aged Care Act 2024* a client may be approved to access aged care services without undergoing an aged care needs assessment owing to exceptional circumstances. This will typically occur where a person is accessing funded aged care services through the alternative entry pathway but pass away prior to receiving an assessment.

Where the client passes away, the assessor should select the 'Notify My Aged Care of a Death' functionality on the assessor portal to complete the assessment.

Client is receiving services but is refusing an assessment

If the Triage delegate or assessor consider there are valid reasons for the person refusing to have an assessment, assessment organisations are to contact the department in the first instance at MyAgedCareAssessment@health.gov.au for assistance. In some cases, the department may exercise delegation to approve services under the exceptional circumstances provision.

If assessment is cancelled or exceptional circumstances do not apply

If an assessment is cancelled and the assessor considers exceptional circumstances do not apply, or if the triage delegate makes an ineligibility decision for the client, the services should cease. There is a process which the department can recover funding from the provider.

3.6. Emergency Residential Care - Application for Care

Older people seeking access to funded aged care services will not be required to complete an 'Application for Care Form', which is a change from the process that occurred before 1 November 2025. The act of applying for access to services will occur through one of the existing registration pathways (e.g. the Contact Centre, support plan review request for existing clients, etc.).

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However, older people seeking access to emergency residential care (ongoing or short term – i.e. respite) may use the 'Emergency Residential Care - Application for Care Form', instead of one of the registration pathways.

Residential care (ongoing or short-term)

To be considered for a Commonwealth subsidy in urgent circumstances for residential care or residential respite, the registered provider can complete and submit a valid Emergency Residential Care - Application for Care Form. This is one of the 'approved forms' under section 71 of the Act to access funded aged care services before an aged care needs assessment.

In completing the form**:**

- The form must have both the Application for approval section and the Emergency case section of the form completed; and
- The provider may submit the form, including supporting information for referral to their local assessment organisation, within 5 calendar days after the day care commenced unless an extension has been granted by the System Governor (on application).

If an older person and/or their active appointed decision maker authorised under s 28(2) of the Act is unavailable, the registered provider may sign the form. If a provider prefers the older person's appointed decision maker to sign the form, they may apply for an extension. Under section 71 of the Act, an extension must be requested if the application cannot be submitted within the required timeframe.

In urgent cases, the person is already receiving care, but this does not mean they are permanently entering aged care or will remain at the current facility.

Triage delegates must review the *Emergency Residential Care - Application for Care Form* for completeness and be satisfied that the requirements under s58 are met. The Assessment Delegate is responsible for reviewing and approving the application form.

3.6.1. Intake and assessment process

When the *Emergency Residential Care - Application for Care Form* is received, the assessment organisation must:

- Ensure the form signed by the older person, or their active, appointed decision maker, and confirm the *emergency case* section is completed correctly by the registered provider.

- Confirm the date the form was received. If it was submitted after 5 calendar days from the care start date, assessment can only proceed if the provider has been granted an extension by the department as System Governor, following an application for extension. Requests for extensions can be sought by emailing **MyAgedCare.Assessment@health.gov.au**.

- Register and self-refer the older person in the My Aged Care assessor portal (if required and self-referral criteria are met).

- Assign assessment priority. Although the older person is already in care, the Triage Delegate must consider the urgency of their circumstances. If the older

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person's condition is rapidly deteriorating, the assessment should be scheduled as soon as possible.

- Upload the verified form to the older person's record.
- Schedule a comprehensive assessment with an assessor. Where possible, this should be face-to-face and collect information to:
    - Determine the older person's required level of care; and
    - Confirm that urgent circumstances existed at entry and that prior approval was not practicable.
    - Note: for respite care assessments, the DEMMI modified tool must be undertaken face to face by clinical assessors only.

The assessor must collect as much information as possible about the urgent situation from the older person, their registered supporters (if available, and in line with the older person's will and preferences), their active, appointed decision maker/s (as relevant), the registered provider, and any other professionals involved at the time of entry.

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4. Chapter 4: Referral for assessment

What you'll find in this chapter

This chapter details how to manage referrals for assessments in the My Aged Care assessor portal.

The following topics are covered in this chapter:

- managing and actioning referrals and assigning referral priority;
- managing preference for Aboriginal and Torres Strait Islander assessments;
- End-of-Life Pathway 'high priority' flag in the system;
- how priority categories are assigned to different assessments including Home Support, Comprehensive (including those completed in a Hospital setting); and
- how assessors can self-refer for eligible and (likely) ineligible individuals.

4.1. Managing referrals

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

4.2. Referral priority categories

A referral for assessment will include a priority rating that relates to the timing of the assessment and the urgency in which services are delivered to an older person. The allocation of a priority category for a referral is based on an older person's level of function, the level of risk in relation to the care situation and any other relevant concerns.

While accepting the referral, the team leader can change a priority allocation set by the My Aged Care Contact Centre or ACSO if their professional view is that it does not align with the guidance on priority for home support and comprehensive assessments (hospital and community setting) in the section below. Timeframes associated with priority categories are specified in assessment organisation contractual agreements with the department. A priority category is also assigned when an older person is referred to services. Note: the timeframe is calculated from the date the referral was issued, not the date the priority was changed.

In the assessor portal, there are visual indicators for referrals and assessments to facilitate timely responses of priority timeframes.

Assessment referrals to assessment organisations must be actioned (accepted, rejected or transferred) within three calendar days from issue. Following acceptance of the referral, other timeframes are applied for managing referrals, as highlighted in Tables 14-16 below.

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4.2.1. Home support assessment priority categories

Based on the older person's needs, a referral for a home support assessment may be classified as one of three priority categories, high medium or low.

Table 14. Home support assessment priority categories

Priority Level	Definition	Timeframes (from day of referral acceptance to completion)
High	Requires an urgent assessment based on the information collected during the referral process indicating the person would need to be hospitalised or leave their current residence without support because they are unable to care for themselves, or their carer is unavailable and/or has serious risks or safety hazards in their home. This may be due to a crisis in the home involving either the older person or the carer, or a sudden change in the older person or carer's medical, physical, cognitive, or psychological status. High priority referrals may also be accompanied by a direct-to-provider referral for urgent CHSP services (see Chapter 3 for more information on the Alternative Entry Pathway).	10 calendar days
Medium	Information available at referral indicates that the older person is not at immediate risk of harm, however there is a progressive deterioration in the older person's current status (physical, mental, cognitive, situational, functional), and/or the level of care that is currently available does not meet the older person's needs and is not sustainable long term.	14 calendar days
Low	Refers to cases where the referral information indicates that the older person has sufficient support at present and does not need immediate assistance but requires an assessment in anticipation of their upcoming care requirements. Examples include the carer planning a holiday which will result in the care recipient requiring the provision of substitute care, or recognition that the person is having increased difficulty living independently and options for care need to be discussed with the older person and their carer or family. Low priority cases would also indicate that an older person can manage with their current living arrangements, can complete most functional tasks without help, and/or there	21 calendar days

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Priority Level	Definition	Timeframes (from day of referral acceptance to completion)
	are no immediate aged care related health and safety risks apparent.	

4.2.2. Comprehensive assessment priority categories- community setting

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

Table 15. Comprehensive assessment priority categories – community setting

Priority Level	Definition	Timeframes (from day of referral acceptance to completion)
High	Requires an immediate response (e.g., response within 48 hours) based on the information collected during the referral process. An urgent assessment is required if the person's safety is at risk (e.g., high risk of falls or abuse), or there is a high likelihood that the person will be hospitalised or required to leave their current residence because they are unable to care for themselves, or their carer is unavailable. This may be due to a crisis in the home involving either the older person or the carer, or a sudden change in the older person or carer's medical, physical, cognitive, or psychological status. End-of-Life Pathway referrals are also in this category and should be prioritised for urgent action.	10 calendar days
Medium	Information available at referral indicates that the older person is not at immediate risk of harm. Referrals should be allocated to this priority category if they indicate progressive deterioration in the older person's physical, mental, or functional status, or that the level of care currently available to the older person does not meet their needs or is not sustainable in the long-term.	20 calendar days

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Priority Level	Definition	Timeframes (from day of referral acceptance to completion)
Low	Refers to cases where the referral information indicates that the older person has sufficient support available at present, but that they require an assessment in anticipation of their upcoming care requirements. Examples include the carer planning a holiday, which will result in the care recipient requiring the provision of substitute care or recognition that the person is having increased difficulty living independently and options for care need to be discussed with the older person and their carer or family.	40 calendar days

4.2.3. Hospital assessment priority categories

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

Table 16. Hospital assessment priority categories

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

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Priority Level	Definition	Timeframes (from day of referral acceptance to completion)
Low	Information available at referral indicates an appropriate response within 10 calendar days and completion within 15 calendar days of referral acceptance).	15 calendar days

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

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

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

4.3. Actioning referrals

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

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

4.3.1. Preference for an Aboriginal and Torres Strait Islander assessment organisation

Some older Aboriginal and Torres Strait Islander people may prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, others may prefer the first available organisation regardless of who it is, and some may prefer to receive an

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assessment from a mainstream assessment organisation. The single assessment pathway supports the choice of each older Aboriginal and Torres Strait Islander person.

My Aged Care system functionality records if an Aboriginal and Torres Strait Islander client would prefer to have their assessment completed by an Aboriginal and Torres Strait Islander assessment organisation.

- This should be recorded when registering a client in the My Aged Care system
- It may also be recorded by an assessor during an assessment.
- The preference will then display in the client details as well as on the client's card.
- If one is available, Aboriginal and Torres Strait Islander assessment organisations will be represented with a prefix "FNAO-" and appear at the top of the list of available services. If none is available in the region, then no organisation on the list will have the prefix.
- Team Leaders will get a warning when they try to transfer if the client has indicated a preference, if the assessment organisation is not an Aboriginal and Torres Strait Islander assessment organisation.
- Sometimes, the older person will want to know the name of the available organisation(s) before being referred to them.

An older Aboriginal and Torres Strait Islander person may also wish to change or remove their preference at any time; assessors are expected to support the wishes, will and preferences of the older person.

> Note:
>
> Aboriginal and Torres Strait Islander assessment organisations have commenced in some parts of Australia from August 2025.
>
> In regions where these services are still being established, an older Aboriginal and Torres Strait Islander person will not be able to be referred to an Aboriginal and Torres Strait Islander assessment organisation. Information about an older person's preference will be collected and used to understand demand for these services. Once Aboriginal and Torres Strait Islander assessment organisation become available in a region, this preference information will guide referrals for an assessment or support plan review.

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4.3.2. Providing assessment services as Aboriginal and Torres Strait Islander assessment organisations are being established

While Aboriginal and Torres Strait Islander assessment organisations are being established, older Aboriginal and Torres Strait Islander people will continue to be assessed by mainstream assessment organisations under the Single Assessment System.

If an Aboriginal and Torres Strait Islander client is already scheduled for an assessment with a mainstream assessment organisation and an Aboriginal and Torres Strait Islander assessment organisation becomes available in their area; the client should be advised of this option. They should be informed that choosing to be transferred to an Aboriginal and Torres Strait Islander assessment organisation may result in a longer wait time for an

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assessment. Clients should also be informed that there will be future opportunities to transfer to the new organisation if their needs change.

When discussing this option, the client's health condition and care needs must be taken into consideration to ensure that any delay in assessment would not adversely impact their wellbeing. Unless the client chooses to transfer the assessment should continue as originally planned.

Any preferences for Aboriginal and Torres Strait Islander assessment organisations should be identified during the assessor's pre-assessment planning. This allows time to arrange a transfer prior to the scheduled assessment, if needed. Making a referral change at the point of assessment may significantly lengthen the client's wait time, which is not the desirable outcome.

It is recommended that assessors discuss this with the client prior to the assessment to ensure that they have choice, control and the ability to make informed decisions regarding their care. If the client's preference is to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, the assessor can manage the referral in accordance with the processes detailed in this Chapter.

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4.3.3. Client scenarios for capturing the preference for an Aboriginal and Torres Strait Islander assessment organisation

Scenario 1: Capturing the preference of an Aboriginal and Torres Strait Islander assessment organisation even though there is not one available in the region.

Sharon is a triage delegate working for an assessment organisation under the Single Assessment System, who is triaging an older Aboriginal and Torres Strait Islander client, Violet. Sharon is up to date with what organisations are available in the region and knows there is not an Aboriginal and Torres Strait Islander assessment organisation available yet; but that there may be one in future.

OPTION A: If there is no information in the FNAO preference field, Sharon needs to capture Violet's preference in case an Aboriginal and Torres Strait Islander assessment organisation becomes available in future.

"Violet, there are Aboriginal and Torres Strait Islander assessment organisations starting to provide aged care assessments in some regions of Australia. I can see that there is no preference logged in your record. There is not one available in this local region yet, but there may be one in future. If an Aboriginal and Torres Strait Islander aged care assessment organisation becomes available, would you prefer to receive future assessments from them? If so, I can record your preference so that you can be directed to those services in the future"

Violet indicates that she would prefer to be transferred to an Aboriginal and Torres Strait Islander assessment organisation in the future, and Sharon records the preference then continues to conduct the assessment.

OPTION B: If there is a FNAO preference captured in the preference field. Sharon notes the preference for an Aboriginal and Torres Strait Islander assessment organisation and knows that there is not one available. Sharon understands that this would have been explained to Violet at the point of triage. Sharon continues

with the assessment as planned without asking Violet to unnecessarily confirm her preference multiple times.

After the assessment Sharon advises Violet that for continuity of care, any future reviews of her care will now come back to Sharon's organisation. Based on Violet's preferences, Sharon will keep that in place for now and can transfer Violet to an Aboriginal and Torres Strait Islander organisation if available when the review is needed.

Scenario 2: Prior to an assessment, the assessor sees the preference for the Aboriginal and Torres Strait Islander assessment organisation which has recently become available.

In the pre-assessment planning, Steve is an aged care assessor working for an assessment organisation under the Single Assessment System, who has an upcoming assessment with an older Aboriginal and Torres Strait Islander Client, Bill.

Steve has had this assessment booked in for some time and knows that since the assessment was booked, an Aboriginal and Torres Strait Islander assessment organisation has become available in the area. Steve wants to get the best outcome for his client, so contacts the client in advance to talk about the availability of the service.

"Bill, there are Aboriginal and Torres Strait Islander assessment organisations starting to provide aged care assessments in your area. I can see you have a preference to be assessed by an Aboriginal and Torres Strait Islander assessment organisation; and since we have had this appointment booked in, an Aboriginal and Torres Strait Islander assessment service has become available in this area. As we are meeting soon, would you like us to continue with the assessment?

If you would prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, I can refer you to them instead. This may take time. We would connect you with the organisation, and then they will be in touch as soon as they can to book an assessment with you. How would you like to proceed?"

Option A: Bill indicates that he would prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation in the future, but to keep the process moving given his health and care needs, would continue the conversation with Steve as planned.

Steve advises Bill that for continuity of care, any future reviews of his care will now come back to Steve's organisation. Based on Bill's preferences, Steve can keep that in place, or transfer Bill to an Aboriginal and Torres Strait Islander assessment organisation when the review is needed.

Option B: Bill indicates that he would prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, he understands that this may take time to get booked in, understands the impacts to his health and aged care needs; and is happy to wait for the referral to be re-directed. Steve makes arrangements to transfer the referral for Bill (referrals and rejections are covered in Section 4.3of the manual).

Best practice for the client is that Steve supports the client's choice and his organisation makes contact with the Aboriginal and Torres Strait Islander

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assessment organisation in the region to ensure that they have capacity and support a warm handover to transfer Bill.

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During the scale up of services, it is important that assessors and assessment organisations stay up to date on which Aboriginal and Torres Strait Islander assessment organisations are available and in which locations. Staying up to date ensures that clients are offered appropriate options and supports timely, culturally safe referrals. To support this awareness:

- The department will provide updates through communications such as email notifications, and messages within the relevant platforms as services roll out.
- Aboriginal and Torres Strait assessment organisation outlets will be prefixed with "FNAO-" and appear at the top of the list of available organisations.
- Aboriginal and Torres Strait Islander assessment organisations are listed on the interactive map of available services.
- The Department's website will be updated regularly.

4.3.4. Unlikely to be eligible for an assessment flag

If a client is found to be **likely ineligible** for an aged care needs assessment during screening, a flag titled 'likely ineligible' will appear on the client's assessment referral once the Team Leader has accepted the referral in the My Aged Care Assessor Portal.

When actioning an assessment referral, Team Leaders may notice an option to reject an assessment referral by selecting the reason as Ineligible at Triage. However, Team Leaders should not use 'Ineligible at Triage' reason to reject a referral.

Using this rejection reason will prevent the client from being formally triaged by the Triage Delegate. If there is no other valid reason to reject the referral (such as the client is deceased, medically unstable, no consent etc.), and the client's assessment referral is flagged as 'unlikely to be eligible', the Team Leader must accept and assign the assessment referral to a Triage Delegate to determine eligibility for assessment.

This flag is an indication only; the decision whether an individual is eligible for an assessment must be made by a Triage Delegate, who acts as the System Governor under the *Act*.

A client who has been found ineligible at triage for an aged care assessment must be sent an 'Ineligible for Assessment' Letter (known as 'Notice of decision not to make an eligibility determination' notice). The letter must be uploaded as an attachment on the client's online account via the My Aged Care Assessor Portal. For further information see Chapter 9.

> Note:
>
> If the older person was previously found 'likely ineligible' during screening and later is eligible the screening information will not change as screening can only be completed once. Triage Delegates should be diligent in reviewing an older person's record to ensure they are eligible for an assessment.

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4.3.5. End-of-Life referrals

Assessors must undertake High Priority Assessments for new End-of-Life clients. The Assessor Portal will include system capability for team leaders and triage delegates to flag clients as an 'End-of-life client' through the High Priority assessment process. The aged care assessment referral will be flagged as an 'End-of-Life referral' and will be given a high priority. Assessors will be able to identify referrals for the End-of-Life Pathway through a visual indicator that marks the referral as End-of-Life, and through filtering for the End-of-Life Pathway. However, **it is important to note that current system functionality does not allow team leaders to identify Support Plan Reviews for the End-of-Life Pathway through the same mechanisms** (team leaders will be able to filter by urgency, but they will be unable to see the visual indicator or filter specifically for End-of-Life). Instead, upon receiving urgent requests for Support Plan Reviews, it is important that team leaders click the double arrow icon to expand the referral card, verify whether it relates to the End-of-Life Pathway and prioritise it accordingly. This must be done for all incoming referrals for Support Plan Reviews to ensure older people seeking access to the End-of-Life Pathway are prioritised.

For CHSP clients who are seeking the End-of-Life Pathway via a SPR, if the assessor or team leader is satisfied the referral is an End-of-Life request, they can select the "recommend new assessment" button under the "before you start the support plan review" tab to proceed directly to a comprehensive assessment.

The End-of-Life Pathway Form does not need to be attached to the client's record for the assessment to proceed. If an End-of-Life Pathway Form has not been submitted, the team leader or triage delegate should advise the older person of the steps required. In cases where an aged care assessment or SPR will be undertaken via telehealth, assessors must assist older people to ensure the completed End-of-Life Pathway Form is submitted. More information on options is included in section 6.3.1.

The End-of-Life Form must be uploaded and verified prior to the Support Plan being completed. Prompts will show to ensure the form is verified. If an assessment referral has been received with an End-of-Life flag, the End-of-Life form can be verified by clicking on the 'edit' icon. During an assessment it can be verified by selecting the 'Verify End of Life Form' Button. The form can be verified as:

Table 17. End of Life Form verification options

Option	When to use
Document Reviewed - valid	The correct, complete document has been uploaded.
Document Reviewed – pending	The documentation is either incomplete or not provided.
Document Reviewed – invalid	The End-of-Life pathway is no longer needed or the documentation is invalid.

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The End-of-Life Pathway can be flagged at any stage of the individual's assessment journey.

My Aged Care – Assessor Portal User Guide 3 – Managing referrals for assessment and support plan reviews | Australian Government Department of Health, Disability and Ageing

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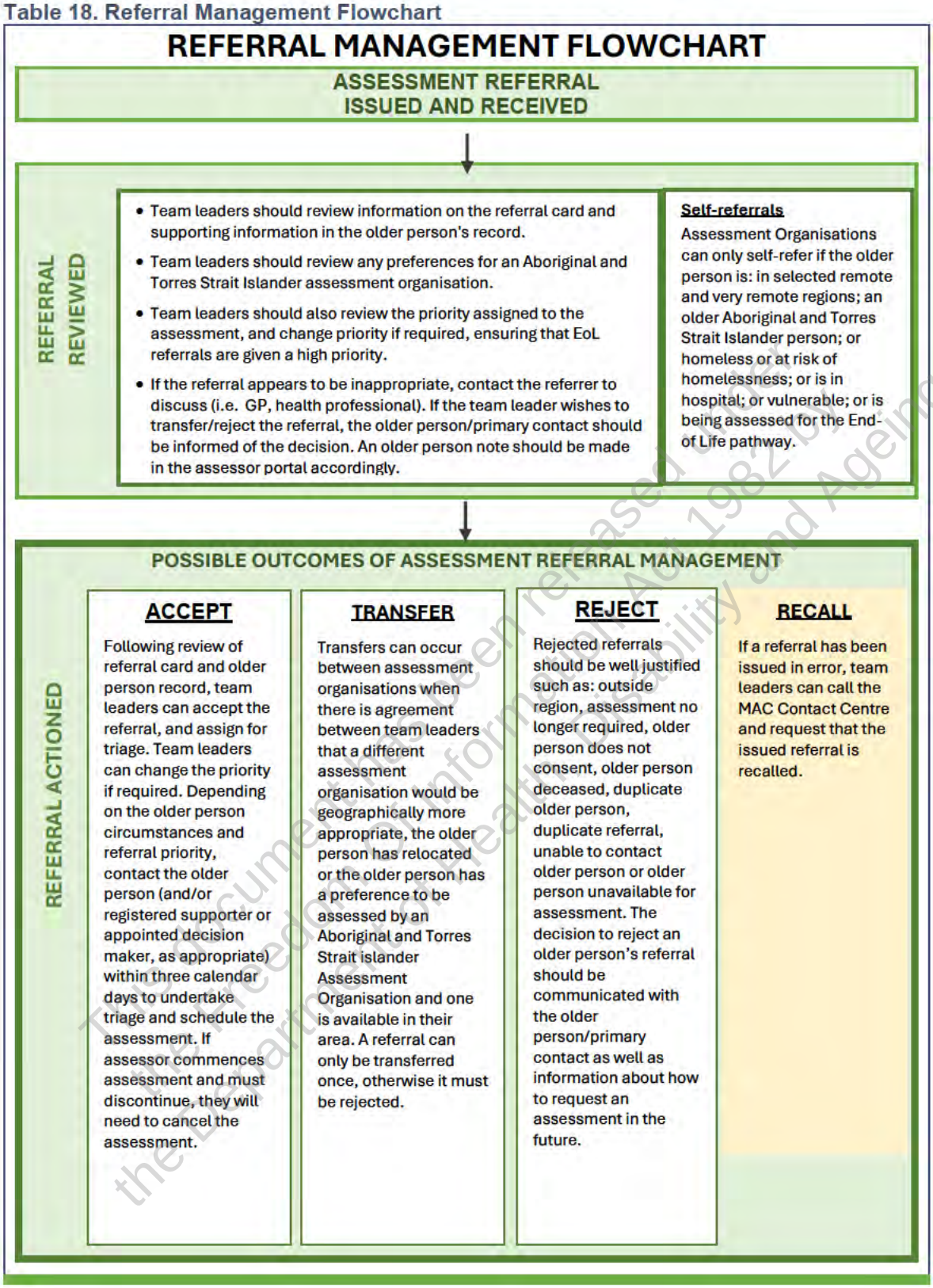
Table 18. Referral Management Flowchart



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4.3.6. Accept a referral

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

A Team Leader must:

- Review the referral information and determine whether the referral is appropriate to be accepted, transferred or rejected.
- Determine whether the referral has been made to the right organisation or outlet (e.g. the older person is in the same geographical location).
- Note any concerns for the triage delegate's consideration relating to eligibility for aged care services
- Note any preference for an Aboriginal and Torres Strait Islander assessment organisation.
- On receiving an assessment referral, any relevant information relating to the older person's referral should be reviewed. Information can be sourced from the older person's record, including:
    - previous screening/assessment details
    - previous Support Plans
    - previous approvals
    - attachments (e.g., hospital discharge summary)
    - notes
    - interactions; and
    - primary contact/registered supporter/agent for the older person.

- Check that the older person's contact details and preferences are accurate and up to date in My Aged Care and amend as necessary. For older people who are approved and seeking services, the Team Leader must ensure the accuracy of the older person and their support network's contact information as this will ensure correspondence is received.
- Check whether a supporter or agent for the older person has been registered or established. If the client is already registered in My Aged Care, Team Leaders can use the assessor portal to find the client, then view their support network (if any supporter relationships have been registered).
- Review the priority assigned by the referrer and change it if it does not align with the guidance on priority for assessment referral. Once a referral is received, it is important that older people are contacted and seen in a timely manner, especially those with urgent needs.
- As web referrals (including referrals submitted by GPs, health professionals and older people using the 'Apply for an Assessment Online' form) are automated to a **medium** priority, it is important to review the referral information and reassign the priority (if applicable) according to the older person's needs. This will prevent urgent cases from being overlooked.
- Older people and/or their registered supporters should be contacted and eligibility determined through triage within three calendar days of accepting the referral.
- Note that assessors should consider workload management between focusing on SPRs versus reassessments to ensure priority is given to older people with the greatest need.

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4.3.7. Transferring referrals

Team leaders can transfer incoming and accepted referrals (that have not been commenced) between assessment organisations. Transfers can occur between assessment organisations when there is agreement between those organisations' team leaders that this is necessary (e.g. due to the location or organisational capacity issues or the older person has a preference to be assessed by an Aboriginal and Torres Strait Islander assessment organisation). A referral can only be transferred once. However, assessment outlets should consider the reasons carefully before rejecting a referral.

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

- The older person understands why their referral is being transferred and consents to the transfer of the referral to another assessment organisation.
- They have contacted the assessment organisation that will be receiving the older person's referral to confirm that they will accept the referral. A referral should not be transferred before confirmation has been obtained that it will be accepted by the receiving assessment organisation. This ensures that the older person does not experience any delay in having an assessment.

4.3.8. Rejecting a referral

Team leaders can reject a referral when first managing the referral or reject or transfer a referral after acceptance. Once an assessor starts the assessment, they will need to cancel it if the assessment should not proceed.

> Note:
>
> If the assessment is going ahead, but needs to be reassigned to another assessor, it should not be cancelled.

If rejecting a referral, a rejection reason from the list of values needs to be selected and relevant comments added on the reason for the rejection where further explanation is required.

Table 19. Referral rejection - List of values

Client/family/rep unavailable	Client age – alternate options
Duplicate client record	Client does not consent
Interpreter not available	Client deceased
Unable to contact client	Clinical staff not available
Outside assessment region	Client prefers a FNAO

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Assessment no longer required	Hospital assessment required
Care approval meets needs (the client is receiving aged care services and they are sufficient)	Client prefers later assessment
Client medically unstable	Other

Note:

The department monitors the rejected referral rates and rejection reasons, including when the 'other' rejection reason is used.

Referral rejection decisions need to align with good practice and place the older person's interests at the centre of the decision. Referrals should only be rejected after careful consideration and for valid reasons.

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

- The assessor is unable to transfer the referral to another assessment organisation.
- A referral may be rejected if it is outside the assessment region, or the older person does not consent to the assessment. An incorrect referral priority is not a valid reason to reject a referral.
- The older person has been admitted to hospital so the assessment is no longer required.
- The older person is medically unstable.
- The older person does not consent, withdraws their consent, is no longer seeking services and/or withdraws their application for assessment.
- The older person has passed away.

- There is a duplicate older person entry or a duplicate referral.
- There is insufficient information to proceed with the referral, or the older person is unable to be contacted after many attempts.

It is recognised that building rapport and trust with older Aboriginal and Torres Strait Islander clients may require multiple contact attempts, particularly for individuals who have experienced trauma or institutionalisation. Assessment organisations should make all reasonable efforts to engage with the client in a respectful and culturally safe manner with their advocate if they have identified they are in contact with one.

Aboriginal and Torres Strait Assessment Organisations are encouraged to consider culturally safe engagement strategies, such as involving trusted agents like Elder Care Support Connectors or other appropriate advocates as well as arranging face to face contact where possible.

Note:

Rejecting a referral should be used as a last resort. A transfer prior to the assessment is preferable to a rejection to ensure a timely assessment.

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

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

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

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

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

The decision to reject a referral must be communicated to the older person/primary contact/appointed decision maker with information about how to request an assessment in the future. Effective communication with the older person/registered supporter on a decision to reject the referral, and effective communication between assessors, assists with managing expectations and reducing complaints.

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4.3.9. Recall a referral

Where a referral is issued to the organisation inappropriately and is not at the status of 'rejected' or 'transferred', the team leader may request that the My Aged Care Contact Centre recall the referral.

The My Aged Care contact centre can recall referrals if it was:

- Sent in error by the My Aged Care contact centre.
- Sent to the wrong organisation and meets the requirements for transfer.

You can call the My Aged Care Service Provider and Assessor Helpline (1800 836 799) if you need a referral recalled. Note, the team leader of the outlet will receive a system notification if a referral has been recalled.

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4.4. Self-referrals

The circumstances in which an assessor can self-refer an assessment referral to themselves or their assessment organisation (and team leaders with a system assessor role) are limited to assessment referrals:

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

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

Where the assessor identifies a potential older person with aged care needs that is cohabitating with the current older person at the time of the assessment, the assessor may wish to encourage that person to contact and register with My Aged Care My Aged Care to register for My Aged Care and request an assessment.

When creating the self-referral, assessors are encouraged:

- to upload any additional documentation relevant to the older person's situation (for example, a hospital discharge notice),

- Provide any reasoning relating to the person's vulnerability under the 'Notes' tab in the assessor portal. With the older person's consent, sensitive information should be recorded in sensitive notes and attachments. Triage and self-referral

All individuals seeking access to funded aged care services are required to undergo triage to determine their eligibility, even if they are self-referred by an assessor. Triage Delegates should be aware assessors are able to complete triage during a self-referred assessment. Unless an assessor also holds the Triage Delegate role, they must complete triage for a self-referred assessment under the supervision of a Triage Delegate.

A triage delegate must actively supervise triage conducted by an assessor, via phone or video conferencing. The decision whether someone is eligible to undergo an assessment, remains with the triage delegate and should not be made in their absence. If a delegate is not available to supervise triage the assessment should be paused until such time a delegate becomes available. Assessors conducting triage during a self-referred assessment must nominate the supervising Triage Delegate. Triage will be unable to be completed unless a supervising delegate has been nominated.

Note:
For triage to be enabled in the Aged Care Assessor App (the App) for self-referred assessments, the referral must be generated in the App. If a referral is generated in the My Aged Care Assessor Portal, it will first need to be triaged before being assigned to an assessor to complete the assessment.

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4.4.1. Conducting triage and self-referral for likely ineligible individuals

There may be circumstances where an assessor self-refers an individual who is 'likely ineligible' for an assessment. Assessors should not advise any person seeking access to funded services they are not eligible for an assessment, that decision remains with the triage delegate.

In community settings when an assessor identifies someone who is likely ineligible for an assessment, they should encourage the person to contact the My Aged Care Contact Centre to apply for funded aged care services. Assessors should avoid self-referring individuals they think are likely ineligible.

When self-referring an individual who is likely ineligible in an in-hospital setting, assessors should refer the individual to an assessment organisation, not to themselves. This approach ensures the referral is appropriately actioned first by a Team Leader and then allocated to a Triage Delegate, for a determination to be made. If an individual is determined to be eligible, the referral will then be allocated to an assessor to complete an assessment.

These processes are only applicable to individuals who have been identified as likely ineligible. If there are no concerns about an individual's eligibility, assessors may refer the individual to themselves and conduct triage under the supervision of a triage delegate.

4.4.2. Prevention of duplicate records

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

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

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

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

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

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

4.4.3. Verifying the individual's legal name

Assessors should use the wallet check process to verify the individual's legal name and birthdate (see section 5.6, Commencing the Assessment, and section 5.6.2 Wallet check).

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Legal name vs preferred name

- When searching for an older person to determine if they already have a My Aged Care older person record, the assessor must ask if the older person prefers to go by a name other than their legal name.
- Conducting searches under each name can help to identify if a previously created record exists.
- Use the wallet check process to verify individual's legal name (see section 5.6 Commencing the Assessment, and section 5.6.2 Wallet check).
- When a record does not exist and you are creating the record, use the legal name in the first name field.

Once the record is created, add a preferred name in the field provided in the personal details section of the older person record.

> Note:
>
> It is important to keep in mind when verifying an older person's legal and preferred name that in some Aboriginal and Torres Strait Islander traditions or communities, people can change the name they use throughout their life or be known by different names by different people. This can occur due to changes in role/status within their community, or significant events such as the passing of a person.
>
> This practice may also be relevant in other cultures. If appropriate and culturally safe to do so, an assessor should explore all names an older person may have used during the period they were eligible for aged care services. This helps ensure accurate records and supports respectful engagement.

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Additional information in name field

- Do not add any additional information in the name fields – putting the relationship of a person to an older person in the name field, for example Mary (Daughter), will prevent the system from matching that record in future searches and may cause the creation of a duplicate record.
- Any additional information that does not have a predetermined field can be entered into the 'Notes' section of the older person's record.
- Where possible, you should enter the older person's date of birth as opposed to entering the older person's age.

Special characters

When completing the name fields for an older person record only use the following characters:

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

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

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4.5. Support plan reviews and reassessments

Section 64 of the *Aged Care Act 2024* provides for aged care needs reassessments. A reassessment may be required when an individual's circumstances have changed significantly, or other circumstances apply to the individual. The Rules prescribe the relevant change in circumstances that may necessitate a reassessment under 64-5 (for significant changes) and 64-10 (for other circumstances).

In the *Aged Care Act 2024* the term 'reassessment' is used as an umbrella term to describe both SPRs and a reassessment for someone already receiving funded aged care services. An individual may request a reassessment if they believe their aged care needs have changed, or it may be identified through a scheduled SPR.

> Note: in this manual, the term 'reassessment' is used to describe an assessment that occurs after an older person has already been assessed at least once. From 1 November, SPRs will be used as a mechanism to adjust an older person's aged care services without needing to undertake a full reassessment. A reassessment will be conducted when there are *significant* changes to a client's needs or circumstances.

In some cases, the Assessment Delegate may approve access to services based on updated information through the SPR process.

However, in cases where a *significant* change is identified, a new aged care needs assessment must be undertaken. Significant changes in care needs and circumstances requiring a higher-level of care or different types of care (and/or changes to priority) will require a reassessment.

Significant change is referenced in section 64 of the *Aged Care Act 2024 (the Act)* and defined in the *Aged Care Rules 2025*:

- a carer for the individual has permanently ceased to provide some or all care to the individual.
- the individual has experienced an event, or a decline in their condition, that is likely to mean that they will require:
- more frequent access to a service they are already receiving, or
- access to a service they have been approved for but are not currently receiving, or
- access to new services not covered in the older person's access approval.

The triage delegate will determine whether an individual is eligible for a reassessment. The information required by Triage Delegates to confirm a reassessment will be gathered by assessors during a support plan review.

All reassessment requests, including reassessments, begin through the SPR workflow in the assessor portal. A reassessment will be requested if required.

When a client undergoes a reassessment, the system will prompt assessors to review and update the client's urgency category, even if care needs have not changed.

One exception to this is the End-of-Life Pathway, where an SPR can be used to transfer a current Support at Home participant from an ongoing classification onto the End-of-Life Pathway.

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Further information on SPRs and reassessments see Chapter 10.

Under paragraph 195(3) of the Act, a provider may submit a SPR to request a second concurrent unit of Restorative Care Pathway (RCP) funding for a person already approved for, and accessing, the RCP. To approve the SPR, an assessment delegate must consider the evidence provided outlines sufficient justification of higher needs for multidisciplinary allied health and/nursing services to achieve identified restorative care goals. Assessment delegates may also consider the availability of RCP funding units for allocation.

4.5.1. SPR and reassessment requests

A SPR request will be referred to the assessment organisation that undertook the most recent assessment.

A SPR may be requested by:

- the older person/registered supporter (through the My Aged Care Contact Centre or ACSO)
- a service provider (through the My Aged Care Service and Support portal)
- a GP, hospital, or community health professional through the My Aged Care contact centre or a My Aged Care web referral.

  Note: If a web referral is received by the My Aged Care Contact Centre, they will create a SPR request.

- If a reablement or linking support period is open, the team leader will ask the assessor to finalise the support period so the SPR request can be issued
- the assessor may initiate a SPR without requiring a request or scheduled SPR.

  Note:

  A SPR may be requested when an older person is undergoing reablement and/or linking support.

  If the older person is undergoing reablement or linking support, the team leader will not be able to assign the SPR until the support period is marked as completed.

  To allow continuity of the support period, the assessor can re-add the support period during the SPR.

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

- why the request has been made (e.g., older person's circumstance)

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- what is the request for (e.g., service type) and why it is needed (e.g., older person's change in needs or goals)
- if the request is urgent and why it is urgent
- if the person has a preference to be assessed by an Aboriginal and Torres Strait Islander assessment organisation
- what services the older person is currently receiving
- identify options explored with the older person to increase their current support
- attach supporting documentation where relevant
- identify significant changes in circumstances that the older person has experienced

4.5.2. Managing an SPR request

Upon receiving a SPR request and understanding the client's preferences and needs, the team leader should consider the most appropriate action:

- assign the request
- transfer the request
- recommend a reassessment, or
- cancel the request

While no priority category for SPRs exists as it does for assessment referrals, assessors should consider prioritising SPRs where there is an identifiable urgent need. This helps ensure older people who require a higher level of care and services due to their condition are afforded an appropriate assessment with minimal delays. In particular, assessors should prioritise:

- End-of-Life SPRs, completing them as soon as possible. These will be marked 'urgent' in the system.
- Referrals where referral information indicates a significant event has occurred or the older person has a rapidly deteriorating condition, all of which will likely result in a reassessment. This will help ensure prompt review by a Triage Delegate, who may recommend interim CHSP services for the individual.
- Requests for **a second unit of restorative care** where there is a need for continuity of services

Otherwise, assessment organisations should make contact with the older person's primary contact (who may be the older person, registered supporter, appointed decision maker or agent organisation) about a non-urgent SPR request within **two** to **four** weeks. SPRs should be completed within 15 days from the date of the SPR referral is accepted, with priority given to older people with the greatest need (as specified within the request indicated by providers or by the My Aged Care contact centre/ACSO).

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Transfer the request

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

> Note:
>
> Extra care will need to be taken by team leaders during the staged rollout of Aboriginal and Torres Strait Islander assessment organisations.

There may be instances where a client has had previous interactions with a single assessment system organisation yet has a preference for an Aboriginal and Torres Strait Islander assessment organisation when one becomes available.

In this instance, it is recommended that the client be transferred to an Aboriginal and Torres Strait Islander organisation as per the current warm transfer process.

Recommend a reassessment

If the older person's circumstances have significantly changed and it is more appropriate to request a reassessment rather than completing a SPR, select 'Recommend a reassessment'. The Triage Delegate will then determine whether or not a full reassessment is required.

Cancel the request

Actions if considering cancelling the SPR:

- If there is insufficient information on the SPR request, however clarification is required on certain aspects, the assessor should contact the older person or service provider where possible to clarify the request, prior to progressing a decision to cancel the SPR. This will manage the risk to older people to ensure the older person is not disadvantaged where they require changes to their aged care support.
- The review request may be cancelled by an assessor and a SPR not undertaken if it is inappropriate or if insufficient information is provided to warrant the SPR, or the assessor (after a number of attempts) has not been able to contact the older person's primary contact (who may be the older person, registered supporter, appointed decision maker or agent organisation).
- As a minimum requirement, where the assessor cancels the SPR, they must include the cancellation reason and provide clear explanation justifying the cancellation in the cancellation details field.
- Indicating a clear cancellation reason allows the person making the request to, if necessary, amend and resubmit the request or follow up with the assessor as necessary.
- Where, through the course of the SPR conversation, the older person and/or their supporter considers no changes are required, they may agree that the SPR can be cancelled and withdraw their application. A notice of decision advising on this outcome is not required as the applicant's application is taken to be withdrawn.

Note:

If an older person is requesting a reassessment, an SPR should be undertaken in the first instance. Doing so will allow the assessor to review whether there has been a significant change in aged care needs and referring for a reassessment is warranted.

In most circumstances, the cancellation of the SPR should only occur where the older person or active, appointed decision maker, (whether registered as a supporter or not), understands and agrees to the cancellation of the SPR. A registered supporter can communicate information, including the decisions of the older person.

This is also applicable where the assessor decides to cancel an SPR due to the older person having been recently provided with an SPR and there has been no

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change in the older person's care needs or situation since the SPR was conducted.

4.6. Deceased older people

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

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

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

In the case of a client passing away before an assessment could be completed, assessors should follow the 'client deceased before assessment' process available through the My Aged Care assessor portal. For further information, see the 'exceptional circumstances' section 3.5 of Chapter 3.

My Aged Care – Assessor Portal User Guide 1 – Registering and referring older people
My Aged Care Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews
My Aged Care – Assessor Portal User Guide 4 – Navigating and updating the older person record

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5. Chapter 5: Assessment activities

What you'll find in this chapter

This chapter includes important information about how to undertake an aged care needs assessment and complete a support plan for an older person. It outlines the different services and programs that can be recommended to meet an older person's needs and goals. This chapter includes:

- Consent for triage and assessment
- Triaging Assessments and Triage Delegate role
- Revocation of Eligibility
- Undertaking a needs assessment using the IAT
- Assessment settings
- Clinical attendance
- IAT outcome
- Recommending service types and services
- Converting a home support assessment to comprehensive assessment
- Support Plan
- Wellness & Reablement Approach
- Recommending time-limited reablement under CHSP
- Linking Supports
- Assessment wrap-up

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5.1. Obtaining consent for triage and assessment

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

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

- Triage Delegates or assessors must use the applicable consent script online via the Assessor Portal (or in the app in the case of self-referrals).
- The Triage Delegate or assessor should read out the consent script/s to ensure the older person understands and is informed of the purpose for collecting the information and how it will be used and stored, and who the personal or sensitive information will be collected from (such as contacting a person's GP, other health professionals, disability service coordinator or service provider, family members or carers). If the older person prefers, the older person can read the consent script/s themselves on a printed form.

- For offline assessments the assessor must use a hard copy version of the My Aged Care Assessment Consent Form. This form includes the consent scripts and fields to record the consent for assessment and service referrals. It is located via the *Reports and Documents* tile within the My Aged Care assessor portal.

- While the My Aged Care Assessment Consent Form and scripts should be used to obtain consent from older Aboriginal and Torres Strait Islander or culturally and linguistically diverse clients assessors should take care to adapt the consent script, or access interpreters as needed, to ensure that it can be clearly understood.

- Given that many Aboriginal and Torres Strait assessment organisations also deliver other services to the community such as Health, aged care or/and Elder Care Support services, consent must be obtained from the client before using information gathered through these services to inform the aged care assessment. Under all circumstances, clients should be given a genuine choice whether they wish to receive an assessment or services from a particular service organisation and should be given the option to seek services from other providers if they so choose.

- An older person may wish to be supported by someone during their assessment. This could include a trusted family member or friend, advocate or cultural broker, care finder or elder care support worker, or community representative. These people do not have to be registered as a supporter under the Act to attend the assessment and support the older person, if the older person consents.

- Note that if a care finder has an Agent relationship established with the older person, the assessor should contact the care finder to assist in scheduling the assessment. The client should explicitly be asked if they would like the care finder to attend the assessment.

- An older person may want, or have, a registered supporter. A registered supporter is a person who is registered under the Act to help the older person make and communicate their own decisions. Registered supporters have duties they must uphold. These include acting in a way that promotes the will and preferences of the older person they are supporting and support the older person only to the extent needed for the older person to make their own decisions.

- Some supporters also have guardianship, enduring power of attorney or similar legal authority for the older person. If the older person is not able to give consent at triage or assessment because they are experiencing a loss of decision-making ability, the assessor should check whether they have an appointed decision maker who has active, legal authority to give this consent, whether or not they are yet registered as a supporter. An appointed decision maker can only make decisions on the older person's behalf in line with their active, legal authority.

- Appointed decision makers are encouraged to register as supporters. However, they are not required to register as supporters in order to exercise the authority they have under a Commonwealth, state or territory arrangement. Assessors can engage with these people before they have formally registered as supporters, as long as the assessor is satisfied that they are an active, appointed decision maker for the decision/s asked. That is, the appointed decision maker is acting within their authority.

- The assessor may make an informal assessment of an older person's decision-making ability if the assessor is aware of matters that may suggest that the older person does not have decision-making ability and consequently may not have legal

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capacity to provide informed consent. If the assessor is satisfied that the older person does not have capacity to consent to the assessment, the assessor cannot continue with the assessment unless the assessor can identify another person who can legally consent on the older person's behalf.

- If an appointed decision maker is required but is not yet in place, people supporting the older person will need to be referred to the processes in their state or territory for appointing decision makers (see Note below). These usually involve formal assessments of decision-making ability by medical practitioners like geriatricians. If an older person has no support network, assessors may consider connecting with the older person's treating medical practitioner such as a GP, if this information is known.

- The older person must be able to make an informed decision about whether they want their personal information disclosed to others. When the older person consents to an assessment, they must be made aware that they are agreeing to their personal information being collected for the purposes of the assessment and, where appropriate, disclosed to or used by other parties for the purposes of providing aged care or other community, health, or social services to the older person. Reference should be made to consent scripting and/or privacy collection notices, where available.

- An older person's right to confidentiality must always be respected. If an assessor considers that maintaining confidentiality will interfere with or compromise their role in relation to an older person, the matter should be discussed with the older person. This discussion can also involve a registered supporter, if the older person wants their registered supporter involved. This discussion can also involve an older person's appointed decision maker, if their active, legal authority relates to the personal information the confidentiality issue relates to.

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

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

- If using online consent, the triage delegate or assessor must use the My Aged Care portal prompts to indicate that consent to triage/assessment was provided. If the older person does not wish to give consent, the triage delegate or assessor will be required to select a reason for not providing consent.

- If using the Consent Form, the assessor must record the informed consent in the My Aged Care Assessment Consent Form and upload it in the older person's record through the 'Attachments' function. The assessor can then use the 'Notes' section in the older person's record to:

    - indicate the signed form has been uploaded and consent given

    - record any detail the circumstances regarding any disclosure of an older person's personal information, and

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- record any instructions relating to the assessor's conversation on informed consent with the older person (and/or active appointed decision maker) and where relevant, any registered supporters.

- If a carer is identified for the first time during the assessment under the 'Carer profile' section of the IAT, the assessor must confirm with the older person that the older person has the carer's consent to provide the carer's telephone number and related personal information.

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

- When seeking consent to make the older person's Support Plan available in their My Health Record (MHR), the assessor should ensure the older person understands that their GP, along with other authorised health professionals, will also be able to view their Support Plan on MHR. The assessor can make a note that the older person does not have to give their consent. They can also withdraw their consent at any time by calling the My Aged Care Contact Centre and requesting removal of their Support Plan from MHR.

Note:

1. If consent cannot be given by the older person or their active, appointed decision maker (either registered as a supporter or not), the triage or assessment cannot proceed, and the referral is rejected. Further information on registered supporters and active, appointed decision makers is available earlier in this manual.

2. The assessor should discuss the implications of approving a Disability Support for Older Australians (DSOA) client for aged care, ensuring DSOA clients are informed of the considerations relating to their DSOA funding and supports when they consent to proceed with the aged care assessment. DSOA clients must confirm they understand that if they are deemed eligible for aged care services their DSOA funding is capped, or they may be required to exit the existing DSOA Program (see Chapter 6).

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Privacy notice for Aged Care Needs Assessment: Privacy notice and consent web page

Federal Register of Legislation website:

- Aged Care Act 2024 - Federal Register of Legislation
- The Privacy Act 1988

Healthdirect website: Healthdirect Privacy policy

My Aged Care website:

- Privacy Policy | My Aged Care

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- Registering a supporter | My Aged Care

5.2. Triaging assessments

Triage is performed after the acceptance of a referral and prior to conducting an aged care assessment. Triage is conducted for every accepted referral, generally over the telephone and should occur within three calendar days of accepting a referral. Triage helps ensure that older people with low needs are not over-assessed and that those with complex needs have access to a comprehensive assessment. Triage also aims to validate the outcomes produced at screening, including the priority allocated to the assessment and whether urgent services are required. For participants seeking access to the End-of-Life Pathway who have submitted their End-of-Life Pathway Form at this stage, triage may also involve verifying this documentation. In addition, the triage process includes scheduling the assessment, work health and safety screening, arrangements for communication needs and confirming support people ahead of the assessment.

Depending on the older person's circumstances and referral priority, triage delegates should undertake triage with the person and/or the nominated contact within three calendar days of accepting the referral. Older people will require faster response times based on level of risk and need.

Please note for Aboriginal and Torres Strait Islander assessment organisations. In alignment with targets under Outcome Two – Culturally safe, accurate and prioritised assessment under the Aboriginal and Torres Strait Islander Aged Care framework, the client or their representatives should be contacted and an eligibility determined through triage within 10 days of a referral being accepted by the Aboriginal and Torres Strait Islander assessment organisation. This timeframe acknowledges the importance of culturally safe engagement, including the need for multiple contacts and additional time that may be needed to establish trust and rapport with the client. However, the timeframe will be dependent on the client circumstances and referral priority. The timeframe should not compromise on older people being able to access timely aged care services. To avoid disadvantaging the client, assessment organisations should still aim to complete the triage process within 3 days to enable the older person to receive a timely assessment.

If an Elder Care Support worker has been facilitating an older person's access to the aged care system, the assessment organisation should, with consent from the client, involve the Elder Care Support worker in the triage process.

Where an assessment is self-referred, and the assessor is with the client, the assessor may be able to conduct triage with the client at the same time as the assessment. If the assessor is not a Triage Delegate, the Triage must be completed with oversight from a Triage Delegate. Note that, in the instance of self-referral, triage constitutes one of the 'approved forms' under section 56 of the Act.

5.2.1. Delegation to the Triage Delegate

Triage delegates have powers and functions afforded to the System Governor under the *Aged Care Act 2024* (the Act) delegated to them. Section 58 of the Act relates to eligibility for an aged care needs assessment.

Within an assessment organisation, the person holding a triage delegate role must meet certain qualifications (detailed in Appendix F) and training requirements (detailed in the Aged Care Learning Strategy).

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The role of the triage delegate is to determine whether an older person is eligible for a needs assessment for funded aged care services. Prior to 1 November 2025, an older person's eligibility for assessment was determined by the My Aged Care contact centre after a person was screened. Under the Act it is determined by the triage delegate.

A triage delegate, in reaching their decision to find someone eligible for a needs assessment, must be satisfied the older person meets the age eligibility requirement and has declared they have an aged care need.

AGE ELIGIBILITY	AGED CARE NEED
The individual must be: Aged over 65 years, **or** An Aboriginal or Torres Strait Islander person and aged at least 50, **or** A person who is homeless, or at risk of homelessness, and aged at least 50.	The individual must have eligible care needs. This means they: o are experiencing physical, mental or social difficulty with daily living activities, **and/or** o need help from another person or use an aid to stay physically, mentally or socially able to function independently, **and/or** o need help from another person or use an aid to stay physically mentally or socially able to function independently.

Figure 2 - Eligibility requirements

In doing this the triage delegate must check all information available on the older person's My Aged Care record to confirm:

- the older person's date of birth, by checking with the older person, their registered supporter and/or active, appointed decision maker
- that the older person has declared they have care needs, noting this can be made by the older person through the registration and screening process or through a written statement from a person applying on the older person's behalf, or through written medical records (see section 58-5 of the *Aged Care Rules 2025*)
- for older people who have already been assessed at least once, the older person has had a significant change in circumstances and a reassessment is required. Significant changes are provided for in the *Aged Care Rules 2025* and include:
    - a carer for the older person has permanently ceased to provide some or all care to the older person;
    - the older person has experienced an event, or a decline in their condition, that is likely to mean that they will require:
        - more frequent access to a service they are already receiving, or
        - access to a service they have been approved for but are not currently accessing, or
        - access to new services not covered in the older person's access approval.

The triage delegate must also undertake the triage section of the IAT to determine the type of assessment (home support or comprehensive) for the individual.

If a person has gone through the screening process and been advised they are likely to be ineligible for the needs assessment, a flag will appear in the My Aged Care Assessor Portal. Triage delegates should use all available information from screening, on the older

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person's My Aged Care Profile and provided during triage to reach their own decision regarding an individual's eligibility. Triage Delegates are ultimately responsible to make a decision about an older person's eligibility for a needs assessment.

In addition to determining the eligibility for an older person to undergo a needs assessment, Triage Delegates should also undertake the triage section of the IAT and determine the assessment type and assign to an appropriate assessor.

Under the Instrument of Delegation, Triage Delegates will also be delegated the power to decide under section 64 of the *Aged Care Act 2024* that an older person has undergone a significant change of circumstances or other change in their circumstances and requires a reassessment of their needs. The information required by Triage Delegates to confirm a reassessment will be gathered by assessors during a support plan review.

Triage Delegates should pay special attention to any clients that are marked as unlikely to be eligible due to their age and check if their application for care was already in-progress before 1 November 2025. See section 1.5.11*Younger people* in Chapter 1.

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5.2.2. Eligibility considerations for older Aboriginal and Torres Strait Islander people

The assessment process for Aboriginal and Torres Strait Islander people between 50-64 years of age is the same process for assessing people aged 65 years and older. Under the *Aged Care Act 2024*, triage delegates will be required to inform people who are under 65 and seeking aged care services of alternative services that may meet their needs, prior to determining their eligibility (see section below). The person seeking assessment is not required to take up these services.

A person does not need to provide proof that they are Aboriginal and Torres Strait Islander. Self-identification, or identification by a person or organisation they trust is sufficient for aged care purposes.

Important: older Aboriginal and Torres Strait Islander people may be members of the Stolen Generations and/or be impacted by displacement and social disruption and therefore may be traumatised by having to demonstrate their Indigeneity. If a person identifies as Aboriginal and Torres Strait Islander it is important for this to be documented during the assessment for eligibility, service and data collection purposes.

5.2.3. Eligibility considerations for people who are homeless or who are at risk of homelessness

The assessment process for people who are homeless or at risk of homelessness between 50-64 years of age is the same process for assessing people aged 65 years and older. Under the Act, triage delegates will be required to inform people who are under 65 and seeking aged care services of alternative services that may meet their needs, prior to determining their eligibility (see section below). The person seeking assessment is not required to take up these services.

The following definitions apply for this cohort and must be used when determining someone's eligibility for an aged care needs assessment who is aged between 50 and 64 years.

Homeless definition

'Homeless' in the context of aged care and for the purpose of receiving Australian Government funded aged care services refers to an individual who:

a) is aged 50 or older, and
b) has prematurely aged and requires services for their aged care needs, and
c) has the following living arrangements:
   - Lacks any adequate roof over their head, or
   - Has no security of tenure, or moves between various forms of temporary or medium-term shelter, or
   - stays in accommodation that falls below minimum community standards4, and
d) does not have the means to change their living arrangements.

At risk of homelessness definition

'At risk of homelessness' in the context of aged care and for the purpose of receiving Australian Government funded aged care services refers to an individual who:

a) is aged 50 or older, and
b) has prematurely aged requiring services for their aged care needs, and
c) is at risk of experiencing the following living arrangements:
   i. having no adequate roof over their head, or
   ii. having no security of tenure, or moves between various forms of temporary or medium-term shelter, or
   iii. staying in accommodation that falls below minimum community standards, and
d) does not have the means to change their living arrangements.

In the context of assessing eligibility criteria to receive Government funded aged care services under the Act, a homeless individual is someone who is currently without adequate, stable accommodation or accommodation that meets minimum standards, has no means to change their living arrangements, is at least 50 years old, has aged care needs and has prematurely aged due to experiencing homelessness, resulting in a need for aged care services.

In the context of assessing eligibility criteria to receive Government funded aged care services under the Act, an individual who is at risk of homelessness, may currently be housed, however is in such a vulnerable position that it is reasonable to expect they will soon experience homelessness (without adequate, stable accommodation or accommodation that meets minimum standards), has no means to change their living arrangements, is at least 50 years old, has aged care needs and has prematurely aged due to experiencing homelessness, resulting in a need for aged care services.

Eligibility criteria assessment

An individual is considered homeless or at risk of homelessness and eligible for Australian Government funded aged care services if all the following conditions are met:

1. **Age:** the individual is aged 50 or older.

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2. **Aged care needs:** the individual has aged care needs requiring personal or clinical care, or both, due to difficulties performing daily living activities and requires assistance to maintain their capacity to function independently.
3. **Prematurely aged due to experiencing homelessness:** the individual's aged care needs are equivalent to those of someone aged 65 or older and has aged prematurely due to experiencing homelessness.
4. **Living arrangements:**
   a) For homeless individuals: the individual lacks secure, fit and adequate housing, or housing that meets minimum living standards from a community or human perspective.
   b) For at risk of homelessness individuals: the individual is at imminent risk of lacking secure, fit and adequate housing, or housing that meets minimum living standards from a community or human perspective in the near future.
5. **Financial resources:** the individual has limited or no financial means, resources or access to any sort of funding that would enable them to change their housing situation. The financial hardship often reflects a lack of control arising from their life circumstances.
6. **Choice and consent:** the individual does not choose to be homeless and consents to accessing Australian Government funded aged care services, particularly entering residential aged care.

See Appendix H for case studies of individuals experiencing homelessness or at risk of homelessness.

5.2.4. Informing the eligible younger person of other services

If the individual is under the age of 65 and falls into one or more of the eligible cohorts, they must inform the eligible younger person of other services that may be available to meet their care needs, noting that it is not a requirement for a person under the age of 65 to take up other services in place of aged care services.

> Note:
>
> Eligible younger people who have been referred via the My Aged Care contact centre would have been informed of other services prior to agreeing to be referred for an assessment. Triage Delegates should check the older person's record to confirm whether they have been advised of other services at the contact centre screening stage.

If the older person advises that they do not wish to explore other options, proceed with triage as usual.

If they indicate they would like the opportunity to explore alternative support options, they can be referred to the services list below at *Figure 3*, where applicable and relevant to their local area. If they choose to pursue this pathway and do not want to be referred to an assessment organisation, triage should not continue, and the assessment can be cancelled. A Notice of Decision does not need to be issued as the application has been

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withdrawn.

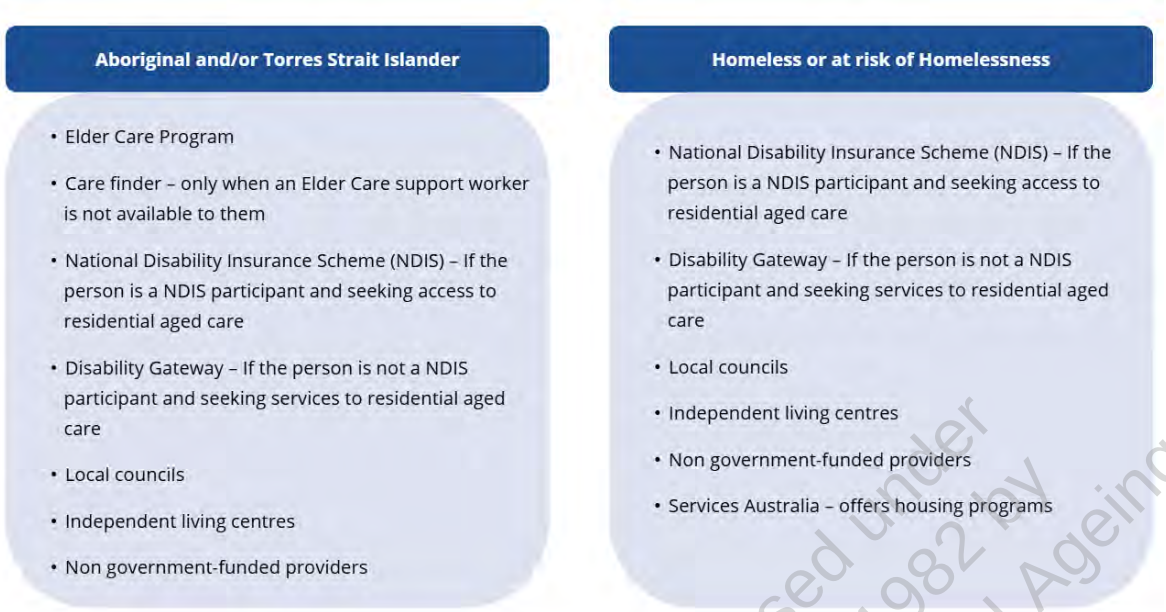

Figure 3 – list of alternative options for the eligible younger person to consider

5.3. Conducting triage

Note

Only appropriately qualified and certified assessment staff can hold the triage delegate role and undertake triage. Please refer to *training requirements for assessment teams* in Chapter 2 and *Aged care assessment workforce minimum qualification requirements* in Appendix F

Prior to calling the older person to conduct triage, Triage Delegates should:

- Review the older person's My Aged Care record
- Note the older person's preferences, choices, any additional needs and communication preferences that will need to be accommodated during the assessment process (e.g. when a hearing impairment is identified or an interpreter is required)
- Note that information will be pre-populated from screening. In some circumstances, if an older person was previously found ineligible, then later is eligible, the screening information cannot be changed. The 'likely ineligible' flag will be unticked however screening information will not be able to be updated
- Where the older person has nominated a primary contact, and the triage delegate is satisfied that the older person nominated this person to be contacted in place of the older person in all instances (or the primary contact has nominated themselves because they are an appointed decision maker for assessment matters), the triage delegate can contact the nominated primary contact in the first instance. This may be to inform the primary contact that the delegate is seeking to conduct triage, what triage would involve, and to ask the primary contact to discuss the process with the older person. An older person is encouraged to be present for triage, but this is not necessary if the primary contact either:

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  - can communicate information for the older person, including in their capacity as an agent or a registered supporter, or
  - is an active, appointed decision maker for the older person and has legal authority to make decisions relevant to triage on behalf of the older person.
- If the triage delegate is contacting the older person's appointed decision maker, the triage delegate must ask them to confirm:
  - that they are acting in line with their legal authority to make decisions for the client (mandatory), and
  - if they have talked to the client about the triage and what it may involve (not mandatory, but this is in line with the principles of supported decision-making).

Note:

Registered supporters must act only within the scope of their roles. For example, the role of a registered supporter is to support the older person to make and communicate their own decisions, acting in line with the will and preferences of the older person. Triage delegates should check that a registered supporter or agent is communicating information for the older person in line with their role, not making decisions on behalf of the older person. If in doubt, the triage delegate should contact the older person.

If an active, appointed decision maker (whether or not registered as a supporter), is making a decision on behalf of an older person, triage delegates must be satisfied that the appointed decision maker is acting in line with their legal authority under a Commonwealth, state or territory arrangement, and that the authority is relevant in the circumstances.

Triage Delegates should review the proof an appointed decision maker has provided to the System Governor to support their authority. A Triage Delegate cannot rely solely on a person's registration as a supporter to assume their decision-making authority for aged care triage or assessment matters or assume that simply because a person has a supporter guardian, the older person does not have decision-making capacity for some or for all matters.

Triage Delegates should also inform the appointed decision maker that it is preferred, where possible, that the older person is present on the call.

If any information or documents must be shared with an older person during the triage process, it must also be shared with certain registered supporters (supporters and supporter guardians) for an older person, in line with the Act (section 29). Information cannot be automatically shared with an older person's 'supporter lite'.

Triage delegates must consider a referral to care finder services for a vulnerable older person who does not have anybody who can support them. Information on care finder services is available at My Aged Care. For Aboriginal and Torres Strait Islander clients, the assessor may also connect the older person with an Elder Care Support worker to provide additional support to the older person.

- Help from a care finder | My Aged Care
- Elder Care Support program | My Aged Care

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5.3.1. Initial discussion

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

- Identify who they are and the organisation they are from and confirm that they have 15 to 20 minutes to discuss their assessment request.
- Complete an identity check and confirm whether there is anyone else with the older person at the time (e.g., registered supporters, family members). If they do not have anyone with them and would like someone with them, call back at a more suitable time.
- Advise they have received the referral, who it is from and the role the assessment organisation plays.
- Advise they will be asking a few questions relating to their general health and wellbeing to help inform assessment needs.
- Confirm consent (consistent with section 5.1) and ensure the older person understands why they are having the assessment, why the assessor needs to come to their home (if applicable) and allay any concerns or fears that they may have about the assessment. Should the older person or their active, appointed decision maker choose not to give consent, the triage process is to end and the assessment referral is rejected.
- Confirm their preference for an Aboriginal and Torres Strait Islander assessment organisation (see below this section for further detail)
- Check the contact information for the older person, and if appropriate, the contact information for the registered supporter or agent, such as a care finder (including address for receiving correspondence) to ensure it is complete, correct and validated.
- Gather any additional information required, including whether the older person would like someone who supports them/registered supporter/agent present for the triage questions asked using the Integrated Assessment Tool or at the assessment.
    - If an older person lacks decision-making capacity, an active, appointed decision maker (whether or not a registered supporter) must be involved in the assessment to ensure the older person is accurately assessed. An active, appointed decision maker for this purpose may already be identified on the older person's record as a person to whom all correspondence must be sent. Triage delegates should review the proof an appointed decision maker has provided to the System Governor to support their authority. Registered supporters who are not active, appointed decision makers can also be involved, in line with the will and preferences of the older person. The assessor can submit a request to create a new registered supporter/agent relationship if required (see Chapter 3).
    - Submitting a 'request' may mean a supporter relationship is recorded in the system as a pending relationship seeking to be registered by the System Governor. There are many ways to submit a request, including with the help of an assessor, online, by calling My Aged Care, or using a printed registration form. More information on the registration pathways is available at: www.myagedcare.gov.au/registering-supporter.
    - A person who is seeking to become a registered supporter who is also an active, appointed decision maker must provide proof to show they are an active, appointed decision maker for the older person. This is likely to be legal documentation. Medical evidence may also be required to establish the older person's loss of decision-making capacity.

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- Organise an interpreter if required (e.g., for interpreting services or Auslan) and ensure other necessary supports are in place for the assessment.

- Acknowledge that multiple contacts with older Aboriginal and Torres Strait Islander people may be required to build trust and rapport but this should not compromise on older people being able to access timely aged care services.

Note: An interpreter may need to be pre-booked, so early action on interpreter arrangements will assist meeting timeliness measures.

- There are several support networks that the triage delegate can refer to for older people who are more vulnerable or hesitant to participate. These include:
  - Home - OPAN
  - Support for older culturally and linguistically diverse people | My Aged Care
  - Getting support in aged care | My Aged Care
  - Help from a care finder | My Aged Care
  - Elder Care Support | Australian Government Department of Health, Disability and Ageing
  - Support for people who are lesbian, gay, bisexual, transgender or intersex or other sexual orientations or are gender diverse or bodily diverse | My Aged Care
- Consider asking the older person if they have a My Health Record to help ensure their Support Plan can be linked to it (subject to their consent, as per section 5.1).

Confirming a client's preference for an Aboriginal and Torres Strait Islander assessment organisation

A client's preference for an Aboriginal and Torres Strait Islander assessment organisation, will usually be captured at registration. The client's preference will be visible on their client card.

It will need to be confirmed when completing the client's demographic details at triage.

- When a triage delegate receives a referral, they should view the client information to gain a preliminary understanding of the client's situation.
- If there is no preference listed, please record the preference after having a conversation with the older person.

It is important to have a conversation with the older person about their preference. It should not be assumed that all Aboriginal and Torres Strait Islander people will want their assessment with an Aboriginal and Torres Strait Islander assessment organisation.

- The client's preference will determine whether the referral is accepted, transferred or rejected.
- If a transfer is required, this will need to be managed with the support of a Team Leader.
- It will also ensure that the assessment process is responsive to the person's individual situation.

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Asking triage questions using the Integrated Assessment Tool

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

See the IAT User Guide for further information.

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

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

When conducting triage with older Aboriginal and Torres Strait Islander clients, a triage delegate should exercise discretion and professional judgement on how information is solicited from clients during the triage process. This includes ensuring that information is collected in a culturally safe manner. including the appropriate use of the IAT. A yarning approach may be employed to collect the necessary information and with consent from the older person, support persons may be present during the Triage process.

Where possible, the triage delegate should liaise with the client's GP, service provider and support networks to help inform the triage process. The approach allows relevant information to be gathered in advance and confirmed during triage, reducing the need for the client to repeat their story multiple times.

> Note:
>
> For referrals for the End-of-Life Pathway, triage questions will be optional so there is flexibility to only ask questions that are appropriate to the individual.
>
> When completing the Triage section of the IAT, the triage delegate must provide clear justification in the 'Outcome/advice for assessment notes' field to support the recommended assessment type. This justification should explain why the selected assessment type is appropriate.

At the conclusion of the triage component of the IAT, triage delegates will confirm eligibility for an assessment, the assessment type, assessment priority and whether urgent services and/or linking supports are required, in instances where these services were not provided at screening. In the case of End-of-Life Pathway referrals, if an End-of-Life Pathway Form has not already been submitted, the triage delegate should advise the older person of the steps required. More information on the End-of-Life Pathway Form is included under section 5.3.4.

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

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

> Note:
>
> If the older person is deemed to be ineligible for a needs assessment, the triage delegate should communicate the decision and inform them how to request an assessment in the future (this can occur at a separate time to the initial phone call, if necessary).
>
> Effective communication with the older person (and their active, appointed decision maker or registered supporter, where appropriate) on a decision to not recommend an assessment, and effective communication between assessors, assists with managing expectations and reducing complaints.
>
> An 'Ineligible for Assessment Letter' will need to be sent to the older person (and registered supporters, as required under the Act) as notice of this decision.

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

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

5.3.2. Referring for urgent services and linking support at triage

Triage delegates are responsible for determining whether individuals require referrals under the Alternative Entry Pathway. This allows clients to access services prior to undergoing an assessment.

The triage section of the IAT includes a question about an older person's need for urgent service provision; *Does the client require urgent service provision (direct to service)?* This is a mandatory question and requires a *Yes* or *No* answer and details must be added to a free text box. This question is used to determine the need for urgent services via the Alternative Entry pathway. Information on issuing referrals under the Alternative Entry Pathway is included in Chapter 3.

Even if the urgent services are only required for a short period, the older person will still be required to undergo an assessment.

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

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5.3.3. Triage for clients who have been referred through a support plan review

In submitting a request for a reassessment following a SPR, the assessor is required to indicate whether they have spoken with the client and provide a summary of that conversation.

- Where a conversation with the client has already occurred, the triage delegate should consider the conversation summary provided by the assessor as necessary.
- If satisfied, the triage delegate should complete the triage questions in the IAT, without needing to speak with the client, given this occurred at the SPR stage. An assessment can then be scheduled for the client at a time that aligns with their priority setting.
- Where this occurs, consent to complete IAT triage questions should be sought by the assessor when the assessor is speaking with the client (or their registered supporter and/or appointed decision maker) at the SPR stage. The assessor should note consent was provided in their summary to the triage delegate, to help enable the triage delegate to indicate the older person has consented to the IAT triage questions without needing to contact the older person again.

If a conversation with the client has not occurred at the SPR stage, the triage delegate should speak with the client to confirm a significant change has occurred, drawing on the IAT triage questions to inform response. If the triage delegate is satisfied a significant change has occurred, they should complete the triage questions and recommend a reassessment.

Fact sheet for Assessors and Triage Delegates on support plan reviews that initiate a new assessment | Australian Government Department of Health, Disability and Ageing

5.3.4. Conducting triage for the End-of-Life Pathway

The End-of-Life Pathway is available to participants already accessing Support at Home as well as older people who are not currently accessing services through the Support at Home program.

A participant can access one episode of the End-of-Life Pathway through the Support at Home program. An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:

- a medical practitioner or nurse practitioner provides an estimated life expectancy of 3 months or less, and
- a score of 40 or less on the Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator)

Older people who are not currently accessing Support at Home, who would like to access the End-of-Life Pathway, can be referred for a high-priority aged care assessment.

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The End-of-Life Pathway Form must be completed before End-of-Life Pathway can be approved. The form captures specific medical information related to the participant's medical condition and evidence of end-of-life. An appropriate medical practitioner (their GP, non-GP specialist or nurse practitioner) will complete the form.

The assessment referral will follow the same process as it does for all assessments and will be assigned by a Team Leader for triage.

All triage questions will be *optional* for the End-of-Life Pathway so there is flexibility in only asking questions that are appropriate to the individual. Questions that would be insensitive to ask during triage can be skipped.

The End-of-Life Pathway Form does not need to be submitted for the triage delegate to complete triage and assign the assessment to an assessor. If an End-of-Life Pathway Form has not already been submitted, the triage delegate should advise the older person of the steps required (e.g. downloading the form and visiting their GP, non-GP specialist or nurse practitioner to have the form signed).

In cases where an aged care assessment or support plan review (SPR) will be undertaken via telehealth, assessors will need to assist older people to ensure the completed End-of-Life Pathway Form is submitted. More information on options for submission is included in section 6.3.1.

For participants seeking access to the End-of-Life Pathway who have submitted their End-of-Life Pathway Form at this stage, triage may also involve verifying this documentation.

If a Triage Delegate identifies a submitted End-of-Life Pathway Form contains a mistake or missing information, triage should still be completed and the older person should be progressed to an assessment, while keeping the form as not validated. An older person should be informed the form contains missing or mistaken information and what they need to do for the form to be fixed. Once fixed, the form can be presented for validation at assessment.

The Triage Delegate can flag a referral as End-of-Life before or after (not during) triage by clicking the 'Flag as End of Life'.

To access the End-of-Life Pathway, existing Support at Home participants can request an urgent support plan review.

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5.3.5. In-hospital triage and self-referrals

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

Where an assessment is self-referred, and the assessor is with the older person, assessors will be able to conduct triage with the older person at the same time as the assessment. For assessors who are not Triage Delegates, triage must be conducted with triage delegate oversight.

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5.3.6. Recording eligibility for an assessment for individuals aged 50-64

When determining whether an individual aged 50-64 years is eligible for an aged care needs assessment, triage delegates should clearly record their decision and the information they relied upon to come to that decision. This should be recorded in the free text box at the end of the IAT triage section. For example, when finding someone aged between 50-64 is eligible for an assessment under the homeless/risk of homelessness provisions of the Act, the triage delegate should make specific reference to which criteria under the relevant definition applies to the individual who is seeking an assessment. Refer to section 5.3 of this Manual for the definition of homeless and risk of homelessness.

The free text box at the end of the triage section of the IAT should also be used by the triage delegate to record confirmation an individual aged under 65 has been informed of other services that may be available to meet their needs before electing to be provided funded aged care before the age of 65.

> Note:
>
> Triage Delegates should review the 'client story' note in an older person's record to confirm if an eligible person aged 50-64 has been informed of other services that may meet their needs during screening.

5.3.7. Preparing an older person for their assessment

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

Additionally, triage delegates should:

- Complete the Work, Health and Safety (WHS)/Home Safety Risk screen and check for alerts and notes in the referral information on the My Aged Care record. Ask relevant questions to identify work, health and safety concerns which could affect the assessment for example: "Are there any risks or hazards the Assessor needs to be aware of before attending the assessment in your home?". The team leader may already have knowledge of information that may be relevant to assessment services and assessor safety.

> Note:
>
> Special WHS requirements (such as the necessary presence of the older person's guide dog) at the assessment. Arrange other responses (such as the need for two assessors to attend the assessment due to safety concerns).

- Upload any additional older person information to the older person record (e.g., WHS screen) and use 'Notes' to record assessment booking details. Include if

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relevant, with older person's consent, sensitive information in sensitive notes and attachments.

- Check to see if there are cohabitating older people in the house who may also require an assessment and refer them to My Aged Care or include a note that they may be self-referred to their assessment organisation if circumstances meet the self-referral criteria and if appropriate.

5.3.8. Preparing for an assessment with an older Aboriginal and Torres Strait Islander person

Taking note of the community the older person belongs to, assessors can support culturally safe and appropriate assessment practices. This information may help ensure the referral is assigned to an assessor who is either from the same community or has a strong understanding of the local customs and cultural context. This alignment may enhance the delivery of culturally safe, trauma aware and healing informed assessments.

In preparation for the assessment, the assessor/triage delegate should collect as much relevant information as possible prior to the assessment. This helps to inform the process and reduces the need for the older person having to re-tell their story.

Where consent is obtained from the older person, this may include:

- information collected by the Elder Care Support workforce
- Information from GPs or the Aboriginal Torres Strait Islander health/medical services, including results from MBS 715 health check
- Information from other health professionals, where appropriate

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

Where possible, Aboriginal and Torres Strait Islander people should be matched with an assessor who is appropriate as per the local customs, protocols, kinship obligations and preferences of the older person. This may include the support of family members or advocates where appropriate.

Department of Health, Disability and Ageing website:

Deaf Connect (free face-to-face sign-language and Remote Video Interpreting Service)

Fact sheet for Assessors on care finders

My Aged Care website: Support for Hearing and Vision Impairment;

Help from a care finder

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5.4. Revoking eligibility during an assessment

An individual's eligibility to undergo an assessment is determined by a triage delegate based on the information available to them when triage is conducted. The Act provides specific circumstances where an eligibility decision may be revoked on the initiative of the System Governor, including during the application process the individual gave information or documents which were false or misleading, omitted any matter or things that without would make the document false or misleading. This may include situations where key facts presented were inaccurate or misleading, resulting in the eligibility decision being granted erroneously. In such cases, it is the departmental delegate's responsibility to assess the evidence, and if warranted, initiate the revocation process to maintain the integrity of the aged care system.

If an assessor or assessment delegate has concerns about the information or documents provided by an older person and/or their registered supporter(s) or appointed decision makers, they should contact their assessment organisation's operational manager, who will make contact with the relevant area of the Department to resolve.

For further information on revocations on the initiative of the System Governor and individual, please refer to Chapter 11 – Reviewable Decisions, Revocations and Complaints.

5.5. Assessment settings

5.5.1. Usual accommodation setting

An initial assessment should be face-to-face in the older person's usual accommodation setting. This will assist with the environmental, physical, and social components of the assessment by observing the older person's level of independence, functioning, and existing support arrangements in familiar surroundings. Due to the nature of transition care services, some assessments will occur in the hospital setting.

However, if this is not possible, assessments for Aboriginal and Torres Strait Islander people should be undertaken at a setting that makes the older person feel safe, at ease and comfortable.

Assessing an older person who is not in their usual accommodation setting

When assessing an older person who is residing in a residential aged care or hospital setting for services to support their transition to residing in the community, the assessor can still complete a 'true' assessment based on their best efforts to understand and assess against the person's functional needs in the community setting they intend to reside in not the setting where the assessment is being carried out. in these circumstances, it may be necessary for assessors to seek information about the older person's home environment from the older person's care and support team to make an as accurate assessment as possible of their functional needs.

5.5.2. Telehealth

It is best practice for assessments to be conducted face-to-face. Assessment organisations are strongly encouraged to ensure assessments are face-to-face wherever

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possible. Where face-to-face contact between the assessor and older person is not possible (e.g., when assessing an older person in a remote area or the older person is inaccessible due to exceptional circumstances such as a seasonal weather event), a telehealth assessment may be undertaken. Where a telehealth assessment is proposed by the assessor, it is important that they explain to the client the rationale of using that assessment setting and any implications this may have such as timing, the need of other people who may be involved before, during and/or after the assessment and logistical considerations such as organising video call capabilities.

The assessor must make additional efforts to ensure the quality of assessment is not compromised when conducting a telehealth assessment and that assessment decisions remain evidence based.

Another suitably qualified person (such as a local health worker) and/or the older person's agent, registered supporter or appointed decision maker may attend the assessment with the older person to assist the assessment process. If a local health worker or provider is involved, and with consent from the older person, the assessor may, work with these individuals prior to an assessment to attain relevant information that can help inform the assessment process.

In cases where an aged care assessment or support plan review (SPR) will be undertaken via telehealth to assess eligibility for the End-of-Life Pathway, assessors will need to assist older people to ensure the completed End-of-Life Pathway Form is submitted. More information on options for submission is included in section 6.3.1.

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5.5.3. Remote setting

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

The Department uses the Modified Monash Model (MMM) as the classification system to define geographical remoteness. The remote assessment flag should only be selected where a face-to-face assessment is undertaken in a remote (MM6) or very remote (MM7) area. You can check the MMM classification by entering their address in the department's Health Workforce Locator.

My Aged Care – Assessor Portal User Guide 6 – Completing an assessment

5.5.4. Hospital setting

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

For those older people in hospital requiring an assessment, they should be assessed in the same way as those assessed at home, utilising the IAT to ensure a nationally consistent approach to assessment of aged care needs, including consideration of the home environment and social issues. An older person needs to be in a stable condition for a hospital-based assessment to take place (unless a rapidly deteriorating condition

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makes this impossible). Being medically stable ensures that the care needs of the older person outside of the hospital can be accurately assessed and the most appropriate care services recommended.

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

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

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

Assessors should be aware that a person being assessed in a hospital setting cannot be approved for the Restorative Care Pathway or a period of reablement.

5.6. Commencing the Assessment

Note

Only appropriately qualified and certified assessment staff can hold assessor roles and undertake assessments. There are different credentials for clinical and non-clinical assessors. Please refer to training requirements for assessment teams in Chapter 2 and Aged care assessment workforce minimum qualification requirements in Appendix F.

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Assessors are required to do the following prior to attending the assessment:

- After the referral has been assigned to the assessor, the assessor must review all information in the older person's record.
- With the older person's consent, consider the collection of information on the older person's situation and medical conditions diagnosed by suitably qualified medical personnel that may be required prior to the assessment. Contact the referrer or health professional if indicated prior to the assessment.
- Note and manage WHS risks.
- Note the timeliness measure for completion of the assessment process.
- Determine whether a cultural broker, interpreter, care finder, elder care support worker or advocate (through OPAN for example) needs to be included in the assessment.
- Gather any anticipated forms or resources, including providing copies of relevant My Aged Care booklets and/or brochures depending on the type of assessment to be conducted.

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- Review *Best practice tools and tips for conducting the assessment* in this manual for guidance on how to achieve a conversational, respectful, and empathetic approach during the assessment. This will allow the assessor to develop rapport with the older person and their support network.
- Download the assessment if using Aged Care Assessor App.
- Check whether a supporter or agent for the older person has been registered or established. If the client is already registered in My Aged Care, assessors can do this by using the assessor portal to find the client, then view their support network (if any supporter relationships have been registered). Refer to Chapter 3 for information on how registered supporters must engage with the older people they support, and how they might be involved in an assessment.
- Check the authority of any active, appointed decision makers of the older person, if they have made themselves known to the assessor or My Aged Care. Appointed decision makers are not required to register as supporters to exercise their legal authority under a Commonwealth, state or territory arrangement. However, this is encouraged to streamline authentication and information sharing to support older people. Assessors can engage with active, appointed decision makers before, or without them, formally registering as supporters, provided the assessor is satisfied they are acting within their authority. To do so, assessors should seek legal documentation that shows the person is an active, appointed decision-maker for the older person and that their decision-making authority is relevant to the assessment. Medical evidence about the older person may also be required to show that the decision maker's authority is active.
- Review notes entered at triage including referrals, attached documents and previous support plans if applicable, to help familiarise yourself with the older person and their needs and limit the need for the older person to repeat their story.
- Connect with the local Aboriginal and Torres Strait Islander community with their knowledge of local services and culture.
- It is recognised that building rapport and trust with older Aboriginal and Torres Strait Islander clients may require multiple contact attempts, particularly for individuals who have experienced trauma or institutionalisation. Assessment organisations should make all reasonable efforts to engage with the client in a respectful and culturally safe manner with their advocate if they have identified they are in contact with one.
- Assessment organisations are encouraged to consider culturally safe engagement strategies, such as involving trusted agents like Elder Care Support Connectors or other appropriate advocates as well as arranging face to face contact where possible.

5.6.1. Confirming an older person's preference prior to the assessment

As it is a phased rollout, Aboriginal and Torres Strait Islander people who are booked with a Single Assessment System organisation need to have the choice to transfer their assessment to an Aboriginal and Torres Strait Islander assessment organisation if one commences in their area.

Preferences for an Aboriginal and Torres Strait Islander assessment organisation should be uncovered during the assessor's pre-assessment planning. This allows the assessor time to contact the client, discuss their preference and organise transferring the client prior to the assessment commencing.

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- This must occur prior to the assessment. Once the assessor starts the assessment, it will need to be cancelled it they are not proceeding with the assessment. The general recommendation would be that the assessor with the booking continues with the assessment as planned, with the agreement of the client.
- The client's condition needs to be taken into consideration, that their health condition and care needs would not be adversely impacted by a delay in assessment if they were to be referred to another organisation.
- A conversation with the client prior to the assessment is recommended to ensure that they have choice and control and the ability to make decisions regarding their care.
- If the client's preference is to be assessed by the Aboriginal and Torres Strait Islander assessment organisation; and they understand the timing impacts; then the assessor can ensure a warm referral.
- A rejection reason 'client prefers a FNAO' is available in the My Aged Care Assessor Portal. An older Aboriginal and Torres Strait Islander person should not be rejected based on a client's preference unless it is a last resort. A transfer prior to the assessment is preferable to a rejection.
- If the referral is cancelled by the assessor at the point of assessment, this may slow down the process for the client which is not the desired outcome.

This above process also applies to support plan reviews, and subsequent new assessments.

At the time of the assessment, the assessor must:

- Be clear to the older person who you are and the organisation you are from and outline your role as an assessor on behalf of My Aged Care.
- Wear the My Aged Care badge or ID according to assessor branding protocols and style guide.
- Inform the older person of the assessment process and potential outcomes,
- Conduct a wallet check:
    - explain to the older person why you need to do this
    - sight two valid identity documents
    - if the wallet check has been attempted but the older person is unable to produce two valid identity documents or has indicated they will provide documents at a later point, enter this information as a note in the older person record as evidence of attempting the wallet check
    - record the results on the older person's record.
- Confirm that the older person understands the role of the assessor and the assessment process and obtain the older person's (or active, appointed decision maker's consent (whether or not they are a registered supporter) before commencing the assessment. Explain to the older person that the assessment has now commenced as they have provided consent, and
- Confirm the identity of other people supporting the older person at the assessment, including the status of registered supporter and agent relationships
- Submit requests to register supporters/agents as required and when practical, ensure any supporting documentation is uploaded, including legal documentation and medical evidence if required.

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- If the assessor is an Enrolled Nurse conducting a comprehensive assessment, they must be under direct or indirect Registered Nurse supervision within the same organisation.

Note: The older person can withdraw their consent at any time. In this case the assessment is discontinued.

5.6.2. Wallet check

A wallet check assists to verify the older person's identity and reduce the risk of duplicate records. Whoever has the first face-to-face contact with the older person following the creation of the older person's record (e.g., an assessor or service provider) is expected to sight two types of valid older person identification and record this information on the older person record. The My Aged Care assessor portal provides a list of types of identification that can be used for the wallet check.

The wallet check only needs to occur once. If a reassessment is being conducted for an older person who has previously had a wallet check it is best practice for the assessor to check the older person's identification and confirm their details have not changed. Where possible assessors should use the wallet check as an opportunity to confirm an individual's age provided at screening or triage matches the age on their identification. If there are concerns that an individual does not meet the age eligibility requirement or one of the exceptions to undergo an assessment based on identification cited during a wallet check, the department should be contacted.

Note: The wallet check can be conducted at any stage of the registration or assessment process and through the Aged Care Assessor App.

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5.6.3. Registering a supporter

Registered supporters help older people to make and communicate their own decisions about aged care. A registered supporter can request and receive information about an older person's aged care, help them to understand information and make their own decisions, and let people like My Aged Care and aged care providers know what the older person's decisions are.

During an assessment an older person and/or their prospective supporter can request to register a supporter relationship by:

- completing the Registration of a Supporter form. The assessor can upload the form and any associated documentation to the client's record. **Note:** a registration form may also be generated following the completion of the online registration form through the My Aged Care website. This will look different to the Registration

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of a Supporter form but should have all the same information. Assessors should treat it the same as the Registration of a Supporter form.

- submitting a registration request online with the assessor via the assessor portal or app, including uploading any associated documentation. If necessary, the Aged Care Assessor App camera can take a photo of document/s to upload as an attachment as long as the document photographs are clear and readable.

A completed registration form and any associated documentation can be uploaded to the client's record. The prospective supporter can also mail a copy of the documents to the My Aged Care contact centre, and the assessor can write a note in the older person's record of this undertaking (see Appendix B. Contact Details).

> Note:
>
> Updated consent scripting and declarations for the registration of a supporter must be used by assessors if they are assisting an older person or prospective supporter through the registration process. These will be available on the Assessor Portal or App, and the printed Registration of a Supporter form.

Assessors must not use scripting or forms previously used for the appointment of regular or authorised representatives, as these are not relevant to the registered supporter role.

It is important to note that while assessors can collect and submit the required information, they may not be able to confirm or approve the registration of a supporter relationship, depending on the circumstances. For example, some applications must be escalated to the departmental team responsible for supporters to consider before a decision to register can be made. This includes applications:

- where the prospective supporter has declared a conflict of interest
- where there is anything to suggest the prospective supporter cannot comply with the duties of a supporter (e.g., the prospective supporter is currently suspended or had a previous registered supporter relationship cancelled), or
- where the prospective supporter is also an appointed decision maker and must provide additional documentation like legal and medical evidence. These documents must be submitted to, and validated by, the departmental delegate responsible for supporters.

The My Aged Care website includes information on the various ways a person can request to register, or become, a supporter.

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www.myagedcare.gov.au/registering-supporter

https://www.health.gov.au/resources/collections/registered-supporter-resources.

If, in submitting a request to register a supporter who is also an appointed decision maker for the older person, proof of legal decision-making authority cannot be obtained, advise the pending registered supporter to provide the required proof, including any legal or medical documentation to the delegate team responsible for registered supporters. This team will process the documents and if validated, register the relationship.

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5.7. Undertaking an assessment using the Integrated Assessment Tool

The assessment starts with getting the older person's consent. Consent from the older person, or their active, appointed decision maker is recorded on the IAT. The IAT is an assessment tool that has been designed to support skilled assessors to assess a client's aged care needs. It comprises questions across social, physical, medical, cognitive, and psychological domains as well as home and personal safety, risk of vulnerability and support considerations.

The assessment component of the IAT is divided into twelve sections. Some sections of the IAT contain nested questions to tailor assessments, only diving deeper into areas where needed. This means that some question sets or validated tools in the IAT will only display to the assessor if certain answers are selected to the question directly proceeding it. The IAT integrates eleven validated tools directly into the assessment process, enhancing the depth and clinical relevance of the assessment.

Assessors may wish to use assessment tools not included in the Validated Assessment Tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). This is at the discretion of the assessment organisation. Each assessment organisation is responsible for providing their assessment staff with training on how to use these tools. General information about each tool is provided in assessor induction training but additional training is recommended to make sure each assessor understands the results from each validated tool.

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

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In completing the IAT, the assessment information should include:

- evidence that the assessor has explored the older person's own supports and/or non-funded services (e.g., state and local government programs, private services) as options to help maintain their independence.
- evidence that the assessor has explored, observed and understands the older person's needs, concerns, strengths and goals to justify the assessor's recommendations for all aged care services.
- evidence of supporting an older person's communication or support person needs.
- a completed 'Support Considerations' section to demonstrate an understanding of what is important for the older person in regard to how support is provided, such as the below list (note some of these may be sensitive topics):
    - any cultural and/or religious values and beliefs
    - gender identity or sexual orientation/sexuality or experience of discrimination
    - history of childhood experiences
    - life experiences including traumatic events and associated triggers
    - other relevant information relating to parole conditions or other information that should be sensitively discussed with the older person when developing the Support Plan and that providers should be aware of.

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The IAT User Guide provides assessors with further advice about each question in the IAT and possible answers. Assessors must refer to the IAT User Guide to ensure accuracy in the use of the IAT and in the delivery of high-quality assessments.

All mandatory questions must be completed, and it is best practice that the older person's concerns and goals are added before finalising the IAT. The assessor then selects 'Finalise IAT' before moving to the support plan. This is so the IAT Classification Algorithm can generate an ongoing home support classification level (IAT Outcome in the system), which may be a Support at Home classification or CHSP. A classification level recommendation must be made for people who choose to access services through the MPSP or NATISFACP.

If the IAT has not been finalised, the IAT outcome and classification will not be displayed. The assessor will not be able to recommend the person for funded aged care services.

Aboriginal and Torres Strait Islander assessment organisations will be required to use the IAT to conduct assessments and must do so in a way that is culturally safe for the region or older person. Assessors may conduct the assessment without a device. In such cases, the assessor should upload the information into the IAT when the assessment is completed. Assessors may also be able to make inferences from the yarn to complete the IAT.

Use the validated culturally appropriate assessment tools as needed (see the IAT User Guide for more information).

> Note:
>
> For End-of-Life Pathway assessments, only mandatory questions that are required to run the IAT Outcome and generate a classification are required to be completed. This is to ensure the older person has a valid classification to return to if they need services beyond the End-of-Life Pathway funding period. Other questions are optional based on the individual's needs and context.

> Important:
>
> Under Support at Home, individuals who are care leavers are eligible for a care management supplement which will be credited to their provider's care management account.
>
> To identify individuals who are eligible for a care management supplement during the assessment, assessors must use the diversity fields in the IAT, which do not currently capture care leavers.
>
> Assessors who have identified individuals who are care leavers during the assessment should select the diversity field 'a person separated from your parents or children by forced adoption or removal'.
>
> This will ensure Services Australia is able to identify these individuals from the assessment and apply a care management supplement to their provider's care management account. Refer to the Support at Home Program Manual for more information on care management supplements

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IAT User Guide

5.7.1. Clinical attendance

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

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

Clinical attendance in practice

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

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

> Note:
>
> Enrolled Nurses (EN) who hold the clinical assessor role cannot provide clinical attendance to non-clinical assessors. This is considered outside an EN's scope of practice.

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

Table 20. Clinical attendance procedure

Tier 1	A clinical assessor who holds a clinical assessor role in the My Aged Care Assessor Portal is available by video or phone call at the time the assessment is taking place to be involved in asking the clinical questions with the non-clinical assessor to the older person being assessed. A video call is preferable.

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

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The assessor will need to speak with a clinical assessor in their organisation about the assessment and the clinical questions.

If it is appropriate for the clinical questions to be asked by a clinical assessor over the phone, arrangements will be made with the older person and relevant support people for this to take place. It is preferable the original, non-clinical assessor is also on the call. If the clinical components are completed over the phone by a clinical assessor, the assessment does not need to be reassigned to this assessor.

It may be determined that the assessment should be reassigned to a clinical assessor to complete the assessment, either in person or over the phone. This may be required because:

- multiple clinical questions are triggered in the IAT,
- the needs of the older person are best assessed in person to ensure a high-quality assessment.

Where an in-person assessment with a clinical assessor is required, a team leader will reassign the assessment to a clinical assessor.

If the clinical process is initiated the assessor must:

- ensure the older person understands that there are questions in the assessment tool that need to be asked with a clinically qualified assessor so that they can apply clinical knowledge and judgment to ensure that the older person's needs are assessed in full and with their safety and wellbeing in mind. This should occur before the clinical assessor is contacted.
- include the older person in the initial discussion when the clinical assessor is being briefed on the older person's situation. The older person and/or their support person should be given the opportunity to describe their circumstances if they feel comfortable to do so.
- ensure the camera is on at both ends so that older person can see the clinical assessor if the clinical assessor is called in on a video enabled device.
- ensure the call is on speaker phone so that the older person and clinical assessor can speak directly to one another, if the clinical assessor is called on a phone without video functionality.
- explain to the older person that a follow-up phone call will be necessary to complete their assessment, if real-time clinical attendance is not possible.

If a follow-up call is necessary:

- the original non-clinical assessor should be present on the phone call to ensure there is continuity of contact with the original assessor.
- it is important that the non-clinical assessor keeps the older person, their primary contact and/or support person up to date on when the follow up phone call will take place.

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5.7.2. Tools and techniques for assessing an older person's needs

The table below details best practice tools and techniques for undertaking aged care needs assessments.

Table 21. Aged care needs assessment best practice tools and techniques

Use the Aged Care Assessment Quality Framework	• Use the four quality goals, personal, effective, connected and safe in your assessment practice.
Use a conversational approach when interacting with the older person	• Confirm with the older person that they are comfortable with digital devices being used during their assessment, ensuring that the older person understands why and how the information recorded is used during the assessment. • Use a conversational approach when asking questions, rather than simply running through the assessment questions and ticking boxes. Ensure your conversation is undertaken in a manner that is respectful, non-judgmental, and non-confrontational. • Know when and how to best use closed, open, direct, and indirect questioning. • Use motivational interviewing techniques such as expressing empathy and eliciting self-motivational statements. • Use active listening skills. • Make eye contact to help engage the older person in the assessment process, unless it is culturally inappropriate to do so. For example, some Aboriginal and Torres Strait Islander people may consider direct eye contacts disrespectful or uncomfortable, but others may be more comfortable with Western norms of communication. If using a computer at the older person's home, ensure you are not focused on just the computer. • Gauge the older person's level of engagement in the assessment. Look for signs of fatigue or discomfort and adjust approach accordingly. For Aboriginal and Torres Strait Islander clients • Observe the local cultures and customs when conducting the assessment. • Start with a social yarn to build rapport and trust. Share stories or other topics of common interest. • Take a whole-of-person approach to the discussion – understanding what motivates a person and contributes to their wellbeing – spiritual, emotional, and physical. • Explain to the older person and any support people present that if they feel uncomfortable during the assessment at any time, the assessment will be paused and rescheduled to ensure their wellbeing. Allow for

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	multiple visits, if required, to build trust and develop a relationship between the assessor and the older person • Welcome the presence of the older person's family member or advocate to be part of the meetings • Take a less formal, yarning approach to aged care assessment.
Use appropriate language when speaking with the older person	• Use needs-focused language, explaining what could be short-term vs. long-term options to meet their needs. • Use language that is positive and not dismissive. If necessary, potentially sensitive topics (such as lack of service availability or older person fees) can be introduced at the appropriate place during the assessment process after the older person's areas of concern and goals have been identified, and when support options are being explored in the Support Plan stage. • Use language that focuses on the older person's strengths, abilities and what they want to achieve and how these could be further supported – a focus on independence. • Take the time to explain what will happen • Use informal and the local language where possible and avoid jargon • Adjust language as needed to ensure sensitivity towards End-of-Life Pathway participants (for example, focusing on more immediate needs rather than longer-term goals). • Reflect the conversation back to the older person to ensure you have understood what was said and agreed on.
Interpreters or support person	• where the older person prefers to communicate in a language other than English or has indicated in their record that a support person is required, an interpreter or support person must attend the assessment (either in-person or via phone).
Supporting people with dementia and other cognitive impairments	• Use simplified language where appropriate. • Repeat questions and information where needed • Be attuned to non-verbal signs that the person may need further information to help them understand. • Seek discrete responses to questions (e.g. 'Yes' or 'No', or choices between two options) rather than multiple options. • Provide ample time for a person to respond to questions.
Using Validated Assessment Tools	Assessors may wish to use assessment tools not included in the Validated Assessment Tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). This is at the discretion of the assessment organisation.

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Clinical assessors should use their clinical judgement to determine if it is appropriate to use other Validated Assessment Tools. If other assessment tools are used, the assessor should make a note of this in their assessment summary.

The assessor should record assessment tool outcomes and recommendations based on these outcomes within the Assessment Summary. The assessor should also make sure that the older person and their support people understand the outcome of any assessment tools used.

Observing functional activities

Where possible, assessors must observe the older person's activities to gain insight beyond information that is conveyed just verbally by the older person, a registered supporter or anyone else who supports the older person. Therefore, collect information through additional means:

- ask the older person to ***show you*** how tasks are completed in the home and ***observe*** the older person undertaking those tasks (this is an 'active' assessment) and
- advise the older person ***what*** you have observed/seen during the task.

5.7.3. Aboriginal and Torres Strait Islander assessments

To support timely access to services, assessors are encouraged to use their professional judgement to determine when an assessment can be completed in one session or, be split over a few sessions without disadvantaging the client from receiving timely services.

By starting the assessment with a yarn, the assessor should be able to gauge whether it is appropriate to proceed with completing the assessment during the session.

Where an assessment cannot be finalised during the initial session and additional sittings are required, the assessors should complete the initial yarn and schedule a follow up assessment. The subsequent sessions should be conducted as soon as practicable, as service referrals cannot proceed until the assessment is completed and the Support Plan has been approved by the assessment delegate.

While the assessment remains open, the assessment organisation should maintain regular check ins with the client to ensure their circumstances have not changed. This ongoing engagement helps ensure the assessment remains accurate and responsive to the older person's needs.

Factors to consider in determining whether to complete the assessment on the first visit include:

- **Support from Elder Care Support worker**: Has an Elder Care Support worker facilitated the older person's entry into the aged care system, explained the assessment process, and help built trust in engaging with aged care?

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- **Client Engagement and Readiness:** Are the client's body language and verbal cues non-responsive, suggesting they need more time to become familiar with the concept of aged care assessments?

- **Availability of Information:** Has sufficient information been collected from various sources to allow assessment to be undertaken in one sitting?

- **Supportive Environment:** Are family and/or community members present and helping to create a safe and non-stressful environment for the assessment?

5.7.4. Aboriginal and Torres Strait Islander assessment organisations delivering home support assessments

The Aboriginal and Torres Strait Islander assessment organisations participating in the pilot are expanding their expertise to deliver comprehensive assessments., If a non-clinical assessor triggers clinical questions within the IAT and the organisation does not yet have clinical assessors or full capability to provide comprehensive assessments including if the IAT Outcome generates a Support at Home Classification level, the following action must be taken to ensure continuity of care and uphold a client centred experience:

- Clearly explain next steps
- If the assessment is not finalised, and a cancellation is necessary, the assessor will only be able to refer the client for urgent aged care services through the alternative entry pathway (see Chapter 3 for further detail),
- To preserve valuable information, the assessor should print the information from the "client's assessment history" tab before cancellation and upload the document to the client's record.
- Facilitate a supported referral by contacting another organisation with capacity for comprehensive assessment.
- Provide information on interim supports and assist with connections where possible.
- Maintain engagement with client and their support network and, where appropriate, include Elder Care Support, to ensure continuity of care throughout the process.

5.7.5. Recording assessment information

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

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

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

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- lays the foundation for creating the Support Plan for the older person and is reflective of what the older person said, was observed doing, and/or reported by carers/support persons
- minimises duplication between the assessment and Support Plan
- provides sufficient evidence for assessment delegate decision
- is required for audit purposes
- helps to inform an older person's provision of care and highlights important information or risks about the older person's situation that needs to be managed by the care provider or other parties
- puts the older person at the centre of the Support Plan

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

Assessment information and evidence should include all relevant documentation that supports the recommendations and decisions made throughout the assessment process. All documents must be in PDF format and finalised in the My Aged Care Assessor Portal. The department is unable to access documents submitted to the Assessor Portal unless they have been finalised. The assessment documentation must include:

- Consent
- IAT and Validated Assessment Tools (VATs)
- Additional Evidence
- Support Plan and Recommendations
- Notice of Decision letter
- Referral Information

The assessment should contain comprehensive information to support the justification of the assessor's recommendation for funded aged care approvals.

Recording sensitive information

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

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

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

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

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> Note:
>
> Assessors must follow their reporting obligation specified in relevant legislation and protocols in their state or territory where they identify an older person is at risk of elder abuse.

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

Given the assessor may be best placed to discuss the sensitive issues with the provider/s, the provider could contact the assessment organisation for enquiries on notes and/or attachments. The provider may also contact the assessor directly if they have a question concerning sensitive attachments. Sensitive information may be disclosed to the provider if it is relevant to their particular service. For example, where it is recorded that an older person has a sensitive health issue, an assessor may be contacted by a garden maintenance provider and the assessor may consider it inappropriate to disclose the information; whereas if the assessor is contacted by a personal care provider, the assessor may have a duty of care to disclose the information as it has implications for the service being delivered.

Where an existing older person currently receiving services has received a reassessment, and has disclosed new information that is categorised and recorded as a 'sensitive' note (that may impact the safety and welfare of the older person, staff or other older people), the assessor should contact the provider/s to make them aware of the sensitive information and enable them to make a risk-determination of how best to support the older person for the safe delivery of services (see section 12.11.413.11.4 older people who are in prison).

Sensitive user flag

The My Aged Care system also enables an older person or registered supporter to be flagged as a 'sensitive user' if the older person or registered supporter requests to limit access to their information, AND the older person or registered supporter:

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

An older person or their registered supporter may request that the older person or the registered supporter is made a 'sensitive user' through the My Aged Care contact centre. The request will be assessed by contact centre team leaders and if appropriate the older person or registered supporter's record will be flagged as a 'sensitive user' record.

The details of a 'sensitive user' will remain available to assessors and service providers who are working with the older person. Older people or registered supporters who are flagged as a 'sensitive user' will need to disclose this status to the contact centre at the time of their interaction, as the information is restricted and will require a team leader to access and edit the record.

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My Aged Care – Assessor Portal User Guide 4 – Navigating and updating the older person record

5.7.6. Urgent service provision in the IAT

The IAT includes a question about an older person's need for urgent service provision, "Does the client require urgent service provision?" This a mandatory question and requires a Yes or No answer. The response to this question is one of multiple factors used by the system to calculate a priority category for the person for the Support at Home Priority System. Other information is also used to calculate a priority category. An older person's priority for ongoing funding is based on their personal circumstances and characteristics.

An older person can be determined to need urgent service provision if the older person:

- is considered at urgent and immediate risk in terms of their personal safety; and/or
- is at immediate risk of admission into residential care; and/or
- is unable to be safely discharged from hospital without timely access to in-home care; and/or
- has a carer, and the carer arrangements are unsustainable, or the carer is at crisis point.

The guide below has been developed to help assessors determine whether an older person requires urgent service provision.

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Table 22. Urgent service provision guide

	Carer arrangements are unsustainable	Older person is at immediate Risk due to personal safety	Immediate risk of admission into residential care	Requires timely access to home care to support discharge from hospital
Criteria for determining urgency	Indicators that a carer arrangement is unsustainable: • Carer in crisis • Carer may have a dual caring role. • Carer's employment is being jeopardised by their caring duties • Carer may be returning to full time employment. • The level of care required by the older person is increasingly more complex and the primary carer is unable to provide the level of assistance required. • Recent changes in the older people' family, cultural, housing or	Some indicators of a person being at urgent and immediate risk with respect to their personal safety may include, but are not limited to: • Neglect of basic needs i.e., unable to access or prepare food resulting in malnutrition, weight loss or dehydration • Inadequate personal hygiene such as severe neglect of personal care leading to serious hygiene issues, infections or injuries. • Repeated hospital admissions due to frequent falls with sustained injuries. • Failure to administer necessary medications/treatments and/or attend medical appointments. For example, medication mishaps with potential for adverse outcomes.	There is an immediate risk of the older person entering Residential Care due to: • carer in crisis and/or inability of carer to offer required support; or • Lack of access to services to meet the older persons' needs and fairly mitigate immediacy of risk to personal safety • If the older person had access to these services (as	The older person cannot be safely discharged from hospital without significant risk, where: • A lack of access to services in the home would create significant risk of re-admission; and • If the older person had access to these services (as soon as possible following hospital discharge), their care needs could be managed at home. Note: As there will still be a wait time for the older person's Support at

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Carer arrangements are unsustainable	Older person is at immediate Risk due to personal safety	Immediate risk of admission into residential care	Requires timely access to home care to support discharge from hospital
social situation resulting in trauma, or feeling unsafe (including culturally unsafe) The carer in crisis is no longer able to provide care due to: • A change in the carer's personal circumstance i.e. death/significant decline in carers own health status • An inability to sustain their caring role due to a lack of assistance being received i.e. the older person has significant needs and no (or minimal) support is being provided. **NOTE**: Carer in crisis is different to caregiver stress. Caregiver stress is a condition of exhaustion, anger, or guilt that results from unrelieved	• Severe cognitive impairments with client engaging in risky behaviours (e.g. wandering) • Person is unable to safely navigate their home and community due to insufficient aids, equipment and/or home modifications. • Recent changes in the older person's family, cultural, housing or social situation resulting in trauma, or feeling unsafe (including culturally unsafe)	soon as possible), they could be managed at home.	Home funding to become available, a comprehensive assessment should be performed as soon as possible to support continuity of care and to not delay discharge.

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	Carer arrangements are unsustainable	Older person is at immediate Risk due to personal safety	Immediate risk of admission into residential care	Requires timely access to home care to support discharge from hospital
	caring for a chronically ill dependent. The stress can vary depending on the individual and generally does not prohibit the carer from providing care. Caregiver stress can be reduced by accessing respite care.			

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Concerns, goals and recommendations

It is important to identify the goals the older person wants to achieve that are associated with the areas of concern that the older person wishes to address. The goals note the older person's strengths and abilities, the domain the goal(s) relate to, their area of difficulty and level of motivation to achieve the goal. The recommendations represent the agreed strategies and support to achieve goals. It is recommended that goals are added under 'Client concerns and goals' on the *Goals & recommendations* tab before accepting or overriding the IAT outcome.

After recording observations under all relevant domains and categories in the IAT and prior to finalising the IAT (noting that once the IAT is finalised, answers in the IAT become read-only) the assessor supports the older person to identify the goals they would like to achieve to help address their areas of concern.

The goals should reflect the older person's current strengths, abilities, and areas of difficulty, along with the relevant domain and their level of motivation to achieve each goal. Recommendations must outline the agreed strategies and supports to help achieve these goals. Historical content from previous Support Plans should not be carried over unless it is clearly identified as historical or dated appropriately. Including outdated information can lead to confusion and reduce clarity. All content must focus on the older person's present needs and circumstances.

Assessors must:

- Draft and include at least one Concern and Goal linked to any recommended services. If no services are recommended or no change to services is required, a Concern and Goal does not need to be included.
- Draft Concerns and Goals that are clear, actionable, realistic and written from the older person's perspective (e.g., I find showering to be painful (concern). I would like to learn ways to have a shower without pain and reduce my pain rating from moderate (6/10) to mild to (3/10) (goal)).
- The older person's Concerns, Goals and recommendations will become clear as the assessor conducts the assessment and records their observations within the IAT. The assessor must ensure that the older person's Concerns and Goals reflect their needs as detailed in the IAT (e.g., Physical and Medical domains of the IAT provide details of the Mr Arnolds functional limitations with showering and the pain he is experiencing)
- Consider whether the older person will benefit from a short-term reablement intervention to maximise their independence, choice and quality of life, and the older person's capability, motivation, and strengths to contribute to their goals. Reablement can be provided by the assessor or by CHSP providers, with assessor review to determine when the reablement period should be finalised and what ongoing support (if any) may be required for the older person.
- Consider whether the goals identified suggest suitability for Restorative Care Pathway (RCP) such as improving function, learning, reablement, or other goals which support delaying the need for higher level or ongoing services. This consideration should include whether a person has the motivation and capacity to actively participate in RCP including attending frequent allied health interventions (over more passive interventions). The need for a multi-disciplinary allied health and/or nursing approach to care must also be required before recommending RCP. Consideration of long-term needs should also be given before approving RCP as it will impact their position on the Support at Home prioritisation system.
- Consider whether available units of funding for the RCP are low. If the recommendation for the RCP classification may not be approved by the Assessment

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Delegate due to no units being available, assessors could contact the older person to discuss alternative supports for recommendation.

- Consider, throughout the assessment, whether the older person will benefit from assistive technology and home modifications funding to support functional needs and safety at home in areas such as:
    - managing body functions
    - self-care
    - mobility
    - domestic life
    - communication and information management

5.7.7. IAT Classification Algorithm (IAT outcome)

About the IAT Classification Algorithm

The Integrated Assessment Tool (IAT) Classification Algorithm (the outcome of the algorithm is known as the IAT Outcome in the assessment workflow) was introduced on commencement of the Support at Home program and *Aged Care Act 2024* to ensure that people with similar clinical care needs receive the same level of funding to access ongoing home support. It is designed to:

- **Achieve consistency** – so that decisions are not influenced by individual discretion or subjective judgment.
- **Ensure equity** – so that everyone is treated fairly.
- **Build confidence** – so older people and their families can trust that the system is transparent and reliable.

The IAT Classification Algorithm was carefully developed over time and built on data from over 22,000 assessments conducted in 2023 through the IAT live trial. Before it was implemented the algorithm was refined on more than 200,000 assessments completed in 2024-25. This process was undertaken to ensure it would achieve the best outcomes for older people, deliver on the policy intent of the Support at Home program and support the responsible use of taxpayer funds.

How the IAT Classification Algorithm works

The IAT Classification Algorithm uses data that an assessor enters into the IAT during an assessment across a number of domains in the tool. It uses this data to evaluate an older person's clinical characteristics and assigns a classification level (or funding level) for ongoing home support (i.e., Commonwealth Home Support Program (CHSP) or Support at Home). The IAT Classification Algorithm: considers a client's needs at three levels:

- Identification of the older person's functional abilities.
- Assessment of how well the older person's functional needs are currently being met.

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- Consideration of compounding factors, which allows the IAT Classification Algorithm to differentiate between people with similar functional status and level of met needs.

For a given set of clinical characteristics, the IAT Classification Algorithm will always generate the same classification level. The rules or criteria that must be met for each ongoing home support classification level are defined in section 81-10 of the Aged Care Rules 2025 (the Rules). The Rules are prescriptive and do not allow for an ongoing home support classification to be approved that is different to the rules it describes and which the algorithm relies on. Therefore overriding the IAT Classification Algorithm outcome to a different ongoing home support classification level (e.g., CHSP to SaH class 1-8; ineligible for CHSP/SaH to CHSP or SaH class 1-8; SaH class 1-8 to a different SaH class 1-8) is unlawful.

The accuracy of the IAT Outcome relies on information that has been entered into the IAT during the assessment. Assessors continue play a critical role in achieving high quality assessment outcomes by using their strong communication and interpersonal skills to complete the IAT during the assessment, and their clinical judgement when undertaking comprehensive assessments.

Accepting the IAT Outcome

If an assessor intends to recommend ongoing home support for an older person through Support at Home or CHSP, the system generated IAT Outcome must be accepted by the assessor. For example, where the IAT Outcome recommends an ongoing SaH class 5 the assessor will accept this IAT Outcome to recommend ongoing SaH class 5.

If the IAT Outcome results in 'ineligible for CHSP/SaH', the person is not eligible to receive CHSP or ongoing SaH. An assessor must not override the IAT Outcome to recommend an ongoing home support classification level. If by considering the eligibility criteria in the *Aged Care Act 2024* for residential care, the assessor wants to recommend residential care, it is appropriate to accept the ineligibility outcome and recommend residential care.

Important:

To support the IAT Outcome recommending a level of care which appropriately addresses an individual's care needs, assessors should ensure all inputs into the IAT are accurate before it is finalised. The IAT will lock once it is finalised and data will not be able to be updated in the IAT after this time.

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Overriding the IAT outcome

Important:

There is functionality in the assessor workflow that allows for actions that must not be taken by assessors as these actions do not align with the *Aged Care Rules 2025 (the Rules),* deeming them unlawful. This includes:

-the IAT Outcome must not be overridden to recommend a different ongoing home support classification (e.g., Ineligible for CHSP/SaH to CHSP or SaH 1-8; CHSP to SaH 1-8; SaH 1-8 to CHSP; SaH 5 to SaH 6). In line with section 81-10 of the Rules the criteria for each classification are prescriptive and does not allow for an ongoing classification to be different to the IAT Outcome to be recommended.

-a CHSP classification can be overridden to recommend Restorative Care Pathway (RCP) during a comprehensive assessment. In line with section 81-15 of the Rules, RCP cannot be recommended for approval when a Support at Home classification has not been generated by the IAT Outcome.

It is important that assessors do not take these actions and delegates do not approve recommendations when these actions have occurred.

It will be necessary to override the system-generated IAT Outcome to recommend the:

- SaH Restorative Care Pathway,
- SaH End of Life Pathway,
- Transition Care Program (TCP) without ongoing in-home services,
- Permanent Residential Care without ongoing in-home services,
- Residential Respite care without ongoing in-home services.

Note: in order to recommend residential care (permanent or short-term) without ongoing in-home services, assessors will need to override the IAT Outcome of CHSP or Support at Home to 'ineligible for ongoing SaH/CHSP'. Assessors can then recommend these care types in the support plan.

An older person can be recommended and approved for CHSP or Support at Home services at the same time as TCP, provided the IAT outcome generates an ongoing home support outcome. For example, Support at Home services can only be recommended if the IAT Outcome generates a SaH 1-8 classification level and interim CHSP services may also be recommended. If the IAT outcome results in a CHSP classification, only CHSP services can be recommended.

If it is not appropriate to recommend ongoing home support services at the same time as TCP for people new to the aged care system, the IAT outcome can be overridden to 'ineligible for CHSP/SaH' and then the transition care option can be chosen under 'Add a Care type for Delegate Decision' button. The system will still allow CHSP services to be recommended concurrently with TCP if required.

For transitioned HCP, SaH clients and CHSP clients who are assessed for TCP, the IAT outcome will need to be accepted, and TCP added as a care type. These

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services can continue to be accessed while accessing TCP, as long as the services are not duplicative. See Chapter 6 for further information.

Once the override button is selected, a screen will display where an assessor can perform these actions. If an assessor overrides the IAT outcome, they will be required to:

- select a reason for overriding the IAT outcome, and
- provide a descriptive reason for overriding.

Tips for assessors when explaining the IAT outcome and recommended classification level for ongoing home support to older people and their supporters.

- I have put the information you/<older person's name> have/has given me during your/their assessment into the assessment tool and the system has generated an outcome for your/their <eligibility for CHSP/level of funding for Support of Home> OR <ineligibility for ongoing home support services> using an algorithm.
- The system uses a set of rules which rely on information that you/they have told me during your/their assessment which include:
    - Your/their functional ability to undertake daily tasks e.g. walking, eating, bathing, toileting, managing their finances, cooking, and shopping, and
    - the extent to which your/their needs are currently being met, and
    - other factors that may introduce additional complexity for you/them such as sensory concerns, medical conditions and co-morbidities (i.e., the simultaneous presence of two or more diseases or medical conditions), carer availability, mental health, continence, and vision impairment.
- Using this set of rules, the assessment tool has determined your/their level of funding for ongoing home care services.
- This helps to ensure consistency in how funding is assigned and means that your/their funding level will be the same as other people who have similar needs and clinical characteristics.
- I have included services in your support plan that will help to meet your goals and needs. Once approved and your funding is assigned to you, you can work with a provider to determine the services you will receive and how often within your funding level.

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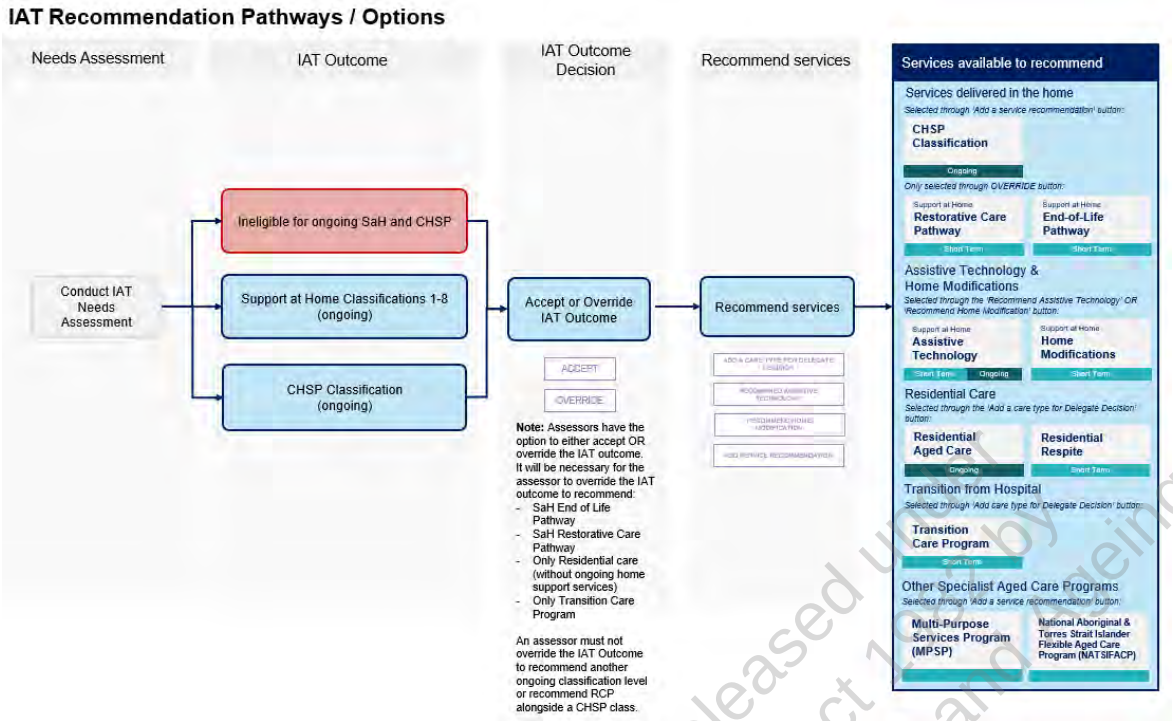

Figure 4 - IAT recommendation pathways and outcomes

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5.8. Converting a home support assessment to a comprehensive assessment

If an assessment is triaged as a home support assessment and the IAT outcome generates a Support at Home classification, and/or the assessor wants to recommend residential care (permanent or short-term), the assessment will need to be converted to a comprehensive assessment under the supervision of a staff member who holds a clinical assessor role in the My Aged Care Assessor Portal.

> Note: Enrolled Nurses (EN) who hold the clinical assessor role may provide supervision to non-clinical assessors if a home support assessment is converted to recommend Support at Home and no clinical questions have been triggered in the IAT. ENs must ensure that they continue to act within their scope of practice.

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

In assessments where services under the Support at Home program and/or residential care are recommended, but clinical questions are not triggered in the IAT during the assessment, a non-clinical assessor will need to seek the supervision of a staff member who holds a clinical assessor role in the My Aged Care Assessor Portal. The supervising assessor will need to be nominated before the assessment can be converted.

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

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

The supervision required to convert a home support assessment to a comprehensive assessment is not the same as the clinical attendance process outlined in Section 5.7. Rather, it is a conversation between assessors to ensure the support plan reflects the needs of the older person and the appropriate care recommendations are included for delegate approval. There is no requirement for the assessment to be undertaken again by the clinical assessor.

5.9. Developing a high-quality support plan

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

The Support Plan sections include:

- Assessment summary
- Concerns and goals
- Service recommendations

The role of an assessor, when developing the Support Plan with an older person, is to consider IAT findings and the older person's needs holistically to recommend support most appropriate to their needs and circumstances.

> Note:
>
> The Support Plan functionality in the system accommodates the Support at Home classes and associated service recommendations and AT-HM scheme.
>
> Once finalised, the Support Plan is sent to the older person, and their registered supporter/s and/or appointed decision maker/s as applicable (via post and/or email), as a record of the assessment, accompanied by a Notice of Decision letter. Registered providers also use the support plan to inform the individual's care plan; therefore, accuracy and clarity is essential.
>
> Referral codes are included in the Support Plan for the majority of services approved however there are several nuances about where they will appear depending on the program or pathway. For further detail on how referral codes will be communicated to clients and providers, see Chapter 7 'Post Assessment Referral and Services Access'

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5.9.1. Assessment summary

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

When completing the assessment summary, the My Aged Care system allows the assessor to pre-populate a summary of the older person's functional ability, support considerations and complexity indicators that were identified during the assessment and recorded in the IAT. The pre-populated information will be displayed in the ISBAR format, which is the required template for recording information in the assessment summary.

Assessors must use a standard template (see ISBAR approach below) to complete the assessment summary to ensure information is recorded in a consistent manner across assessment types. It is simple to adopt and helps make information easier to read while better supporting the delegation process and assisting the service provider to develop the care plan.

The assessment summary must:

- Be written in a succinct manner (using the ISBAR approach), focusing on relevant/essential information.
- Be presented in a structured way that makes the information easy to interpret.
- Be understandable to anyone without prior knowledge. Limit spelling and grammatical errors and avoid acronyms, abbreviations, jargon, and unnecessary headings.
- Provide a holistic and complete summary of the older person's assessment at that time.
- Be relevant. Only include information that is relevant to the older person's current situation. This may mean updating previous information.

Assessors must also:

- Use the 'pre-populate' function in the Assessor Portal to enable the ISBAR template to tailor the pre-populated assessment information in consultation with the older person. Ensure the Assessment summary is not limited to pre-populated information but includes a holistic, comprehensive view of the older person as per information collected from the assessment.
- Avoid simple dot point form. Information should be re-written in a sentence format that is succinct, objective, supports the client's needs, readable to the older person and justifies funding for My Aged Care services. See template in the Table 23 below.
- Review and edit information populated from the assessment – such as functional needs, health conditions, support considerations, and complexity indicators. For a SPR or reassessment, the assessor (in updating previous information) may need to remove content that is no longer current to remain within the 5000 character system limit. All past versions of the Support Plan are retained as a record of any deleted content. Each Support Plan must reflect the older person's current needs and circumstances. Historical content needs to be clearly identified or removed to ensure clarity of current needs.
- If clinical attendance occurred during the assessment process, the assessor must make a note of this in the Support Plan.
- Enrolled Nurses (EN) who complete a comprehensive assessment must include a statement in the support plan that the assessment has been conducted under direct or indirect RN supervision within the same organisation

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Note

Learner assessors must be supervised by an experienced certified assessor through their learning pathway. The Support Plans developed by learners must include a statement that the assessment was conducted under supervision and include the supervisor name.

All support plans within the assessment summary must be written using the ISBAR approach. It is expected assessors use the ISBAR format as a guide on how information is structured in the assessment summary with clear headings and subheadings where required. This ensures readability for not only the older person, but for their carers, service providers or future assessors, providing a holistic view of the assessment and older person.

Note to Aboriginal and Torres Strait Islander Assessment organisations:

Assessors should be mindful that the Support Plan should be written in a way that can be understood by the older person and their support network. If needed, the assessor may follow up with the older person to explain the Support Plan to the older Aboriginal and/or Torres Strait Islander person.

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Table 23. Assessment summary template using the ISBAR approach

ISBAR topic	Assessment information
Introduction	• Older person's name and age • Reason for assessment, including referral details (who made the referral and why, if appropriate) • Assessment details – type (home support or comprehensive), date, location, mode, attendees, assessor name • Whether the assessor is an EN requiring direct/indirect supervision from an RN.
Situation	• Key health conditions that impact functional limitations and need for an aged care assessment • Medical issues (clinical assessors to include diagnosis status) *

Background	• Living arrangements*
	• Diversity considerations supporting the Statement of Rights and Principles
	• Current social situation and social history*
	• Current support
	  ○ Carer profile (including details of Power of Attorney in place)
	  ○ Other informal supports*
	  ○ Current and previous services including aged care, mental health, disability, palliative care

ISBAR topic	Assessment information
Assessment	• Assessment observations (include carer involvement/carer strain) under the relevant domains: Function • Medical and medications • Physical and personal health and frailty • Social • Cognition • Behaviour • Psychological • Home and personal safety • Financial or legal • Support considerations • Whether clinical attendance was sought by a non-clinical assessor • Reference the use of any validated assessment tool (including those conducted through use of clinical attendance), the outcome of the tool and how that outcome was incorporated into the assessment.

Recommendations	• Previous approvals
	• Current recommendations*
	  o Reason for the recommendation (the older person benefit from X)
	  o Comments to support recommended interim services
	  o Comments relating to the urgency of service
	  o Who is to action the recommendation – older person, assessor
	  o Recommendations associated with the carer and/or affected support person/s
	  o Recommendations must be justified by a clear link to assessment outcomes and support the older person's goals and concerns.
	• Referrals*
	  o Status of referral (e.g., referral made with consent, older person declined referral)
	  o Who is responsible for contacting services
	  o Time-limited/end date or review date, or a rationale for ongoing services.
	• Contact details (if not older person) *
	• Who has been sent a copy of the Support Plan, including whether it has been linked to the older person's My Health Record*

*Indicates items that are not pre-populated

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Further guidance on **the information that should be included under each heading is below:**

Introduction section: Sets the scene for the assessment. This section should include the client's name and age, the type of assessment being conducted, the reason for assessment, support persons present such as carers/registered support persons/translation services, the date of when the assessment took place, whether the assessment was conducted face-to-face or via telehealth or telephone, the name of the assessor including supervising assessors (including registered nurses if assessor is an enrolled nurse).

Situation section: Ensure this section outlines the primary reasoning for the referral for aged care reason including any linkages to functional, social, psychosocial and environmental factors. This section should include an older persons' medical history with specific reference to the primary health condition(s) that impact their activities of daily living and/or social situation. Include any recent hospitalisations or access to ongoing medical intervention. This should link to any medical services the older person is currently receiving including any specific specialists, doctors or other medical professionals they are currently seeing (e.g. GP)

Background section: Include information that pertains to the older person's current social situation and any social history with details on living arrangements, work and/or social engagements. This includes caring arrangements (formal or informal) that are in place for the older person and what specific supports they are currently providing to the older person. This should also outline any carer stress or carer sustainability issues pertaining to the older person. Assessors should outline any aged care services (past and present) or other government or state-based services that are being accessed at the time of the assessment.

Assessment section: Include all relevant sections of the assessment and highlight any complexity indicators. Record detailed observations against the domains and use language such as 'the older person experiences X and has difficulty with Y, they would benefit from Z'. It should include all validated assessment tools and its scores that were used in the 'assessment' section along with an explanation of what the score indicates. The assessor should exercise clinical judgement on whether specific scores should be excluded (e.g. sensitivity content for the older person)

Recommendation section: Include all new recommendations/continuation of existing approvals, status of service referrals, time limited/ongoing/interim supports, who is responsible for actioning next steps, older persons' contact details and whether clinical attendance was required. Ensure that recommendations can be justified clearly through the Assessment Summary ISBAR format. Ensure that the information provided here can be linked to the older persons' service recommendations and approvals under the Goals and Concerns. It is best practice to revisit the recommendations section of the Assessment Summary following recording the older person's Concerns and Goals and prior to finalising the IAT.

5.10. Wellness and reablement approach

Wellness and reablement are person-centred, holistic approaches to service delivery. They build on people's strengths, capacity and goals to promote greater independence and autonomy. Wellness and reablement approaches are based on the premise that, even for individuals who experience frailty, older people want to improve their physical, social and emotional wellbeing, and remain living at home, connected to their community.

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By focusing on capacity-building and restoring or maintaining function, wellness and reablement approaches directly contribute to the wellbeing outcomes described in the Act and the strengthened Aged Care Quality Standards. These support older people to live safely, independently, and with a sustained sense of meaning and connection in their own homes and communities.

5.10.1. Delivering reablement

The provision of wellness and reablement approaches should be embedded in the assessment and support planning processes. Wellness and reablement underpins all assessment and service provision, drawing on the wellness philosophy to inform a way of working with people. Wellness and reablement are inclusive approaches that involve assessment, planning and delivery of supports that build on the strengths, capacity, and goals of individuals irrespective of age, capacity, diagnosis or setting[3]. Additionally, these approaches build on people's strengths and goals to promote greater independence and autonomy in daily living tasks, as well as reducing risks affecting the ability to live safely at home. They avoid 'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves (or with less assistance), and to increase satisfaction with any gains made.

Reablement approaches involve time-limited services for a period of up to 12 weeks and always include a specific goal. Time-limited support aims to address a specific barrier to independence and to support the older person getting back to doing things for themselves. This involves a targeted timeframe, developed with the older person, to achieve their goals.

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

A wellness and reablement approach to assessment means where possible, assessors undertake a 'show me' (active) assessment in which older people demonstrate how they undertake certain tasks to better understand their limitations and identify risks. This is distinct from the traditional "tell me" approach used by assessors.

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

Time-limited reablement under the CHSP that assessors may refer older persons for can include:

- Learning a new skill, or actively working to regain or maintain an existing skill
- modification to a person's home environment,

[3] Metzelthin, S.F., Rostgaard, T., Parsons, M., & Burton, E. (2020). Development of an internationally accepted definition of reablement: a Delphi study. *Ageing and Society, 42*, 703 - 718.

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- Providing access to assistive technology to help live more independently and safely in the home.

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

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

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

- rebuild confidence and independence in mobility
- rebuild confidence and independence in cognitive abilities, including for people living with dementia
- adaptation to functional limitation
- support the development/relearning of daily activities
- task simplification and energy conservation for managing housework
- promote social contact, community access and participation
- skills development in using public transport
- supporting independence through assessment for appropriate assistive technology
- training in the use of assistive technology
- supporting independence through assessment for home modifications ensuring safe living environments.

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

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

The reablement function on My Aged Care is designed so that the Support Plan can be finalised but also kept open for the support period to allow additional edits to be made (by the assessor who completed the assessment). The timeliness Key Performance Indicator (KPI) will not be impacted. The timeliness KPI ends at the "finalise Support Plan & keep open for support period".

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For a smaller sub-set of older people, CHSP restorative care may also be appropriate, where assessment indicates that the older person has potential to make a functional gain. Restorative care under CHSP involves evidence-based interventions led by an allied health worker or professional that allows a person to make a functional gain or improvement after a setback, or to avoid a preventable injury.

The department's expected proportion is that assessment organisations recommend a period of reablement, which will include reablement based strategies and short-term support from the Aged Care Assessor and, where required, a referral to short-term CHSP Reablement based support services, to a minimum of 10% of older people.

The following Steps/Activities are required for facilitating reablement:

- Consider if the older person would benefit from short-term reablement support, particularly if the older person has experienced some functional loss and expresses the desire to improve independence and/or regain confidence and capacity to resume activities, including connecting with their community.
- Consider assistive technology or home modifications for reablement support. Support at Home participants for example, if the older person would benefit from a shower chair under the AT-HM scheme or for CHSP clients, an equipment and products referral to assist them with showering and preserve their dignity, instead of having a support worker to attend and shower them.
- Where reablement is to be provided by one or more CHSP providers, recommend a period of reablement on the older person's Support Plan. This function allows assessors to identify older people who would benefit from reablement and allow assessors to make changes to the older person's Support Plan during the reablement period. Users accessing the older person's record (such as older people and service providers) will be informed that the older person is undergoing a period of linking support and/or reablement.
- Focus on elements of functional tasks that an older person can complete, and discuss what specific assistance they would benefit from in order to complete the task by themselves (to maintain and continue the independence to live at home)
- Discuss strategies an older person can employ to more easily manage day-to-day tasks (e.g., transport planning to meet goals around the use of public transport to maintain usual activities)
- It is important to ask what goals the older person wants to achieve. This can be as simple as making a cup of tea without help, or to understand their bus timetable. A goal could be walking to the local bus stop to go shopping, or to get to regular senior's events. Even small goals go a long way towards building self-confidence and regaining (or maintaining) skills to get back to doing things for oneself, to be more independent;
- When looking at what goals the older person could achieve, start by asking what a good day looks like for them? Then work out with the older person what goals they need to achieve to have more of those good days.
- Consider the older person's need for a mix of short-term, episodic, or ongoing services across CHSP service types (e.g., short-term personal care, episodic allied health, ongoing transport). Review this approach regularly to ensure the intensity of services matches the older person's needs.
- Maintain regular contact with the older person and providers and during the period of reablement.
- In consultation, determine when the reablement period should be finalised and what ongoing support (if any) may be required for the older person.

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- Develop local knowledge of reablement-type services in the region. Discuss with local providers their capacity and willingness to take on short-term older people as part of a reablement episode.
- An expanded in-depth description of Supporting Independence: Reablement including older person scenarios is at Appendix E.

Department of Health, Disability and Ageing website:

- Commonwealth Home Support Program (CHSP) 2025-27 Manual | Australian Government Department of Health, Disability and Ageing
- Wellness and reablement resources
- Living Well at Home – CHSP Good Practice Guide

5.10.2. Linking supports

The department has established services that will assist clients requiring support to access aged care services, including Care Finders, and Elder Care Support services.

For Aboriginal and Torres Strait Islander assessment organisations, Elder Care Support workers can be key partners in delivering culturally safe, trauma-aware, and healing informed assessments. where it is needed.

With a client's consent, Elder Care Support workers could attend an assessment to provide trusted experience for the older person. The assessor should work closely with Elder Care Support staff to facilitate a warm handover. This collaboration ensures continuity of care and supports a culturally safe and trusted transition for the older person into aged care services.

If an Elder Care Support worker has not been engaged prior to the assessment, the assessor should assist the older person in connecting with Elder Care Support services delivered by Aboriginal Community Controlled Health Organisations This support can help build trust, improve understanding of the aged care system and facilitate a smoother transition into services.

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Department of Health, Disability and Ageing website:

- List of Elder Care Support Providers | Australian Government Department of Health, Disability and Ageing

Where a client's complex circumstances may be impeding their access to aged care services, linking service support will assist in linking them to the various services they require to live in the community with dignity, safety and independence. The aged care needs assessor must determine if a client requires linking support.

Linking service support activities are aimed at working with the client to address areas of vulnerability that are preventing access to receiving mainstream aged care support, to the extent that the client is willing or able to access aged care services. The issues include

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homelessness, mental health issues, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage and cognitive decline.

Linking service support through the assessment organisation is limited to short-term case management or care coordination to the Point of Effective Referral. It is not designed to provide ongoing support services. The role of the aged care needs assessor is finalised when:

- a referral for services is accepted by a service provider.
- the client has accepted responsibility for managing their own referral for services;
- the client has made a choice not to proceed with aged care needs assessments or aged care needs assessment related services; or
- the outcome of the aged care needs assessment is that no further action is required by the aged care needs assessor.

If longer term support is needed, with consent from the older person, Elder Care Support workers or care finders should be engaged to help clients navigate the aged care system.

Key Performance Indicators have been set by the department for assessment organisations to increase the referral of older people to time limited Linking Services Support. This KPI specifies that 2.5 per cent of all clients will receive a time-limited Linking Services Support to address areas of vulnerability that are preventing access to receiving mainstream aged care support. Support may include short-term case management and non-aged care support.

Delivering linking support/care coordination to vulnerable older people

Facilitating linking support can greatly benefit some older people whose circumstances may impede their access to aged care services. Linking support may be conducted by providing short-term case management or care coordination to the point of effective referral. Activities are aimed at working with the older person to address areas of vulnerability which prevent access to receiving mainstream aged care supports or care, to the extent that the older person is willing or able to access aged care services. Issues leading to vulnerability could include homelessness, mental health concerns, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage, cognitive decline and/or living in a remote locality.

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

Identifying a vulnerable person for linking support

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

The older person:

- is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, wellbeing, and ability to remain living in the community,
- is at risk of, experiencing (or suspected to be experiencing) abuse,
- has emotional or mental health issues which significantly limits self-care capability, requires intensive supervision and/or frequent changes to support,

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- is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support,
- has experienced adverse effects of institutionalisation and/or systems abuse (e.g., spending time in institutions, prisons, foster care, residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and wellbeing,
- is exposed to risks due to drug and/or alcohol related issues and is likely to cause harm to themselves or others,
- is exposed to risks or is self-neglecting of personal care and/or safety and is likely to cause harm to themselves or others,
- has a cognitive impairment (e.g. memory problem or confusion) that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support.

The assessor may also need to consider challenges faced for people living in remote or very remote regions.

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

a) Culturally and linguistically or ethnically diverse individual; and/or
b) Aboriginal or Torres Strait Islander
c) Living in a rural or remote area
d) Financially or socially disadvantaged
e) A Veteran
f) Homeless or at risk of homelessness
g) Lesbian, Gay, Bisexual, Transgender, Intersex, or other gender diverse
h) Individuals
i) A person separated from their parents or children through forced adoption or removal
j) A socially isolated individual
k) Other (assessor to specify)

Further information on identifying and supporting vulnerable cohorts is included in Chapter 12 'Supporting Diverse Experiences and Needs'.

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

(a) whether complexity indicators impact the older person's ability to live independently in the community

(b) whether urgent intervention is required and

(c) whether the older person has indicators that impede access to delivery of aged care services.

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

Linking support and short-term case management activities

The level of linking service support offered by assessors is time-limited and is not designed to provide ongoing support services.

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However, it is understood that in some circumstances due to ECS services not being available in their area or due to preferences of older people who have already established trusted relationships with an assessor from an Aboriginal and Torres Strait Islander assessment organisation, an assessor may have a role in providing ongoing case management services to their clients.

The activities that an assessor chooses to undertake when providing linking support will be dependent on the needs, circumstances, and preferences of the older person, and may include one or more of the following:

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

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

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

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

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

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

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

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It is expected that assessors will work closely with vulnerable older people on a low income who are living with hoarding behaviour or in a squalid environment and at risk of homelessness or unable to receive the aged care services they need. Where there is no coverage for hoarding and squalor assistance, the eligible older person can be referred to CHSP services such as social work and other services targeted at avoiding or reducing the impact of hoarding and squalor situations (see Chapter 6 Aged Care Programs – Hoarding and squalor assistance).

All Care Finder and Elder Care Support Program clients seeking aged care services must be assessed by My Aged Care via the assessment services to determine eligibility and the need to receive additional CHSP services. People receiving assistance through the Care Finder program or Elder Care Support program may be eligible to access CHSP services targeted at avoiding homelessness or reducing the impact of homelessness. Any entry level CHSP services made available to a Care Finder or Elder Care Support Program older person between the age of 50 and 65 must be targeted at avoiding homelessness or reducing the impact of homelessness.

My Aged Care system function – linking support

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

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

5.11. Vulnerable older people relating to aged care services

Where the assessor wishes to monitor the older person's access to aged care services more closely, they can elect (or at the older person or appointed decision maker's request) to be notified of correspondence sent to the older person. This particularly applies to vulnerable older people who need assistance with the process of finding a suitable provider, and do not have support to assist them. Only one person from an assessment outlet can be selected to receive this notification. This person's contact details will also appear on all correspondence with the older person.

An assessor should also consider whether a person can access support through the Care Finder and Elder Care Support Program.

This notification can be enabled from any tab in the older person's Support Plan or on the 'Approvals' tab in the older person record. The notification link will only be enabled if the older person has been marked as 'seeking services', or a recommendation has been made.

Where an assessor is receiving Support at Home notifications for a vulnerable older person who has been approved to access funded aged care services, the assessor is able to extend an older person's acceptance period for ongoing services beyond the 56-

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day entry period, and extend the older person's time to select provider for an additional 28 days through the extension process on My Aged Care.

Care finder program | Australian Government Department of Health, Disability and Ageing

Elder Care Support | Australian Government Department of Health, Disability and Ageing

The assessor must carry out the following steps and activities:

- Consider if linking support is required – particularly if the older person presents with two or more complexities (and/or risk of vulnerability) – and may have been further confirmed through the support considerations process.
- If identified as 'vulnerable', with the older person's agreement, the older person will be provided with linking support. If not applicable, check an appropriate plan is in place. Therefore, the IAT and/or the Support Plan evidences the complexity or risk of vulnerability support has been considered and documented. If linking support is applicable, develop the Support Plan to include linking support, recommending the period of linking support and the planned activities. Action the recommended activities, monitor progress and record the outcomes (using the linking support function).
- Consider all available care and support options appropriate to the needs of the older person and facilitate the provision of services to the point of effective referral.
- Liaise, consult, and work collaboratively with all stakeholders and service providers in a multidisciplinary approach across service sectors to support individual older person needs. For example:
    - Contact relevant experts and service providers to discuss the older person's current situation and Support Plan moving forward, and to assist with the co-ordination of the older person's care whilst receiving linking support (e.g., care finders, CHSP Hoarding and Squalor providers, health, housing and legal services, community Geriatric Evaluation and Management teams, advocates, social, case management and/or mental health workers and local councils).
    - With older person's consent, obtain the necessary older person information from various sources and organisations.
    - Maintain regular contact with the older person, providers, and those co-ordinating services during the period of linking support.
    - Assist older people with issues relating to transition to alternate service options.
    - In consultation with the older person, determine when the linking support period should be finalised, and what ongoing support (if any) may be required for the older person
    - If aged care service access is not approved, consider referral to a support service outside of aged care and if relevant a support service which provides a coordination or case management function.
- Offer the information in a variety of formats to promote equitable access (e.g., paper-based, electronic, face-to-face, over the phone, etc.) and where appropriate, include information to self-refer to the identified services and supports and information on rights, responsibilities, and mechanisms for complaints.

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5.12. Recommending aged care services

> Note:
>
> Providers will not be able to deliver or claim for any services for an individual that are not approved in the support plan (even if there is an immediate need).

Once the IAT has been finalised, an assessor will assess an older person's need for aged care services as defined in **Sections 66 to 68** of the *Aged Care Act 2024*.

If ongoing Support at Home, Restorative Care Pathway or End-of-life Pathway, are recommended assessors will be taken directly to the 'Add Home Support services' page. On this page specific services are grouped by service type. These service types relate to the services in the Aged Care Rules 2025.

Under each service type, specific services will appear (known as service levels). For example, under the service type *Domestic Assistance*, services such as general house cleaning, laundry service, shopping assistance etc. will display. All services are pre-selected, except for services in the 'prescribed' service types *Allied health and Therapy* and *Therapeutic Services for Independent Living*. This is due to the specific nature of these services and should only be recommended if an older person has a need for them.

> Important:
>
> For any service type other than *Allied health and Therapy* and *Therapeutic Services for Independent Living* (the 'non-prescribed' service types), if you think the older person needs <u>any</u> service in the service type, then you need to select <u>all</u> services in the service type.
>
> This is because, for the non-prescribed service types under the Act, an older person is approved for access *at the level of service type only*. This applies to service recommendations for Support at Home classifications and CHSP.
>
> Under Section 65 of the *Aged Care Act 2024* an older Aboriginal and Torres Strait Islander person only needs an approval at the level of service group and classification type to receive aged care services. This means that if the older person is approved for a service group, they are automatically approved for *all service types and services* in that group.
>
> In the system, however, for the *home support* service group you must ensure all service types and services are selected in the 'Add home support services' page, if the older person is Aboriginal or Torres Strait Islander. If you add Assistive Technology, Home Modifications or residential aged care to the support plan, there is no need for you to select specific services.

On the *Add Home Support services* page, assessors can also:

- recommend the frequency and intensity of services
- link the older person's concerns and goals to the services that have been selected.

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Care types and services that are not part of Support at Home can be recommended by clicking 'Add a Service Recommendation' or 'Add a care type for delegate decision' under *other recommendations* in the *Goals & recommendations* tab. This applies to MPSP and NATSIFACP services, Residential Care, Transition Care and CHSP.

5.12.1. Making service recommendations

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

a) **Service recommendations** represent referrals that can be made through the Assessor Portal to Commonwealth-subsidised aged care services.
b) **General recommendations** relate to a type of support that is non-government funded or where a referral is made outside of the Assessor Portal. All recommendations – whether government-funded services, specialist programs, linking support, or general actions – must be clearly documented in the Support Plan.

Recommendations for aged care services must be aligned to an older person's current needs. If multiple services are recommended, the assessor must clearly link each service to a relevant concern and goal. If there are no recommendations as a result of the assessment, the assessor must provide clear reasons for the outcome within the Support Plan and communicate clearly to the older person.

Assessors must clearly articulate the service recommendation details – service type and services (if applicable), start, end and review dates (if applicable), frequency, intensity, priority, and outcome,

- The frequency and intensity of the services may be recorded if indicated, however may be decided at a later point by the service provider with the development of the Care Plan. Example: Two times weekly.
- The priority for the service recommendations is based on the older person's needs and urgency for services. The determination of urgency for services is based on the older person's circumstances, such that there is an urgent need for services which, if not met immediately, may place the older person's health and safety at risk.
- Include CHSP service (short-term or ongoing) information in the assessment summary (see previous sub-section: Assessment Summary).

> Note:
>
> If a non-clinical assessor is recommending services other than CHSP, they must seek the supervision of a clinical assessor to assist with providing recommendations for those services e.g. Support at Home ongoing, residential care and AT-HM.
>
> If clinical attendance occurred during the assessment, this supervision should be given by the clinical assessor who provided this attendance.
>
> If services that are not CHSP services are recommended and clinical questions were not triggered in the IAT, the non-clinical assessor will need to seek the supervision of a clinical assessor upon converting the assessment to a comprehensive assessment.

Detail all care options agreed with the older person, ensuring general and service recommendations:

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- Are evidence-based, defensible and are clearly drawn from and linked to the older person's goals and needs/area of concern. For example: a recommendation for respite, links to information on the older person/carer relationship, dementia support, and any difficulties or concerns that are experienced to reduce carer stress and support the care relationship.
- relate to the older person's current unmet needs and are supported by the assessment.
- take into account their identified support considerations when recommending options for support.
- consider the availability and capability of services and supports to meet the older person's care needs including:
- services in and outside of aged care
- informal supports, what family, friends and neighbours contribute (including the sustainability of these)
- General recommendations include responsibility to action (older person/other).
- In some instances, Aboriginal and Torres Strait Islander assessment organisations may also be an aged care provider. It is critically important that clients are provided with choice and control over service providers from whom they would like to receive aged care services. Assessors should discuss all the options with the older person.

Important: If a person can access some services from an MPSP or NATISFACP provider, you must add an MPSP or NATISFACP service recommendation. See Chapter 6 for more information.

5.12.2. Setting the 'service seeking' preference for prioritised services under the Support at Home program

Access to ongoing Support at Home (SaH) classifications and AT-HM under the Support at Home program (the AT-HM scheme) is managed through three independent priority systems:

- the Support at Home Priority System – for the ongoing SaH classifications
- the Assistive Technology Priority System – for AT under the SaH program
- the Home Modifications Priority System – for HM under the SaH program.

As part of the assessment process, it is important for assessors to have a clear conversation with the individual about whether they are seeking to receive these services through the Support at Home program.

There is a separate 'seeking services' preference field in the Support Plan section of the Assessor Portal for each of these recommendations (ongoing SaH classification, AT and HM). Assessors must record if the client is 'seeking services' or 'not seeking services' through the Support at Home program for each of the recommendations, in line with the following guidance:

- For clients seeking these services through the Support at Home program, the assessor should set the relevant service seeking preference to 'seeking services'. This ensures that the older person is placed on the appropriate priority system(s).

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- For clients not seeking these services through the Support at Home program, the assessor should set the relevant service seeking preference to 'not seeking services'.
- This option makes sure the client **does not** enter the relevant priority system(s) and will not be allocated funding under the Support at Home program. Relevant circumstances include when:
    - the client has chosen to access services through NATSIFACP or MPSP and so they do not require services from a SaH provider (or funding from the SaH program)
    - the client does not want to access the recommended services at this time.

If the older person later wants to access one of these services through the Support at Home program, they can change their preference and enter the relevant priority system. Older people wanting to enter the AT or HM Priority System will need to be a Support at Home participant (for ongoing home support) to do this. For all three priority systems, wait time is always counted from the original access approval date of effect. That is, for older people who enter any of these priority systems at a later time, it will be as if they had stayed in the queue from their first approval.

An older person can change their service seeking preference by:

- contacting My Aged Care
- using the My Aged Care Online Account.

5.13. Review of Support Plan

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

A review date of no longer than 12 months should be set for older Aboriginal and Torres Strait Islander people to ensure the services still meet their needs:

5.13.1. Scheduling a support plan review for Aboriginal and Torres Strait Islander assessment organisations:

Acknowledging that it may take a longer time to accurately identify the holistic aged care needs of an older Aboriginal and Torres Strait Islander person, following an initial assessment, an SPR should be scheduled to ensure the Support Plan remains responsive to the client's needs at the time of the assessment. The date should be:

- no later than 12 months after the assessment, and
- sooner if appropriate.

This approach enables the older person to access aged care services while enabling adjustments to the Support Plan if more needs are identified over time (most likely identified by the service provider) at the review date.

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5.14. Assessment wrap-up

At the end of the assessment, an assessor should inform the older person of the next steps so they have a realistic expectation of what will occur following the assessment. This will help the older person to feel more assured and increase their satisfaction in the overall assessment experience. There are a variety of resources an assessor might leave with an older person at the conclusion of an assessment that are also available in many languages other than English (see Chapter 13. Aged Care Resources for Consumers).

An assessor must:

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

5.14.1. Aboriginal and Torres Strait Islander Assessment Organisations assessment wrap-up

Due to the higher likelihood of older Aboriginal and Torres Strait Islander people being vulnerable and require additional support to access services, it is best practice to routinely follow up with the client (or their support network) post assessment, particularly for those who:

- have complex social need;
- have limited family or community support;
- have experienced recent changes in health, housing, or care arrangements;
- have communication or cognitive difficulties that may impact understanding of the assessment;
- have referrals rejected/not actioned;
- have experience difficulties with accessing services;
- work on short-term goal(s) in line with the length of time stipulated in the Support Plan;
- need linking support and require short-term linking assistance for the purpose of implementing the Support Plan;
- have expressed uncertainty or concern about the process or services recommended; and/or

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- are at risk of disengaging from services due to past negative experiences or systemic barriers.

Follow up may include, but not limited to:

- monitoring of referrals to services or negotiating with service providers for the provision of alternative services if necessary;
- discussion with the service provider and give advice to client on any follow up actions taken; and/or
- explaining any notifications/notices the older person may have received from My Aged Care.

Resources | My Aged Care

5.14.2. Providing an assessment report for approval

Once the assessor has finalised the assessment, they must submit it for approval by an assessment delegate. For a comprehensive assessment, this delegate approval can be done on system. For home support assessments, this delegate approval workflow will be offline. A fact sheet is available to assessors and assessment organisations to manage this workflow.

Under the *Aged Care Act 2024*, assessors are required to provide the System Governor with a report of the assessment as soon as practicable after the assessment has been completed. This report is the support plan. System Governor functions at this stage of the assessment process are performed by (delegated to) Assessment Delegates. The assessor portal will support assessors to recommend the following to the assessment delegate for approval:

- **service groups**,
- the **classification type** (short-term, ongoing or hospital transition) for each recommended service group;
- the **classification level**
- any **service types** or **services**
- the **priority category** if required.

For older Aboriginal and Torres Strait Islander people, an assessment delegate only requires to approve services at the service group level. This means the clients are automatically approved for all the service types and individual services within any service group they are approved for.

Assessors must also include in the support plan any information to support the Assessment Delegate to decide that the individual meets the relevant criteria (in the Act and its related rules) for the recommended approvals.

Assessors must ensure all information generated during the assessment is uploaded to the older person's My Aged Care Record following the completion of an assessment.

The fact sheet on non-clinical delegate workflow will be provided in the next addition of the Assessment Manual.

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6. Chapter 6: Aged care programs

What you'll find in this chapter

This chapter includes important information about the aged care programs that can be recommended by assessors to meet an older person's assessed needs and goals. It includes information about:

- Support at Home (Ongoing 1 – 8)
- Support at Home (Restorative Care Pathway)
- Support at Home (End of Life Pathway)
- Support at Home (AT-HM)
- Commonwealth Home Support Program (CHSP)
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)
- Multi-Purpose Service Program (MPSP)
- Transition Care Program (TCP)
- Permanent residential care
- Residential respite

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6.1. Support at Home - ongoing classifications 1-8

Support at Home improves on the four Home Care Package levels and consists of 8 ongoing classifications (1 – 8) with increasing levels of funding based on varying need in terms of the frequency and intensity of those services.

For participants assessed from 1 November 2025, a new classification framework will specify different funding levels based on the information captured during their assessment.

Funding amounts for each Support at Home classification are outlined below. Note that these amounts include the funding for care management, are indicative and are subject to indexation revisions.

In addition, there are 3 short-term pathways which are part of the Support at Home program, and these are defined as stand-alone service groups under the Act:

1. Restorative Care Pathway
2. End-of-Life Pathway
3. The Assistive Technology and Home Modifications (AT-HM) scheme

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Table 24. Budgets for Support at Home classifications

Classification	Quarterly Budget	Annual Amount
1	$2,682.75	$10,731.00
2	$4,008.61	$16,034.45
3	$5,491.43	$21,965.70
4	$7,424.10	$29,696.40
5	$9,924.35	$39,697.40
6	$12,028.58	$48,114.30
7	$14,537.04	$58,148.15
8	$19,526.59	$78,106.35
Restorative Care Pathway	$6,011.04 (up to 16 weeks) May be increased to $12,000 when eligible and if units of funding are available	
End-of-Life Pathway	$25,035.36 (up to 16 weeks)	
Assistive technology short-term (12months)	Low ($500), medium ($2,000) and high ($15,000) funding tiers based on assessed need. A higher amount maybe approved with a valid prescription from a suitably qualified health professional. For progressive condition bundles, funding is available for 24 months (may be extended for another 24 months if required with declaration).	
Assistive technology On-going	Assistance dogs $2,000 per year	
Home modifications Short-term (12 months)	Low ($500), medium ($2,000) and high ($15,000) funding tiers based on assessed need.	

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Classification	Quarterly Budget	Annual Amount
	Providers may apply for a funding tier time extension of an additional 12 months for HM high tier (24 months in total).	

A participant's annual Support at Home budget is divided into quarterly (3-monthly) budgets. Older people receiving Support at Home (known as participants) can carry over unspent funds of up to $1,000 or 10% of the quarterly budget (whichever is greater) from one quarter to the next.

These budgets are segmented into quarterly allocations to provide tailored support based on the participant's classification.

Ten percent (10%) will be deducted from each participant's quarterly budget for care management delivered by their service provider. Care management involves:

- planning and coordinating services
- checking in with participants to ensure they are being well supported
- clinical advice and practical support to address any changes in need or issues that arise
- providing support and education where needed.

Support at Home funding and finding a provider

When funding (including interim funding) becomes available and is allocated, the eligible participant will receive a letter notifying them that they have been allocated Support at Home funding. After funding has been allocated, participants have 56 calendar days from the date their funding was allocated to find a provider, and start services.

If a participant wants more time to find a suitable provider, they can contact My Aged Care and request a 28 day extension, giving them a total of 84 calendar days to start services.

If a participant has not started services within 56 calendar days (or 84 calendar days with the extension), their Support at Home funding is withdrawn. This means funding for their classification is no longer available and providers cannot provide government-funded services.

If the participant later decides they want to receive Support at Home services, they need to re-join the Support at Home Priority System by contacting My Aged Care. People who re-join the Support at Home Priority System will have their date of entry recorded as the date they were originally approved for Support at Home. Refer to Page 54 of the Support at Home program manual for more information.

Support at Home Program Manual

An Assessor's role in budget planning and contributions

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Assessors are not expected to develop detailed budget plans or explain contributions with Support at Home participants. The assessor may wish to give a high-level overview based on the information in this guidance document and direct their client to the Support at Home fee estimator tool.

A full fee estimator is available via the department's website myagedcare.gov.au/support-at-home-fee-estimator. This tool will allow people to plan budgets and estimate their contributions.

The assessor should emphasise that there will be an opportunity to discuss contributions further with their registered provider's care partner. A budget must be developed between the participant and their provider alongside the development of the care plan. The budget must outline how funding for participant's ongoing and/or short-term services will be spent in relation to the types and frequency of services outlined in their care plan, as well as any contributions for services to be delivered.

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6.1.1. The Support at Home Priority System

An older person approved to access ongoing Support at Home services (SAH classifications 1 to 8) will enter the Support at Home Priority System in one of its four priority categories:

- Urgent
- High
- Medium
- Standard

An older person's priority category is based on the information collected during the aged care needs assessment. It is automatically calculated using the responses to six different criteria. The amount of time the older person waits to receive their funding will depend on the priority category they are given. The priority category will be displayed under 'Approvals for a Client' in the Assessor Portal.

If an assessor makes changes to the following fields in an older person's client profile after the priority category has been calculated and the person has been placed in the queue, the system will automatically recalculate the priority category and queue position:

- Accommodation type
- No fixed address
- Lives with
- Aboriginal and Torres Strait Islander Status

An older person can request to be set as 'seeking services' or 'not seeking services' at any point. This can be done by contacting My Aged Care, or by using the My Aged Care Online Account.

6.2. Support at Home - Restorative Care Pathway

The Restorative Care Pathway (RCP), under the Support at Home program, is designed to provide early intervention support to older people by:

- preventing or delaying the need for ongoing in-home care services or the need to access higher levels of ongoing care
- supporting participants to regain their ability to carry out daily activities
- helping participants to manage new or changing age-related conditions
- providing reablement education and skills to participants on how they can retain better function as they age for longer independent living.

The RCP can be provided in a home or community setting, or a combination of both. An older person can receive up to a maximum of two units of RCP in any 12-month period. The RCP cannot be undertaken consecutively and must allow a minimum 90-day period between episodes.

The RCP can be delivered for up to a duration of 16 weeks. Participants may have a shorter RCP episode, for example, where they reach their goals earlier.

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The RCP may also be accessed in addition to a participant's ongoing Support at Home budget. A participant with an ongoing Support at Home budget who is approved for RCP, can continue to access their ongoing services while undergoing the Restorative Care Pathway. Restorative care partners will need to ensure that services are complementary.

Important:

An approval for RCP is equal to 1 unit of RCP funding (approximately $6,000). RCP units are capped to 20,000 units of funding annually (managed as 5,000 units of funding per quarter) across Australia.

System-based visibility of RCP caps is not available. As a result, there are no in-system prompts or controls to prevent the approval of RCP units beyond the quarterly caps.

Twice-weekly reports of allocations are generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

Assessors and Assessment Delegates should remain aware of any communication from the Department's Assessment Delivery Section regarding RCP units. This applies to decisions made through assessment/reassessment and SPRs.

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6.2.1. Assessing for the Restorative Care Pathway

RCP provides a coordinated, multidisciplinary package of allied health and/or nursing services. An individual must require a range of different allied health and/or nursing interventions to be eligible for the RCP. For example, an individual only requiring physiotherapy, domestic assistance and gardening is not eligible as they do not meet the requirements for a multidisciplinary allied health and/or nursing team.

Supporting people to regain independence and function to facilitate less reliance on higher levels of care is a critical objective of RCP. The intent of the RCP is not for an older person to receive passive 'care' services but to be an active participant to safely regain lost independence based on their individual circumstances.

A reablement approach underpins the Support at Home RCP, aiming to restore capability and keep people as independent as possible.

A person is eligible to receive RCP only if they meet all of the following criteria:

- The person is assessed as experiencing functional decline that is likely to be reversed through frequent, multidisciplinary allied health and/or nursing interventions over a short period of time
- The person has goals which align with restorative care outcomes (improve function, want to be independent, rely less on others' help, regain previous levels of function, etc)

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- The person demonstrates motivation through willingness and capacity to engage and actively participate in short-term clinical interventions to increase independence (for example, willing to attend frequent allied health appointments, engage in exercise and/or nutrition classes, learn how to apply techniques to regain independence, increase health literacy and education, etc)
- The person has received an ongoing SaH classification through the IAT Outcome (more information is included under section 6.2.3)
- The person is not receiving or, eligible for, the Transition Care Program (they should also not be in hospital at the time of assessment)
- The person is not in permanent residential care
- The person is not eligible for, or has recently received, the End-of-Life Pathway
- The person has not been approved for more than two units of RCP funding in any 12-month period and/or at least 90 days have passed from the end of the 16 weeks period associated with the original episode.

Assessors must only recommend the RCP if all the above eligibility criteria are met.

Assessors may consider contacting the older person to discuss alternative supports for recommendation if the RCP units are near exhaustion.

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Case Study: Omar, age 66

Omar is 66 and lives with his wife, Barbara. He recently had a little fall which has left him with a few small issues but has severely impacted his confidence. He is after some help around the home, so he doesn't fall again. After talking to both Omar and Barbara, the assessor suggests he might like to consider Restorative Care Pathway (RCP) as:

- Omar still has quite good mobility but needs some help building up his balance and strength to restore his confidence.
- Omar has the support of Barbara and family who are keen to help him stay independent.
- Omar initially had some concerns about undertaking the RCP but after discussion with the assessor, he is willing to try it as he would like to remain independent at home.

Omar's restorative care provides:

- Biweekly strength classes which start as individual classes at Omar's home with an exercise physiologist but, as his confidence increases, transitions into group exercise classes at the allied health centre. This also provides opportunity for Omar to connect with others while supporting increases in physical and mental function.
- Nutritionist support which provides insight and education into nutritional requirements to support his increased activity and support good health (plus meeting any cultural food requirements).
- Two podiatrist appointments to assess for issues with his feet which are impacting his balance.
- A restorative care partner who works with him on his goals and continues to support Omar, checking in periodically, monitoring his progress and continuing to discuss how problems achieving his goals can be resolved to help restore his confidence with the multidisciplinary team (MDT).

Outcomes

Omar regains confidence in his mobility. He teaches Barbara what he learns during his time receiving RCP services. They start attending strength building classes together at the local gym and join a walking group. After discussion with Omar and Barbara, the exit plan recommends no ongoing services are needed.

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Case study: John, age 55

John is a 55 year old Aboriginal man. He currently receives Support at Home classification 1 to help support him at home. He has several chronic health conditions and lives with his wife and adult son. His GP has recommended he be reassessed to help him manage his health conditions. After yarning to John and his family, the assessor recommends the Restorative Care Pathway (RCP). This is because services and education on how he can remain independent at home could help the household which is a good outcome for everyone. John knows he can manage his health conditions if given the support to do so.

His goals support restorative care outcomes (to regain function, keep level of independence, delay needing higher level of services). John was also approved for assistive technology and home modifications funding to support his RCP episode. This is funded through the Assistive Technology-Home Modifications (AT-HM) scheme.

Delivery

John's restorative care provides:

- Support and referrals to help manage his health issues including to a care manager at the local primary health network for his diabetes
- Support from a registered nurse who provides education and advice around how John can manage his health conditions.
- An occupational therapist (OT) visits several times to talk to John and his family about what assistive technology and home modifications can help him and, how John and his family can use the assistive technology safely and to check that home modifications meet John's needs.
- Administration and coordination costs of sourcing relevant AT-HM to support his restorative care goals.
- An Aboriginal and Torres Strait Islander Health Worker works with John to help provide cultural support, treatments and conduct relevant health assessments and provide connection to other relevant services, as required.

John's ongoing Support at Home services continue. A restorative care partner helps ensure restorative care services complement his ongoing Support at Home services.

Outcomes

John's restorative care partner finalises the exit plan after reviewing the goals identified in John's goal plan. John feels that he can apply what he learnt about managing his conditions, deciding he was happy with his current level of ongoing support. His RCP episode ceases and his ongoing Support at Home services continue.

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6.2.2. Expectation setting

Expectation setting is an important part of ensuring restorative care is successful and helps ensure people receive the care they need. Assessors should ensure the roles, responsibilities and objectives of RCP are fully explained during the assessment (including in comparison to ongoing care). This should happen before the RCP is recommended to ensure the older person fully understands the support that will be

available to them and their role. Older people who do not have the capacity or the willingness to engage with the RCP should not be recommended and approved for it.

For older people new to the aged care system and who are not receiving aged care services:

- an ongoing Support at Home or CHSP classification cannot be recommended at the same time as the RCP.
- the RCP is not a mechanism to access urgent services.

For older people who are receiving aged care services through an ongoing classification:

- The RCP can be recommended and approved where eligibility criteria **are** met.
  - Assessors must consider the potential for functional improvement that would delay the need for a higher-level classification when approving RCP (as a higher ongoing Support at Home classification cannot be recommended at the same time).
  - The RCP is not a mechanism to provide additional funding to supplement ongoing services.

- If, through a reassessment, the IAT outcome is a higher ongoing classification, assessors will only be able to select the higher ongoing classification OR the RCP.
  - If the RCP is selected, the person will remain on their current ongoing classification (rather than the higher classification recommended).

- Assessors should consider if the older person's current provider delivers the RCP.
  - Under Support at Home, services must be delivered by a single provider (service delivery branch level). If the provider does not deliver the RCP, the participant will need to change providers to access both RCP and ongoing services. This should be considered before approving the RCP for people already accessing ongoing services through Support at Home.

For those already accessing ongoing care, assessors should carefully consider ongoing needs before recommending the RCP. Assessors cannot recommend a new higher classification and the RCP at assessment. This will impact a new ongoing Support at Home classification entry into the Priority System.

For new participants, eligibility for ongoing services will need to be determined at the end of the RCP episode (if RCP is recommended).

6.2.3. Recommending Restorative Care Pathway in the assessor portal

Upon finalisation of the IAT, if the IAT outcome recommends an ongoing Support at Home classification, this can be overridden to change the IAT outcome to the RCP by clicking the override button. By overriding to the RCP, assessors will be navigated to the '*Add Home Support Services*' page to add services.

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> Note:
>
> The IAT will allow 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.

Older people approved for the RCP can only access services they have been approved for.

Assessors should consider what services are being accessed under the person's ongoing Support at Home classification and ensure they are complementary (and be based on need connected to their restorative care approval). Assessors should note that delivery of multidisciplinary intensive allied health/nursing services is a key element of the RCP.

Restorative care management is also a mandatory service type when undertaking the RCP. To search for a RCP provider, people can search for the service type 'restorative care management' through the 'Find a Provider' website (when 'Support at Home program' is selected.

> Note: Hoarding and Squalor services cannot be recommended alongside a recommendation for the Restorative Care Pathway.
>
> Note: If the client is assessed in hospital, the Restorative Care Pathway should not be recommended. Assessors should consider appropriate alternative services.

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6.2.4. Interactions with other programs

Table 25. Restorative Care Pathway interaction with other programs

Program	Interaction with Restorative Care Pathway (RCP)
Ongoing Support at Home	If an older person receives an ongoing Support at Home classification through the IAT, this can be overridden to recommend the RCP.
Assistive Technology and Home Modifications (AT-HM) scheme	Older people approved for the RCP may also require Assistive Technology or Home Modifications to support good restorative care outcomes. Assessors must always ensure these needs are considered when approving the RCP. Older people who are approved for the RCP are eligible to receive an Assistive Technology low, medium and high funding tier, and low and medium tier **home modifications**. Participants with an ongoing Support at Home classification who are already have high

Program	Interaction with Restorative Care Pathway (RCP)
	tier home modifications funding can keep this approval, noting this approval is connected to their ongoing classification approval. The assessor will need to select assistive technology and home modifications for these to be added to the support plan.
CHSP	Though the IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment, an assessor must **not** recommend or approve the RCP for: • an older person new to the aged care system and not receiving aged care services, who is recommended CHSP by the IAT outcome; or • an older person already accessing CHSP, who is recommended CHSP by the IAT outcome. (Noting, where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.) If an older person accessing CHSP is recommended an ongoing Support at Home classification through a reassessment using the IAT, this can be overridden to recommend the Restorative Care Pathway. Note: Older people can access allied health and therapy services through CHSP. Assessors can recommend reablement and/or allied health and therapy services on their support plan
End-of-Life Pathway (or if they have recently accessed this pathway) Transition Care Program Permanent Residential Care	Cannot receive the Restorative Care Pathway at the same time (applicable for EoL, TCP and permanent Residential Care).

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6.2.5. Lapse in Restorative Care Pathway access

Access to the Restorative Care Pathway (RCP) will lapse if:

- the older person's episode of RCP ends (maximum 16 weeks); or
- a person does not enter into an agreement with a provider to deliver the RCP before the access code expires (within 56 days of approval with a further 28 days if My Aged Care is contacted for an extension).

An older person will need to be reassessed if they wish to access the RCP after their access period ends lapses (with a 90 day break applied).

6.2.6. Manual oversight of Restorative Care Pathway places

RCP places are capped at 20,000 units per year across Australia, managed as around 5,000 units per quarter. There are no in-system prompts or controls to prevent the approval of RCP funding units beyond the quarterly caps. Twice-weekly reports of approvals made are generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

Those with an active Short-Term Restorative Care (STRC) approval (who did not start STRC before 1 November 2025), have had their approvals transferred into an approval for RCP.

Note for this cohort using their STRC approval to access the RCP:

- This cohort will also be accessing the RCP units of funding for the first six months from 1 November 2025.
- A second unit of funding to use within a single RCP episode can be requested via a support plan review (SPR) request. However, assessors will need to self-refer this for reassessment to grant access to a second unit of funding. This is because the ability to add a second unit via SPR will not be available on the assessor portal for those with an STRC approval.
    - The reassessment can be done over the phone and does not require queuing for a face-to-face assessment.
    - The decision to approve a second unit will be informed by evidence submitted by the provider with the SPR request.
    - Availability of RCP funding units may also be considered.
- When a request for a second unit of RCP is received assessors should confirm if there is approval for STRC and RCP on the client's record. If there is approval for both, the assessor will need to confirm with the client if the client entered care under the RCP after 1 November 2025 using the STRC approval. If this is the case, then the assessor must not approve a third unit of RCP funding.
- If the participant is eligible to access an additional RCP unit they must wait at least 12 months before accessing another episode.

Assessors will need to remain acutely aware of any communication from the department regarding RCP caps to ensure you are making informed decisions. These communications will be the **primary tool** for identifying when RCP units are nearing exhaustion. Being responsive to these insights is essential for maintaining compliance with pathway limits and avoiding over-allocation.

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Before recommending the RCP for approval, assessors should consider whether other service types—such as other Support at Home services or reablement options under the Commonwealth Home Support Program (CHSP)—could provide an equivalent level of support. This ensures that recommendations for approval are appropriate to an individual's needs, consider if a place will be available for the older person to access, and aligned with the sustainable allocation of places.

If an RCP recommendation is not made due to no places being available for allocation, the assessor should consider discussing with the older person alternative supports for recommendation. Assessors may also consider if an alternative classification could be recommended to meet the care needs of the individual.

6.2.7. Restorative care funding

The RCP provides around $6,000 of funding, for up to 16 weeks. The total amount of funding a participant uses and length of time to complete an episode can differ. Restorative care partners will consider this when developing the goal plan.

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode. If the participant requires additional funding within a single 16-week episode, the provider can submit a request for a support plan review. If certain circumstances are met, approval can be given for the additional $6,000 in funds to support the episode (see Chapter 10 on support plan reviews).

If approved, a participant can access an additional unit of funding (up to $6,000), to provide a combined total of up to $12,000, for a single RCP episode. If additional funding is approved, a participant will not be eligible for a further episode of RCP within a 12-month period as they have accessed the maximum 2 units of funding within the first episode.

The decision to approve additional funding to the RCP episode is made under *subsection 195-3 of the Rules*. It is a non-reviewable decision. The criteria in the Rules includes that required evidence must be given by the participant's provider and there must be units of funding available for approval.

Evidence to support the additional funding may include:

- Goal plan and individualised budget outlining how the required clinical interventions are not supported by the initial funding
- Information as to why ongoing funding cannot be used to complement restorative care clinical goals.

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The assessment delegate must send a letter to the older person (and their registered supporter/s, if required under the Act) notifying them of the outcome of the application for the additional funding. The assessment delegate should choose the appropriate template under 'Reports and documents' > 'Forms' in the Assessor Portal.

> Note:
>
> This is a different template to the Notice of Decision issues for other approval decisions.

6.2.8. Restorative Care Pathway and the Support at Home Priority System

The Restorative Care Pathway (RCP) is not subject to the Support at Home Priority System. People can access RCP once a Notice of Decision letter has been received after delegate approval. Please note that selecting the RCP will mean that any new ongoing or higher ongoing Support at Home classifications cannot be selected. As such, assessors should consider long term need when approving for the RCP. An assessor may only select an ongoing (or new ongoing) Support at Home classification which will put them in the Priority system OR select RCP.

RCP participants will have immediate access to any recommended assistive technology and home modifications under the AT-HM scheme based on their assessed needs.

6.2.9. Hospitalisation, residential respite and leave

People may need to enter hospital or residential respite while accessing the RCP. There are no leave provisions under Support at Home. If a person's RCP episode finishes while they are in hospital or residential respite, they will need to consider reassessment to determine what will meet their needs.

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6.3. Support at Home - End-of-Life Pathway

The End-of-Life Pathway is one of the short-term home support classifications under the Support at Home program. A participant can access one episode of the End-of-Life Pathway. A total of $25,000 is available per eligible participant over a 12-week period. This is the highest funding classification category (per day) available in the Support at Home program.

An older person is eligible to access this pathway if they meet the following criteria:

- A doctor or nurse practitioner advises an estimated life expectancy of 3 months or less to live
- Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator) of 40 or less.

Funding can be used to access the participant's approved services from the Home Support service list, including care management.

6.3.1. End-of-Life Pathway form

The End-of-Life Pathway form is used to document the required medical evidence for accessing the End-of-Life Pathway under the Support at Home program. An individual seeking access to the End-of-Life Pathway must complete all relevant sections and present this form to a medical practitioner or nurse practitioner for completion. The completed form should then be submitted as part of the assessment process—either before or during triage, or assessment—and reviewed to confirm eligibility for the End-of-Life Pathway.

The End-of-Life Pathway Form is required to be completed and submitted before a participant can be assessed as eligible for the End-of-Life Pathway. Assessors are responsible for ensuring they receive the completed End-of-Life Pathway Form to proceed with the assessment. In cases where an aged care assessment or support plan review (SPR) is undertaken via telehealth (and where digital referral or GP e-referral is not used), assessors must assist older people to ensure the completed End-of-Life Pathway Form is submitted. Options for lodging the completed End-of-Life Pathway Form include:

- An older person or their support person may nominate to send the signed form directly to the assessment organisation via their preferred mechanism (for example, email). Assessors should contact the person to discuss their options and assist to obtain the form in cases where a person is unable to send the form themselves due to circumstances such as digital barriers or limited access to support; or
- Assessors contact the relevant medical or nurse practitioner to request they send the completed End-of-Life Pathway Form to the assessment organisation via their standard processes for information sharing (for example, fax)

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Assessment delegates are responsible for verifying the completion of this form in the older person's record when the End-of-Life Pathway has been flagged in the My Aged Care assessor portal.

Reviewing the form will involve:

- Checking the individual's details to ensure they match the record in the portal.
- Verifying the completion of all areas of the Medical Assessment section to confirm:

1. The individual has a prognosis of a life expectancy of three months or less, and
2. An Australian-modified Karnofsky Performance Status (AKPS) score of 40 or less.
3. Medical practitioner or nurse practitioner has completed and signed the form.

An individual will **not** be eligible for approval for the End-of-Life Pathway if the required criteria outlined in the medical assessment section are not met.

6.3.2. Accessing the End-of-Life Pathway

Existing Support at Home participants can access End-of-Life Pathway through a support plan review. This is usually requested through the My Aged Care Service and Support Portal by the older person's provider and should be made using the approved form.

Older people can seek a referral through their medical practitioner or other health professional (using the Make a Referral or GP e-referral channels) or by contacting the My Aged Care contact centre or using Apply Online. The End-of-Life Pathway form must be attached for referrals using Make a Referral or GP e-referral. For other entry pathways, Triage is still able to be undertaken without a completed End-of-Life Pathway Form. In these instances, participants should be advised at Triage to have the form completed by an appropriate medical practitioner (their GP, non-GP specialist or nurse practitioner.) The End-of-Life Pathway Form must be completed before the End-of-Life Pathway is approved.

Once approved, services are delivered under the End-of-Life Pathway classification and care partners work with any relevant state and territory palliative services to ensure care is appropriate and tailored to the individual's preferences and needs.

6.3.3. Interactions with other programs

Table 26. End-of-Life Pathway interactions with other programs

Program	Interaction with the End-of-Life Pathway
Assistive Technology and Home Modifications (AT-HM) scheme	Individuals receiving support through the End-of-Life Pathway can be approved to access assistive technology low or medium tier only at the same time. If approved for assistive technology, immediate AT-HM scheme funding can also be used to access products and equipment from the AT-HM list. If eligible, primary supplements will also apply to participants. The assessor will need to select assistive technology for this to be added to the support plan.

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Program	Interaction with the End-of-Life Pathway
	Access to home modifications is not permitted. If home modifications are already underway through the AT-HM scheme at the time the End-of-Life Pathway is approved, these modifications can continue while accessing the End-of-Life Pathway.
Residential Respite	Participants accessing the End-of-Life Pathway may continue to access these services during a period of Residential Respite, as long as services are not duplicative.
Transition Care Program	Participants accessing the End-of-Life Pathway are not eligible to receive transition care.
CHSP	Participants accessing the End-of-Life Pathway can access CHSP services, including urgent services, in limited circumstances. See Table 29 for more information.
Support at Home ongoing	
Restorative Care Pathway	An individual cannot access these services under the End-of-Life Pathway
Permanent Residential Care	

If an individual is eligible for the End-of-Life Pathway, they can be referred and transitioned out of any of the above programs to begin receiving services under the End-of-Life Pathway. Individuals who are accessing services through MPSP or NATSIFACP, can access their SAH End-of-Life approval through those programs as well. Participants accessing the End-of-Life Pathway may continue to access these services during a period of Residential Respite, as long as services are not duplicative.

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6.3.4. Funding for the End-of-Life Pathway

Funding for the End-of-Life Pathway is discrete from other Support at Home classifications. If an existing Support at Home participant moves to the End-of-Life Pathway, this will replace their ongoing Support at Home classification.

Unlike an ongoing classification, participants cannot accrue funds under the End-of-Life Pathway. This means that any unspent budget from an End-of-Life Pathway classification will not follow a participant if they live beyond the End-of-Life funding period and move to an ongoing classification.

Transitioned HCP clients can access the End-of-Life Pathway via an SPR, like all existing Support at Home participants. If they require services beyond the End-of-Life Pathway funding period, they can return to their previous transitional classification via an SPR.

6.3.5. Allocation of ongoing Support at Home to the client after End-of-Life Pathway

If the participant requires ongoing Support at Home services following the completion of the End-of-Life Pathway, the following will apply:

Participants who were accessing ongoing Support at Home services prior to accessing the End-of-Life Pathway can be transferred to their previous Support at Home classification via an urgent support plan review.

Participants who were new to Support at Home when they commenced the End-of-Life Pathway can be transferred to the inactive classification that was assigned at their aged care assessment, via an urgent support plan review.

6.3.6. Assessing for End-of-Life Pathway

When assessing for the End-of-Life Pathway, only mandatory questions that are required to run the IAT Outcome and generate an ongoing Support at Home classification are required to be completed. This is to ensure the older person has a valid classification to return to if they need services beyond the End-of-Life Pathway funding period. Other questions are optional based on the individual's needs and context.

6.3.7. Recommending the End-of-Life Pathway in the assessor portal

Assessors can select the End-of-Life Pathway for older people under the '*Goals & recommendations'* tab within the Support Plan and services section of the My Aged Care Assessor Portal. It is best practice for End-of-Life to be flagged and verified prior to the commencement of the assessment, however there are allowances to be able to complete these two tasks after an assessment has started.

Upon finalising the IAT, the system will recommend either a single CHSP classification or an ongoing Support at Home classification (in nearly all instances, it will be a Support at Home classification for this cohort). If a Support at Home classification is generated, assessors will need to override the recommendation and choose 'End-of-Life'. Assessors will be navigated to the 'Add Home Support Services' page where services are pre-selected. Assessors should only unselect service sub types if they think the client may not have a need for this service.

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This will then enable assessors to allocate this pathway for assessment delegate approval.

6.4. Support at Home – Assistive Technology and Home Modifications (AT-HM) scheme

The Assistive Technology and Home Modification (AT-HM) scheme is a short-term pathway that supports older people to live at home and within their community with increased independence, safety, accessibility and wellbeing. The AT-HM scheme provides separate supports under Support at Home, with separate funding tiers (called *classification levels* under the Act) and program settings. Participants can access both assistive technology and home modifications funding tiers at the same time if needed. This will provide upfront funding to access products, equipment and home modifications. The AT-HM scheme is delivered in parallel to a participant accessing ongoing services through Support at Home. This means that participants can access these supports without needing to save up funds from their Support at Home quarterly budgets.

Older people new to the aged care system who are approved for the Support at Home AT-HM scheme cannot be issued referrals to Commonwealth Home Support Program (CHSP) AT and/or HM services while they wait for AT-HM scheme funding.

If an older person receiving CHSP services is reassessed for Support at Home and the AT-HM scheme, they may keep accessing CHSP AT and HM, if they have referrals for these services, until their AT-HM scheme budget becomes available. After that, CHSP-funded AT and HM services will no longer be available for them to access.

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6.4.1. AT-HM scheme participants

AT-HM scheme participants are empowered to actively participate in informed decision-making regarding the care, products, equipment and home modifications they receive. Providers are expected to consult participants to determine their support needs to ensure services are individualised and relevant.

Through the AT-HM scheme, participants will:

- have access to the AT-HM list to understand what equipment, products and home modifications are available to meet their assessed need,
- actively participate in the care planning process and have the AT-HM scheme explained in a way that they understand,
- identify their needs, life goals, strengths, and service delivery preferences including choice of health professionals,

6.4.2. Assistive technology

Assistive technology (AT) is any item, piece of equipment or product that is used to help an older person do things more easily or complete activities they can no longer do independently at home or in the community.

Examples of assistive technology include:

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- mobility equipment such as walking sticks, walking frames and wheelchairs
- toileting supports including bedpans and commodes
- bathing devices including shower chairs and bath boards
- alternative and augmentative communication (AAC) products
- products for food preparation and eating including adaptive cutting boards and knives, as well as modified cutlery
- a contribution toward costs associated with assistance dog maintenance.

The AT-HM scheme does not include items such as:

- everyday household appliances e.g., a dishwasher
- assessment or therapy tools used by a therapist
- products or technologies funded through an alternative national or state-based program (e.g., the Medical Aids Subsidy Scheme).

Assistive Technology and Home Modifications list (AT-HM list)

6.4.3. Home modifications

Home modifications (HM) provide changes to an older person's home to create a home environment that is safer and more accessible, so they can remain living safely at home.

Examples of home modifications include:

- lever tap sets or lever door handles
- grab rails in the shower or bathroom
- internal and external handrails
- modified door locks
- non-slip materials and surfaces for floors and stairs.

In some circumstances, participants may be approved for more significant home modifications including:

- bathroom modification (e.g., level access shower and modifications to improve accessibility)
- ramps and stairlifts.

The AT-HM scheme does not include:

- general renovations to a home or dwelling
- restorations or repairs which are considered normal maintenance of home or dwelling
- changes to a home layout that do not relate to a participant's support needs.
-

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6.4.4. Funding tiers for AT-HM

The table below outlines the 3 funding tiers for assistive technology and home modifications.

Table 27. AT-HM funding tiers

Funding tier	Funding allocation cap	Funding period
Assistive technology		
Low	$500	12 months (in most instances)
Medium	$2,000	12 months (in most instances)
High	$15,000[1] (nominal)	12 months (in most instances)
[1] Products and equipment with costs greater than $15,000 are available to participants with a prescribed need.		
Home modifications		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000	12 months[2]
[2] Funding may be extended for an additional 12 months to complete complex home modifications (24 months in total) if evidence is provided to Services Australia		
Other funding		
Assistance dog maintenance	$2,000 per year	Ongoing[3]
[3] Funding for assistance dog maintenance will be automatically allocated every 12 months; however, the funding cannot accrue or rollover.		

This funding may cover the following:

- Assistive technology equipment and products
- Home modifications and associated services
- Repairs or maintenance of assistive technology items available on the AT-HM list
- Prescription of items, where appropriate, by a suitably qualified health professional working within their professional scope of practice
- Associated administration activities (cap will apply – see the AT-HM scheme guidelines for further details).

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Participants will be allocated a funding tier for 12 months (in most cases) to spend their assistive technology and home modifications funding.

The cost of wrap-around services—such as delivery, setup, training, and follow-up—are also drawn from the AT-HM funding tier. Providers can add a 10% charge on administration costs for AT claims and a 15% charge for coordination costs for HM claims. Assessors must consider these costs when allocating a funding tier.

Participants may be required to contribute towards their assistive technology or home modifications.

AT-HM funds will not accrue over time and funding will be available for 12 months (in most instances) once a participant is assessed (or reassessed) and approved. If major home modifications take longer than 12 months, funding may be available for a further 12 months if the participant can provide evidence the work has commenced. This will ensure enough time to complete the work to the required standards.

Older people identified at assessment with specific progressive conditions may be eligible to access assistive technology funding for 24 months to meet their rapidly changing needs. The 13 conditions listed below are all eligible AT-HM progressive conditions under Support at Home.

These conditions are:

- Cerebral Palsy
- Epilepsy
- Huntington's Disease
- Motor Neurone Disease (MND) noting different phenotypes require different management
- Multiple Sclerosis (MS)
- Parkinson's Disease
- Late effects of Polio
- Spinal Cord Injury
- Spinal Muscular Atrophy
- Stroke
- Acquired Brain Injury noting different types of brain injury require different management
- Muscular Dystrophies and Muscular Atrophies.

In some cases, this funding can be extended for another 24 months, providing a total of 48 months of support. If available, Home Care Package unspent funds must be used to access assistive technology and home modifications before AT-HM scheme funding is used.

6.4.5. AT-HM list

The AT-HM list sets out the assistive technology and home modifications that can be accessed and funded through the AT-HM scheme.

The AT-HM list is sorted into the following categories:

- **managing body functions** – including pressure cushions, anti-oedema stockings and memory support products
- **self-care products** – including adaptive clothing or shoes and assistive products for toileting, bathing and showering

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- **mobility products** – including walking frames, wheelchairs and lifting devices
- **domestic life products** – including assistive products for food preparation, eating, drinking and house cleaning
- **communication and information management products** – products and equipment that assist with reading and writing, as well as alternative and augmentative communication (AAC) devices
- **home modifications** - including accessible showers, grabrails, fixed ramps and safety barriers.

The AT-HM list also includes a guide on the recommended prescription category for each item. The prescription category is the suggested level of skill or qualification required to effectively provide recommendations for the safe and effective use of assistive products or equipment or installation of home modifications.

Assistive Technology and Home Modifications list (AT-HM list)

6.4.6. Assessing the need for AT-HM scheme funding

Existing questions in the IAT will help to identify and determine an older person's need for assistive technology and home modifications. The AT-HM tier guide will assist the assessor to make a funding tier recommendation. For example, the function section will provide a more detailed understanding of a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

Assessors are **not required** to determine the exact item or product to be provided. Rather, an assessor's role is to identify whether the person is likely to benefit from AT or HM supports based on observed and reported difficulties, risks, or goals. Assessors are asked to assign a funding tier for AT and HM based on the assessed need with the support of the AT-HM tier guide. It is recommended that assessors also familiarise themselves with the AT-HM list and how it is utilised in the AT-HM scheme. The specific types of AT-HM best suited to the client, and any required prescriptions, is the responsibility of the registered provider at the point of service delivery.

During the assessment, consider whether the older person:

- has needs and goals that could be met through using assistive technology and home modifications
- can have those needs met through the products, equipment and home modifications included on the AT-HM list.
- may require prescription or wraparound services for the assessed needs of the assistive technology and home modifications. This will need to be considered and captured under the recommended funding tier allocation.

Older Aboriginal and Torres Strait Islander people may not reveal the full care needs to service providers who they may not know or with whom they have a trusted relationship. If trust and rapport has already been built with the FNAO assessor through the assessment process or with the ECS worker, the assessor/ECS worker may (if appropriate) choose to facilitate service providers and the client with the process of identifying specific types of AT-

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HM which are best suited and advise on any cultural matters that may need to be considered.

6.4.7. AT-HM funding tier guide

If assessors identify that the older person requires AT-HM they are required to recommend a funding tier. AT-HM funding tier guidance has been developed to assist assessors to make a funding tier recommendation for AT and HM based on the older person's assessed need in the IAT. This includes considering their current functional ability and home environment.

The guidance has been designed to consolidate the main elements of the IAT relevant to AT-HM and support assessors in choosing a funding tier. The guide will suggest an assessment tier which should sit where the majority of tier indicators have been selected. The guide groups indicators into three tiers: **low, medium, and high**—and uses a checkbox format for ease of completion. The AT-HM tier guide provides a non-scored pattern of recommendation—the more indicators selected within a particular tier, the stronger the alignment with that level of support.

Where the guide does not produce a clear outcome, or in more complex cases, clinical reasoning based on the person's functional ability, safety, independence, and home environment should guide the tier allocation. Progressive conditions—particularly if multiple are present—may also justify a higher tier allocation, even if fewer indicators are ticked.

Assessors should ensure their recommendations align with the participant's goals, safety, independence, and overall ability to remain living at home. They may choose to select an alternate tier if funding does not align with assessed need. Assessors can upload the document as an attachment to allow the assessment delegate to review as supporting evidence for any funding tier recommendations made.

> Note:
>
> Assessment operation managers will have access to the AT-HM tier guide document on the assessor SharePoint site. Operation managers can download and provide the template to assessors.

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6.4.8. Instructions for assessors completing the AT-HM Tier Guide

The AT-HM Tier Guide should be used by assessors and assessment delegates to determine the appropriate funding tier for an older person who has been assessed as having a need for AT and/or HM.

Assessors are asked to complete the following:

- use the relevant information from the older person's assessment when completing the AT and HM tier guide
- select the relevant indicators on the tier guide for either AT and HM based on the older person's assessed need

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- review the guide to support tier allocation recommendation. The AT-HM tier guide will suggest a tier where the highest number of tier indicators have been selected.
- upload the completed AT-HM tier guide to the assessor portal under ‘other' and title the document ‘AT-HM Tier Guide.’ The Assessment Delegate should consider the guide when approving or declining the AT-HM funding tier.
- manually add the recommended AT and HM tier in the support plan once a funding tier is determined.

Assessment decisions for AT-HM funding tier allocation can be reviewed through a support plan review if the funding tier does not cover the assessed need.

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CASE STUDY: AT low tier

Carol is 65 and has just been assessed and during her comprehensive assessment it was found that she is managing daily activities independently but would benefit from some help with housework and getting to and from the shops. She mentioned that she has some difficulty washing her legs, feet and back in the shower and finds it hard to bend down to put her shoes on.

The assessor thinks Carol may benefit from some basic items such as a long-handled sponge, a non-slip bathmat and a long-handled shoehorn. After looking at the AT-HM list the assessor believes that all these items are low-cost and low risk and Carol should be allocated Assistive Technology low tier (AT Tier 1) funding to cover the cost of these items.

Using the assessment findings the assessor completes the assistive technology section of the AT-HM tier guide. All selected indicators sit within Tier 1. The assessor allocates Carol with an Assistive Technology low tier (AT Tier 1) on the support plan. This decision is supported by the information gained during the assessment and the AT-HM tier guide recommendation.

The assessor uploads the AT-HM tier guide to the assessor portal under 'other' naming the document 'AT-HM tier guide.' This is considered by the delegate as supporting evidence of AT-HM tier recommendation.

Carol's AT recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate, Carol will receive a Notice of Decision letter informing her that she has been approved for a SaH on-going classification and AT low tier funding for assistive technology. Once funding is assigned and the Funding Assignment Notice is sent to the participant, she can then find a provider to help source the low-cost and low risk AT items she needs.

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