CASE STUDY: HM high tier

David is 55 and lives in a small rural community in Western Queensland. He attends an Elders' social group at his local Aboriginal Community Controlled Organisation (ACCO). The ACCO's Elder Care Support worker supported David during an aged care needs assessment conducted by an Aboriginal and Torres Strait Islander assessment organisation. David has just been assessed. During David's assessment he explained that he would like to be able to come and go from his home more easily so he can do things for himself like shopping. During the subsequent discussion, the assessor noted that David has significant issues managing at home safely due to his home environment. He lives alone and is not able to easily enter or exit his house because of the steep front stairs and difficulties carrying his walking frame on the stairs.

After spending time with David to build his trust and understanding of the assessment process, David explained he feared falling when entering and exiting his shower due to a large step into his shower recess. David's son helps him when he can, but he lives in another town and can only visit a couple of times a week.

The assessor and Elder Care Support worker identify in the AT-HM list that David could benefit from some modifications to his home which could include a ramp or railings at the front and modifications to his bathroom. David agrees with this assessment. The assessor completes the tier guide, and the indicators show mostly in the high tier, with some also in the medium tier. As it is likely he will need major modifications to his front access or bathroom, the assessor recommends a HM high tier (HM Tier 3).

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.

David's HM tier recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate, David will receive a Notice of Decision letter informing him that he has approval for a SaH on-going classification and approval for a home modifications high tier. Once funding is assigned and the Funding Assignment Notice has been sent, he can then find a provider to help source the prescriber and home modifications he needs. The Elder Care Support worker can assist David with this process. When this is explained to David, he says he is excited to think about being able to do shopping and other tasks for himself whenever he needs to. He is also glad this will take some of the pressure off his son.

CASE STUDY: Progressive Condition

Margaret is 68 and was assessed at home to increase Support at Home services as she is not managing with her current allocation. The assessor reviews her medical history and finds that she suffered a stroke 5 years ago which left her with left sided weakness. Recently she has found it much harder to manage at home, she cannot get up and down the stairs by herself and her family report she is unsteady when walking around her home. She lives with her son and daughter-in-law but does not like being reliant on them for daily tasks. As Stroke is one of the identified AT-HM progressive conditions, the assessor selects it in the health condition section of the assessment. The assessor thinks that Margaret may benefit from a range of assistive technology and home modifications to support her current needs and as her condition declines. She will require assessment and prescription from a suitably qualified health professional to determine her AT and HM needs.

The assessor fills out the AT-HM tier guide which indicates a AT high tier (AT Tier 3) and a HM medium tier (HM Tier 2), this aligns with the complex needs identified at assessment. The assessor recommends a SaH on-going classification and allocates AT high tier and HM medium tier in the support plan. Margaret will have access to her AT funding allocation for 24 months and this can be further extended to 48 months if needed, as she has an identified progressive condition.

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.

Margaret's AT-HM tier recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate Margaret will receive a Notice of Decision letter informing her of her new SaH ongoing classification and AT-HM funding. She has been recommended AT high tier and HM medium tier funding approval and once funding has been assigned and the Funding Assignment Notice sent, she can then find a provider to help source the prescriber, assistive technology and home modifications she needs.

6.4.9. Recommending AT-HM tiers in the assessor portal

The option to recommend an AT and HM funding tier will be available for those who have recommended ongoing Support at Home classification. The Restorative Care pathway and End-of-Life Pathway will display the AT and HM funding tier options that apply to that pathway.

Assistive technology

- **Short-term classification** should be selected if AT is recommended for all AT needs other than assistance dogs.
- **Ongoing classification** should be selected if AT is recommended for assistance dogs.

Assistance dogs

If a participant is not eligible or is unable to access the Physical Assistance Dogs Program, costs associated with essential assistance dog maintenance may be included under the AT-HM scheme where the services directly relate to the upkeep of the dog.

A dog must meet the definition of an assistance dog used by Health Direct and be required to enable participation in activities of domestic life.

Funding for assistance dogs is capped at $2,000 per annum for ongoing maintenance of the assistance dogs e.g., paying veterinary bills, animal vaccinations, deworming and flea treatments, essential grooming and dog food.

Participants requiring assistance dogs will be identified and approved for funding through their aged care assessment. Funding for assistance dogs is a specific need, with separate funding for this purpose. If the participant no longer requires this specific funding, the provider must notify Services Australia through the Services Australia Aged Care Provider Portal.

If an older person has an assistance dog, the assessor will need to identify this in the free text box under ‘Sensory concerns’ in the Physical, Personal Health and Frailty domain of the IAT.

Home modifications

By clicking the ‘Recommend a Home Modification’ button you will navigate to the Add Home Modification recommendation’ page. On this page you must select an HM tier.

If the recommended classification is Support at Home Restorative Care Pathway, then only Medium and Low Tier will be available.

If there are concerns and goals on the older person’s support plan, the option to link goals will be available.

Service type and services will be pre-selected and read-only.

6.4.10. AT-HM Scheme Priority System

The AT-HM scheme has a separate priority system to the Support at Home Priority System. The AT-HM scheme has an Assistive Technology Priority System and a Home Modifications Priority System that allocate AT-HM scheme funding. An older person assessed as eligible for AT and HM will enter the AT-HM Priority Systems in one of its four priority categories (immediate, high, medium or standard). The older person will not be able to access AT-HM under Support at Home until funding has been allocated. The amount of time they wait for services will depend on the priority category they are in.

The AT-HM Priority Systems ensure the equitable allocation of funding based on standardised criteria determined using information collected by an assessor through the IAT. This is used to calculate the priority category which is generated by the system. The assessor is not required to choose the priority category.

The following criteria are used. If the individual/'s:

1. lives alone
2. has an assessed severe mobility impairment
3. is an Aboriginal or Torres Strait Islander person
4. current place of residence poses a severe risk to their health or safety
5. has waited more than 6 months from initial referral and resides in a rural or remote area categorised under MM5-7

Older people actively seeking AT-HM at the time of their approval will be automatically placed in the AT and HM Priority System and set as 'seeking services.'

> Note: Participants assigned to the Restorative Care Pathway or the End-of-Life Pathway who have an assessed need for AT and HM will be allocated AT-HM funding immediately once approved by the assessment delegate. Note that the system will display an AT-HM priority of 'High' in this scenario, however the funds are allocated immediately. Further information will be available in the AT-HM scheme guidelines.

6.4.11. Interactions with other programs

Table 28. AT-HM scheme interactions with other programs

Program	Interaction with the AT-HM scheme
Support at Home ongoing	Can access funding through the AT-HM scheme at the same time.
Restorative Care Pathway	Older people accessing the Restorative Care Pathway can access: • Assistive technology: low, medium and high tiers • Home modifications: low and medium tiers

Program	Interaction with the AT-HM scheme
End of Life Pathway	Older people accessing the End-of-Life Pathway can access: Assistive technology: low and medium tiers
Residential Respite	Can receive AT-HM in their home while in respite
Transition Care Program	TCP clients who have an on-going Support at Home classification will be eligible for the AT-HM scheme under Support at Home. TCP clients who are *not* currently on a Support at Home package will be able to access AT through TCP.
CHSP	Clients who are not eligible for Support at Home that require low level on-going services as well as equipment and products and/or home adjustments will receive a CHSP classification. These services will be delivered under a CHSP AT and/or HM classification.
Permanent Residential Care	Cannot access AT-HM

6.5. Commonwealth Home Support Program (CHSP)

The CHSP is a grant funded program suitable for people who can live independently at home but need small amounts of entry-level support to do so. CHSP is not designed for people with intensive or complex care needs. People with higher needs are supported through other aged care programs such as the Support at Home program or residential aged care.

The CHSP operates under the *Aged Care Act 2024* (the Act). Individuals seeking CHSP services, even if they are time-limited, must meet the eligibility criteria under section 58 of the Act to be assessed for aged care services and then meet the eligibility requirements for CHSP as specified in the Act and Aged Care Rules 2025.

CHSP will transition to Support at Home no earlier than 1 July 2027.

The service catalogue for CHSP is aligned with the Support at Home list. See the CHSP service catalogue for further information.

CHSP service catalogue 2025-2027

Commonwealth Home Support Program (CHSP) 2025–27 Manual (from 1 November 2025) | Australian Government Department of Health, Disability and Ageing

6.5.1. Care Finder program and Elder Care Support program participants

Clients in the Care Finder program and Elder Care Support program may be eligible for CHSP services that help to avoid homelessness or reduce the impact of homelessness. To access these CHSP services, clients must meet the eligibility requirements under section 58 of the *Aged Care Act 2024* and then meet the eligibility requirements for CHSP specified in the Act and Aged Care Rules 2025.

Elder Care Support program

Care Finders program

6.5.2. Access to CHSP services

- An older person seeking CHSP services must be approved through an aged care needs assessment.
- Once the assessment has been finalised, based on the information entered into the IAT, the My Aged Care assessor portal or Aged Care Assessor App will indicate whether the client requires CHSP or Support at Home (SAH) services.
- If the IAT Outcome is CHSP, the assessor will proceed to recommend a set of services.
- When assessors also recommend urgent services or periods of time-limited reablement under CHSP, they are requested to record any additional information about the client's situation in the assessment summary, as comments entered in the My Aged Care assessor portal will not appear on the Support Plan.
    - For example "client needs time-limited transport services until 28 February 2026 to purchase groceries/attend medical appointments, as they are unable to drive while recovering from acute episode/surgery".
- If the CHSP episode is ongoing, the recommendation should explain why ongoing services are needed for the client (e.g., 'due to an ongoing health condition'). Ensure the explanation is justified, well-evidenced and consistent with the 2025 – 2027 CHSP Manual.
- If there is a significant change in the client's needs, they should be reassessed to determine if they should continue accessing services through CHSP or are better suited to Support at Home.

- There are some existing CHSP clients who have never been assessed for services. This includes clients who have been 'grandfathered' into the CHSP from previous programs. It is a requirement for all clients to be referred for an assessment, even if they are already accessing CHSP services. These CHSP clients need to be directed to contact My Aged Care or their provider and be referred for an assessment to continue receiving services if eligible.
- Unassessed clients, including those who choose not to be assessed, need to move to full fee-for-service arrangements, if they wish to continue accessing aged care services.
- If the client has pre-existing CHSP referrals in My Aged Care, and those services are approved in an assessment, the **referrals must be reissued by the assessor.**

Note: Assessors should not issue CHSP referral codes until *after* the assessment delegate has approved the recommendation. This is because all CHSP services require assessment delegate approval.

6.5.3. Hoarding & squalor assistance

Hoarding and squalor assistance aims to support clients who are experiencing symptoms of hoarding disorder or are living in severe domestic squalor. Under the CHSP it is intended these services are accessed by individuals on a low income, who are living with hoarding behaviour or in squalid conditions, and are at risk of homelessness.

Note that people under 65 intending to access this service must first meet eligibility requirements under section 58 of the Act and then be assessed for ongoing home support.

Note:

New clients that are Aboriginal and Torres Strait Islander people who are 45-49 years old are no longer eligible to access Hoarding and Squalor assistance.

Older people eligible for hoarding and squalor assistance keep their eligibility indefinitely and do not need reassessment, even after pausing services for years. They can also access other CHSP services aimed at reducing or preventing hoarding and squalor.

Assessment organisations should work collaboratively with hoarding and squalor assistance service providers to ensure services match the person's particular circumstances. Services may include:

- one-off clean-ups
- developing a client plan and reviewing care plans
- linking to specialist support services.

Aged care assessors may also refer suitable clients identified during the assessment process to care finders for further support.

Where there are significant changes in need or additional services needed, CHSP providers can request a support plan review, which may lead to a reassessment.

Hoarding and squalor assistance does not include:

- Assessment (referrals) and advocacy services (financial, legal), unless targeted at avoiding or reducing the impact of hoarding and squalor situations.
- Funding to purchase accommodation for clients.

Hoarding and squalor clients do not pay a client contribution towards their services.

6.5.4. Understanding AT and HM under CHSP

Equipment and products and Home adjustment services are available to eligible people under the CHSP. There is no urgent service referral available for these services through the CHSP. Under the CHSP, Equipment and products and Home adjustments are separate services and described in the CHSP service catalogue as:

- Equipment and products: subsidised low-cost assistive technology and products up to $1,000 per year.

- Home adjustments: subsidised home modification services up to $15,000 per year.

To access these services through the CHSP, eligible people will be approved for:

- the Home Support Service group with a classification level CHSP class, and
- the Assistive technology service group with a classification level of AT CHSP or
- the Home adjustment service group with a classification level of HM CHSP.

> Note:
>
> AT and HM services under CHSP do not get allocated a funding tier like there is under the Support at Home AT-HM scheme.

The Notice of Decision template (described in detail in a later chapter) will prompt you to ensure the correct approvals are included for AT CHSP and HM CHSP.

Equipment and products

- Self-care products
- Mobility products
- Domestic life products
- Communication and information management products
- Managing body functions

Home adjustments

- Home modifications

6.5.5. Interactions between CHSP and other programs

There are limited circumstances where a person can access CHSP services in addition to other government funded services, detailed in tables 29 and 30 below.

Services should not be duplicative. For example, if a client has access to domestic assistance from the Veterans' Home Care Program, they cannot access domestic assistance through the CHSP at the same time.

New entrants to the aged care system are not able to take up any AT or HM services though CHSP, while awaiting funding under Support at Home, for the AT-HM scheme.

Current CHSP participants can continue to access CHSP services they are already approved for including CHSP AT-HM (equipment and products and home adjustments) while awaiting for funding to be approved under the Support at Home AT-HM scheme. Once AT-HM Support at Home funding is approved and funding has been accepted and allocated, participants will no longer be able to access these services under CHSP.

Older people may choose to seek services for SaH ongoing whilst not seeking services for AT-HM and vice versa. Seeking services for AT and HM are also separate from each other. This means, if approved for both AT and HM, the older person may seek services for AT whilst not seeking services for HM and vice versa. Older people 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.

Table 29. Guide to approval for concurrent access to CHSP services with other government funded services

Program	Can participant access CHSP services?
Support at Home participants (including Restorative Care Pathway and End-of-Life Pathway)	There are five circumstances where a Support at Home participant can access additional services through the CHSP. These are: 1. Pre-existing CHSP social support group 2. Hoarding and Squalor 3. Cottage respite, Community and centre-based respite and Flexible respite 4. Emergency Access 5. Specialised support (Vision advisory services)
Waiting for a Support at Home place allocation	The participant can access interim CHSP services. Interim CHSP services are available for a participant who has been assessed as needing a higher Support at Home classification but is waiting for their increased budget.

Program	Can participant access CHSP services?
	This does not include CHSP AT or HM. Participants who are waiting for a SaH allocation must be referred for the AT-HM scheme **not** CHSP AT or HM. If a Support at Home participant declines to take up the classification, they can continue to access entry level CHSP services as a CHSP client. They will not access CHSP services to the level of the Support at Home classification they were approved for.
Residential Aged Care	Individuals in Residential Aged Care cannot access Government-funded CHSP services.
Disability Support for Older Australians, National Disability Insurance Scheme (NDIS), NATSIFAC Program, Transitional Care Program (TCP) and Veterans' Home Care Program	Can access CHSP services, as long as they have a referral for each of the service/s **and there is no duplication of services**.

Table 30. Circumstances when a Support at Home participant can access CHSP services

1. Pre-existing CHSP social support group	Support at Home participants who have transitioned from the CHSP may continue to access their pre-existing CHSP social support group through the social support and community engagement service on an ongoing basis to allow the continuity of social relationships. This only applies to participants attending a pre-existing CHSP social support group service.
2. Hoarding and Squalor	Support at Home participants who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need, can access time-limited Hoarding and Squalor services through the CHSP (in addition to their Support at Home funding) via reassessment.
3. Community and centre-based respite, Flexible respite and Cottage respite	Support at Home participants may access additional planned respite services through the Home or community general respite service or Community cottage respite.
4. Emergency access	In emergency situations, where a Support at Home participant has an urgent and immediate health or safety need, and their individualised budget has been fully allocated or they are waiting for their budget allocation, some additional time-limited CHSP services can be accessed on a short-term basis. These instances must be time limited, monitored and reviewed.
5. Specialised support services (Vision advisory services)	Support at Home participants may access Vision advisory services under Specialised support services on an ongoing basis to receive the aged care supports they need.

6.5.6. Recording the decision for CHSP service recommendations in the Notice of Decision

Assessment delegates should review any CHSP service recommendations listed. If they disagree with any of them, they should contact the assessor to discuss and amend the list if required.

Currently, assessment delegates are not able to record their agreement or disagreement alongside each CHSP service recommendation in the assessor portal. Their decision to agree with the recommended CHSP services must be recorded in the Notice of Decision.

6.5.7. Recording CHSP classification and Support at Home classification 1 to 8 approvals in the Notice of Decision

For CHSP Ongoing – there is one classification in the system. However, when an individual is approved to access CHSP services alongside Support at Home 1 to 8 classification, the older person will ***only*** be approved for the Support at Home classification.

However, **the CHSP section will still display in the Notice of Decision.** If Support at Home 1 to 8 classification is approved, assessment delegates will need to manually remove the CHSP classification level approval in the Notice of Decision.

Replacement text and instructions are provided to inform the client what CHSP services they have been approved for and how to access their referral codes, which are contained in the client's Support Plan.

Detailed instructions are provided in the Notice of Decision to help assessment delegates complete the required steps accurately.

However, if an older person is approved for one of the Support at Home classification levels, and has not previously been approved for funded aged care services in the home support service group, they can be referred to access their approved services through a CHSP provider while they wait for the Support at Home place to be allocated, **without** having an assigned CHSP classification level (CHSP class).

See 6.5.5 section for further details about when an individual with a SaH classification can be approved to access CHSP services.

6.5.8. Time-limited definition

What short term or time limited means depends on the specific circumstances and needs of each individual client. As a guide, up to 2 months would be considered short-term services.

6.5.9. Wellness and reablement under CHSP

Reablement approaches under CHSP involve recommending time-limited services for a period of up to 12 weeks. 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.

All providers are able to deliver this service under every CHSP service type. (i.e. assessors can refer for short-term reablement to any CHSP provider).

For further guidance taking a wellness and reablement approach through CHSP, see 'Delivering Time Limited Reablement' section in Chapter 5 of this Manual.

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

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

The NATSIFACP funds service providers to provide flexible, culturally safe aged care to older Aboriginal and Torres Strait Islander people close to their home and/or community.

Service providers deliver a mix of residential and home care services in accordance with the needs of the community which are located mainly in rural and remote areas.

The NATSIFACP is administered under the *Aged Care Act 2024* as a specialist aged care program.

The services provided through NATSIFACP must reflect the service list prescribed by the *Aged Care Rules 2025*.

6.6.1. Assessing for NATSIFACP

Anyone seeking NATSIFACP aged care services requires an aged care needs assessment under the *Aged Care Act 2024*. NATSIFACP providers can also make this application on the older person's behalf, either by phone or online. This may include supporting the older person by self-referring the assessment to known assessment organisations in the area, including Aboriginal and Torres Strait Islander assessment organisations where one is available.

Under the NATSIFACP, providers deliver a mix of residential, home and community care services in accordance with the individual's assessed care needs, and the needs of the community. Services may be provided on a permanent (ongoing) or short term (non-ongoing) basis, as well as to support emergency needs. To support this flexible service delivery model, the NATSIFAC Program is block funded. This means individuals accessing care under the program do not have allocated budgets. Arrangements for care recipient contributions are also variable and take into account the capacity of individuals to contribute toward the cost of the services delivered to them.

Older people already receiving NATSIFACP services in the 12-months before 1 November 2025 will be deemed across to the *Aged Care Act 2024 (the Act)* and will not have to have an aged care needs assessment if they wish to continue receiving NATSIFACP services after the Act starts.

In all cases, assessors should work with NATSIFACP organisations already providing care to inform their aged care assessments. By working together, assessors and providers can avoid older Aboriginal and Torres Strait Islander people having to tell their story multiple times and ensure culturally safe assessments are conducted. This includes using information the NATSIFACP provider has gathered to help inform the assessment.

More information is available on the department's website at National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

6.6.2. Recommending NATSIFACP pathway

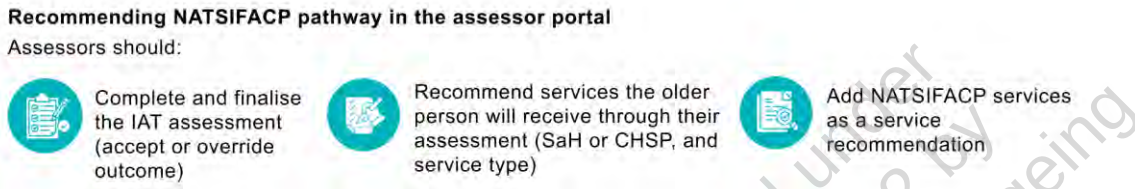

Figure 5 – recommending NATSIFACP pathway in the assessor portal

The option to add NATSIFACP services as a service recommendation in an older person's Support Plan are available via the 'Add a service recommendation button' on the 'Support plan and services page'.

When adding a service recommendation for NATSIFACP, a drop-down box will require the assessor to select a priority. From 1 November 2025, there is no priority system in place to receive services through NATSIFACP and the priority value in the service recommendation tab will not impact the timeliness of receiving these services. For consistency, assessors are required to set the priority value for the NATSIFACP service recommendation to low.

It is best practice for a NATISFACP service recommendation to be fully recorded in the assessment notes to ensure that information in the support plan is accurate and complete.

In the Notes section, assessors should include the following information:

- If the older person would benefit from accessing services through a NATISFACP provider in their local area
- If the person would like to access services through a NATISFACP provider in their local area

6.6.3. Interactions with other programs

All service groups and types can be delivered under NATSIFACP.

In general, home care services must not be provided to individuals who are receiving other government-subsidised services that are similar. However, individuals may access both the NATSIFAC Program and Support at Home at the same time, provided the services accessed under the programs are different. For example, a participant could access gardening through Support at Home and personal care via the NATSIFAC Program They may require a reassessment to change providers, this will depend on whether they only have a NATSIFACP default classification level, the service types they require and the range of programs available at their new location.

For further information, please refer to the NATSIFACP Manual.

6.7. Multi-Purpose Service Program (MPSP)

The MPSP provides integrated health and aged care services for older people living in small rural towns and remote areas that cannot support stand-alone aged care and health services.

The MPSP is managed under the *Aged Care Act 2024* as a type of specialist aged care program.

The following aged care services can be delivered under the MPSP:

- Permanent residential care services
- Residential respite
- Home or community services

6.7.1. Assessing for MPSP

Any person seeking to access services under the MPSP must make an application for funded aged care services. This must be in the approved form.

6.7.2. Recommending MPSP pathway in the assessor portal

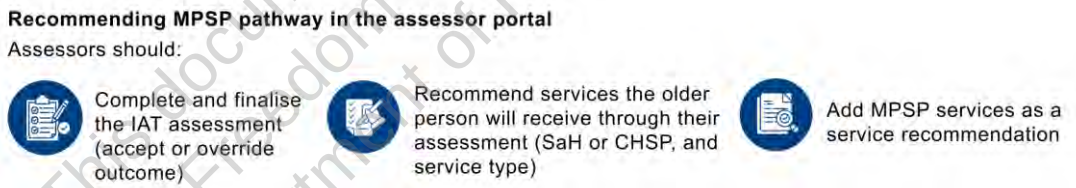

Figure 6 – Recommending MPSP pathway in the assessor portal

When adding a service recommendation for MPSP, a drop-down box will require the assessor to select a priority. There is no priority system in place to receive services through and MPSP and the priority value in the service recommendation tab will not impact the timeliness of receiving these services. For consistency, assessors are required to set the priority value for the MPSP service recommendation to low.

It is best practice for all MPSP service recommendations to be fully recorded in the assessment notes to ensure that information in the support plan is accurate and complete.

In the Notes section, assessors should include the following information:

- If the older person would benefit from accessing services through a MPSP provider in their local area

- If the person would like to access services through a MPSP provider in their local area

6.7.3. Interactions with other programs

An older person cannot usually access services in the home and community and in a residential care home at the same time.

A person approved for home support, assistive technology and home modification service groups may concurrently access some services through an MPSP, and other services through a mainstream registered provider (e.g. a provider who delivers services under the Support at Home program). For example, the person could access gardening and meal delivery services through Support at Home, while accessing nursing care through the MPSP. However, they cannot access the same type of service on the same day from a specialist aged care program provider and another service provider.

Where the needs assessor discussed the person seeking access to services through their local MPS, the decision and plan should also include a specific referral code that a provider delivering services under the MPSP can use.

About the Multi-Purpose Service Program | Australian Government Department of Health, Disability and Ageing

6.7.4. Referrals to NATSIFACP and MPSP providers

If a person is recommended for one or more services groups (e.g. Home Support, Assistive Technology, Home Modifications or Residential Care) and they intend to access the services under MPSP or NATSIFACP, the assessor should provide a MPSP or NATSIFACP service recommendation for the person as appropriate.

This is in addition to providing service recommendations for one or more service groups which the assessor considers they meet the criteria for (e.g. Home Support, Assistive Technology, Home Modifications or Residential Care).

This will ensure the person will have a lawful access approval under the *Aged Care Act 2024*, but also that they can be referred to a specialist provider in their local area where they are approved to access services. It will also ensure that additional information about the relevant specialist aged care program is included in their decision letter.

Assessment delegates are responsible for approving service recommendations.

Important
It is not sufficient to only make a service recommendation for MPSP or NATSIFACP, as an individual cannot access services under these programs without an access approval from a delegate for one or more service groups. If the client has been approved for home support with an ongoing Support at Home (SaH) classification or for the AT-HM scheme, but intends to initially access services through their local MPSP or NATSIFACP provider, the assessor should set the 'Seeking Services' field to 'No' for one or all of these recommendations as needed.

This must be confirmed with the individual before selecting the field. This will prevent the individual from being added to the prioritisation queue(s) for these services and being offered a place which they do not intend to accept at that time. You should not do this if you expect the older person will need to concurrently access services from both the MPSP/NATSIFACP and SaH program and/or the AT-HM scheme.

If the client has only been approved for Home Support with a CHSP class, then an assessment delegate will need to ensure that:

- the MPSP or NATSIFACP service recommendation is recorded in the Notes section (as well as being a service recommendation in the support plan)
- the support plan and Notice of Decision include the required MPSP and/or NATSIFACP text.

6.8. Transition Care Program (TCP)

Transition care is available to older people following admission to hospital. The program is delivered under the service groups home support, assistive technology, and residential care**.** Transition Care is designed to support individuals in the period immediately after discharge from hospital. It aims to facilitate recovery, improve functional capacity, and provide time and support in a non-hospital environment while long-term care arrangements are being considered.

Services include:

- social work
- nursing support
- personal care
- allied health care
- equipment and products to assist with mobility.

Transition care can take place in a person's home, a community setting or a residential aged care setting. Older people accessing Support at Home can also access TCP services if they are assessed as eligible to receive transition care and there is no duplication in service provision.

6.8.1. Access to transition care

Transition care is time-limited, with individuals allocated a funded period of 12 weeks to access services under the program. However, if the individual's recovery requires additional time, the service provider can apply for an extension.

The Transition Care Program is defined under the *Aged Care Act 2024* as a specialist aged care program. The number of places available for this care type is determined by the Federal Minister for Health, Disability and Ageing, based on state and territory needs.
Only registered providers are permitted to deliver hospital transition care using these allocated places.

Importantly, to be eligible for the program, the individual must be:

- medically stable at the time of assessment; and
- is in the concluding stage of a hospital episode; and

- has the potential to benefit from accessing services delivered through the relevant service group under the TCP; and
- at the time the assessment was carried out, an admitted hospital patient. This includes people receiving hospital-in-the-home.

Once an individual is approved for hospital transition care, it is usual practice for hospital discharge staff to refer them directly to their local Transition Care provider, following delegated approval.

6.8.2. Recommending transition care

When recommending Transition Care in the support plan, assessors will add the care type Transition Care – After Hospital Care. When approved by the assessment delegate, the client will be approved for the following Service Groups:

- Home Support;
- Assistive Technology; and
- Residential Care.

The client will then have access to all of the required Transition Care service types under each service group, to allow them to receive transition care across different care settings including their home/in the community and Residential Care or a mixture of both. The Assessor and Assessment Delegate are not required to action any additional tasks such as selecting service types within the system in order for the client to be approved for all of the service groups above. These service group approvals will appear in the Notice of Decision Letter.

Approving all three service groups will allow TCP to provide all of the following Service Types to TCP clients when needed:

- Section 8-15 – Allied health and therapy
- Section 8-20 – Assistance with transition care
- Section 8-35 – Domestic assistance
- Section 8-45 – Home maintenance and repairs
- Section 8-55 – Meals
- Section 8-60 – Nursing care
- Section 8-65 – Nutrition
- Section 8-70 – Personal care
- Section 8-110 – Equipment and products
- Section 8-140 - Residential accommodation
- Section 8-145 - Residential everyday living
- Section 8-150 - Residential non-clinical care
- Section 8-155 - Residential clinical care.

These service types are all funded through the Transition Care daily subsidy rate (paid to providers). There is no need to apply for separate funding through Support at Home or Residential Care.

Under Assistive Technology, the provision of loaned equipment and products to assist clients with mobility will continue to be offered by providers, funding for this will continue to be covered through the transition care daily subsidy rate (paid to providers). There is no need to apply for separate funding under the Assistive Technology Service Group.

However, the provision and management of equipment under TCP is determined at the discretion of each state and territory. Jurisdictions may choose to provide equipment on either a permanent or loaned basis, depending on their local policies and operational arrangements.

When the older person is approved as eligible for transition care at the time of the initial assessment, they may need a support plan review or reassessment before the completion of their transition care episode, to establish their long-term care requirements. Where this is necessary, the assessor should review any changes to the person's care needs and ensure that the long-term care recommendations reflect the revised level of need and the person's preferences. For older Aboriginal and Torres Strait Islander people, where applicable, an ECS worker may work with the client, the client's family and assessor to assist with identifying the best care arrangements.

6.8.3. Accessing Support at Home or CHSP and transition care Program

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. The assessor must accept the IAT outcome in line with 81-10 of the Rules.

Assessors should consider whether a hospital setting is the most appropriate setting to assess a patient for ongoing home support. They may determine the older person would be better assessed in their home. Alternatively, they may seek information about the older person's home environment from the older person's care and support team to make as accurate an assessment as possible of their ongoing aged care needs. See Chapter 5 for further information on undertaking assessments in a hospital setting.

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. The client may need a support plan review or reassessment at the end of their transition care period to establish their long-term care requirements.

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.

Transitioned HCP, SaH and CHSP clients, can continue to access Support at Home and CHSP services while accessing TCP, as long as the services are not duplicative. For example, an older person may elect to continue receiving gardening services under Support at Home in order to maintain a safe home environment, while they receive other services under TCP. It is the responsibility of the participant to notify their Support at Home or CHSP provider of their intention to enter transition care. It is expected that the participant's Support at Home or CHSP provider and the relevant transition care provider will discuss and coordinate care provision to ensure the participant's needs are met.

Accessing residential care/residential respite and transition care

A person in permanent residential care who is receiving Transition Care must take Hospital Transition Leave for the duration of their TCP episode. In addition, they are not eligible to receive services under the Restorative Care Pathway under Support at Home.

An individual receiving Transition Care is unable to access residential respite care while Transition Care is in effect.

6.8.4. Duration of transition care

The standard period for a transition care episode is 12 weeks (84 days).

This period may be extended by 6 weeks so the total transition care episode is 18 weeks (126 days) if the provider makes an application on behalf of the individual in accordance with the requirements of the Rules and is determined to require access to the services for the additional period.

Lapsing of transition care approval

A transition care approval will lapse under the following circumstances:

1. **Delayed Entry into Care:** If the individual does not commence transition care within four weeks (28 days) following the approval date, the approval will lapse.

2. **Re-entry After Hospitalisation:** If an individual completes a transition care episode and, after a subsequent hospital stay, seeks to begin a new transition care episode beyond the initial four-week entry period, a new approval is required.

Breaks in care

Individuals in the Transition Care Program (TCP) may take breaks in their care, known as break days, for up to seven days in total during a single episode of transition care. These leave days do not need to be consecutive and may be used for a range of reasons, such as brief hospital readmission or personal/social circumstances.

If the individual exceeds the seven-day leave limit, their TCP approval will automatically expire. In such cases, the individual must be reassessed, and the older person must receive a new approval before they can recommence transition care.

6.8.5. Transition care extensions

If an individual is still making functional gains and would benefit from additional time in Transition Care, the Transition Care provider can request an extension of up to 42 days, with the potential for a further 42-day extension if clinically appropriate.

To initiate the process, the Transition Care provider must submit an extension request via the My Aged Care Service and Support Portal to the assessment organisation. This request must be submitted before and approved by the 84th day of the care episode. The request should include the reason for the extension, the duration requested, and any supporting information relevant to the individual's ongoing care needs. Note there is no right of review if an extension request is declined.

The assessment organisation will receive and action the request through the My Aged Care Assessor Portal. The Assessment Delegate will be responsible for reviewing and making a decision on the request.

When recording a decision to approve an individual for Transition Care, a drop-down box will require the assessor to select a priority. There is no priority system in place to receive services through Transition Care, and the priority value will not impact the timeliness of receiving these services. For consistency, assessors are required to set the priority to 'high' for all assessments.

Transition Care Program Guidelines – November 2025 | Australian Government Department of Health, Disability and Ageing

6.9. Residential care

Residential aged care is a care type that can be recommended to an older person. There are two types of residential care: ongoing (permanent) and short-term (respite).

An ongoing residential care approval does not compel an older person to enter residential care, it simply enables a person to commence residential care services if and when they choose to do so, without the need for further assessment.

Matters relating to residential care must be decided with the consent of the older person, and if they do not have capacity, their appointed decision maker (whether or not that person is a registered supporter). Appointed decision makers must have authority to make any decisions relative to residential care, and that authority must be active.

Where possible, older people should be supported to live in their community for as long as possible. An assessment may, however, identify residential care as a suitable option for an older person who is no longer able to be adequately cared for by carers or family, and is incapable of living in their community without support.

Application and approval for residential care means the person meets the eligibility criteria and the care type is appropriate for their care needs. To be approved for residential care a delegate must be satisfied that section 68 of the Act applies to an older person (except for older Aboriginal and Torres Strait Islander people who access services on a different constitution basis). The older non-Aboriginal and Torres Strait Islander person must require aged care services due to their sickness as defined under the Act. For further information on the Act's definition of sickness and approvals under sections 67 and 68, refer to section 7.6.4 of Chapter 7.

On 1 October 2022, the Australian National Aged Care Classification (AN-ACC) residential care funding model replaced the Aged Care Funding Instrument.

Following an older person's admission to residential care, a residential aged care funding assessor (RAC funding assessor) will conduct an assessment using the AN-ACC assessment tool. The assessment information is uploaded and is used to determine the resident's classification.

A person who is eligible for residential care may require daily assistance with:

1. meals (including special diets)
2. bathing, showering, dressing and personal hygiene

3. toileting and continence management
4. general nursing care (e.g. wound management)
5. organising and taking medication
6. communication (including fitting sensory or communication aids)
7. transfers and mobility
8. assessment and referral for appropriate support; and/or
9. emotional support

If an older person's concerns and goals identify the need for residential care, ongoing and short-term residential care can be added to a person's support plan through the 'add care type' button on the *Goals & recommendations* tab.

An assessor will need to consider the person's:

- physical needs – how much support does the person need for daily living activities (i.e. preparing meals, eating, showering, dressing etc.) their level of mobility and whether they need assistance to walk, sit and stand
- health needs - does the person have chronic health issues that require nursing intervention or regular clinical/medical procedures
- cognitive needs – does the person have issues with memory, orientation, or thinking abilities, is there a diagnosis of dementia, such as Alzheimer's disease
- psychological and wellbeing needs – do they have any symptoms of depression, anxiety or other mental health challenges, or isolation. Is there a strong social support network for the person
- current living arrangements – what is their living situation and is their living environment safe, do they have family and friends for informal support
- carer impacts – does the carer need a break and would respite support the person's wishes to stay in their own home longer

There may be a combination of any of the above needs or factors, or a single need that results in the assessor determining that an individual is incapable of living in a home or community setting without support (*Aged Care Rules 2025* Section 65-20 eligibility requirement – service group residential care) and has a continuing need for funded aged care services, including nursing services (*Aged Care Act 2024*, Division 3, Section 68).

6.9.1. Recommending residential care

If an assessor recommends that a client only receive ongoing residential care and/or short-term residential care, there are two pathways to consider when recommending these services:

- An assessor can choose to override the IAT outcome to 'ineligible for CHSP/SAH' and then choose Residential Permanent and/or Residential Respite options under the 'Add a Care type for Delegate Decision' button
- An assessor can accept a 'SaH Classification' or 'CHSP' IAT outcome, then choose Residential Permanent and/or Residential Respite from the 'Add a care type for delegate decision' button. The assessor must then ensure that the Support at Home classification is switched to 'not seeking services' and kept as a latent class. This provides the client with flexibility in case they want to return home in the future and access home support services.

6.9.2. Priority for ongoing residential care

To meet the requirements of the *Aged Care Act 2024*, an older person being approved for permanent residential care will be assigned a priority category (1, 2 or 3). Although important, the priority category will not impact when a person can access residential care services or services under a specialist aged care program.

Table 31. Description of priority categories

Category	Description
1	The person: • has a high urgency rating; or • resides in a rural or remote area classified as MM 5, MM 6 or MMM 7; or • is Aboriginal or Torres Strait Islander, homeless, or is entering residential care due to emergency circumstances.
2	The person does not meet the criteria for Priority Category 1 and has a medium urgency rating.
3	The person does not meet the criteria for Priority Category 1 and has a low urgency rating.

The priority category is automatically generated by the assessor portal based on the individual's circumstances, urgency rating and in accordance with the criteria specified by the Aged Care Rules 2025.

Assessment Delegates will need to verify that the urgency rating assigned to the individual accurately reflects their needs and are supported by the evidence provided.

6.9.3. Urgency rating for residential care

A person's urgency rating is different to their need for residential care. While it is expected that all people with a recommendation for residential care have been assessed as having high-level care needs, their level of urgency indicates the extent to which a person may be at immediate risk, including to personal health and safety, if they are not admitted to residential care within a timely manner.

This rating will not undermine the older person's ability to choose to remain in their home but will provide a guide for providers of residential care homes and others (such as Care Finders) to prioritise people who may be most at risk.

When selecting 'Residential Permanent' under the 'Add a care type for Delegate decision' in the My Aged Care assessor portal, assessors will be required to give a response to 'What is the urgency of this care type'. This question is a mandatory question with a rating to be selected from high, medium or low.

The Rules specify when an urgency rating of low, medium or high will apply to an individual in relation the classification type ongoing for residential care. The table below summarises the criteria for each urgency rating.

Provide a rating (low, medium or high) which balances objective consideration of needs with the subjective perspective of the older person. The older person's perspective may be conveyed by their registered supporter. Include a brief note in the *reason or comments* section explaining key reasons for the rating, which may include:

- Key individual, care related or contextual needs and how these relate to any safety/wellbeing risks
- Whether the older person/ has expressed an urgent need to enter care
- Perspective on estimated timeframe the older person needs to enter care

Relevant factors to consider in determining urgency may include:

- Current care settings (including if the person is transitioning into residential aged care from hospital or residential respite care)
- Significant and visible decline in the level of function, cognition and/or ability to perform activities of daily living in the home with available support
- Health conditions and ability to manage these in the home with available support
- Severe incontinence that cannot be managed within the current care settings
- High risk to personal safety (e.g. hazardous home environment, high risk of falls, wandering, or elder abuse)
- Complex factors, including but not limited to homelessness or risk of homelessness; drug and alcohol abuse; mental health issues; or severe social isolation
- Lack of available and sustainable formal, informal support (including any impacts on carers)

Where the older person has a registered supporter, who is not an appointed decision maker, that registered supporter can be involved in any discussions in line with the will and preferences of the older person. Registered supporters help older people to make and communicate their own decisions about aged care. This includes supporting the older person to make aged care decisions and communicating information for the older person. Family members, carers, care finders and Elder Care Support staff may also assist the older person in making their own decisions about aged care.

The following can be used as a guide to what urgency may look like within each category. Examples are provided for demonstrative purposes only and each case will need to be judged independently based on diverse individual factors.

Table 32. Guide to urgency ratings for residential care

Level of urgency	Description
High urgency	**This rating applies if:** • The individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk. **Indicators**: Recent falls, hospital admission, unsafe to return home, severe decline.

Level of urgency	Description
	Example: A client in hospital post-fall who lives alone and whose needs exceed Home Care supports. Example: John has an ongoing Support at Home classification 8. He recently had a fall and is currently in hospital. John feels like he is unable to return home, and the hospital requests an urgent aged care assessment. The outcomes of John's assessment reveal several risk factors. His health and function are declining, and he has experienced several incidences of falls in recent months leading to hospital admissions. He lives alone, feels socially isolated and needs substantially more hours of care than is possible through the formal support he can receive through Support at Home. The Assessment Delegate approves John for ongoing residential aged care services, with a high urgency rating.
Medium urgency	**This rating applies if:** • The circumstances for a high urgency rating do not apply to the individual; and • When considering the individual's circumstances and preferences, the individual is expected to seek access to permanent residential care within the next 6 months. Example: Mei has been receiving CHSP services for a few years and recently requested a support plan review to have her needs and services reviewed. As her needs have increased, and she has some complex factors, including declining cognition and moderate incontinence, a reassessment was arranged by the assessor. Mei's daughter, Tao, is her primary carer and is becoming overwhelmed. She's concerned about how much longer Mei will be able to remain living at home by herself, should her cognition and incontinence deteriorate. Mei speaks to her GP and requests a reassessment. The assessor has a conversation with Mei and Tao about the option of ongoing residential care, and they agree that Mei will likely move into an aged care home within the next three to six months. Mei is approved for ongoing Support at Home as well as ongoing residential aged care services, with a medium urgency rating.

Level of urgency	Description
Low urgency	**This rating applies if**: • The circumstances for a high or medium urgency rating do not apply to the individual. Example: Maria has been receiving CHSP services in her home. She can still complete many basic and daily living tasks without help but has had a few minor falls recently and is becoming less mobile around the house. Through a reassessment, an ongoing Support at Home classification is approved to meet her current needs. She's feeling very lonely as many of her friends in the community have already moved into aged care facilities, and her children live interstate. She is worried that she might have another fall and need to move into an aged care home. Maria's son agrees to move in with her to provide informal care for 6 months, but she knows that she'll probably need to move into residential aged care once he leaves. Maria is approved for ongoing residential aged care, with a low urgency rating.

Clients residing in rural and remote areas

IT System enhancements have been built to map a client's residential address to their relevant Modified Monash Model (MMM) 2023 region which is needed to determine their priority. This will be completed automatically for every client approved for residential aged care.

If the client is being assessed in a temporary location, the address where the client is generally located should be used. If the older person is being assessed in a city whilst staying with family, this will greatly skew the urgency rating.

When an older person registers with My Aged Care, they will be prompted to enter in relevant contact details including their home address. If a home address has not been inputted or is incorrect, an assessor may input or update a clients address at the time of assessment. This is a mandatory field as part of My Aged Care registration/assessment. If you update the individual's address, you will need to click on the 'validate this address' button to populate the MM classification.

A yellow text box may appear when residential care is added or edited as a care type in the *'goals and recommendations'* section of the support plan and the MM classification has not been mapped to the individual's record. The yellow box will seek to update the clients address in their record or manually select the appropriate Modified Monash (MM) area.

Modified Monash Model | Australian Government Department of Health, Disability and Ageing

6.9.4. Place allocation

The residential care system allocates residential care places (permanent or respite) directly to older people. This is the 'Places to People' reform.

Places will be assigned directly to older people who can then access government-funded residential care services. This will give them more choice and control over what provider delivers their services.

Mainstream residential care providers will no longer need an allocation of places to deliver government-funded aged care services.

Providers that deliver residential aged care through a specialist program (such as MPSP or TCP) will still get allocated places, for further information see resource below.

Places to people – Embedding choice in residential aged care | Australian Government Department of Health, Disability and Ageing

If a person has been approved for residential care, (permanent or respite), they will be allocated a place immediately. They will be advised on this in the Notice of Decision letter.

There will be no delays to allocate the place. Once the person has their place it stays on their My Aged Care account and will not be withdrawn. There are no time limits for when people need to enter into care.

6.9.5. Exiting residential care

If an individual has an existing transitioned Home Care Package or Support at Home approval and chooses to exit residential care, they can rejoin the Support at Home Priority System queue by:

- being formally exited by their residential care provider in the Services Australia system
- calling My Aged Care and requesting to opt back in, once formally exited.

When an older person with an existing transitioned Home Care Package or Support at Home approval contacts My Aged Care and requests to opt back in to the Priority System, their queue status will be re-activated and place determined by their previous approval date and priority.

Depending on the date of their previous approval under HCP/SaH, they will be assigned funding when it is available. While waiting for assignment of Support at Home funding, individuals may have other care options available.

They could consider accessing aged care services through the Commonwealth Home Support Program (CHSP), state or privately funded services.

If an individual has approvals for residential respite care, this service may also be accessed, noting it is a temporary arrangement.

If an individual is interested in understanding if CHSP or residential respite is an option in the interim, they can call My Aged Care for support with accessing approvals and arranging services.

Additionally, all Australians are eligible to access the primary care health system through hospitals, GPs and allied health practitioners. All Australians, regardless of age can and should access these services as needed.

6.10. Residential respite care

Short-term (respite) care is provided as an alternative care arrangement with the primary purpose of giving a carer or an individual in need of care a short-term break from their usual care arrangement. Residential respite is not intended as an alternative to restorative care.

Older people will continue to be able to access emergency respite care through the alternative entry pathway, even if they have not been assessed and approved for short-term residential care.

6.10.1. Recommending residential respite care

When recommending an individual for residential respite care, assessors should complete the De Morton Mobility Index – modified (DEMMI-modified) assessment. This tool assesses the individual's mobility and determines their eligibility for one of three respite funding classes: Respite class 1, Respite class 2, Respite class 3, based on the level of mobility observed.

The DEMMI-modified assessment is available within the IAT, and can only be used as part of a comprehensive assessment, as it must be completed by a clinically trained assessor. A non-clinical assessor cannot complete the DEMMI-modified even with clinical attendance.

The question, '*Are you likely to recommend residential respite care'* in the IAT is only available in comprehensive assessments. Assessors who are completing a home support assessment and likely to recommend residential respite must convert the assessment to a comprehensive assessment.

If the DEMMI-modified assessment cannot be completed at the time of assessment, the individual will be temporarily assigned a default funding class (Class 0). This classification remains in place until a formal RAC funding assessment is carried out within the residential aged care home, by a RAC funding assessor, at which point the appropriate funding class can be determined based on the individual's assessed mobility.

> Note:
>
> Approvals for short-term residential care will not be prioritised. When you view the care type recommendation for Residential Respite Care, you will see the 'Urgency' field has been automatically set to 'High' and cannot be edited.

6.10.2. Extensions for residential respite

Assessment delegates may receive requests for a 21-day extension to residential respite care —for example, when a carer is unwell or temporarily unable to resume their care responsibilities. There is no limit to the number of extensions that may be granted beyond the standard 63 days of respite care per financial year.

Typically, the residential aged care provider submits the extension request via the My Aged Care Service and Support Portal, and the assessment organisation receives it through the Assessor Portal for the assessment delegate's action.

An assessment delegate's responsibility is to review the request and either approve or decline it. Once a decision is made, they must communicate the outcome to the provider.

The assessment delegate will need to be satisfied that an increase in the number of respite days was necessary due to any of the following:

(a) carer stress

(b) severity of the individual's condition

(c) absence of the individual's carer

(d) any other relevant matter (for example, where a provider delivers an episode of respite care in good faith but subsequently finds out the care recipient's allocation of respite days had already been exhausted).

Note:
There is no right of review if an extension request is declined.

Once decided, the assessment delegate must give written notice to the registered provider of your decision whether to extend within 28 days after the application was made. This written notice must include the day the decision takes effect, which may be before the day the decision is made.

Extensions are granted only at the previously approved level of care. If a higher level is needed, a reassessment and new approval by a Clinical Assessment Delegate is required before the extension can be granted

Where multiple extensions are being requested in one financial year, the assessor should review the Support Plan in consultation with the client, family and provider, to confirm the appropriateness of the residential respite care with the possibility of considering other care options. This will include whether there is an appropriate Support Plan in place to safely support the person to return home following the residential respite care episode (see section: Residential Care).

For more information on managing residential respite extensions, refer to Managing residential respite care | Australian Government Department of Health, Disability and Ageing

6.11. Other programs and supports

6.11.1. Dementia specific programs and supports

Counselling, education, information, and other support for people living with dementia or experiencing cognitive decline, and their care partners, families, and representatives is available through the National Dementia Support Program (NDSP). They can be contacted 24 hours a day, 7 days a week via the National Dementia Helpline on **1800 100 500** or by visiting the Dementia Australia website.

Chapter 12 outlines a system to refer carers of older people living with dementia or experiencing cognitive decline to the National Dementia Helpline, with their consent. A trained professional from Dementia Australia will call the older person and speak to them about dementia-specific services and supports that might assist to help improve or maintain their quality of life.

Note: A person does not need to have a formal dementia diagnosis to be referred to Dementia Australia for support.

6.11.2. Dementia Carer Respite and Wellbeing Program

The Dementia Carer Respite and Wellbeing Program (also known as the Staying at Home program) delivers models of respite care through a shared respite experience, attended by both the person living with dementia and their care partner.

The program expands on existing supports to:

- maintain or improve quality of life for care partners and people living with dementia
- increase care partner knowledge, skills and capability to care for a person living with dementia at home improve the experience and quality of respite care for care partners and people living with dementia
- support people living with dementia to stay at home for longer
- provide peer support connections for care partners and people living with dementia

Care providers (supported by Dementia Support Australia) deliver the Staying at Home program. Informal carers can register their interest on the Dementia Support Australia website or by contacting the 24-hour DSA helpline on **1800 699 799.**

There are also a small number of dementia specific innovative respite care programs being trialled across Australia.

6.11.3. Dementia behaviour supports

The Australian Government funds national dementia behaviour support programs through Dementia Support Australia (DSA) to support carers and service providers, which can be accessed by contacting the 24-hour DSA helpline on **1800 699 799**.

Dementia Behaviour Management Advisory Service (DBMAS), delivered by DSA, provides free personalised support and advice to service providers and individuals caring for people with dementia in any location or setting in Australia. It provides support when the behavioural and psychological symptoms of dementia (BPSD) start to impact a person's quality of care.

Severe Behaviour Response Teams (SBRT), also delivered by DSA, is a mobile service that responds onsite within 48 hours. It offers free support and advice to approved aged care providers where there is heightened severity of BPSD or risk to the person living with dementia, or their care network. SBRT will partner with the person living with dementia and their care network to understand the causes that led to changes in behaviour and support their needs.

The **Specialist Dementia Care Program (SDCP)** supports people with very severe BPSD whose support needs cannot be met in a residential aged care home. Care is provided in a small unit in a cottage-like dementia friendly environment. The program enables specialised care in circumstances where the person has very severe BPSD complicated by physical aggression or other behaviours that the person's residential aged care home or carer partners cannot manage, even with help from other services.

The program provides transitional care aimed at stabilising behaviours over approximately a 12 month period to enable the resident to transition to a less intensive care setting when they no longer need SDCP care.

Referral and eligibility for the program is undertaken by Dementia Support Australia (DSA) through the Needs Based Assessment service.

The **Hospital to Aged Care Dementia Support Program** helps older people living with dementia transition from hospital into residential aged care or home with aged care support. The program supports hospital and aged care staff, the older person and their family or carers:

- during their hospital stay
- when transitioning out of hospital
- following hospital discharge into an aged care supported environment for up to 3 months

DSA are delivering the program in 11 locations with a presence in all states and territories and referrals are accepted from hospital staff in participating hospital sites.

A HACDSP program framework has been developed and provides high level program overview, scope, and administrative arrangements and is available by emailing HACDSP@health.gov.au

Information about the program, eligibility and how to refer can be found on DSA's website Hospital to Aged Care Dementia Support Program (HACDSP)

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Dementia Support Australia

Staying at Home

Assessing for Eligibility for the Specialist Dementia Care Program (SDCP)

Specialist Dementia Care Program information booklet

6.11.4. Department of Veterans' Affairs (DVA)

Veterans have the same right of access to community and aged care programs as any other member of the community. The *Aged Care Act 2024* lists veterans under the Statement of Principles (section 25). Veterans should not be discriminated against or refused care when accessing services from other community and aged care programs on an assumption that DVA will provide for all their care needs. DVA provides some entry-level care services but does not provide higher-level care services.

Veterans' Home Care (VHC) Program

Veterans' Home Care (VHC) is a DVA program designed to assist veterans and war widows/widowers who need a small amount of practical help to continue living independently in their own home. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance. VHC is not designed to meet complex or high-level care needs.

Community nursing (CN)

CN provides clinical nursing and/or personal care services to eligible members of the veteran community in their own home. CN services can assist with medication, wound care, hygiene and dressing. CN services can help to restore or maintain health and independence at home and assist to avoid early admittance to hospital or residential care. Veterans requiring high-level care require prior approval by DVA.

CN services are provided by a mix of personnel including registered and enrolled nurses and nursing support staff, who work within the framework of their relevant national standards.

Duplication of services

As long as there is no duplication of services between the programs, Veterans may access DVA's VHC and CN services at the same time as accessing **different services** from:

- Ongoing Support at Home
- CHSP
- TCP

For ongoing Support at Home, this access can occur regardless of the level of the package.

CHSP offers services that are not available through the VHC Program or other DVA arrangements, such as a wide range of social support, food services, community transport and centre-based day respite.

Assistance with fees

DVA may assist with the cost of fees for government funded aged care services for veterans, depending on the type of aged care and the eligibility of the veteran. We recommend the older person contact DVA on 1800 838 372 to check if they are eligible for assistance. If the person is a Prisoner of War or Victoria Cross recipient that served with the Australian Defence Force, DVA may provide additional fee assistance.

- Department of Veterans' Affairs
- Care at home and aged care services
- Community nursing
- Community Nursing Services and Providers

6.11.5. NDIS participants

For NDIS participants who have turned 65 requesting access to CHSP, assessors must ensure a person is not referred for services they are already receiving through the NDIS and/or other Commonwealth, state, territory or local government programs.

An assessment delegate should be aware of and advise NDIS participants that under the *NDIS Act 2013* (NDIS Act) an under 65 NDIS participant can remain in the NDIS if they are an aged care recipient who subsequently turns 65. However, a NDIS participant whose first permanent entry to residential care or home care (but not residential respite care) is after the age of 65, ceases to be a NDIS participant. (NDIS Act section 29 (1)(b)).

6.11.6. Disability Support for Older Australians (DSOA) and aged care

The Disability Support for Older Australians (DSOA) Program commenced on 1 July 2021. It is a closed program with no new participants and provides funding for a range of services including Assistance in Supported Independent Living, Assistance with Self-Care Activities, Specialist/Behavioural Intervention Support, Therapy, and Case Management.

DSOA supports older Australians with a disability who cannot be supported by the in-home aged care system and were not eligible for the NDIS when it was rolled out in their region.

Assessments for aged care services can impact a person's eligibility for funding under DSOA, and assessors should ensure a person has provided informed consent before proceeding to undertake an assessment.

The following services under CHSP will not affect DSOA funding:

- Hoarding and squalor assistance
- Social support and community engagement (Social Supports Group and Individual)
- Equipment and products
- Home adjustments
- Domestic assistance (General house cleaning and other approved household activities)
- Home maintenance and repairs (Home and Garden Maintenance)
- Meals

- Transport
- Specialised support services

Specialist aged care services also do not affect DSOA funding (i.e. TCP).

All other assessment outcomes will affect DSOA funding, and will do so in the following ways:

- An assessment for permanent Residential Aged Care will result in DSOA funding being capped at current levels. This also applies to CHSP service referrals not listed above. If a DSOA client is assessed as eligible for Support at Home and commences services, they will be required to exit the DSOA Program from the date aged care services commenced. These dates will be verified through My Aged Care.
- If a client commenced their Home Care Package prior to 1 July 2021 and are a transitioned HCP care recipient under SaH, they can continue in the DSOA Program. However, their DSOA funding will remain capped.
- If a client commenced CHSP services that are available through the DSOA program, they will be required to exit the DSOA Program from the date the aged care services commenced. These dates will be verified through My Aged Care. However, if a client commenced CHSP services, which are not available via the DSOA program, **prior to 30 June 2021**, the client can continue to access these services as a grandfathered support without any impact to their DSOA funding.

If an assessor receives a referral for a DSOA older person they should:

- establish if the older person has advised their DSOA service coordinator (provider) that they are seeking a referral for an aged care assessment;
- establish if the older person discussed with their DSOA service coordinator their options to increase supports under the DSOA Program prior to an aged care assessment;
- establish if the DSOA service coordinator has initiated a Change of Needs application and reviewed the DSOA older person's Individual Support Package prior to consideration of an aged care assessment; and
- establish that the DSOA older people understands the impacts on their DSOA funding should they proceed to assessment.

Aged care assessors should keep these policy settings in mind when making recommendations for aged care supports for a DSOA older person. That is, in making a recommendation, the aged care assessor needs to consider whether aged care services can appropriately support the older person were they to exit the DSOA Program.

Department of Health, Disability and Ageing website:

Disability Support for Older Australians Program (DSOA) manual

About the Disability Support for Older Australians Program

6.11.7. Carer support

Assessors should inform carers there is support and services specifically for them to access. This support is available through **Carer Gateway** and the National Dementia Helpline (for care partners of people with dementia or experiencing cognitive decline), both funded by the department.

Carer Gateway provides early-intervention and preventative supports and services to carers to help improve their well-being and long-term outcomes.

Carer Gateway is for all carers, no matter their age or the condition of the person they are caring for.

Carer Gateway consists of a website (www.carergateway.gov.au) and a national network of Carer Gateway service providers (CGSPs) (located in each state and territory).

CGSPs support carers with access to in person and digitally based supports and services including support planning, counselling, peer support, coaching, tailored support packages (including access to planned respite), emergency respite, and information and practical advice:

- Support Planning – assess the carer's needs and work with the carer to develop an agreed individual support plan.
- Counselling - professional counsellors for carers who are experiencing difficulties with anxiety, stress, depression and low mood as a result of their caring role.
- Peer Support – a service for carers to connect with people in similar caring circumstances and learning from their peers through the sharing of lived experiences.
- Coaching – carers work one to one with a coach, taking time to think about their own wellbeing and steps towards personal life goals.
- Tailored Support Packages – offers a range of practical supports to support carers access education and/or employment or assist carers in their caring role (e.g., access to planned respite, assistance with transport).
- Emergency Respite - help with accessing emergency respite support when a carer can no longer maintain the caring role due to illness for example.

CGSPs also assist with navigating relevant, local services available to carers, including My Aged Care, National Disability Insurance Scheme, Dementia Australia and referrals to other state/territory government funded carer support services.

CGSP staff talk with carers about the registration and support planning process, and then work with them to provide access to supports and services based on their individual needs and caring circumstances. The intent of the support planning is for carers to have the most appropriate supports in place to help maintain their wellbeing, which in turn helps maintain their capacity to continue their caring role and also to participate in their communities.

Assessors should collect carer information in the My Aged Care Assessor Portal or Aged Care Assessor App and register the older person and their carer's consent to request a call back from Carer Gateway and/or the National Dementia Helpline. The carer's local CGSP and/or the National Dementia Helpline will then contact them to assist with accessing supports to help them in their caring role.

Alternatively, assessors may inform carers they can contact their local CGSP by calling 1800 422 737 (selecting Option 1), Monday to Friday, between 8am and 5pm, or by visiting the Carer Gateway website (www.carergateway.gov.au) and completing the online 'Request for Call Back' form.

The Carer Gateway website also provides carers with practical advice, information and resources to help them in their caring role, as well as access to:

- a national carer phone counselling service to help them manage daily challenges, reduce stress and strain, and plan for the future;

- an online peer support forum, connecting carers with other carers for knowledge and experience sharing, emotional support and mentoring;
- online self-guided coaching resources with simple techniques and strategies for goal-setting and future planning; and sources to increase skills and knowledge of carers relating to specific caring situations, to build confidence and improve wellbeing.

Assessors should also **note**, that CGSPs currently **do not** have the capability to receive referrals to book flexible, centre-based, cottage or residential respite for carers of My Aged Care older people.

Assessors should also be aware that under the Carer Gateway model, assistance for young carers to continue with or commence study through the Young Carer Bursary Program is available. Further information on the Young Carer Bursary Program and the application process is available at www.youngcarersnetwork.com.au/young-carer-bursary.

Dementia Australia's support for carers, family members, and representatives of people with dementia or experiencing cognitive decline includes providing in person, phone-based, or online dementia-specific counselling, peer support, and education.

Dementia Australia's carer supports can help people better understand the nature and impact of dementia, develop strategies to manage stress and mixed emotions, plan for the future, and manage grief.

Carer Gateway website

Carer Gateway service provider free call:1800 422 737

Department of Health, Disability and Ageing website:

My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships

Young Carers Network website

Dementia Australia website.

National Dementia Helpline: 1800 100 500 - 24 hours a day, 7 days a week

6.11.8. Aged Care Volunteers Visitors Scheme (ACVVS)

The Aged Care Volunteer Visitors Scheme (ACVVS) provides friendship and companionship to older people who are feeling lonely or socially isolated by matching them with a volunteer visitor. The ACVVS is a free program for eligible aged care recipients. Visits are available to anyone receiving Australian government-subsidised residential aged care or the Support at Home services. This includes care recipients approved or on the Support at Home Priority System and excludes those with a Commonwealth Home Support Program (CHSP).

The program requires the volunteer to make 20 ACVVS visits per year. These occur for approximately an hour a fortnight.

Anyone can refer an eligible older person to the ACVVS, including Aged Care Assessors, aged care service providers, health professionals, family members and friends. Older people can also refer themselves.

You can request a volunteer for an older person via the ACVVS website.

Aged Care Volunteer Visitors Scheme (ACVVS) | Australian Government Department of Health, Disability and Aged Care

6.11.9. Interpreting and translation services for people from culturally and linguistically diverse backgrounds

Every older person has a right to communicate in their preferred language or method of communication, with access to interpreters and communication aids as required.

If an older person requires an interpreter or translation services, it is the responsibility of the assessment organisation to access these services as needed to support the older person through the assessment process.

Sign language interpreting services

Older Australians who are deaf, deafblind or hard of hearing, who are seeking to access or are in receipt of Commonwealth funded aged care services can access **free** sign language interpreting and captioning services. Sign language services can be provided face-to-face or by Video Remote, and live captioning services are available to support older people to better engage and fully participate in their aged care journey and activities of daily living.

Information on how service providers can access interpreting services is available online at My Aged Care (or by calling 1800 200 422) or Deaf Connect (or by calling 1300 773 803).

If an older person enquires about sign language interpreting for daily activities, not aged care related, please refer them to Deaf Connect where they can also receive free services.

Sign language services are available in Auslan, American Sign Language, International Sign Language, and Signed English for Deaf or people who are hard of hearing, and tactile signing and hand over hand for people who are deafblind.

6.11.10. Interpreting services for Aboriginal and Torres Strait Islander people

It is important for older Aboriginal and Torres Strait Islander people accessing or thinking of accessing Australian Government-funded aged care services to be able to communicate in an Aboriginal and Torres Strait Islander language if that is their preference.

To access Interpreter Connect, an Aboriginal and Torres Strait Islander person should call My Aged Care on 1800 200 422 and ask for an interpreter from the following list of languages. Through the interpreter, My Aged Care will answer the person's aged care questions and then, if asked to, will assist them with accessing services. Languages available include:

- Alyawarre
- Anmatyerre
- Arrernte (Eastern and Central)
- Arrernte (Western)
- Djambarrpuyngu
- Gumatj
- Kriol (Top End)
- Murrinh Patha
- Ngaanyatjarra
- Ngaatjatjarra
- Pintupi-Luritja
- Pitjantjatjara
- Torres Strait Creole/Yumpla Tok
- Warlpiri
- Yankunytjatjara
- Yolngu Matha

If an interpreter from the above list is not available at the time of the call, an appropriate time that suits the Aboriginal and Torres Strait Islander person will be arranged. This service aims to make it easier for older Aboriginal and Torres Strait Islander people, their families and carers to access information on ageing and aged care, to have their needs assessed and to be supported to find the most appropriate services.

6.11.11. Elder Care Support

The Elder Care Support Program was established to recruit and train a trusted workforce to support older Aboriginal and Torres Strait Islander people and their families throughout their aged care journey. This support contributes to older people achieving a better, safer experience when accessing aged care services and having the information to make decisions on the care they need and receive.

The Elder Care Support program provides services that include:

- supporting older Aboriginal and Torres Strait Islander people to understand aged care services, navigate the assessment process and help with choosing a provider
- supporting families, friends and carers to understand how to access aged care services
- advocating for older Aboriginal and Torres Strait Islander people by working with assessors and providers to meet their needs
- supporting older Aboriginal and Torres Strait Islander people while they receive aged care services
- assisting with other types of health needs, such as disability supports.

The National Aboriginal Community Controlled Health Organisation (NACCHO) Aged Care Programs team can provide further information about the program at agedcare@naccho.org.au.

Elder Care Support

6.11.12. Care Finder Program

The care finder program offers tailored, intensive support to people who have one or more reasons for requiring assistance to interact with My Aged Care and access aged care services and other relevant community supports.

Care finders help vulnerable older people understand and access aged care and connect with other relevant supports in their community. This includes people who are, or are not yet, receiving aged care services or other relevant supports.

Care finders support people who don't have family, friends, a carer or any other person they are comfortable receiving help from and who is willing and able to help them access aged care services and supports. Care finders conduct outreach and then register the older person through the My Aged Care contact centre.

Primary Health Networks (PHNs) are responsible for commissioning and managing care finder services, leveraging their commissioning expertise and in-depth understanding of local community needs.

Contact information for care finder services in each region is on the My Aged Care website at Help from a care finder.

Care finder program

7. Chapter 7: Delegations and approvals under the Act

What you'll find in this chapter

This chapter 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.

7.1. Delegation of powers and functions under the *Aged Care Act 2024*

Under section 339 of the *Aged Care Act 2024* (the Act), the System Governor plays a key role in the governance of the aged care system responsible for facilitating equitable access to funded aged care services. Section 7 of the Act specifies the position of the System Governor is occupied by the Secretary of the Department of Health, Disability and Ageing.

The System Governor has the power under section 567 of the Act to delegate their functions and powers to others who may exercise them on their behalf. The Instrument of Delegation outlines the specific functions, powers and responsibilities of the System Governor which are delegated to certain positions within assessment organisations. Staff who occupy these positions are considered delegates and will continue to be nominated through the on/off delegate form.

Delegations are tied to the position, not to the individual. This means that the powers and functions stay with the role, and any qualified person who has been approved to hold the position can exercise these powers. The Instrument of Delegation outlines which positions within each assessment organisation can hold these responsibilities.

These delegations operate within the Single Assessment System and delegates must comply with Commonwealth guidelines, and any directions issued by the Secretary. This ensures that the delegation framework remains in line with current policies and standards.

7.2. Delegate responsibility

The role of the delegate is that of a primary decision-maker within a structured legal system. This means delegate decisions must be based on the legal requirements, facts, evidence, and clear reasoning. Understanding the legal framework and decision-making requirements is essential to making sound, defensible judgments.

The Single Assessment System relies on delegates to fulfil their role efficiently and effectively. Delegate decisions ensure that due process is followed and that eligible clients receive the care and support they need.

Decisions made by assessment delegates may be subject to review in various contexts. This could include reconsideration requests or formal reviews by bodies such as the Administrative Review Tribunal (ART).

As a result, it is important that delegates maintain accurate, complete records and clear justifications for every decision they make.

There are three delegate positions which sit within assessment organisations:

- Triage delegates
- Clinical assessment delegates
- Non-clinical assessment delegates

Under the *Aged Care Act 2024*, these delegate positions will be involved in certain assessment related activities outlined in the table below.

Table 33. Assessment related activities of delegate positions

Delegate position	Delegate activity
Triage Delegates	• Consider and determine an older person's eligibility for an aged care needs assessment or reassessment • Determine whether an older person requires a reassessment • Notify an older person of decisions and their right to review
Non-clinical Assessment Delegate	• Approve an older person's eligibility to access aged care services under the Commonwealth Home Support Program • Limit or vary an older person's approval for funded aged care services • Notify an older person of decisions and their right to review • Consider and approve any appropriate changes to an older person's access approval for services under the Commonwealth Home Support Program as a result of a support plan review
Clinical Assessment Delegate	• Approve an older person's eligibility to access funded aged care services • Limit or varying an older person's approval for funded aged care services • Approve extensions for transition care and residential respite care services • Notify an older person of decisions and their right to review • Consider and approve any appropriate changes to an older person's access approval for services as a result of a support plan review • Consider and determine the outcome of a classification reassessment

For information about how to assign individuals to delegate positions, see Chapter 13

7.3. Triage delegates

Triage delegates are delegated under the *Aged Care Act 2024* (the Act) to decide:

- under Section 58 of the Act, whether an older person is eligible for a needs assessment for government funded aged care services.
- under section 64 of the Act, whether an older person has undergone a significant change of circumstances or other change in their circumstances and requires a reassessment of their needs.

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

See Chapter 5 for information about the function of the triage delegate and conducting triage.

7.4. Assessment delegates

7.4.1. Non-clinical assessment delegates

Non-clinical Assessment Delegates are delegated the authority under the Act to approve entry-level services arising from a home support assessment.

This means they are restricted to approving access to the following:

- the Commonwealth Home Support Program (CHSP)
- assistive technology (AT) and/or home modifications (HM) under CHSP (*not* under the AT-HM scheme).

If any approvals other than those listed above are required, the assessor must convert the assessment to a comprehensive assessment. Once an assessment is converted to a comprehensive assessment, the approval will flow to a Clinical Assessment Delegate. Clinical Assessment Delegate approval is required for all other approvals as outlined in detail in the next section.

All needs assessors will have delegation under the Aged Care Act 2024 (the Act) to approve entry-level services. Assessment organisations can determine whether to permit all needs assessors to perform this function.

When approving the recommendations from an assessment they have undertaken, needs assessors, acting in their capacity as a non-clinical assessment delegate should exercise due care to ensure the assessment is complete, evidence based, free from errors, contradictions, or omissions.

7.4.2. Clinical assessment delegates

Clinical assessment delegates are delegated the authority under the Act to approve an older person for all service groups, classification types and classification levels.

> Note: Clinical Assessment Delegates can approve entry-level home support services (as non-clinical assessment delegates do) if assessment organisations have chosen to allocate home support assessments to clinical assessment delegates.

7.5. Overview of approvals under the Aged Care Act 2024

The Aged Care Act 2024 (the Act) standardises the approval approach for funded aged care services, with all approvals given under the Act, using one service list which is divided into four Service Groups. This makes it more straightforward to give an older person a tailored package of care that meets their needs.

To be eligible for any funded aged care service an individual must first meet the criteria for an aged care needs assessment (as specified in Section 58 of the Act). Eligibility is now determined by a triage delegate, who holds relevant decision-making powers delegated by the System Governor.

Once determined as eligible, an aged care needs assessment is conducted to determine whether the older person requires funded aged care services. Based on this assessment, the assessor recommends funded aged care services they consider the individual needs to meet their care needs as well as any services, service types and service groups they consider the individual should be approved for under section 65 of the Act. It should be noted that under the same provision, older Aboriginal and Torres Strait Islander persons only need an approval at the service group level to receive aged care services. These recommendations are documented in a support plan, which is issued to an assessment delegate for consideration shortly after the assessment has been completed.

For an older person to start using funded aged care services, they need to be approved for the following under the Act:

1. **Service groups,** which specify the setting and nature of care an individual can access
2. **Classification types,** which specify the different time periods that services are delivered for under the service group.
3. **Service types** and **services** (for some older people, in some circumstances) – Service types are groups of different services. The services under these types are set out under the Aged Care Service list. Different service types sit under each service group. Older Aboriginal and Torres Strait Islander people only need an approval at the service group level - they are automatically approved for all service types and services in that group.
4. **Classification levels,** which determine the amount of funding available to deliver funded aged care services to the individual. The individual receives a classification level for the classification type for the service group they have been approved to access. The classification levels are specified in the Rules (see Division 3 Part 3 of Chapter 2 of the Rules).
5. **Priority categories** – determines priority for a classification type for a service group.

Note: individuals must be approved under the *Aged Care Act 2024* to access any funded aged care services, including if they are delivered through CHSP, MPSP and NATISFACP. This is a significant change as individuals could previously access services through these programs without approval under the *Aged Care Act 1997*.

7.6. Delegate decisions under the Aged Care Act 2024

Although assessors provide recommendations and supporting evidence via the assessment report (support plan), the final approval decision rests with the assessment delegate, except an ongoing home support classification level and assigning a priority level for Support at Home which are automated decisions.

While assessment delegates exercise the powers of the aged care System Governor, they remain personally accountable for the decisions they make under the *Aged Care Act 2024* (the Act). This underscores the significant responsibility of the Assessment Delegate role.

Once an aged care needs assessment is finalised, 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 comply with the conditions outlined in sections 65-68 of the Act and any additional eligibility criteria set by the relevant rules must be satisfied. If these requirements are not met, the assessment delegate cannot approve the provision of aged care services.

7.6.1. Deciding if the older person requires aged care services

Assessment delegates must first determine whether the 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 section 65(2) of the Act.

This decision is made based on:

- An assessment report (referred to in practice as the support plan),
- In the case of reassessments in accordance with 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 the following sections.

Table 34: Approval to access funded aged care services under section 65

Section criteria of the Act		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.
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
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

Figure 7 below provides a visual summary of the three pathways to access approval (sections 66, 67 and 68).

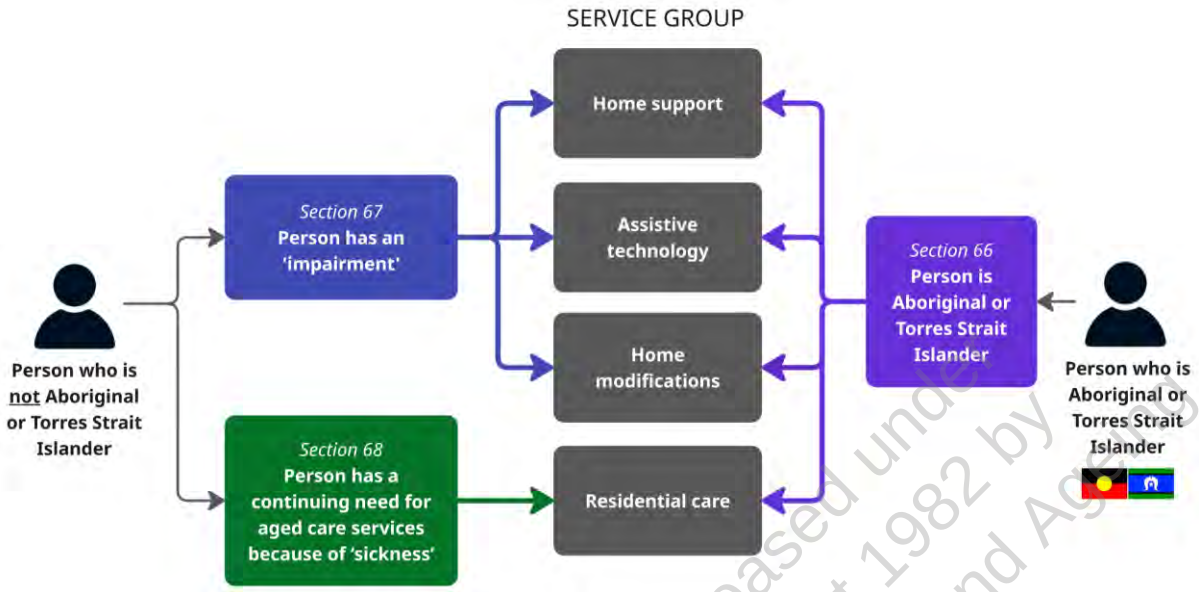

Figure 7 – Overview of pathways to approval for service access under the Act

7.6.2. Section 66 – Aboriginal or Torres Strait Islander persons

Section 66 provides a special pathway for Aboriginal or Torres Strait Islander people to be approved under section 65(1) to access funded aged care services. This pathway is unique for Aboriginal and Torres Strait Islander people because it relies on a different power in the Constitution to the other eligibility for approval provisions.

Under section 66, an older Aboriginal or Torres Strait Islander person can be approved under section 65(1) for any service group, which includes all of the service types and services in the group.

Figure 8 below gives an overview of the section 66 pathway to access approval for older people who are Aboriginal or Torres Strait Islander.

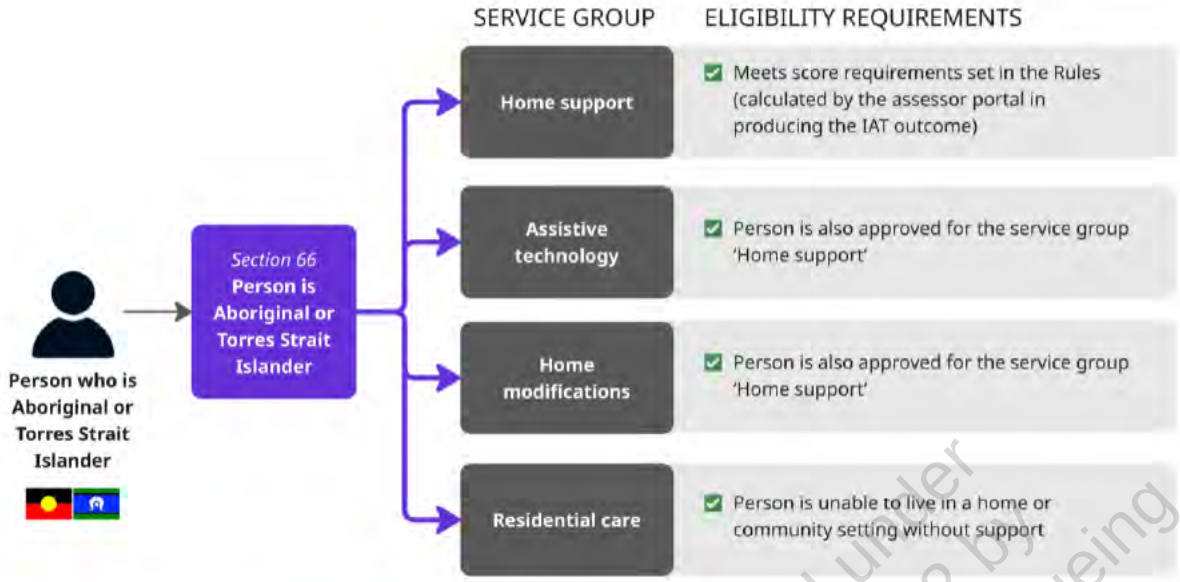

Figure 8 – Overview of section 66 pathway to approval for service access

Additional eligibility requirements

While an older Aboriginal or Torres Strait Islander person can be approved at the service group level for any service group, delegates will still need to take into account the additional eligibility requirements in the *Aged Care Rules 2025* (the Rules) for the service group (or groups) the person is actually approved for (section 65-10 to section 65-20 of the Rules). This is required because of section 65(3) of the Aged Care Act 2024.

The additional requirements for each service group are set out below.

Additional eligibility requirements for home support

The system will calculate the score necessary to determine whether an older person has met the additional eligibility requirements for the home support service group listed below. This calculation is made by drawing on the responses from within the Integrated Assessment Tool (IAT). The role of an assessment delegate is to ensure information is accurately recorded in the IAT and to have consideration for the legislative eligibility criteria even though the score is calculated by the system.

The additional requirements for the home support service group are that the person meets any of the 'score' requirements for the particular questions in the IAT. These are outlined in the table below.

Table 35. Additional eligibility requirements for the home support service group under section 66

A person has a total score of less than 20 for the questions in the IAT with the following headings:	• Climb stairs • Eating • Dressing • Take a bath or shower • Grooming • Transfers • Toilet use

The person has a total score of less than 14 for the questions in the IAT with the following headings:	• Toileting – bladder • Toileting – bowels • Walk
	OR
	• Get to places out of walking distance • Undertake housework (heavy/moderate) • Go shopping (assuming transportation) • Prepare meals • Take medicine • Handle money • Use the telephone
	OR
The person has a score greater than zero for the questions in the sections of the IAT headed:	• Cognition • Medical and Medications
	OR
The individual has a score greater than zero for questions in the section of the IAT headed:	• Psychological
	OR
The individual has a score greater than zero for the questions in the section of the IAT headed:	• Physical, Personal Health or Frailty

Additional eligibility requirements for assistive technology and home modifications

- the individual is also approved for the home support service group.

Additional eligibility requirements for residential care

- the individual is incapable of living in home or community setting without support.

7.6.3. Section 67 – a person who has an impairment or sickness

Section 67 is the pathway for non- Aboriginal or Torres Strait Islander people to be approved under section 65(1) for the following service groups:

- home support
- assistive technology
- home modifications.

There are special requirements for approving a person where section 67 applies to them, because of the legal basis in the Constitution that supports the approvals.

When approving a person for service types or particular government-funded aged care services because section 67 applies to them, it is not possible to approve them at the service group level. Assessment Delegates will need to select and decide the particular service type/s the older person requires, or for particular service types the individual service/s (further information below). This is a necessary legal requirement because of the constitutional powers that support the provision of these types of services under the *Aged Care Act 2024 (the Act)*.

Figure 9 below gives an overview of the section 67 pathway to access approval.

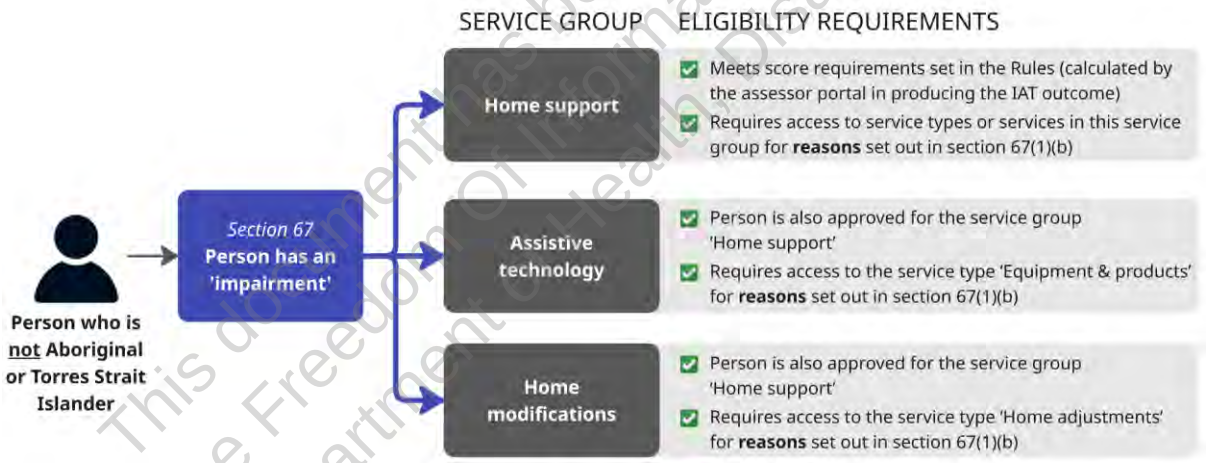

Figure 9 – Overview of section 67 pathway to approval for service access

Deciding if the person should be approved

When deciding if an older person should be approved for the Home Support, Assistive Technology or Home Modifications service group/s under section 65 of the Act where section 67 applies to them, assessment delegates will need to take the following steps:

1. Assessment delegates must be satisfied that the older person has a disability or an "impairment"

    a. the impairment must be long-term and be a physical, mental, sensory or intellectual impairment, and

b. because of its interaction with various barriers, the impairment may hinder the person's participation in society on an equal basis with others.

2. Decide which service types the older person requires access to.

   a. For the service types 'Allied health and therapy' and 'Therapeutic services for independent living' an assessment delegate must also decide which individual services in those service types they require access to.

3. Assessment delegates must then be satisfied that there is a specific reason why the person requires access to the service types (or the particular funded aged care services – see step 2a.). These reasons are set out in section 67(1)(b) of the Act and explained further below.

4. Assessment delegates must also be satisfied that the person meets the additional eligibility criteria in the Rules. These criteria are outlined below.

Impairment

Information about the person's "impairment" will already be reflected in the information collected using the Integrated Assessment Tool (IAT) and any other relevant information gathered during the assessment, such as information from the person's GP or other health records. For the purposes of recording the approval decision, an assessment delegate will need to be satisfied the information provided identifies the long-term impairment (or impairments) that the older person has. This should be evident from the assessment information.

It should also be evident from the assessment/IAT/Support Plan information the barriers the person faces to their independence because of their impairment and how this impacts their ability to participate and be included in the community.

EXAMPLE 1

The older person may be physically impaired because of a musculoskeletal disorder or be vision impaired, which was identified through their assessment and recorded in the IAT, or evidenced in a record or report for the person provided by a GP or other health professional. This may impact, among other things, their functional ability and be recorded under the Function section of the IAT.

EXAMPLE 2

The older person may have a diagnosis of a pre-existing condition, such as arthritis or another physical or neurological condition, such as dementia or Motor neurone disease, as identified through their assessment in the IAT. This may be recorded as a health condition under the Medical and medications section.

For both above examples, the older person's condition may impact their ability to participate in the community, as they would require support to enable them to continue living at home and maintain their independence.

Special requirements for 'Allied health and therapy' and 'Therapeutic services for independent living'

When approving an older person for the service types 'Allied health and therapy' and 'Therapeutic services for independent living,' assessment delegates will need to consider which individual service (or services) in the service type the person requires access to because of their needs.

This is because each funded aged care service that is considered an allied health, therapy or other therapeutic service is directed at a different physical, functional or cognitive issue – it's not possible to determine that a person with disabilities requires access to allied health or therapeutic services *generally* without considering if each particular service is required. This is an essential requirement because of the changes to the legal basis supporting the Aged Care Act 2024 (the Act).

Specific reason/s why access is needed under Section 67

The Act requires Assessment Delegates to consider reasons why an older person needs access to the service types or particular services. Assessment Delegates must turn their minds to these reasons when deciding on the service types/services.

The reasons are that the service type (or service(s) within the service types of *Allied health and therapy* and *Therapeutic services for independent living*):

i. is an in-home, residential or community support service that is necessary to support the person to live and be included in the community and prevent them from being isolated or segregated from their community

ii. will facilitate personal mobility of the person in a way that the individual chooses

iii. involves a mobility device or equipment, or assistive technology, that will facilitate personal mobility

iv. is a health service that the person needs because of their impairment or because of the impairment and the interaction with various barriers

v. is a habilitation or rehabilitation service

vi. is a service that will assist the person to access any of the services they need because of any of the reasons above

vii. will minimise the prospects of the person, or prevent the person from, acquiring a further impairment

viii. is a medical service required by the person because of sickness.

For ease of understanding, these have been re-framed as needs of the older person in the table below (this is how they appear in the Notice of Decision).

Table 36. Reframed reasons for access under section 67

It has also been determined that you require access to the stated service types and/or services because you …
require support to live and be included in the community and prevent you from being isolated or segregated from their community [doesn't apply to the Nursing service type]
require support with your personal mobility
would benefit from services to minimise the chances of you, or prevent you from, acquiring a further impairment
require support with rehabilitation or to gain a new skill or function (also known as habilitation)
require health services because of your impairment or because of the impairment and its interaction with various barriers
need support to access any of the services you have been approved for

When making a decision, assessment delegates must consider the older person's circumstances overall and what service types and services they need, and for what reason. This should already be evident from the information recorded in the Integrated Assessment Tool (IAT) or the support plan, which detail what the person's needs are, and why the person needs support and what help they need.

Potential applicable reasons for service types/services are set out in the table below.

Table 37. Service types/services and potential applicable reasons under section 67

Reason	Reason may apply when approving the older person for…
1. Requires support to live and be included in the community and prevent from being isolated or segregated from their community	• any service type **except** 'Nursing care' from the service group 'home support' (including services accessed through TCP) • 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme, CHSP or TCP
2. Requires support with personal mobility or requires a mobility aid/device/assistive technology	• the service type 'Transport' from the service group 'home support' (included in any approval for TCP)

Reason	Reason may apply when approving the older person for…
	• 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme or CHSP
3. Would benefit from services to minimise the prospects of them, or prevent them from, acquiring a further impairment	• the service type 'Assistance with transition care' (part of any approval for TCP) • 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme or CHSP
4. Needs support to access any of the services they have been approved for	• 'Equipment and products' under the AT-HM Scheme or CHSP • The service type 'Restorative care management' under the service group 'home support' (e.g. Restorative Care Pathway) • the service type 'Assistance with transition care' (part of any approval for TCP)
5. Requires health services because of their impairment or because of the impairment and its interaction with various barriers	• The service type 'Allied health and therapy'[4] • The service type 'Nursing care' • The service type 'Therapeutic services for independent living'[5] *Note that all of the above may be accessed through TCP*
6. Requires support with rehabilitation or to gain a new skill or function (habilitation)	• the service type 'Assistance with transition care' (part of any approval for TCP)

Once an Assessment Delegate has considered which service types are needed and why, they need to record the reasons for their decision in the Notice of Decision. Assessment Delegates will be required to delete the reasons which they consider do not apply from the list of reasons above.

[4] Remembering that for this service type you will need to decide the individual service (or services) the older person needs and turn your mind to the reason why they need that particular service (or services).
[5] Remembering that for this service type you will need to decide the individual service (or services) the older person needs and turn your mind to the reason why they need that particular service (or services).

Health services - examples

An example of a health service is physiotherapy or other services delivered by a registered health professional.

An example of approving access to a service because it is a 'health service' required 'because of the individual's impairment' could be approving them for the service 'Physiotherapy' in the 'Allied health and therapy service type'. This is because the physiotherapy is required to support them with managing their diagnosis of Motor Neuron disease.

Habilitation and rehabilitation services - examples

Allied health services such as occupational therapy or physiotherapy are examples of habilitiation or rehabilitation services.

An example of approving access to a service because it is a 'habilitation or rehabilitation service' could be approving them for 'Acupuncture' in the 'Therapeutic services for independent living' service type, to support them in rehabilitation following a stroke.

Additional eligibility requirements

When approving a person under section 65(1) because section 67 applies to them, Assessment Delegates will also need to turn their mind to the additional eligibility requirements in the Aged Care Rules 2025 for the service groups the person is actually approved for. This is required because of section 65(3) of the *Aged Care Act 2024*.

The additional requirements for each service group are set out below.

Additional requirements for home support

The system will do the work in calculating the score necessary to determine whether an older person has met the additional eligibility requirements for the home support service group listed below. This calculation is made by drawing on the responses from within the Integrated Assessment Tool (IAT). The Assessment Delegate is to ensure information is accurately recorded in the IAT and that you have consideration for legislative eligibility criteria even though the score is calculated by the system.

The additional requirements for the home support service group are that the person meets any of the 'score' requirements for the particular questions in the IAT, outlined in the table below.

Table 38. Additional eligibility requirements for the home support service group under the Rules

A person has a total score of less than 20 for the questions in the IAT with the following headings:	• Climb stairs • Eating • Dressing • Take a bath or shower • Grooming • Transfers • Toilet use • Toileting – bladder • Toileting – bowels • Walk

The person has a total score of less than 14 for the questions in the IAT with the following headings:	• Get to places out of walking distance • Undertake housework (heavy/moderate) • Go shopping (assuming transportation) • Prepare meals • Take medicine • Handle money • Use the telephone
OR	
The person has a score greater than zero for the questions in the sections of the IAT headed:	• Cognition • Medical and Medications
OR	
The individual has a score greater than zero for questions in the section of the IAT headed:	• Psychological
OR	
The individual has a score greater than zero for the questions in the section of the IAT headed:	• Physical, Personal Health or Frailty

Additional requirements for assistive technology and home modifications:

- the individual is also approved for the home support service group.

7.6.4. Section 68 – 'individuals with a sickness'

Section 68 is the pathway for non Aboriginal or Torres Strait Islander people to be approved under section 65(1) for funded aged care services in residential care.

This covers the residential care service group which includes both permanent (ongoing) and respite (short-term) residential care. It also covers older people who will access funded aged care services through the residential care service group under the Transition Care Program (TCP).

Approving a person for the residential care service group because section 68 applies to them will automatically approve them for all residential care service types, including the services under those types.

Figure 10 below gives an overview of the section 68 pathway to approval to access the residential care service group.

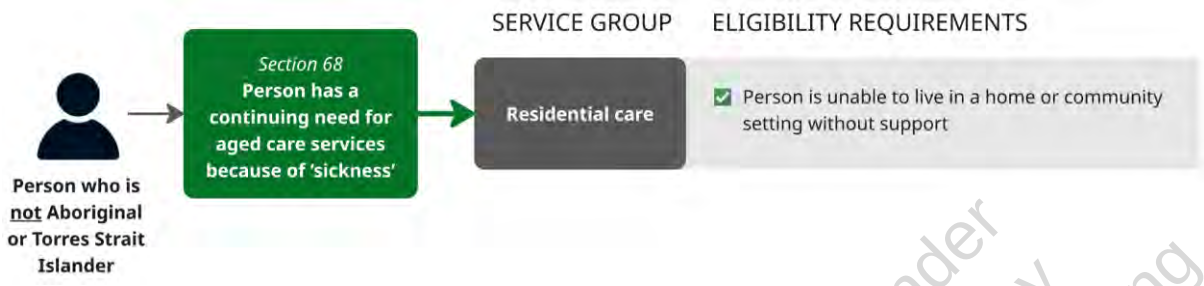

Figure 10– Overview of section 68 pathway to access approval for residential care

Deciding if the person should be approved

When approving an older person for the residential care service group, Assessment Delegates will need to be satisfied that:

1. the person is "sick," and
2. Because of their "sickness," they have a continuing need for residential care services, including nursing services.
3. The person meets the additional eligibility criteria in the Rules. These criteria are outlined below.

Sickness

"Sickness" for the purposes of the *Aged Care Act 2024* (the Act) means an infirmity, illness, disease, incapacity or impairment. Sickness can be a strictly physical illness, such as a heart condition but will also encompass mental health conditions like depression or anxiety, or neurological disorders, such as dementia or Alzheimer's.

Information about the person and their "sickness" will already be reflected in the information collected using the Integrated Assessment Tool and any other relevant information gathered during the assessment, such as information from the person's GP or other health records. For the purposes of recording the approval decision Assessment Delegates will need to be satisfied the information provided identifies that the older person is "sick" and because of that they have a continuing need for residential care, including nursing services. This is a necessary legal requirement because of the constitutional powers that support the provision of residential care under the Act.

The requirement that the person is sick and has a "continuing need" for residential care "including nursing services" applies in the same way to respite care (short-term) and Transition Care (hospital transition) as it does to permanent (ongoing) residential care. While the person will only be approved to access care for a limited period of time if they are approved for respite or Transition Care, Assessment Delegates will still need to be satisfied

they at the time of the assessment that they have a continuing need for residential care including nursing services due to their sickness.

Additional eligibility requirements

When approving a person for the residential care service group because section 68 applies to them, Assessment Delegates will also need to turn their mind to the additional eligibility requirement in the Rules. This is required because of section 65(3) of the Act.

The additional requirement is:

- the person is incapable of living in a home or community setting without support.

7.7. Approvals for service groups, classification types and classification levels

The foundational building blocks of approvals under the *Aged Care Act 2024 (*the Act) are service groups, classification types and classification levels.

- 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.

Under the Act, approvals for a service group, a classification type and a classification level combine to create something that is comparable to an approval for a program under the *Aged Care Act 1997*.

The table below compares some examples before and after the introduction of the Act.

Table 39. Comparison of approvals under the Aged Care Act 1997 and Act 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
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

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.

7.7.1. Service group: Home support

Table 40. Possible combinations of classification type and classification level under the service group of 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)

7.7.2. Service group: Assistive technology

Table 41. Possible combinations of classification type and classification level under the service group of 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 that classification levels are also referred to as 'funding tiers' in the Support at Home program.

7.7.3. Service group: Home modifications

Table 42. Possible combinations of classification type and classification level under the service group of home modifications

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

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

7.7.4. Service group: Residential care

Table 43. Possible combinations of classification type and classification level under the service group of 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 to Respite class 3
	Hospital transition	RC HT class

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

7.8. Approvals for service types and services

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

Important:

For 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.

If the older person is not an Aboriginal or Torres Strait Islander person, and an Assessment Delegate is approving the Home Support, Assistive Technology or Home Modifications service groups, they must decide:

- which **service types** to approve within each service group
- which **services** to approve, but **only if they are being approved for the following 'prescribed' service types**: *Allied health and Therapy* and *Therapeutic Services for Independent Living.*

Note:

If an Assessment Delegate is approving an older person for any service type other than the 'prescribed' service types (Allied health and Therapy and Therapeutic Services for Independent Living), they are also approved for all services in that service type.

Any older person approved for the residential care service group is automatically approved for **all service types and services in that service group.**

Section 65(2) of the Act has more information about these requirements.

7.9. Approvals for priority categories

Priority categories are assigned to individuals (under section 86 of the Aged Care Act 2024 (the Act)) to 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.

The Assessment Delegate does not make decisions on priority category under the Act. Priority categories are assigned by the system (assessor portal). However, Assessment Delegates are responsible for ensuring the correct information is used to calculate any priority category and communicating any priority category decision to the older person.

Under Section 86 of the Act, the Assessment Delegate is required to assign a priority category for an individual for the following service groups and classification types:

- Home support – ongoing (excluding CHSP class)
- Assistive technology – ongoing and short-term
- Home modifications – short-term
- Residential care – ongoing

In practice, this looks like the following:

1. The aged care needs assessment is carried out.
2. A priority category is calculated and assigned by the system (**not** the assessor) at the end of an assessment. In some cases, there is only one applicable priority category.
3. The assessment delegate confirms the information that has been used to calculate the priority category.
4. The priority category is pre-populated into the Notice of Decision (the assessment outcome letter).

Approvals for Transition Care, End-of-Life Pathway, Restorative Care Pathway, short-term residential care (respite care), and CHSP class do not require a priority category. The Notice of Decision template marks the priority category for these as 'N/A,' you should leave these fields unchanged.

The below table summarises the service groups, classification types, classification levels, and priority categories covered in this section.

Table 43. Priority categories for service groups, classification types and classification levels

Service group	Classification type	Classification level *Referred to as 'funding tiers' for AT and HM*	Priority category
Home support	Ongoing	SAH class 1 SAH class 8	Urgent, High, Medium, Standard

Service group	Classification type	Classification level *Referred to as 'funding tiers' for AT and HM*	Priority category
	Ongoing	CHSP class	N/A
	Short-term	SAH restorative care pathway SAH end-of-life pathway	N/A
	Hospital transition	HS HT class	N/A
Assistive technology	Ongoing	assistance dogs	Immediate, High, Medium, Standard
	Short-term	AT low AT medium AT high	Immediate, High, Medium, Standard
		AT CHSP	Immediate
	Hospital transition	AT HT class	N/A
Home modifications	Short-term	HM low HM medium HM high	Immediate, High, Medium, Standard
		HM CHSP	Immediate
Residential care	Ongoing	Class 0 (pre AN-ACC assessment) Class 1 to Class 13	Priority One, Priority Two, Priority Three
	Short-term	Class 0 (pre AN-ACC assessment) Respite class 1 to Respite class 3	N/A
	Hospital transition	RC HT class	N/A

7.9.1. Home support – ongoing

The priority category for ongoing Support at Home is assigned by the system and calculated based on six different criteria captured in the Integrated Assessment Tool (IAT) or on the client's record. These are whether the person:

1. lives alone
2. identifies as Aboriginal or Torres Strait Islander
3. has an assessed cognitive impairment
4. is experiencing homelessness or is at risk of homelessness
5. requires urgent service provision
6. has waited more than six months from the initial assessment referral and lives in a regional or remote area.

7.9.2. AT-HM scheme

The Priority categories for AT-HM is calculated based on 5 different criteria captured in the Integrated Assessment Tool (IAT) or on the client record. These are whether the person:

1. lives alone
2. has an assessed severe mobility impairment
3. Identifies as Aboriginal or Torres Strait Islander person
4. current place of residence poses a severe risk to their health or safety
5. Individual has waited more than 6 months from initial referral and resides in a rural or remote area categorised under MM5-7.

Further information is available in the AT-HM scheme guidelines.

The priority category for all ongoing CHSP services will be 'Not applicable'.

7.9.3. Residential care

The priority category for Residential Care is calculated based on 5 different criteria captured in the IAT or on the client's record. The criteria is the older person/'s:

1. identifies as Aboriginal or Torres Strait Islander
2. is experiencing homelessness
3. resides in a rural or remote area (MM 5 to 7)
4. has entered residential care through emergency circumstances
5. Urgency rating for residential care

7.10. Period of effect of approvals

Each access approval, classification level, and priority category has a period of effect that is prescribed under the Aged Care Act 2024 (the Act). This means that access 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, 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 decision made by Assessment Delegates are detailed in sections 71, 80 and 89 of the Act.

7.10.1. Period of effect of access approvals

When an individual is approved for access to funded aged care services 65(2) of the Aged Care Act 2024 (the Act), the approval takes effect from the access approval date of effect specified in the Notice of Decision (as outlined in Section 70). The approval stays in effect unless it is revoked under the Act or replaced by a new decision.

7.10.2. Period of effect of classification levels

Classification levels are in effect for the period specified in the Aged Care Rules 2025 (the Rules). Once the specified period has elapsed, the classification level will cease to be in effect. A classification may also cease to be in effect once another classification level comes in effect.

Written notice must be provided to an individual in accordance with section 79 of the Act which specifies the day when each classification level comes into effect. For individuals approved for the service groups home support, assistive technology or home modifications this notice is usually included in the Notice of Decision provided under section 70 of the Act.

Some classification levels, such as *CHSP class*, come into effect on the access approval date of effect. Others, such as the residential care classification levels, do not come into effect until the service provider notifies Services Australia that service has commenced.

The Rules also prescribe that, for some classification levels, the maximum period of effect may be extended. The criteria and requirements for granting such extensions are prescribed within the rules under the Act.

7.10.3. Period of effect of priority categories

A priority category for a classification type for a service group determines the level of priority for accessing those services.

An individual's priority category for a classification type for a service group takes effect immediately from when the prioritisation decision is made and remains in effect until either:

- The individual is allocated a place for that classification type and service group (under section 92), or
- A new priority category decision is made for that classification type for that service group following a reassessment of the individual (as per subsection 86(1) and paragraph 61(1)(b)).

7.11. Reassessment of a classification level

Depending on the classification type for service group, an individual or a registered provider acting on behalf of the individual may have the right to apply for a reassessment of a classification level under section 82. Section 82 of the Act outlines who may apply for a classification assessment for each classification type for a service group and when an application may be made. This is outlined in the table below.

Table 44. Circumstances when a classification reassessment can be sought

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
Ongoing or short-term for home support, assistive technology or home modifications	The individual	If: • the classification type is in effect for the individual; and • the individual considers a different classification level in the classification type for the service group should be approved; and • the funded aged care services are not being delivered under a specialist aged care program; and • you consider the circumstances (if any) prescribed by the rules apply.
Ongoing for residential care	The individual A registered provider on behalf of the individual	If: • The registered provider is delivering ongoing funded aged care services to the individual through the service group in an approved residential care home; and • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • the funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply: o if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(2) of the Act in that time period; o you consider the circumstances (if any) prescribed by the rules apply.
Short-term for residential care	The individual The registered provider on behalf of the individual	If: • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • an access approval is in effect for the individual for the classification type for the service group; and • if the application is made by the registered provider: o the registered provider is delivering short-term funded aged care services through the residential care service group to

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
		the individual in an approved residential care home; and o those funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply: o if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(3) of the Act in that time period; o You consider the circumstances (if any) prescribed by the rules apply.
Hospital transition (for any service group)	A registered provider on behalf of an individual	All of the following apply: • the registered provider is delivering hospital transition funded aged care services to the individual through the service group; and • the registered provider or the individual considers that an extension of the period of effect for the classification level that is in effect for the individual for the classification type for the service group should be approved for the individual.

When a reassessment is needed (for all classifications except those for the residential care service group), triage delegates will review the application, considering the individual's current care needs and whether they still meet the requirements for a classification reassessment.

If the application meets the necessary criteria, a reassessment will be carried out, and a new recommendation will be prepared and presented to the assessment delegate. Assessment delegates are responsible for deciding whether to approve a different classification level for the classification type for a service group or an extension of the classification level (if relevant) under section 78 of the Aged Care Act 2024 (the Act). All new decisions must be documented in a new Notice of Decision letter which must be made in accordance with the requirements of section 79 of the Act.

Note that a classification reassessment for ongoing residential care is commonly known as an AN-ACC reclassification and is the responsibility of Residential Aged Care funding assessors.

7.12. Summary of assessment delegate responsibilities under the Act

The table below summarises all of the decisions that assessment delegates are empowered to make or actions they are empowered to take under the Act, assessment delegate responsibilities include notifying the older person (and their registered supporter/s, if applicable) of the outcome of their assessment; this is explained in detail in the following chapter.

Table 45. Summary of decisions and actions Assessment Delegates are empowered to undertake

Decision Type	Section	Decision/Action
Access Approval Decisions	65(1)	An assessment delegate receives and considers an individual's support plan, deciding whether to approve access to funded services
	65(2)	An assessment delegate must decide whether to approve one or more service groups and the classification types for the service groups In making this decision, the assessment delegate must be satisfied that all the criteria prescribed in s 65(3) is met.
	65(2)	If the service group is home support, assistive technology or home modifications and the individual is not an Aboriginal and Torres Strait Islander person, an assessment delegate must decide: • Whether to approve one or more service types in that group • If the service type is allied health therapy or therapeutic services for independent living whether to approve one or more funded services in that type
	65(4)	In exceptional circumstances an assessment delegate can approve access for an individual who has not undergone an assessment if: • The assessment delegate is satisfied exceptional circumstances apply • An individual or registered provider makes an application on behalf of the individual in an approved form • Any circumstances prescribed by the rules do not apply.

Decision Type	Section	Decision/Action
	70	The System Governor must give written notice of a decision under subsection 65(1) or (2) to the individual within 14 days after the decision is made
	71(2)	The access approval date (which is specified in the notice of decision) may be a date earlier than the access approval/notice is given. This can occur if you (as the assessment delegate), are satisfied: • An individual needed urgent access to funded services and there was a significant risk of harm if services were not provided before an approval was given • The individual is an Aboriginal or Tores Strait Islander person and at the time they were seeking services there was a lack of available assessors to undertake a culturally safe assessment • An individual commenced receiving services through a specialist program before an approval was given and at the time an individual was seeking services there was a delay in the availability of a needs assessor • And all other criteria in s71(2) are met.
	71(6)	If an application has been submitted to extend the available period to apply for an access approval under the alternative entry provisions, the assessment delegates must decide to: • Determine a longer period for the individual, or • Reject the application Written notice of this decision must be provided.
Classification Decision	78(1)	An assessment delegate must approve a classification level for the classification type and service group they have approved for the individual. The classification level decision for ongoing home support (i.e., CHSP or Support at Home 1-8) is an automated decision and is determined by the IAT Classification Algorithm.
	80	Section 80 requires a period of effect to be set for a classification level that has been established under section 78. The Rules allow for a registered provider to apply for an extension to the maximum period of effect. The assessment

Decision Type	Section	Decision/Action
		delegate must consider the application and decide if a longer period should apply. Extensions can be sought in some circumstances for the following service groups, classification types and classification levels: • Home support, assistive technology or residential care – hospital transition • Home modifications The Rules also allow a registered provider to apply for an increase in the number of days for the classification level for the service group residential care, classification type short-term. An assessment delegate must consider the application and decide whether to approve an additional 21 days for the classification level because you are satisfied it is necessary because of any of the following: • Carer stress • Severity of the older person's condition • Absence of the older person's carer • Any other relevant matter
Registration and cancellation of a supporter	37(1)	A decision to register a person as a supporter of an older person seeking or receiving aged care services. For Assessment Delegates, this responsibility does not include the registration of a person as a supporter without the consent of the older person, nor where the prospective supporter has declared a conflict or there is anything else to suggest they may not be able to comply with the supporter duties (e.g., the prospective supporter is currently suspended or had a previous supporter relationship cancelled). In these circumstances, the Assessment Delegate should progress the request to register the supporter relationship to the departmental delegate team responsible for supporters.
	37(7)	The System Governor may make a registration under section 37(1), in the circumstances described, verbally or in writing.
	52	Cancellation of a supporter's registration upon request of the registered supporter. This applies to supporter, supporter lite and supporter guardian relationships.
	53(1)(a)	Cancellation of a supporter's registration upon request of the older person, where the registered supporter is not also an active, appointed decision maker for the older person (that is,

Decision Type	Section	Decision/Action
		a person captured by section 28(2)) – meaning it is **not** a supporter guardian relationship).
	54	The System Governor must give written notice of a decision to cancel a supporter's registration under sections 52 or 53(1)(a) to the person whose registration has been cancelled and the older person. The notice must be given as soon as practical after the registration is cancelled and include the reasons for the decision.

8. Chapter 8: Delegate decisions in practice

What you'll find in this chapter:

This chapter 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).

8.1. Decision-making fundamentals

Effective decision-making requires sound judgment, evidence-based reasoning, and a commitment to fairness and accountability.

8.1.1. Essentials of good decision-making

Delegates need to exercise independent judgment when determining whether an individual is eligible to be approved for funded aged care services. Delegate decisions must be based on all relevant information obtained through the assessment process. Delegates are considered to possess the necessary skills and expertise to fulfil this delegated role with honesty, integrity and accuracy.

To minimise the risk of errors and ensure consistency in decision-making, Delegates should adhere to the following key principles:

- **Identify all material facts:** Delegates must establish all material facts that are essential to the decision. Only facts supported by reliable evidence should be taken into account.
- **Base decisions on evidence:** Avoid making decisions based on unsubstantiated facts. Every finding must be backed by relevant and logical evidence that clearly supports the conclusions.
- **Ensure reasonable judgement:** Delegate decisions must be reasonable and not be based on findings that are manifestly unreasonable. This means that the conclusions should be rational, defensible, and clearly justifiable.
- **Observe natural justice:** Delegates must respect the principles of natural justice throughout the decision-making process. In essence, this means ensuring that individuals are given a fair opportunity to explain their circumstances before a decision is made.
- **Comply with legal requirements:** Delegates must comply with any statutory obligations, including understanding the important new eligibility criteria for approvals and the requirement to provide a written statement of reasons when necessary.

8.1.2. Best practice guides for decision-making

To support delegates in this role, the Administrative Review Council (ARC) has developed a series of Best Practice Guides. These guides serve as both a training resource and a reference tool for primary decision-makers in Commonwealth agencies, including Delegates. They cover key aspects of decision-making and provide practical guidance to help you make sound, evidence-based decisions.

You can refer to the five ARC Best Practice Guides on the Attorney-General's Department website.

ARC Best Practice Guides : Administrative Review Council publications | Attorney-General's Department

Note:

The Administrative Review Council (ARC) published the Best Practice Guides prior to 2015. While they continue to be regarded as sound policy, it is important to note that they have not been updated to reflect any changes in case law or relevant legislation since their publication.

8.2. Quality assurance

Delegates play a crucial quality assurance role within the aged care needs assessment system. It is the delegate's responsibility to ensure that due process is followed. Delegates are responsible for ensuring that the person being assessed genuinely requires government-funded aged care services. Additionally, delegates must ensure that any missing information or gaps in the required evidence have been identified, followed up, and clarified with the assessor. This is essential to support accurate, well-informed delegate decisions and uphold the integrity of the assessment process.

It is essential that assessment delegates maintain accuracy and consistency in their practice. Assessment delegates can do this by:

- Regularly consulting this Manual
- Adhering to the Aged Care Assessment Quality Framework to ensure continuous monitoring and enhancement of assessment practices in alignment with the Framework's goals.
- Seek guidance in situations that are complex or uncommon e.g. from a Team Leader, Manager, Workplace Trainer, or another assessment delegate who can provide appropriate support and clarification.
- Understanding and adhering to the legal requirements set out in the *Aged Care Act 2024)*.

8.2.1. Validating the assessment process and evidence

To ensure evidence-based reasoning, and a commitment to fairness and accountability, it is essential that throughout the delegate decision making process assessment delegates:

- Validate the assessment process
- Review the assessment evidence

> Note: It is important that assessment delegates check that an individual's eligibility for an aged care needs assessment is thoroughly documented and supported by evidence. The Corrections and Reconsiderations sections in Chapter 11 provide information on what assessment delegates should do if you have concerns about their eligibility for an aged care needs assessment.

8.2.2. Validating the assessment process

Assessment delegates must ensure that the correct assessment processes have been followed by the assessor. Section 62 of the Aged Care 2024 (the Act) *Undertaking aged care needs assessments*, sets out how an aged care needs assessment must be completed and the key components it must include.

In line with the Act, assessment delegates must confirm the assessment:

- Was completed by an approved aged care assessor.
- Was completed using the Integrated Assessment Tool
- Used the appropriate assessment tools.
- Has appropriately evidenced and aligned recommended funded aged care services with the older person's immediate care needs.
- Includes a discussion with the older person about:
    - What the assessment has identified in terms of funded aged care services.
    - How recommended aged care services may assist the older person to maintain their independence.
    - The older person's strengths and motivations in setting individualised goals.
    - The next steps in their application for funded aged care services.
    - Advising the older person how they will be informed of the outcome of their application, including the expected timeframe for receiving a notice of decision, and the support available to help them make appropriate linkages to services as required.
- Involves the registered support persons, if this was required and requested by the individual.

Assessment delegates can find further detail and guidance regarding best practice for the above steps in Chapter 5 *Assessment Activities* and Chapter 6 *Aged Care Programs* of this manual.

Note:

Supporting independence, autonomy, empowerment and freedom of choice.

During the assessment, the assessor must ensure the individual they are assessing is aware of their rights under Section 23 Statement of Rights of the Aged Care Act 2024 and support them to understand and empower them to exercise these rights.

8.2.3. Review the assessment evidence

Assessment delegates must ensure that all assessment information and documentation submitted by the assessor is accurate, relevant, and of high quality.

Assessment delegates must carefully examine the documentation to confirm:

- It provides a thorough and clear record of the entire assessment process.
- It demonstrates the assessor's reasoning.
- The evidence presented adequately supports their recommendations for aged care services.

Assessment delegates may return the support plan to the assessor if it lacks sufficient detail, contains errors, or includes inconsistencies. When doing so, delegates must clearly outline the required amendments and ensure that appropriate quality assurance checks are completed.

Note: once the 'Finalise IAT' button is selected, the IAT becomes locked and cannot be edited by either the assessor or the delegate.

Once the revised documentation is resubmitted, Assessment Delegates must conduct a final review to check that it meets the required quality standards before granting final approval. To support continuous improvement, Assessment Delegates should provide assessors with constructive feedback that promotes best practices and helps them understand and meet documentation expectations.

8.2.4. Assessment information and evidence

Assessment information and evidence should include all relevant documentation that supports the recommendations and decisions made throughout the assessment process. The assessment documentation must include:

- Consent
- Integrated Assessment Tool and Validated Assessment Tools
- Emergency Residential Care - Application for Care Form (where applicable)
- Additional Evidence
- Support plan and Recommendations
- Referral Information

Assessment Delegates must ensure that the assessment information contains comprehensive information to support the justification of the assessor's recommendation for funded aged care approvals. The following sections provide further detail on the requirements and how to ensure the evidence is sufficient.

Support plans

Under the Aged Care Act 2024 (the Act), two key types of reports are required when assessing an individual's eligibility and needs for aged care services: the Assessment Report (as per Section 63) and the Classification Report (as per Section 77).

In practice, these reports comprise the support plan and the finalised Integrated Assessment Tool (IAT) respectively.

The support plan and its associated areas of concern, goals, and recommendations are among the most important pieces of needs assessment documentation available to the Assessment Delegate. The support plan helps determine whether to approve an individual for access to aged care services and must contain all relevant information from the older person's aged care needs assessment.

It is essential that the assessment summary is written clearly and succinctly, following the ISBAR format−Introduction, Situation, Background, Assessment, and Recommendation in Chapter 5.

Particular emphasis should be placed on the Assessment section, as it typically forms the most substantial part of the summary. This section should comprehensively detail the findings of the assessment, providing a clear and accurate reflection of the individual's needs and circumstances.

The support plan must be consistent with the information collected using the IAT and any other relevant information gathered during the assessment, such as GP health summaries. The assessment summary should clearly inform the goals, recommendations, and any areas of concern outlined in the support plan. These elements should reflect what the person is concerned about, what they hope to achieve or change, and how funded aged care services can support them in addressing their needs and aspirations. Any cultural considerations or preferences expressed by the older person during the assessment or identified through the information gathering process should also be captured within the support plan to ensure culturally appropriate services are delivered. E.g. Whether older Aboriginal and Torres Strait Islander people would like to receive services from First Nations providers.

It is crucial that support plan recommendations are not just presented as a list of needs without context or explanation. Instead, the document should include clear elaborations on how each identified need was assessed and how this assessment informs the recommended care interventions or services.

When reviewing a support plan, assessment delegates should consider the following questions to ensure the documentation is thorough and meaningful:

- **Why is the person having a needs assessment?** - The support plan should clearly articulate the purpose of the assessment. Look for background information that explains the circumstances leading to the referral and the rationale for undertaking the assessment.
- **What are the older person's identified needs?** - Confirm that the support plan provides a comprehensive and evidence-based description of the older person's

needs. This should encompass physical, medical, psychological and social domains as identified through the IAT and other validated assessment tools.

- **What types of support are required, and why?** - Ensure the support plan outlines the specific supports recommended along with a clear justification for each. These should be directly linked to the older person's assessed needs and supported by relevant evidence.
- **What barriers are limiting the older person's independence?** – Assess whether the support plan identifies any factors, such as cognitive impairment, physical limitations, or safety risks; that prevent the older person from performing tasks independently. These barriers must be clearly connected to the recommended supports and services.
- **What are the older person's concerns and priorities?** - Ensure the support plan accurately reflects the older person's concerns, perspectives and priorities. These may relate to safety, daily living, mobility, or social participation and should be acknowledged and addressed appropriately.
- **What goals does the older person wish to achieve with support?** – Verify that the support plan includes the older person's goals and desired outcomes. Ensure recommended supports align with these goals and demonstrate respect for the older person's autonomy, preferences and aspirations.
- **Are the recommended supports appropriate and proportionate?** - Evaluate whether the recommended services are reasonable, tailored to the older person's current circumstances and likely to achieve the intended outcome.

Once finalised, the support plan is sent to the older person, and their registered supporter/s and/or appointed decision makers as applicable, 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 essential.

Referral information

The support plan will contain referral codes for services that have been approved and listed in the Notice of Decision letter, except where the referral code has not yet been issued.[6] or used to action a referral. Referral information is a vital component of the older person's record and typically consists of documents and notes gathered from various sources during the initial screening, triage, and assessment process.

In most cases, referral information will be attached to the older person's record or documented as 'client notes' within the My Aged Care assessor portal.

It is essential to use referral information when making a decision, as it provides important context and justification for any recommendations made.

Record of consent

Assessment Delegates must ensure that consent has been properly recorded in the system before making any approval decisions.

Consent is a mandatory part of the assessment process and must reflect that the older person—or their appointed decision-maker—has agreed to the assessment and referral to services. This protects older person's rights and ensures decisions are made in accordance with legislative and procedural requirements.

[6] At the time of delegate approval, the referral code will not yet be available when the older person is awaiting funding through the Support at Home, AT or HM Priority Systems.

Application for Care form

Older people seeking access to funded aged care services will not be required to complete an Application for Care Form. The act of applying for access to services will commence through one of the existing registration pathways (i.e. the My Aged Care contact centre).

However, older people seeking access to residential care and emergency respite care will be required to complete an *Emergency Residential Care - Application for Care Form*. This form is used by providers and must be completed and uploaded to the older person's My Aged Care Record, to confirm when they commenced receiving services.

Triage Delegates must review the 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.

See the section titled *Further guidance Application process for people who have received aged care services but not yet applied for an assessment under My Aged Care* at the end of this chapter for more information.

Integrated Assessment Tool (IAT) and Validated Assessment Tools (VaTs)

The IAT and its VATs is the prescribed tool that assessors must use under s62-5 of the Rules. 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.

Assessment delegates must evaluate the information captured in these tools to determine an older person's eligibility for aged care services. This means cross-referencing the assessor's recommendations with the data recorded in the IAT to ensure the decision aligns with the support plan and matches the level and type of care identified during the assessment process.

If assessors choose to use any additional VATs beyond the IAT, assessment delegates must ensure they are uploaded as attachments to the 'client record'. This is essential for maintaining complete documentation.

Additional evidence

Assessment evidence can come from a range of sources, including letters or emails from health professionals such as geriatricians, GPs, or social workers. Additional useful documents might include written information from family or friends, GP medical summaries, completed AT-HM tier guide, hospital discharge summaries, and correspondence from current service providers, Care Finders, Elder Care Support workers, government or non-government agencies, or others involved in the older person's care. These documents offer valuable insights into the older person's needs and may help identify the type and urgency of required care and support.

Assessment organisations may also hold regular delegation meetings to review assessed individuals and ensure a multidisciplinary approach has been applied. These meetings help guide assessors in making well-informed recommendations before support plan submission and support assessment delegates, in fully understanding an individual's aged care needs, enabling accurate and informed decision-making.

Note:

If Assessment Delegates have any concerns about the quality or completeness of the evidence provided, it is important they discuss these with the assessor before proceeding with approvals. Assessment Delegates may also involve a manager or team leader in this discussion, if necessary, to ensure that all aspects of the assessment are properly addressed.

8.3. Approving home support

8.3.1. Step 1. Decide if the older person is eligible for home support

Before approving a recommendation for the home support service group, the Assessment Delegate first needs to decide if an older person requires and is eligible to access this service group.

During the assessment, once the IAT is finalised, the IAT Outcome will generate a recommendation for the older person to receive ongoing home support through the Commonwealth Home Support Program (CHSP) or Support at Home (SaH). It may also recommend 'ineligible for CHSP/SaH'. As such, the IAT Outcome will guide the Assessment Delegate to determine whether the older person is eligible for ongoing home support through CHSP or Support at Home.

Note: An IAT Outcome of 'ineligible for CHSP/SaH' means that the older person has not met the minimum threshold to receive ongoing home support through CHSP or Support at Home.

8.3.2. Step 2. Decide the classification type and level

The IAT Outcome includes a service group (care type), classification type (duration) and classification level (funding). For example, a person who has been assessed as needing access to ongoing home support services under Support at Home, the approval will be the following:

- **Service group:** Home support
- **Classification type:** Ongoing
- **Classification level:** SAH class (1 to 8)

Section 81-10 of the *Aged Care Rules 2025* provides criteria that an older person must meet to be approved access for ongoing home support through CHSP or Support at Home. These criteria are based on a defined set of rules that has been built into the IAT to generate the IAT Outcome. This means that the IAT Outcome will determine whether the older person meets the criteria in section 81-10 of the Rules and the classification level (funding) for ongoing home support.

Chapter 5 provides guidance to assessors to accept the IAT Outcome if they are intending to recommend ongoing home support services through CHSP or Support at Home. Before approving any recommended classification level, assessment delegates must ensure that the classification level recommended by the assessor is the same as the classification level generated by the IAT Outcome. The system-generated recommendation is labelled 'IAT outcome', and the assessor's recommendation is labelled 'Recommended classification'. If these two values are different, then the assessor has overridden the IAT outcome.

In instances where the assessor has overridden the IAT outcome to another ongoing home support classification (e.g. SaH class 4 to SaH class 5, CHSP to SaH class 1, 'ineligible for CHSP/SaH' to CHSP), the delegate must disagree with the assessor's recommended classification level and edit it to the classification level recommended by the IAT Outcome.

Note:

It will be necessary for the assessor to override a CHSP/SaH classification (or accept in the case of an 'ineligible for CHSP/SaH) generated by the IAT Outcome to recommend the following pathways.

-SaH Restorative Care Pathway,

-SaH End of Life Pathway,

-Transition Care Program without ongoing in-home services,

-Permanent Residential Care without ongoing in-home services,

-Residential Respite care without ongoing in-home services.

Approving CHSP services alongside Support at Home classifications

Under the Aged Care Act 2024 (the Act), an older person cannot be approved for the Commonwealth Home Support Program (CHSP) class at the same time as any Support at Home (SaH) classification level (SaH class 1-8, SaH Restorative Care Pathway or SaH End-of-Life Pathway).

In limited circumstances, SaH participants can access additional CHSP services and assessors can issue referrals for CHSP services for individuals with a SaH classification.

See tables 27 and 28 in Chapter 6 for further details about when an individual with a Support at Home classification can be approved to access CHSP services.

Approving the SaH Restorative Care Pathway

Each financial year, 20,000 Restorative Care units of funding will be available nationally, distributed across four quarters at approximately 5,000 units per quarter. These units of funding are limited and must be carefully allocated to ensure the pathway remains sustainable and appropriately targeted to individuals with short-term restorative care needs. Assessors will be able to recommend Restorative Care Pathway (RCP) regardless of the caps on units of funding. The Assessment Delegate may not approve this recommendation if RCP units of funding have run out.

For SaH participants receiving ongoing services at the time the RCP is approved, the RCP episode can be accessed concurrently with their ongoing services. This allows individuals to

continue using their ongoing services while also receiving additional, clinically focused services through RCP.

However, it is important to ensure that services provided under RCP are complementary to ongoing services. The restorative care partner and ongoing care partner should ensure coordination of services to achieve this.

Services delivered through RCP should focus on reablement and allied health and/or nursing interventions—aimed at improving function and independence, rather than duplicating routine or maintenance care.

For those already accessing ongoing care, assessors should carefully consider ongoing needs before recommending RCP. Assessors cannot recommend a new higher classification and the RCP at assessment. This will impact a new ongoing classification entry into the SaH Priority System.

For new individuals being assessed for SaH and considered for RCP, eligibility for ongoing services will need to be determined at the end of the RCP episode. Individuals cannot be simultaneously approved for both RCP and an ongoing SaH or CHSP classifications at the time of assessment.

When selecting the RCP, an assessor will not be able to select a new ongoing classification.

For those accessing ongoing services, an assessor may select a new ongoing SaH classification OR RCP. If RCP is selected, the person will automatically retain their current classification.

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 by the IAT to override and recommend RCP for approval.

To recommend the RCP classification, the individual must have received an initial ongoing SaH classification through the IAT Outcome. This is then overridden by the assessor to recommend the RCP.

Participants assigned to the RCP who have an assessed need for AT and or HM will be allocated AT-HM funding immediately.

After a restorative care episode, a participant will undertake a reassessment to get an approval for an ongoing classification and be placed in the SaH prioritisation system, if required.

Approving restorative care - guidance for assessment delegates

An assessment delegate is responsible for approving access to the Restorative Care Pathway (RCP). The assessment delegate can only approve someone for RCP if all eligibility criteria are met. They may consider if places are available for allocation. The assessment must clearly show that the individual is likely to benefit from short-term, multidisciplinary allied health and/or nursing support aimed at improving their function and independence. An assessment delegate must make sure that their decision is backed by appropriate evidence.

> Note: To be approved for the RCP, the person must not be residing in permanent residential care at the time of the assessment; the older person must be residing in the home or community setting. The older person should also not be in hospital.

The assessment delegate is also responsible for making sure all decisions follow pathway rules, including:

- The person has not already been approved for two units of funding for Restorative Care in the past 12 months
- It has been 90 days from the maximum period of effect from a previous episode of Restorative Care.
- For the relevant transition period, delegates should also confirm if a person has accessed RCP through a Short-term Restorative Care (STRC) approval to determine eligibility for further RCP funding units.

If an additional unit of funding is requested through a support plan review (SPR), the assessment delegate must ensure that the documentation clearly explains the reason, how it links to the person's goals, and that evidence is provided to support your decision. The assessment delegate's role in reviewing and approving these cases is essential to making sure the RCP is used fairly, consistently, and in line with the pathway's goals of early intervention and reablement. Availability of RCP units may also be considered.

If the participant is accessing two separate episodes of restorative care, they will need to wait at least 3 months from the end of the 16 weeks period associated with the original episode before being eligible to receive a second episode within the 12-month period.

An RCP recommendation may not be approved due to no RCP places being available for allocation. The assessor may contact the older person to discuss alternative supports for recommendation.

> Note: Decisions made about RCP through the IAT are made under s65 and s78 which are reviewable decisions under the Act. Decisions made about the additional unit of Restorative Care Pathway funding through an SPR are made under section 195-3 of the Rules and are not reviewable.

Eligibility considerations and exclusions

An individual **cannot** access the Restorative Care Pathway (RCP) if they:

- Are receiving, or are eligible to receive, the End-of-Life Pathway
- Have been approved for two episodes or two separate units of Restorative Care funding within the past 12 months or have recently accessed Restorative Care (a 90

day gap is required from the end of the 16-week period associated with the first episode of care).

- Are receiving, or are eligible to receive, services under the Transition Care Program
- Are in permanent residential aged care.

Individuals who have been approved for the RCP may access services through Multi-Purpose Services Program or National Aboriginal and Torres Strait Islander Flexible Aged Care Program, if eligible for those programs and in-line with program rules.

Assessment delegates should be aware when a client who has an ongoing Support at Home (SaH) classification and is reassessed for the RCP there is no impact on the person's current ongoing SAH classification or position in the SaH System. A new ongoing SaH classification and RCP are unable to be recommended at the same time. Assessors and Assessment Delegates should consider a person's current ongoing needs before recommending the RCP episode. If an older person needs a new ongoing classification, they will need to be reassessed following the RCP episode.

Manual oversight of restorative care places

RCP places are capped at 20,000 units per year, managed as around 5,000 units per quarter. From 1 November 2025, system-based visibility of Restorative Care units will not be available. As a result, there will be no in-system prompts or controls to prevent the approval of RCP funding units beyond the quarterly caps. Twice-weekly reports of approvals made will be generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

In addition to RCP approvals confirmed after 1 November 2025, those with an active Short-Term Restorative Care (STRC) approval (who did not start STRC before 1 November 2025), will have their approvals transferred into an approval for RCP.

Note for this cohort using their STRC approval to access the RCP:

they 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 noting the assessor will need to self-refer this for reassessment to grant access to a second unit of funding (see Chapter 6).

The decision to approve a second unit will be informed by evidence submitted by the provider with the SPR request. Availability of the 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 they 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 restorative care pathway they must wait at least 12 months before accessing another episode.

Assessment delegates will need to remain acutely aware of any communication from the department regarding RCP caps to ensure they 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.

Restorative care funding

The Restorative Care Pathway (RCP) provides around $6,000 of funding (one unit), 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.

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 (two units), for a single episode of restorative care. If additional funding is approved, a participant will not be eligible for a further episode of restorative care within a 12-month period as they have accessed the maximum 2 units of funding within the first episode.

Important:

- The decision to approve additional concurrent funding to the RCP episode is made under subsection 195-3 of the *Aged Care Rules 2025 (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.
- The assessment delegate must send a letter to the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) notifying them of the outcome of the application for the additional funding.

Approving the End-of-Life Pathway

The End-of-Life (EoL) Pathway is one of the short-term home support classifications under the Support at Home program. It provides 12 weeks of funded support at around $25,000 for older people who are medically assessed to have three months or less to live and have an Australian-modified Karnofsky Performance Status score of 40 or less. The pathway is designed to enable people to remain at home with appropriate care during their final stage of life.

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 assessment delegate is 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
    - The individual has a prognosis of a life expectancy of three months or less, and
    - An Australian-modified Karnofsky Performance Status (AKPS) score of 40 or less.
    - 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.

8.3.3. Step 3. Decide the service types and services

Older person is Aboriginal and Torres Strait Islander

If the older person is an Aboriginal or Torres Strait Islander person, the *Aged Care Act 2024* (the Act) provides that they only need to be approved for one or more service groups. That is, under the Act they are automatically approved for all the service types and services in any service group they are approved for. However, an Assessment Delegate will still need to make sure that all the service types and services they are approved for are selected in the system (more guidance on this follows below).

Older person is neither Aboriginal nor Torres Strait Islander

If the older person is not an Aboriginal or Torres Strait Islander person, and an Assessment Delegate is approving the Home Support, Assistive Technology or Home Modifications service groups, they must decide:

- which service types to approve them for within each service group
- which services to approve them for, but only if the Assessment Delegate is approving the following 'prescribed' service types: *Allied health and Therapy* and *Therapeutic Services for Independent Living.*

For any service type other than *Allied health and Therapy* and *Therapeutic Services for Independent Living* (the 'non-prescribed' service types), if an Assessment Delegate thinks the older person needs any service in the service type, then they need to make sure that all services in the service type are selected.

Check to make sure the required services are selected

The system currently allows services to be de-selected in the non-prescribed service types, which leaves open the possibility that services the person is actually entitled to are left out.

Assessment delegates need to carefully check to make sure that the all the required services have been selected. This is particularly important for any approvals given under CHSP, as the services under the service type are not pre-selected in the system.

Recording the decision for Support at Home classes (ongoing and short-term)

This process applies if the approved classification level (labelled 'classification' in the system) is any of the following:

- SAH class 1 to 8
- SAH Restorative Care Pathway
- SAH End-of-Life Pathway.

> Note:
>
> The Support at Home AT-HM scheme is referred to as a 'short-term pathway'. Under the Act, the AT-HM scheme is enabled through the Assistive Technology and Home Modifications service groups. AT-HM can be added to an older person's support plan, if there is an assessed need, after adding one of the ongoing or short-term Support at Home classifications above.

Review CHSP service recommendations

Assessment delegates should review any CHSP service recommendations listed. If they disagree with any of them, they should contact the assessor to discuss and amend the list if required.

At the moment, assessment delegates are not able to record their agreement or disagreement alongside each CHSP service recommendation in the assessor portal. An assessment delegate's decision to agree with the recommended CHSP services must be recorded in the Notice of Decision. Step 4. Confirm the priority category

Access to the ongoing Support at Home classifications (SAH classification 1 to 8) will be prioritised using information collected during the assessment process and on the client's record, through the Support at Home Priority System.

An older person's priority category will be automatically determined by the system during their aged care needs assessment based on six different criteria and assigned one of four levels. The six criteria have 'points' allocated to them, and how many points an individual has determines their eligibility for the priority category.

The AT-HM scheme has its own priority systems and this is described further under the section *Approving AT and HM under Support at Home*, below.

The six criteria captured in the IAT or on the client's record that calculate the Support at Home priority category relate to whether the person:

1. lives alone (1 point)
2. identifies as Aboriginal or Torres Strait Islander (1 point)
3. has an assessed cognitive impairment (1 point)
4. is experiencing homelessness or is at risk of homelessness (1 point)
5. requires urgent ongoing service provision (2 point)

6. has waited more than six months from the day they applied to access services, or applied for reassessment and lives in a rural or remote area (in a Modified Monash Model category 5, 6 or 7 area) (1 point)

Although the system calculates priority automatically, Assessment Delegates should check the responses to the six fields above to make sure that the correct priority category is applied.

> Note:
>
> Assessment delegates will not know the priority category until after they click the 'Save and Delegate' button in the portal.

The four priority categories are as follows:

Table 46. Priority categories for ongoing Support at Home classifications

Urgent	The older person has five or more points.
High	The older person has four points.
Medium	The older person has two or three points.
Standard	The older person has one or no points.

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

8.3.4. Step 5. Confirm service seeking status (ongoing Support at Home classifications only)

As part of the assessment process, assessors are expected to have a clear conversation with the individual about whether they are seeking to receive services through the Support at Home program. This helps ensure the individual's current needs are met and supports fair and timely access to services for others. When individuals who are not actively seeking services through the Support at Home program remain on the Support at Home Priority System, it can cause delays for those who are ready and actively seeking services.

Before referring the client for services, the assessor should confirm with the client if they wish to seek home support from the Support at Home program and record their preference in the support plan:

- For clients seeking to access their ongoing home support through the Support at Home program, the assessor should set the service seeking preference for the ongoing SaH classification to 'seeking services'
- For clients not seeking to access their ongoing home support services through the Support at Home program, the assessor should set the service seeking preference for their ongoing SaH classification 'not seeking services'. The assessor should do this for clients who choose to access services through NATSIFACP or MPSP and so do not require services from a Support at Home provider. This option makes sure the client does not enter the Support at Home Priority System and so is not allocated funding under the AT-HM scheme.

If the older person later wants to use their ongoing SaH classification through the Support at Home program, they can change their preference and enter the Support at Home Priority System. Their wait time will be counted from their original access approval date of effect. That is, it will be as if they had stayed in the queue from their first approval. They can change their preference by:

- contacting My Aged Care
- using the My Aged Care Online Account.

Assessment Delegates are responsible for confirming that the client's preference−whether to seek or not seek services through the Support at Home program−has been accurately recorded in the support plan and that it aligns with their assessed needs.

8.4. Approving Assistive Technology and Home Modifications under Support at Home

This section relates to approving Assistive Technology (AT) or Home Modifications (HM) under the AT-HM scheme. The AT-HM scheme is one of the short-term pathways of the Support at Home (SaH) program. To be approved for the AT-HM scheme, the older person must also be approved for home support with a SAH classification level. A later section will show how to approve AT-HM when the classification level of the older person is *CHSP class*.

8.4.1. Step 1. Decide if the older person is eligible for AT or HM

Before approving a recommendation for AT or HM, an Assessment Delegate first needs to decide if an older person requires and is eligible to access one or both of these service groups.

Existing questions in the IAT will help to identify and determine an older person's need for AT or HM. For example, the purpose of the function section is to understand a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

As part of an Assessment Delegate's decision-making, they must consider whether the older person:

- has needs and goals that could be met through using assistive technology or home modifications, or both
- can have those needs met through the assistive technology or home modifications service groups, and therefore the products, equipment and home modifications on the AT-HM list.

8.4.2. Step 2. Approve the classification type and level (funding tier)

Assessment Delegates are responsible for approving the classification type (ongoing or short-term) and funding tier for AT and HM recommended by the assessor. Once approved, funding must be used within the 12-month period (in most instances).

A 'funding tier' for AT-HM has been implemented as a 'classification level' under the Aged Care Act 2024 (the Act). These funding tiers determine the maximum budget (except for AT high tier where there is no maximum budget) available and are valid for 12 months (in most instances) from the date the individual started care with their provider (as notified by the provider in the start notification for the person).

Individuals can access AT ongoing (assistance dogs) and short-term and HM tiers concurrently if needed and may be required to contribute financially depending on the category of support.

The cost of prescription and wrap-around services—such as delivery, setup, training, and follow-up—are also drawn from the AT-HM funding tier. Providers may charge:

- up to 10% of the cost of the item or item bundle or up to $500 (whichever is lower) on administration costs for AT.
- up to 15% of the total quoted cost of a participant's home modification or up to $1,500 (whichever is lower) on coordination costs for HM.

The AT-HM funding tier must align with the individual's assessed needs and be documented in their support plan. An Assessment Delegate's approval ensures appropriate funding allocation, program compliance, and timely access to essential supports.

Assessment Delegates must consider the costs of prescription and wrapround services when approving a funding tier.

An individual is not eligible for the AT-HM scheme if they are currently receiving permanent residential aged care.

AT-HM scheme funding tiers

If AT or HM are approved, individuals will be assigned a funding tier for AT, HM, or both - based on their assessed needs.

Table 47. Funding tiers for both AT and HM: Low, Medium and High

Funding tier	Funding allocation cap	Funding period
Assistive technology		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000[1] (nominal)	12 months
[1] Participants can access more than $15,000 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.		

An AT-HM tier guide has been developed to assist assessors to make a funding tier recommendation for assistive technology and/or home modifications 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 to support assessors in choosing a funding tier. The guide will suggest a funding tier which should sit where the majority of tier indicators have been selected. 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 Assessment Delegates to review as supporting evidence for any funding tier recommendations made.

The assessment delegate may also use the completed AT-HM tier guide, uploaded by the assessor, to review evidence related to the decision making process on allocation of a particular AT or HM funding tier.

See Appendix G for further information regarding the AT-HM Terms and Chapter 6 for AT-HM case studies

AT-HM list

The AT-HM list sets out the equipment, products and home modifications that are available for Support at Home participants under the AT-HM scheme. The AT-HM list sits under the main Aged Care Service list, which lists all other services and service types.

The list was constructed using the internationally agreed instruments and Australian-adopted AS/NZS ISO Assistive Product- classification and terminology standard (2023) and informed by subject matter experts.

Participants may use their AT-HM scheme funding on items listed under 'Inclusions' where an assessed need is documented in their support plan. Conditional inclusions are subject to additional criteria.

Home modification items are included on the AT-HM list. Services associated with the sourcing, supply and provision of the home modification products on the AT-HM list, such as installation, fitting, council approval and planning, will also be funded through the AT-HM scheme.

The AT-HM list includes 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
- 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 – aids 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

The AT-HM scheme guidelines

8.4.3. Step 3. Confirm the priority category

The AT-HM scheme has separate priority systems to the Support at Home Priority System, as the funding is separate. The AT-HM scheme has an Assistive Technology Priority System and a Home Modifications Priority System that allocate AT and/or HM funding. An older person assessed as eligible for AT and/or HM will enter the AT-HM Priority Systems in one of its four priority categories (immediate, high, medium, standard). The older person will not be able to access AT-HM under Support at Home until funding has been allocated. The amount of time they wait for services will depend on the priority category they are in.

The AT-HM Priority Systems ensure the equitable allocation of funding based on standardised criteria determined using information collected by the aged care assessor through the IAT.

The criteria captured in the IAT or on the client's record that calculate the priority category are:

1. Individual lives alone
2. Individual has an assessed severe mobility impairment
3. Individual is an Aboriginal or Torres Strait Islander person
4. Individual's current place of residence poses a severe risk to their health or safety
5. Individual has waited more than 6 months from initial referral and resides in a rural or remote area categorised under MMM5-7.

Individuals who are being approved for the Restorative Care or the End-of-Life pathways under Support at Home will have immediate access to any AT-HM funding allocated. Note that the system will display an AT-HM priority of 'High' in this scenario, but the funds are allocated immediately. Further information is available in the AT-HM scheme guidelines.

Although the system calculates priority automatically, the Assessment Delegate should check the responses to the five fields above to make sure that the correct priority category is applied.

Note the priority category will not be displayed until **after** you click the 'Save and Delegate' button in the portal. The Priority Category will be displayed under 'Approvals for a Client' in the My Aged Care Assessor Portal.

8.4.4. Step 4. Confirm service seeking status (AT-HM)

Assessment Delegates are responsible for confirming that the individual's preference—whether to seek or not seek AT-HM funding through the Support at Home program—has been accurately recorded in the support plan and that it aligns with their assessed needs.

Assessors are expected to confirm with the client if they wish to seek AT-HM funding from the Support at Home program and record their preference in the support plan.

For clients seeking AT and/or HM services through the Support at Home program, the assessor should set the AT and/or HM service seeking preference to 'seeking services'. This ensures that the older person is placed on the AT and/or HM Priority System(s).

- **For clients <u>not</u> seeking AT and/or HM services through the Support at Home program**, the assessor should set the AT and/or HM service seeking preference to 'not seeking services'. This option makes sure the client **does not** enter the AT or HM Support at Home Priority Systems, and so is not allocated funding under the AT-HM scheme. Relevant circumstances include when:
    - the client has chosen to access services through NATSIFACP or MPSP and so they do not require services from a Support at Home provider (or funding from the Support at Home program)
    - the client does not want to access AT and/or HM services at this time.

There are separate AT and HM Support at Home Priority Systems with independent 'service seeking' statuses for each. This means that if the older person is approved for both AT and HM, they may seek services through the Support at Home program for one, both or neither.

If the older person later wants to access their AT or HM services through the Support at Home program, they can change their preference and enter the AT or HM Priority Systems. The older person will need to be a Support at Home participant (for ongoing home support) to do this. Their wait time will be counted from their original access approval date of effect. That is, 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

Note:

Participants assigned to the Restorative Care Pathway or the End-of-Life Pathway who have an assessed need for AT and HM will be allocated AT-HM funding immediately.

8.5. Approving AT and HM under CHSP

This section relates to approving AT or HM for an older person who are also approved for ongoing home support with a classification level of CHSP class.

8.5.1. Understanding AT and HM under CHSP

Under the Aged Care Act 2024 (the Act), AT and HM services will continue to be available to older people under the CHSP. The relevant service types will be:

- **Home adjustments**: subsidised home modification services will continue to be available through the CHSP. CHSP home modification funding will be aligned to Support at Home and will increase the subsidy from $10,000 to $15,000 per annum.
- **Equipment and products (replacing GEAT):** low-cost equipment and products will continue to be available through the CHSP, with support of up to $1,000 per year in total and not per item.

Under the Act, eligible people will be approved for:

- the home support service group with a classification level CHSP class, and
- the assistive technology service group with a classification level of AT CHSP or
- the home modifications service group with a classification level of HM CHSP.

There is only one funding level for AT or HM under CHSP – there are not multiple funding tiers as there are under the Support at Home AT-HM scheme.

The Notice of Decision template (described in detail later) will prompt you to ensure the correct approvals are included.

8.5.2. Step 1. Decide if the older person requires AT or HM under CHSP

Before approving a recommendation for AT or HM, Assessment Delegates first need to decide if an older person requires and is eligible to access one or both of these service groups.

Existing questions in the function section of the IAT will help to identify and determine an older person's need for assistive technology or home modifications. The purpose of the function section is to understand a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

When reviewing the assessment and IAT, Assessment Delegates will need to consider whether the older person's:

- needs and goals that could be met through using assistive technology or home modifications
- can have those needs met through the services under Assistive Technology and Home Modifications

8.5.3. Step 2. Review service recommendations for AT or HM under CHSP

Service recommendations represent referrals that can be made through the Assessor Portal to Commonwealth-subsidised aged care services.

Review the service recommendation details for CHSP Assistive Technology and CHSP Home Modifications including:

- service type and service (sub-type) – if applicable
- start, end and review dates – if applicable
- frequency, intensity
- priority
- outcome.

8.6. Approving permanent residential care

8.6.1. Step 1. Decide if the older person requires ongoing residential care

Permanent residential care is delivered through the service group residential care and an access approval for the ongoing classification type. It is provided by registered providers in approved residential care homes.

Before approving a recommendation for residential care, Assessment Delegates first need to decide if an older person requires and is eligible to access this service group.

There is one key point to remember when deciding on access for non-Aboriginal or Torres Strait Islander people. **Section 68** of the Aged Care Act 2024 (the Act) requires these older people to have a continuing need for funded aged care services because of sickness in order to access the residential care service group. Assessment Delegates need to be satisfied, that the person's sickness at the time of assessment means that they have a continuing need for residential care.

8.6.2. Step 2. Confirm the priority category

To meet the requirements of the Act, an older person being approved for permanent residential care will be assigned a priority category (1, 2 or 3). The priority category is not currently being used to prioritise access to residential care.

Table 48. Priority categories for permanent residential care

Category #	Description
1	The person: • has a high urgency rating; or • resides in a rural or remote area classified as MM 5, MM 6 or MMM 7; or • is Aboriginal or Torres Strait Islander, homeless, or is entering residential care due to emergency circumstances.
2	The person does not meet the criteria for Priority Category 1 and has a medium urgency rating.
3	The person does not meet the criteria for Priority Category 1 and has a low urgency rating.

The priority category is automatically generated by the assessor portal based on the individual's circumstances, urgency rating and in accordance with the criteria specified by the Aged Care Rules 2025 (the Rules).

Assessment Delegates need to verify that the urgency rating assigned to the individual accurately reflects their needs and are supported by the evidence provided.

8.6.3. Urgency rating for residential care

A person's urgency rating is different to their need for residential care.

When selecting Residential Permanent assessors will be required to give a response to ' What is the urgency of this care type'. This question is a mandatory question with a rating to be selected from high, medium or low.

The Rules specify when an urgency rating of low, medium or high will apply to an individual in relation the classification type ongoing for residential care. The table below summarises the criteria for each urgency rating.

Table 49. criteria for urgency ratings for residential care

Urgency rating	Description
High urgency	**This rating applies if:** • The individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk. **Indicators**: Recent falls, hospital admission, unsafe to return home, severe decline. **Example**: A client in hospital post-fall who lives alone and whose needs exceed Home Care supports.
Medium urgency	**This rating applies if:** • The circumstances for a high urgency rating do not apply to the individual; and • When considering the individual's circumstances and preferences, the individual is expected to seek access to permanent residential care within the next 6 months. **Indicators**: Declining function, rising carer stress, complex but not urgent risks. **Example**: A client with moderate incontinence and cognition issues whose carer is overwhelmed.
Low urgency	**This rating applies if**: • The circumstances for a high or medium urgency rating do not apply to the individual. **Indicators**: Some decline, minor falls, current supports are working, client prefers to delay move. **Example**: A client managing at home with informal support but thinking about future needs.

> Note: The urgency rating reflects how soon an individual needs residential care to avoid significant risk to their health or safety. This is separate from whether they *require residential care* or have *high-level care needs*—it's about the *timing* of that need.

Assessors are expected to select the rating which balances objective consideration of needs with the subjective perspective of the older person and/or appointed decision maker/s. Assessors should include a brief note in the *reason or comments* section explaining key reasons for the rating. See Chapter 6 for more information.

8.7. Approving residential respite care

8.7.1. Step 1. Decide if the older person requires short-term residential care

Like permanent (ongoing) residential care, residential respite is delivered through the service group residential care. Access to residential respite requires an access approval for the short-term classification type. It is provided by registered providers in approved residential care homes.

Before approving a recommendation for residential care, assessment delegates first need to decide if an older person requires and is eligible to access this service group.

There is one key point to remember when deciding on access for older non-Aboriginal or Torres Strait Islander people. **Section 68** of the Aged Care Act 2024 (the Act) requires these older people to have a continuing need for funded aged care services (including nursing) because of sickness in order to access the residential care service group. This requirement is also applicable to time-limited approvals including residential respite care. As an Assessment Delegate approving an individual for residential respite care assessment, they need to be satisfied that an older person's sickness at the time of the assessment means they have a continuing need for residential care including nursing services for a limited period of time.

Residential respite care is provided on a temporary basis within an approved residential care home. It is intended to give either the individual or their carer a short-term break from ongoing care responsibilities. Residential respite should only be recommended and accessed when there is a genuine short-term requirement for care. It is important to note that residential respite care is not a substitute for aged care rehabilitation or restorative care services.

Individuals approved for residential respite care are entitled to up to 63 days per financial year, with a possible 21-day extension under the Aged Care Rules 2025. These respite days do not need to be taken all at once and can be used flexibly throughout the year. Note that these timeframes do not apply where services are accessed under a specialist aged care program.

8.7.2. Step 2. Decide the classification level

When recommending an individual for residential respite care, assessors should complete the De Morton Mobility Index – modified (DEMMI-modified) assessment. This tool assesses

the individual's mobility and determines their eligibility for one of three respite funding classes: Respite class 1, Respite class 2, Respite class 3, based on the level of mobility observed.

The DEMMI-modified assessment is available within the IAT, but can only be used as part of a Comprehensive Assessment, as it must be completed by a clinically trained assessor that has completed the DEMMI-modified training.

It is a Clinical Assessment Delegate's responsibility to ensure that the DEMMI-modified has been accurately completed.

If the DEMMI-modified assessment cannot be completed at the time of assessment, the individual will be temporarily assigned a default funding class (Class 0). This classification remains in place until a formal Residential Aged Care funding assessment is carried out within the residential aged care home, at which point the appropriate funding class can be determined based on the individual's assessed mobility.

8.7.3. Extensions for residential respite

Assessment Delegates may receive requests for a 21-day extension to residential respite care – for example, when a carer is unwell or temporarily unable to resume their care responsibilities. There is no limit to the number of extensions that may be granted beyond the standard 63 days of respite care per financial year.

Typically, the residential aged care provider submits the extension request via the My Aged Care Service and Support Portal, and an assessment organisation receives it through the Assessor Portal for an Assessment Delegate's action.

It is the responsibility of the assessment delegate to review the request and either approve or decline it. Once a decision is made, the Assessment Delegate must communicate the outcome to the provider.

An assessment delegate will need to be satisfied that an increase in the number of respite days was necessary due to any of the following:

(a) carer stress

(b) severity of the individual's condition

(c) absence of the individual's carer

(d) any other relevant matter (for example, where a provider delivers an episode of respite care in good faith but subsequently finds out the care recipient's allocation of respite days had already been exhausted).

Please note, there is no right of review if an extension request is declined.

Once decided, you must give written notice to the registered provider of your decision whether to extend within 28 days after the application was made. This written notice must include the day the decision takes effect, which may be before the day the decision is made.

Extensions are granted only at the previously approved level of care. If a higher level is needed, a reassessment and new approval by you (or another Clinical Assessment Delegate) is required before the extension can be granted

Managing residential respite care | Australian Government Department of Health, Disability and Ageing

8.8. Approving transition care

8.8.1. Step 1. Decide if the older person requires transition care

Available following a hospital admission, transition care is delivered under the service groups of home support, assistive technology and residential care**.**

The Transition Care Program (TCP) is designed to support individuals in the period immediately after discharge from hospital. It aims to facilitate recovery, improve functional capacity, and provide time and support in a non-hospital environment while long-term care arrangements are being considered. The 'non-hospital environment' may be a home or community setting, or a residential care home.

Transition care and the *Aged Care Act 2024*

Before approving a recommendation for transition care, Assessment Delegates first need to decide if an older person requires and is eligible to access to one of the relevant service groups.

Please note section 68 of the Aged Care Act 2024 (the Act) (relating to 'people who are sick') applies to approving transition care in the same way it applies to approving residential respite care. Section 67 of the Act (relating to people who have a disability) also applies to approving people for transition care in the same way as it applies to approving people for home support (under the Support at Home program or CHSP) and assistive technology (under the AT-HM scheme or CHSP).

To access hospital transition care, an individual must first undergo an aged care needs assessment following a hospital admission. If it is decided they require and are eligible for hospital transition care, under the Act Assessment Delegates must approve them for:

- the classification type hospital transition for all three of the following service groups: home support, assistive technology and residential care
- the service type assistance with transition care under the home support service group
- all service types that can be delivered through the Transition Care Program, as specified in sections 50, 53 and 62 of the Aged Care Rules 2025
- the corresponding classification level for each of the service groups approved: *HS HT class* for home support, *AT HT class* for assistive technology and RC HT class for residential care.

If the support plan includes a recommendation for TCP, the Notice of Decision template the assessment delegate generates in the Assessor Portal will include wording covering all the required approvals listed above. The table below summarises the service group,

classification type and classification level approvals given whenever an older person is approved for transition care through TCP.

Table 50. Summary of approvals under the Act for hospital transition care

Service group	Classification type	Classification level
Home Support	**Hospital transition**	HS HT class
Assistive technology	**Hospital transition**	AT HT class
Residential Care	**Hospital transition**	RC HT class

Access to transition care

Transition care is time-limited, with individuals allocated a funded period of 12 weeks to access services under the program. However, if the individual's recovery requires additional time, the service provider can apply for an extension.

The Transition Care Program is defined under the Aged Care Act 2024 as a specialist aged care program. The number of places available for this care type is determined by the Minister, based on state and territory needs. Only registered providers are permitted to deliver hospital transition care using these allocated places.

Importantly, to be eligible for the program, the individual must be:

- medically stable at the time of assessment; and
- is in the concluding stage of a hospital episode; and
- has the potential to benefit from accessing services delivered through the relevant service group under the TCP; and
- at the time the assessment was carried out, a hospital inpatient.

It is an assessment delegate's responsibility to confirm medical stability before approving access to the program.

Once an individual is approved for hospital transition care, it is usual practice for hospital discharge staff to refer them directly to their local Transition Care provider, following delegated approval.

Accessing residential care/residential respite and transition care

A person in permanent residential care who is receiving Transition Care must take Hospital Transition Leave for the duration of their TCP episode. In addition, they are not eligible to receive services under the Restorative Care Pathway under Support at Home.

An individual receiving Transition Care is unable to access residential respite care while Transition Care is in effect.

Duration of Transition Care

The standard period for a transition care episode is 12 weeks (84 days).

This period may be extended by 6 weeks, so the total transition care episode is 18 weeks (126 days) if the individual makes an application in accordance with the requirements of the Rules and is determined to require access to the services for the additional period.

Transition Care Program Guidelines | Australian Government Department of Health and Aged Care Transition Care Program | Australian Government Department of Health, Disability and Ageing

8.8.2. Step 2. Record the decisions

When recording a decision to approve an individual for transition care, Assessment Delegates will be required to confirm a priority level for the care type. For transition care approvals, assessment delegates must ensure a priority level of 'high' is assigned to all approvals.

8.9. Other approvals and considerations

8.9.1. Alternative entry – giving approval after service commencement

Care, including urgent care, can be approved when assessment wasn't possible prior to accessing those services. Section 71 outlines that an individual can be approved for services even if an assessment was unable to be conducted prior to accessing those services if the individual applies within the specified period under the Aged Care Act 2024 (the Act) and the System Governor is satisfied that certain circumstances applied to the individual. Further information around this is detailed in Chapter 3.

If an assessment delegate is satisfied one of the alternative entry circumstances applies to an individual and that the other requirements under section 71 have been met, the Act allows the date of effect of approval to be set to the date care began. The Notice of Decision (approval letter) template includes wording to cover this scenario, to ensure that providers are paid from the beginning of service delivery. Delegates prompted by the system to enter a 'Delegation date' for their approval should always enter the actual day they make the decision, not the day when care began.

In most cases, individuals who have accessed a service prior to an assessment would have accessed this service through the My Aged Care contact centre urgent services pathway. Other circumstances may be emergency respite care and services provided by National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC) and Multi-Purpose Services Program (MPSP).

Services delivered before an assessment may not always be visible in the Notice of Decision (approval letter). Assessment delegates should always check the Support Plan in the Assessor Portal to view these services and be sure that they consider whether or not to approve these services.

Application process for people who have received aged care services and have not yet applied for an assessment under My Aged Care

NATSIFCAP and MPSP

Alternative entry pathways are available for individuals who commenced accessing specialist aged care services such as NATSIFACP and MPSP before an approval was given and at the time they were seeking access to services there was a significant delay in the availability of an approved needs assessor to conduct an assessment.

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). The service provider may help the client with completing/submitting the application. Unless an extension is granted by the System Governor, applications must be lodged within 30 days after the first day of care commencing. The application should include the date the individual began receiving care, ensuring appropriate alternate access dates are approved.

Residential care or residential respite care

Alternative entry pathways are available for individuals who require urgent residential care or residential respite care. To be eligible, at the time they accessed this care, there must have been 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 for access to residential care or residential respite care 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) or by submitting the *Emergency Residential Care - Application for Care* form (see below). The service provider may help the client with completing/submitting the application. Unless an extension is granted by the System Governor, applications must be lodged within 5 days after the first day of care commencing. The application should include the date the individual began receiving care, ensuring appropriate alternate access dates are approved.

If completing the *Emergency Residential Care - Application for Care* form, the form must:

- have both the Emergency application section and the provider details section of the form completed; and
- The provider may submit the form, including supporting information for referral to their local assessment organisation, within 5 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, active, appointed decision maker authorised under section 28(2) of the Act is unavailable, the registered provider may sign the form.

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.

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.

Intake and assessment process for an Emergency Residential Care – Application for Care

When the form is received, the assessment organisation must:

- Ensure the form is 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 System Governor, following an application for extension.
- Register and self-refer the older person in the My Aged Care Assessor Portal (if required and self-referral criteria are met).
- Assign intake priority. Although the person is already in care, the triage delegate must consider the urgency of the individual's circumstances. If the 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.
- Record the Emergency Care start date (for residential care or residential respite) before sending to the assessment delegate.
- 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.

Making a decision about alternative entry

Assessment delegates are responsible for determining whether an older person who commenced care before applying for approval can be approved under alternative entry. To do this, they must ensure that the application process meets all relevant requirements described in this content, including, that the older person is eligible for the type of care being provided, and that the care was urgently needed at the time it began. Assessment delegates must also be satisfied that it was not practicable to obtain approval before the care commenced (see circumstances described above). The decision must be based primarily on the care needs of the older person at the time they entered care.

If care is approved under urgent circumstances, an assessor will need to update the My Aged Care assessor portal. This includes checking the *Emergency Care* flag and recording the date the older person entered care. Doing so ensures the registered provider receives the appropriate Commonwealth subsidy from the correct start date. An assessor will also send the referral to the provider via the portal, allowing them to access the older person's record and view all relevant approval details.

Assessment delegates should also be aware that this process applies in cases where the assessment has been completed but the older person passes away before a decision is made.

Not all circumstances qualify as urgent. Situations such as a bed becoming available in a residential aged care facility, or a transfer from an acute care setting to another care environment, do not meet the criteria for urgent admission. If an assessment delegate

determines that the older person did not urgently require care at the time of entry, but they are otherwise eligible, the application can still be approved, however the date of effect will be the date you make the decision.

The decision about whether to approve alternative entry dates for an older person is a **reviewable decision** under section 557 of the *Aged Care Act 2024.*

Assessment delegates are required to record their justification for approving under alternative entry so that there is clear evidence of a person meeting one of the requirements under section 71.

Extensions

While it is best practice for providers to submit the *Emergency Residential Care - Application for Care* form−complete with the emergency case section−within the required timeframes of the older person entering care, the Aged Care Act 2024 allows an application for an extension of time under section 71 if this is not possible.

If the form is not signed and submitted within the required five-day timeframe, it is considered incomplete. In this case, the registered provider must first apply to the System Governor for an extension The delegation for granting extensions for those seeking access to funded aged care services through alternative entry will sit outside Assessment Organisations.

In considering an extension the System Governor will either decide to:

- Approve the application and determine a longer period for the individual, or
- Reject the application

As soon as practicable after a decision has been made, the System Governor must provide notice of their decision. Included in the notice will be the reasons for the decision and how to apply for a reconsideration of the decision.

Where the older person has not made their application in the required timeframe, an extension may be granted by the department. In these instances, please email a request for an extension to AssessorSupport@health.gov.au. Please include a brief explanation on the reason for the extension.

If an assessor believes the older person urgently needed care but the approval is already recorded in My Aged Care with a later date, they must initiate the **corrections process** to backdate the approval. If the required backdating exceeds **42 days**, a correction cannot be made, and a reassessment is required.

8.9.2. 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.

In a case where the older person has passed away, assessors should follow the *Client Deceased Before Assessment* process available through the My Aged Care assessor portal.

This ensures the approval is properly recorded in the system and automatically submitted to **Services Australia**.

If there are complications preventing the use of the online process, an assessor should consult their Team Leader for advice. Do not cancel the assessment in My Aged Care using the reason ‘client deceased’. This action changes the older person’s status to ‘deceased’ and locks the record as read-only, preventing an assessment delegate from recording an assessment decision.

If the record has already been locked, the assessor must contact the My Aged Care Service Provider and Assessor Helpline (1800 836 799) to temporarily reactivate the record so the assessment outcome can be recorded. Once the decision is entered, the status must then be changed back to ‘deceased’ to reflect the older person’s passing.

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.

9. Chapter 9: Finalising the assessment and service referral

What you'll find in this chapter

This chapter includes guidance about:

- finalising the assessment
- recording and communicating the assessment outcome
- referring the older person for services, and supporting them to access 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).

9.1. Overview of assessment finalisation

An assessment is finalised when:

- the assessment and support plan are completed; and
- all required decisions have been made and recorded by the Assessment Delegate; and
- when effective referrals have been made or the older person has decided not to proceed with accessing aged care services, and
- the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) has been notified of the assessment outcome.

An effective referral is where:

- a referral is accepted by a service provider who can deliver a service response consistent with the relevant service recommendations on the older person's Support Plan, **or**
- the older person has accepted responsibility for managing their own referral(s) through a referral code, **or**
- the outcome of the assessment is that no further action is required by the assessor; **or**
- the assessor has made all available and reasonable efforts to connect the older person with a service provider appropriate to their assessed care needs.

For older Aboriginal and Torres Strait Islander people, FNAO assessors may facilitate the client's entry into aged care or refer the client to an Elder Care Support worker to assist the client to connect with services after the assessment is finalised.

When the Support Plan is finalised and effective referral has been made, the assessor should inform the older person to contact their provider, ECS worker or the My Aged Care contact centre if there is a future change in needs, goals, or preferences. If within their remit, the My Aged Care contact centre will assist the older person with their enquiry. This could include re-issuing a referral code or if a referral is rejected, sending a referral to another

provider. The contact centre or the provider can send a support plan review request to the assessment organisation if it is an appropriate request.

Where appropriate, assessors are encouraged to follow up vulnerable or at-risk older people post-assessment who:

- have referrals that have been rejected/not actioned - this may include the monitoring of referrals to services or negotiating with service providers for the provision of alternative services if necessary,
- are working on short-term reablement goal(s) – in line with the length of time stipulated in the Support Plan, and/or
- are vulnerable older people, as determined by complexity indicators or need for linking support and required short-term linking assistance purpose of implementing the Support Plan.

After finalising the assessment, where the department becomes aware that an older person is having difficulty with accessing services, an assessment organisation may be required to follow up with the older person or service provider and provide advice on any follow-up action/s taken.

9.2. Setting the access approval date of effect ('delegation date')

For an older person's application, the access approval date of effect that Assessment Delegates decide applies to all of the following decisions under section 65 of the Aged Care Act 2024 (the Act):

- the service groups, and the classification types for those service groups
- the service types (and services if applicable).

Unless the older person is being approved for CHSP only via a Home Support Assessment, Assessment Delegates record this date in the Assessor Portal after giving responses to all of the care recommendations. In the 'Save decision and delegate' popup, the Delegate should enter the day that they are making the decision (that is, that day's date) and click 'Save decision.' Note that even if the older person has received services before assessment (using the alternative entry provisions under Section 71 of the Act), the Assessment Delegate should still enter the date the decision is made - not an earlier date.

There is wording in the Notice of Decision (approval letter) relating to alternative entry scenarios and the access approval date of effect.

For emergency residential care or residential respite, the assessor is required to record the date care began through the "Emergency Care Start Date" flag in the Integrated Assessment Tool. This date will allow the service provider to claim for the days prior to the delegation start date. The Assessment Delegate should check this to ensure that the correct date is recorded in this field before proceeding with their decision.

9.3. Recording and communicating the assessment outcome

A critical record of the assessment outcome is the Notice of Decision (NoD). Note that the NoD is referred to as the 'assessment outcome letter' in materials and website content for older people, and is labelled as the 'approval/non-approval letter' in the assessor portal.

The older person (and registered supporter/s and/or appointed decision maker/s, if applicable) should be sent the following documents in hard copy via post:

- the NoD
- the finalised Support Plan
- the referral code letter (at a minimum for older people who have been approved for CHSP services)
- any relevant aged care consumer information not provided at the time of the assessment
- the older person satisfaction survey of the organisation's performance requirements
- other associated notification documents.

The assessor must:

- call the older person once the NoD is finalised to notify them that their assessment has been completed (where needed, FNAO assessors may also explain the letter to the older Aboriginal and Torres Strait Islander client)
- advise the older person that their Support Plan and NoD can be accessed via their My Aged Care Online Account (under 'documents' and 'plans' for the Support Plan) and their My Health Record (if the older person has consented)
- advise the client that if they have provided consent, their registered supporter/s are able to access these documents (via their own separate login information) to the client portal
- advise the initial referral source of the assessment outcome and referral outcome - if requested by the referrer and with the consent of the older person.

While it is considered good practice to offer an older person a hard copy of their Support Plan and relevant information, where this is not feasible for an assessment organisation, the minimum requirement is that the older person, and where relevant, registered supporter:

- is clear on what is in their finalised Support Plan and are agreeable to this and which Associate People it will be shared with,
- agrees to be provided a soft copy of the finalised Support Plan and if appropriate the referral code letter (noting that older people will receive a letter once they have been assigned a package), and/or
- is aware of how to obtain a copy of the Support Plan and relevant information via their My Aged Care Online Account.

9.3.1. Notice of Decision of assessment outcome

Assessment Delegates are required under the Aged Care Act 2024 (the Act) to issue a Notice of Decision (NoD) to the individual within 14 days of making a decision under subsection 65(1) or (2).

This supports the Act's rights-based approach by promoting transparency, accountability, and informed decision-making, and by ensuring individuals understand decisions that affect their care and access to aged care services.

The NoD must clearly communicate:

- the assessment outcome, including decisions to approve or not to approve access to services,
- the reasons for these decisions, and
- how the individual may apply for a review of the decision(s).

NoD requirements under the Act

For assessment delegates to meet their obligations under the Act, they must ensure that the notice sent to the individual satisfies the requirements of the Act. Assessment delegates can generate NoD templates in the Assessor Portal with most of the critical information pre-populated and which also includes guidance on how to complete a legally compliant letter. The NoDs must satisfy the requirements in the following sections of the Act:

- **Section 70:** notify the individual about the decision regarding their access approval, including information on the approved service group(s), and the classification type(s) for the service group(s), any service types, and funded aged care services, and the date the access approval takes effect. The reasoning behind the decision and how the older person can apply for a review of decision, if necessary, must also be clearly explained. The Reasons for Decision section in the NoD gives more information on what must be considered and included in the reasons.
- **Section 79**: inform the individual about the classification decision, including the classification level(s) for the approved service group(s), and when the classification level(s) did or will come into effect, and how they can apply for reconsideration if necessary.
- **Section 88:** If necessary, notify the individual about any priority category assigned to a classification type for a service group, clearly explaining the reasoning behind the decision and how they can apply for reconsideration if necessary. This is necessary in the scenarios listed in the table below.

Service group	Classification type
Home support	Ongoing (except when the classification level is 'CHSP class')
Assistive technology	Ongoing Short-term
Home modifications	Short-term

Residential care	Ongoing

- **Section 92(4):** If necessary, inform the individual of any place they have been allocated, and the day the allocation of the place takes effect.

When is a NoD required?

A NoD must be issued following an initial assessment, reassessment, and (in most cases) a support plan review (SPR). A NoD is required after all SPRs, except when the SPR:

- leads to a referral for a full reassessment, or
- only approves a second concurrent unit of funding for the Restorative Care Pathway[7], or
- transitions the person back to a previously approved ongoing Support at Home classification after an End-of-Life Pathway finishes, or
- is adding a service that is within a service type[8] that has already been approved *from the perspective of the Act*[9] unless the service is within one of the prescribed service types ('Allied health and therapy' or 'Therapeutic services for independent living').

Triage, alternative entry provisions and the NoD

If the older person does not meet eligibility requirements to receive an aged care needs assessment under Section 58 of the Act (i.e., at triage), the triage delegate should prepare a **Notice of Decision – Not eligible for assessment** letter and complete it in line with the instructions within the letter.

If a triage delegate makes a referral for urgent services through the alternative entry provisions under Section 71 of the Act (refer to section 3.2 of this manual), they do not need to generate a NoD at that point in the process. Once the assessment is complete, the assessment delegate will generate the NoD covering approvals for these services.

If the older person does not meet the eligibility requirements under Section 65 of the Act, they are not eligible to receive the service provided through an alternative entry pathway under section 71 of the Act. The assessment delegate must apply the Act's eligibility criteria when making their decision and, if required, not approve the service at the time of assessment.

[7] A separate letter is required in this instance – see section 9.3.2 below for more information
[8] The Aged Care Service List in Chapter 1, Part 3 of the *Aged Care Rules 2025* lists all the service types and services
[9]The older person's Support Plan may not list all of the services the older person is actually approved for under the Act. For example, if the older person's support plan shows they are only approved for the service 'Laundry services', they are actually approved under the Act for *all* the services in the service type 'Domestic assistance' – including 'General house cleaning' and 'shopping assistance'.

9.3.2. Notice of Decision templates

NoD templates can be generated in the My Aged Care Assessor Portal after assessment delegate decisions have been made and recorded. Much of the critical information is pre-populated and the templates include detailed guidance on how to complete a legally compliant letter.

There are two NoD templates:

i. **Approval letter**:
   - Used when the Assessment Delegate is approving access to any services – even if some of the services recommended have not been approved.

ii. **Non-approval letter**:
   - Used after initial assessment, when the assessment delegate is not approving the older person for access to *any services at all.*
   - After Reassessment or SPR when the assessment delegate is not approving the older person to access *any additional services.*

If a reassessment does not add any new approvals and existing approvals remain unchanged, the system will prompt the delegate to generate a non-approval letter only. This does not affect the client's current approvals. The non-approval letter simply confirms that no additional services were approved during the reassessment or SPR.

System generated NoD letters for CHSP only approvals

As part of the phased digital delivery process, both clinical and non-clinical assessment delegates were previously required to produce the NoD 'off-line' (without system automation) for CHSP only approvals.

Assessors can now generate or upload NoD letters directly in the My Aged Care assessor portal and the Aged Care Assessor App after completing a Support Plan with an Integrated Assessment Tool (IAT) outcome of CHSP or Ineligible for CHSP/SaH. Three buttons appear:

1. Generate Approval Letter – use this if the client is being approved to access CHSP services.
2. Generate Non-Approval Letter – use this if the IAT outcome displays 'Not eligible for CHSP/SaH' as the client is ineligible for ongoing home support services and/or the client is not being approved for any services.
3. Upload Approval/Non-Approval Letter - use this after you have generated and edited the relevant letter so that it is saved to the client's record.

The system auto-populates client and delegate details and shows placeholders if anything is missing. Reasons for decisions are now selected within the NoD template, and the clinical assessment delegate pop-up has been simplified so it only asks to confirm generation. Assessors and assessment delegates must update these letters in line with the instructions provided in the templates.

Ensure the NoD letter is generated before finalising the support plan. This enables an

assessment delegate to complete and sign the NoD prior to referral codes being issued to the older person or service providers.

Support Plan Reviews (SPRs) with an outcome of CHSP-only or ineligible for CHSP/SaH

SPRs with an outcome of CHSP-only or ineligible for CHSP/SaH have a slightly different process for generating the NoD Approval or Non-Approval letter than the assessment or reassessment process outlined above. Following an SPR there are no options to generate the NoD in system until after the SPR has been finalised.

Please refer to the resources below which can be found on the Assessment Hub SharePoint page:

- Manual Delegate Approval for CHSP - Standard Operating Procedure
- Your guide to changes to letters from 23 February 2026 - Video Slides

IMPORTANT

Despite this difference in process flow, it is essential that referral codes are not provided to the client before the NoD is generated. If referral codes are issued to the older person and/or providers before a NoD is finalised—and a NoD is subsequently not issued—this may invalidate the assessment outcome. The NoD is the formal legal instrument that records the System Governor's decision for a client to receive a funded aged care service, and it must always be generated before any referral codes are released.

9.3.3. Completing an NoD

To ensure the NoD is tailored to the individual and includes all required legal information, assessment delegates must:

- generate the letter from the My Aged Care Assessor Portal
- save the letter locally and make the necessary edits following the guidance text in the template
- clearly set out the reasons for their decisions (see following sections for further guidance)
- include the Commonwealth Coat of Arms and the My Aged Care logo
- **not** include any co-branding – logos of individual assessment organisations must not be included, as specified in the contractual agreements between the Department and individual assessment organisations.

To ensure the NoDs remain legally compliant, assessment delegates must follow the guidance provided in the Notice of Decision templates and associated departmental guidance materials.

Assessment delegates may only remove or amend text where explicitly directed by the department.

Detailed instructions for applying manual language changes are provided in the NoD Language Change Instructions included in email C206 — **Notice of Decision: Reminders and guidance update (including language changes)**, issued on 9 December 2025. These documents are also available on the Assessment Hub SharePoint page:

- Notices of Decision Guidance Update
- Notices of Decision Language Change Instructions

The previous offline CHSP NoD templates incorporated some of this updated wording; however, the new system generated NoD letters for CHSP only do not currently reflect these changes. Assessment delegates should therefore apply the approved wording manually across all NoD templates until system updates are released.

Delegates must use only the approved wording provided in departmental instructions to ensure NoDs remain legally compliant. All other text must remain unchanged.

9.3.4. Reasons for decisions

Assessment delegates must consider and record reasons for approval and non-approval decisions relating to service groups, service types or services. Assessment delegates must turn their mind to these reasons when making approval decisions and then record them in the NoD.

Delegate decision reasons must:

- demonstrate how the individual meets or does not meet the criteria for approval under the relevant sections 65–68 of the Aged Care Act 2024 (the Act),
- be tailored to the person's specific circumstances, drawing on the information provided in the IAT, support plan and assessment report,
- clearly explain (for approvals) how the individual satisfies the relevant eligibility criteria under the Act and the rules, with reference to their unique situation.
- The NoD templates provide detailed guidance on how to record reasons that fulfil these requirements. Chapter 8 provides a comprehensive explanation of the eligibility requirements set out under sections 65-68 of the Act and the relevant rules.

Reasons for decisions: approvals

When making a decision, assessment delegates must consider the older person's circumstances overall, what service types and services they need, and for what reason. This should already be evident from the information recorded in the IAT, and the support plan, which detail what the person's needs are, and why the person needs support and what help they need.

Reasons for approval decisions are recorded in the version of the NoD known as the 'approval letter'.

There are three reasons sections to choose from based on which section of the Aged Care Act 2024 (the Act) applies, the individual's circumstances and their approvals as follows[10]:

Table 51. Summary of approval reasons sections of the Act and applicable circumstances of individuals

Section of the Act	Approval reasons section	Applies when:
Section 66	Section A *(Section B and C not required if this is chosen)*	• the older person is Aboriginal or Torres Strait Islander
Section 67	Section B *(most complex to complete – more info below)*	• the older person is **not** Aboriginal or Torres Strait Islander, **and** • the older person has been approved for the **home support**, **assistive technology** or **home modifications** service groups
Section 68	Section C	• the older person is **not** Aboriginal or Torres Strait Islander, **and** • the older person has been approved for the **residential care** service group.

Section B is the most complex for the assessment delegate to complete. It includes a list of pre-defined reasons why an older person may need access to service types/services in the home support, assistive technology or home modifications service groups. An assessment delegate must choose the reasons that underpinned their decision to give access to these service types/services.

For further guidance, see *Specific reason/s why access is needed under Section 67* in Chapter 7, which includes a mapping of service types/services to potential applicable reasons.

Reasons for decisions: non-approval

If one or more approvals were recommended by the assessor and/or requested by the older person but were **not** approved, an assessment delegate must provide reasons why they did not to approve access to the service group, service type or service. Relevant situations are summarised in the following table.

[10] Note that an approval for the Transition Care Program (TCP) is an approval for three service groups under the Act: home support, assistive technology and residential care. An approval for TCP is always an approval for all three service groups, regardless of which TCP services are used.

Table 52. Summary of situations relevant to non-approval of recommend and/or requested approvals

Situation	Applicable Notice of Decision template
An initial assessment or reassessment/Support Plan Review where some of the services recommended or requested have not been approved (while others have been approved).	**Approval Letter**
A first assessment where the older person has been found ineligible to access to any services. A reassessment/Support Plan Review where no **additional** services have been approved.	**Non-Approval Letter**

For non-approval reasons an assessment delegate must: consider how the individual's circumstances relate to all the relevant eligibility criteria set out in the *Aged Care Act 2024* and the *Aged Care Rules 2025* for the particular service.

For an older person to be considered eligible for a particular service group, service type etc, an assessment delegate must be satisfied that **all** of the relevant eligibility criteria apply. If they do not meet all of the criteria – they cannot be approved.

The free text sections in the NoD template can be used to provide a brief summary of the reasons why the older person does not meet the eligibility criteria.

An assessment delegate must refer to the individual's unique circumstances and information in the assessment report (support plan). The assessment delegate must include details of how the individual's circumstances related to the eligibility criteria and therefore informed the decision not to approve.

The instructions in the NoD templates prompt the delegate when free text description is required. They also include example text to demonstrate the level of detail Assessment Delegates must provide when completing the free-text section for non-approval reasons.

The generated NoD account for the scenarios that are most likely to occur in practice. If the Assessment Delegate encounters a scenario that is not covered in the template, their Operational Manager can contact the department at myagedcare.assessment@health.gov.au for further guidance.

Reasons for decision – Transition Care Program

An approval for TCP is an approval for three service groups under the Act: home support, assistive technology and residential care. An approval for TCP is always an approval for all three service groups, regardless of which TCP services are used.

As such the NoD does not include a specific reasons section for decisions relating to TCP. To correctly reflect reasons for decision relating to TCP the assessment delegate must complete the following:

- If the person is non-Aboriginal and/or Torres Strait Islander, complete **both** sections B and C for all TCP approvals.
- If the person is Aboriginal and/or Torres Strait Islander, make sure the home support, assistive technology and residential care sections are all included within Section A.

Uploading and sending the NoD

Once the NoD letter is finalised and signed, assessment delegates must upload it to the assessor portal (all documents must be uploaded in PDF format) for record-keeping purposes, and then post, email, or notify the individual the NoD is available via the MAC online portal (and their registered supporter/s and/or appointed decision maker/s, if applicable) using their preferred communication method/s.

Important:

The Support Plan needs to be included as an attachment whenever the Notice of Decision is sent. The Support Plan lists any approved service types and services, so it is legally considered part of the Notice of Decision.

The Referral Code letter also needs to be attached whenever approvals for CHSP services are given.

Providers can view the Notice of Decision and support plan via the My Aged Care Service and Support Portal.

Older people can also view their Notice of Decision, Support Plan and Referral Code letter (for CHSP approvals) via their My Aged Care Online Account. An older person's registered supporter/s (if any) may also be authorised to access this information.

Where an assessment delegate determines that no funded aged care services are required, the delegate will also need to send a NoD to the older person to formally advise them of this outcome.

Note:

Older people who request/are recommended for the End-of-Life Pathway but are not approved *do not* receive a 'Non-approval letter'.

The Act requires the NoD to be given to the individual within 14 days of the delegate's decision.

To mitigate potential issues in meeting the timeframe for giving the notice, assessment delegates should:

- obtain agreement of the older person for **electronic delivery** of notices (email or portal) where possible
- upload the NoD promptly to the client's **My Aged Care Online Account**

- confirm client and supporter contact details before dispatch and send the notice as soon as possible to the designated postal or email address

When the notice is provided to the client via their My Aged Care Online Account the assessment delegate must notify the client that the notice has been uploaded and can be retrieved. Delegates should use the notes tab on the client's record to document that this notification has occurred and the date it happened.

If providing the notice electronically to an address that has not been designated by the client, the notice is given when it is capable of being retrieved. Assessment delegates should clearly communicate to a client which address the notice has been provided to so it can be retrieved within the 14-day period.

Note: If a client is unable to readily access their emails or My Aged Care Online Account, the notice **must be sent via pre-paid post**. Assessment Delegates should confirm this with the client when obtaining their agreement for electronic delivery of the notice.

Postal delays are outside the control of assessment organisations. Where a notice is to be given by post, **Assessment Delegates must**:

- send the notice as soon as possible by **pre-paid post**, properly addressed to the individual at their **last known postal address**, and
- **record the date** on which the notice was sent.

9.3.5. Notice of outcome of application for second concurrent unit of restorative care funding

If a support plan review is being conducted and a second concurrent unit of restorative care funding has been requested, a letter must be sent to the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) notifying them of the outcome of the application for the additional funding.

The decision to approve additional funding to the Restorative Care Pathway episode is made under section 195-3 of the Aged Care Rules 2025.

The appropriate template can be found under the 'Forms' tab in 'Reports and Documents' tile in the Assessor Portal. This is a different template to the Notice of Decision issued after an assessment. Do not use the Notice of Decision you would usually use to communicate assessment outcomes.

Once finalised, the letter must be signed and uploaded to the assessor portal for record-keeping purposes, and then post or email it to the individual (and their registered supporter/s and/or appointed decision maker/s, if applicable) using their preferred communication method/s.

9.3.6. Registered supporters who are authorised to receive copies of letters

If an older person has a registered supporter/s who is authorised to automatically receive certain information or documents about an older person, they must be given a copy of the information or document. Registered supporters can access these documents if they have arranged their own login to the client portal via My Aged Care. If an older person has multiple registered supporters who are all authorised to receive copies of an information or document, each registered supporter must receive a copy. This includes a Notice of Decision.

Section 29 of the Aged Care Act 2024 (the Act) provides that any information or document that is required or authorised under, or for the purposes of, the Act to be given to an older person must also be given to their registered supporters if:

- the older person has consented to sharing this kind of information with their registered supporter, or
- regardless of whether the older person has consented, the registered supporter is a person covered by subsection 28(2) of the Act. That is, they are a registered supporter who is also an active appointed decision-maker for the older person.

These registered supporters are called ‘supporters’ and ‘supporter guardians’ in the assessor portal and app.

A registered supporter who is recorded as a ‘supporter lite’ cannot automatically be given information or documents about an older person. This is because the older person has not consented to that registered supporter receiving their information and documents under section 29 or the registered supporter is not a person covered by subsection 28(2) of the Act. That is, they are not a registered supporter who is also an active appointed decision-maker for the older person.

For example, assessors must not send a supporter lite a Notice of Decision. If a request has been made by a supporter lite to access a Notice of Decision letter, this should be escalated to the departmental team responsible for supporters.

9.3.7. Using electronic signatures

Under Section 10 of the Electronic Transactions Act 1999, electronic signatures can be used when a Commonwealth law requires a person’s signature. Assessment Delegates can use an electronic signature instead of a handwritten one.

However, before using an electronic signature, Assessment Delegates need to make sure that all legal requirements have been met under Section 10 of the Electronic Transactions Act 1999.

To do this effectively, follow these practices:

1. **Monitoring Use:** Set up procedures to track when their electronic signature is applied, so Assessment Delegates are always aware of its use.

2. **Administrative Assistance:** Assessment Delegates can get help from administrative staff to attach their electronic signature, but they should remember that the final responsibility for the notification remains with the Assessment Delegate. Administrative staff do not have the authority to apply the signature on their own.

Acceptable forms for an electronic signature include a typed name, personal mark, signature image, personal email, clicking an 'I accept' box, or using a digital signing platform, provided they clearly demonstrate the person's identity and intention. Please see link below for further advice from the Attorney-General's Department regarding types of electronic signatures that can be used.

Note:

The signature block in the offline NoD template lists the Delegate Position Number or Staff Member ID option. We previously instructed non-clinical delegates who do not have a delegate ID to include their MAC staff ID in the signature block instead. This is no longer required. Non-clinical Assessment Delegates can simply complete the signature block with their name.

Electronic Transactions Act 1999

Attorney-General's Department - Types of electronic signatures that can be used

9.4. Referral and support for service access

9.4.1. Referral codes

A referral code is a unique reference number used to connect an older person with a provider, enabling them to begin receiving services. Referral codes will be generated at different stages and through different mechanisms depending on the program recommended during the aged care needs assessment.

9.4.2. When to share referral codes

From 1 November 2025, all Australian government-funded aged care services fall under the *Aged Care Act 2024*. This includes CHSP services, which were not under the *Aged Care Act 1997*. This means that for all service approvals (including for CHSP), referral codes cannot be issued to the older person or service providers until the Assessment Delegate has completed and signed a Notice of Decision.

This is an important change that assessment organisations must adhere to, to ensure compliance with the *Aged Care Act 2024*. If referral codes are given to the older person and/or provider(s) and a Notice of Decision is ultimately *not* issued, this risks invalidating the assessment outcome. The Notice of Decision is the key legal mechanism that records a decision by the System Governor for the client to receive a funded aged care service.

The Notice of Decision does **not** include the referral code(s) for the recommended service(s). Referral codes displayed in the Support Plan can be used to reach out to as many service providers as preferred. The Support Plan must be sent as an attachment to the Notice of Decision. For CHSP service referrals, the referral code letter must also be sent as an attachment to the Notice of Decision.

> Note:
> Providers should not be asking older people to provide them with a copy of the Notice of Decision (NoD). Team leaders in service provider organisations are able to access the NoD through the Provider Portal both before and after accepting the referral

9.4.3. Generating referrals/recommendations

An assessor must ensure that older people are referred to service providers according to service availability and the older person's needs and preferences.

Assessors may send referrals electronically to one or more government-funded service providers of the older person's choice or provide the older person with a referral code for the older person to self-manage the referral. The client can also ask for the code to be broadcast to several local providers to find availability.

Prior to sending the referral, the assessor must ensure that the older person (or their appointed decision maker, regardless of whether they are a registered supporter):

- consents to the My Aged Care referral method (broadcast, preference, or referral code)
- consents to the department providing information from the older person's My Aged Care online account to the provider for the purposes of the provider actioning the referral (including to provide the agreed service recommendation on the Support Plan.

9.4.4. Support at Home referrals

A single provider will oversee and deliver all Support at Home services (including ongoing services, short-term services through the Restorative Care Pathway, End-of-Life Pathway and AT-HM scheme) for a participant.

Under this model, registered providers will be required to hold registration that covers all services the participant will receive.

> Note some providers may not be able to deliver all services a participant needs. Providers can choose to engage a third-party (associated provider) to deliver services on their behalf, however the provider remains responsible for delivery of services and compliance with relevant obligations.

If an older person prefers a particular service provider who does not have availability, the older person can elect to be referred to that service provider's waitlist on the system (if a waitlist is available). Older people can be on multiple waitlists at any one time.

A participant can change Support at Home providers at any time. Once a participant has chosen their provider, the provider will receive a referral in the My Aged Care Service and Support Portal.

Where a service provider is not available to meet the needs of the older person and the older person does not want to be put on a waitlist, the assessor should have a further conversation with the older person to consider other alternative options for support. Other options may include:

- a different service provider that could meet the need (on an interim or ongoing basis)
- non-Commonwealth-funded services; or
- the older person and/or their carer, registered supporter or other person who supports the older person being able to address their need.

Where required, the assessor is to provide short-term assistance to the older person for the purpose of implementing the Support Plan. This may include monitoring referrals or discussing options with service providers for the provision of alternative services if necessary, or in cases of providing for vulnerable older people, linking support or care coordination.

Referrals for Restorative Care Pathway, the AT-HM scheme and End-of-Life Pathway

If a participant receiving ongoing Support at Home services is referred to a short-term pathway (Restorative Care, the AT-HM scheme and End-of-Life), and their current registered provider does not deliver services under these pathways, the participant will be required to change providers to access their short-term pathway.

Assessors should ensure the individual is aware of this and confirm referral needs with the individual.

For further information see the Support at Home Program Manual.

Support at Home referral codes

The same referral code will be issued for every Support at Home (SaH) classification level (this includes ongoing and short-term services). This referral code will apply to all services approved under that classification level. The older person can present the referral code directly to their preferred provider or alternatively they can request assistance from the contact centre or the assessor for assistance in issuing a referral to a provider(s).

Referral codes are not listed in the Notice of Decision letter. Referral codes are generated and listed in the support plan in circumstances where a referral code is needed.

For an individual approved for an ongoing SaH classification or AT-HM, the referral code is generated once the individual has been allocated a place (and therefore funding) through the Support at Home, Assistive Technology or Home Modifications Priority Systems. A separate Funding Assignment Notice with the corresponding referral code will be sent to the older person.

In circumstances where a participant is already receiving services from a SaH provider (for example, moving from the End-of-Life Pathway back to ongoing services), a referral code is not generated. In these circumstances a referral code is not required as the connection with a provider and access to the participant's record is already established through the initial use of the referral code.

For new Support at Home participants approved for the End-of-Life Pathway or Restorative Care Pathway:

- if a service referral has been made, the provider will contact the participant
- if no service referral has been made, the referral code will be displayed in the support plan.

If a participant is already receiving services and wants to change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral code, enabling it to be used as a way to connect with a new provider. Alternatively, if the participant indicates during their assessment that they want to change providers and have the assessor make the service referral, the referral code can be found in the assessor portal.

9.4.5. CHSP referrals

Assessors should not issue CHSP referral codes until *after* the assessment delegate has approved the recommendation. An exception to this is the alternative entry pathway.

For CHSP services, a Support Plan may contain recommendations for multiple services within the same service type (e.g. Laundry, General House Cleaning and Shopping assistance services under the Domestic Assistance service type). The assessor will generate a separate referral code for each service type recommended.

If a service aligns with the older person's assessed needs and goals, assessors can issue more than one referral code for the same service type – allowing the person to access two services (sub-types) from two different providers, provided there is no duplication of service.

- For example, if an older person wishes to access services under the Social Support service type from two different providers (e.g. individual social support and group social support), the assessor should create two separate service recommendations using the 'Add a service recommendation' function. Each recommendation will generate a distinct referral code, ensuring that each provider receives a unique referral code
- For Allied Health and Therapy and Therapeutic Services for independent living service types, the assessor should always generate a separate referral code for each service recommended (e.g. separate referral codes for Physiotherapy and Occupational Therapy) as outlined above.

Reissuing CHSP referrals – Grandfathered CHSP clients

Certain CHSP clients were 'grandfathered' into the CHSP with service referrals but have not undergone an assessment through My Aged Care.

- These referrals are not valid under the Aged Care Act 2024.
- These clients must undergo an aged care assessment to comply with the Act.
- If found eligible, assessors must generate new referrals for any CHSP services that are approved following an assessment.

Reissuing CHSP referrals – Urgent services

Clients who have accessed urgent services are required to undergo an assessment, and new referrals must be generated for any approved ongoing CHSP services.

- CHSP providers will continue to deliver urgent services until an assessment occurs.
- When ongoing CHSP services are approved, the urgent service referral should end.
- New CHSP referrals are required for the provider to continue delivering services.

9.4.6. Residential care referrals

For residential (including through Multi-Purpose Service Program (MPSP)), the assessor can issue a referral code following the assessment and approval of services to enable the older person to take time to look for a suitable residential facility. Referral codes are contained within the client's support plan.

When selecting a residential aged care service provider to issue a referral to, assessors can use Star Ratings to help compare the quality of aged care facilities (not applicable for MSPS and National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC)). Star Ratings are available via the 'Find a provider' tool on the My Aged Care website. All aged care facilities receive an overall Star Rating and ratings against Compliance, Residents' Experience, Staffing and Quality Measures).

Assessors can share a client's referral code with as many providers as the client chooses. A provider will use the referral code to view the client's approved services and specific needs in the service and support portal. If the provider and client agree they will take a bed in the residential care home, a formal agreement will be exchanged between the parties, and the referral will be formally accepted in the My Aged Care portal. Once a provider accepts a referral and payments commence from Services Australia, all other open referrals will close.

My Aged Care - 'Find a provider' tool

9.4.7. Generation of referral codes for different programs and pathways

The table below provides further details regarding referral codes across the different approval pathways and programs.

Table 53. Guide for generation of referral codes for aged care programs

Aged care program	Pathways	Generation of a referral code
Support at Home program	SaH ongoing	Once the older person is allocated a place through the Support at Home Priority System, they will be sent a funding assignment letter containing their recommended services and the referral code for ongoing SaH services classifications 1 - 8. If a participant is reassessed to a higher ongoing classification the upgrade notice letter will contain a referral code. However, the participant does not need to take any action as the referral code will already be active with their provider. To change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral

Aged care program	Pathways	Generation of a referral code
		code which can then be used to connect with a new provider. This follows the same pathway previously used in the Home Care Packages Program. Note: If the older person has previously been approved for the End-of-Life Pathway, a referral code is not generated
Support at Home	End of Life Pathway (EoL)	Referral code is generated into the Support Plan attachment provided to clients (if no service referral has been made AND the older person has not been approved for an ongoing Support at Home classification previously)
Support at Home	Restorative Care Pathway (RCP)	Referral code is generated into the Support Plan attachment provided to clients (if no service referral has been made and the older person has not been approved for an ongoing Support at Home classification previously). **Note:** If the current provider does not provide Restorative Care the older person will need to change providers. To change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral code which can then be used to connect with a new provider.
Support at Home	Assistive Technology and Home Modifications (AT-HM) scheme	Once the older person is allocated a place through the Assistive Technology and/or Home Modifications priority system/s, they will be sent a funding assignment letter containing their recommended services and the referral code for their AT and/or HM classifications. This is the same referral code used for SaH ongoing, EoL and RCP classifications. If the participant is already receiving services from a Support at Home provider, they do not need to take any action as the referral code will already be active with their provider. Note: For the below circumstances, where AT-HM funding is allocated immediately, the participant does not receive a funding assignment letter. 1. AT and HM short-term with RCP 2. AT short-term with EoL 3. AT ongoing, AT and HM short-term for participants who have been previously assigned the EoL pathway.

Aged care program	Pathways	Generation of a referral code
		4. Approval for a higher AT or HM short-term tier through an SPR. If the participant is not already receiving services from a Support at Home provider, the referral code is generated into the Support Plan attachment.
Commonwealth Home Support Program (CHSP) National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) Multi-Purpose Service Program (MPSP)		CHSP, NATSIFACP and MPSP services will require assessment, delegate approval, and a Notice of Decision (letter outlining their decision) to be issued. The Support plan attachment provided to clients will include the referral code(s) for CHSP. MPSP and NATSIFAC (if no service referral has yet been made). For CHSP services, a Support Plan may contain recommendations for multiple services within the same service type (e.g. Laundry services, Shopping assistance and General house cleaning under the CHSP Domestic Assistance service type) **Note:** For Allied health and Therapeutic services for independent living Service types, referral codes should be generated and display at the service level in the Support Plan. For any CHSP referrals, these codes will also be contained in a separate Referral Code Letter which is sent to the older person for ease of access. **Note:** if older person consents to electronic notifications, the Assessment Delegate can send these letters via email.
Transition Care Program (TCP)		The hospital discharge staff will identify and liaise with a TCP provider to access these services using the referral code.
Residential Care		For residential (including through MPSP), the assessor can issue a referral code following the assessment and approval of services to enable the older person to take time to look for a suitable residential facility. Referral codes for residential care will be contained within the Support Plan attachment.

9.4.8. Steps an assessor must take

An assessor must:

- Check availability of service providers in the older person's region. Commonwealth funded service provider contact details can be accessed in the My Aged Care

Service Finder. Service providers will find the name of an older person's assessing outlet in the 'Plans' tab of the older person's record.

- If required (e.g. for vulnerable older people) contact providers on behalf of the older person when referring.
- Add additional documentation in the 'Notes' to ensure all pertinent information is available to service providers.
- Consider all referral options (through portal by broadcast, preference, direct referral, or issue referral code) and the service priority (excluding support at home).
- Consider referrals/recommendations to services not listed in My Aged Care.
- Where service availability is limited, work with the older person to explore alternative options of support to meet their areas of concern and goals.
- Discuss and record carer information and advise older people and/or their carers of carer support options available including requesting a call back for carers from a local Carer Gateway service provider or the National Dementia Helpline.

Assessors must ensure they are aware of appropriate care options within and outside Commonwealth funded aged care, such as local supports, health, community services and private services. To offer a broad range of strategies to assist the older person to achieve their goal, the assessor builds and maintains effective working relationships with service providers and extends connections with services and organisations in their local community, including those not listed in My Aged Care.

9.5. Corrections process

Assessment delegates are responsible for ensuring that all recorded decisions are accurate and complete. Diligent quality checks are essential to minimise the need for corrections and maintain accurate records.

Despite thorough quality checks, errors may occasionally occur. If an assessment delegate identifies an administrative or typographical error after submitting a decision, it is essential to initiate the correction process promptly.

When an error is identified, assessment delegates must submit a correction request within 42 days of the original decision. The correction request will be forwarded to the department for consideration.

See Chapter 11 for more information about the corrections process

10. Chapter 10: Support plan reviews and reassessments

What you'll find in this chapter:

This chapter provides guidance around the circumstances for conducting a support plan review (SPR) or a reassessment for each aged care program.

10.1. Reassessments under the *Aged Care Act 2024*

Section 64 of the *Aged Care Act 2024 (the Act)* provides for aged care needs reassessments. A reassessment may be required when an individual's circumstances have changed.

In the Act the term 'reassessment' is used as an umbrella term to describe both SPRs and reassessments. 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.

SPRs are used as a mechanism to adjust an older person's aged care services without needing to undertake a reassessment. In some cases, the Assessment Delegate may approve access to services based on updated information through the SPR process.

A reassessment will be required when there are *significant* changes to a client's needs or circumstances.

Significant changes in care needs and circumstances require higher-level of care or different types of care (and/or changes to priority).

For example, an older person approved for ongoing Support at Home at the Classification 4 level who requires a higher classification level of package (e.g. Level 5) due to increased care needs or a change in priority for home care service must first undertake a reassessment by an assessor and approved by an Assessment Delegate.

Significant change is referenced in section 64 of the *Aged Care Act 2024* 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.

A triage delegate will determine whether an individual is eligible for a reassessment.

All reassessment requests 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.

For more information, refer to the user guide on how to conduct SPRs within the My Aged Care portal.

10.1.1. Support plan reviews (SPRs)

The introduction of Support at Home expands the circumstances in which an SPR can be undertaken.

SPRs are most likely initiated by the older person's provider (with the older person's consent), who can submit a request through the My Aged Care service and support portal. When requesting SPRs, providers must attach supporting documentation about the participant's current care arrangements, such as their quarterly budget and/or care plan.

Alternatively, an older person or provider can ask for a SPR when:

- the older person's needs, goals or circumstances have changed,
- they need additional services that are not on their support plan, or
- a time limited service has ended.

An older person can request a SPR through My Aged Care, from a Services Australia Aged Care Specialist Officer or with assistance from a Care Finder or ECS worker. A SPR may lead to:

- no changes to the support plan as it meets the person's needs
- updates to the support plan to address changed needs; or
- a reassessment due to significant changes.

Where someone has made a request on behalf of the individual receiving the aged care service, it is important that the assessor confirms that the individual has consented to this occurring when beginning the SPR.

Team leaders are responsible for reviewing and prioritising SPRs, accepting an SPR and assigning it to an assessor. Urgent SPRs should be prioritised, particularly those for clients requiring access to the End of Life pathway. The assessor will review the information provided and determine whether the older person's updated needs can be addressed through a SPR or if a reassessment is required.

If the SPR is valid, any proposed changes to the Support Plan will require a decision by an Assessment Delegate. If a reassessment is required, the referral will proceed through the standard triage and assessment process, with new recommendations subject to delegate approval.

A key change which aims to reduce the need for SPRs is the flexibility of service recommendations in the IAT for any Support at Home classification. When an assessor accepts the Support at Home recommendation for a client, all services in the list will be pre-selected, with the exception of *Allied Health and Therapy* and *Therapeutic Services for Independent Living* service types. This is due to the specific nature of these services and should only be recommended if an older person has a need for those services.

10.1.2. Key principles of a support plan review

An assessor may set a review date on the support plan at the time of the assessment or initiate the review on an ad-hoc basis. Unplanned/ad hoc reviews may be requested by the service provider or through the contact centre or ACSOs.

- The SPR may be completed over the phone with the older person, their appointed decision maker, or in line with the older person's will and preferences, their registered supporter.
- Assessors are best placed to make the decision as to whether an older person requires a reassessment following a review. This decision is supported by the information provided by the older person, the contact centre, service providers and health professionals.
- All SPRs are required to go through a delegate for approval.
- The My Aged Care contact centre has the ability to issue a direct referral to the assessment organisation for an urgent comprehensive assessment for residential care, residential respite care or transition care.
- If appropriate to the older person's aged care needs, a non-clinical assessor can create an assessment referral after starting the SPR.
- If an older person is admitted to hospital, it is best practice for an SPR to be conducted once the older person is discharged from hospital and there is a clear picture of the care needs and type and level of support that will be required.
- If an urgent referral is required before discharge, the SPR can be conducted in the hospital setting. This may mean that the referral needs to be transferred to an assessment organisation that is contracted to conduct assessments in a hospital setting (limited to State and Territory Governments). Alternatively, the assessor may contact the state or territory assessment organisation to self-refer directly.
- Where there is a significant change in an older person's needs or circumstances which affect the objectives or scope of the existing Support Plan, a reassessment may be undertaken.
- If the assessor has enough clear evidence to determine that a reassessment is required (due to a significant change in older person's circumstances), they can bypass the SPR process and refer direct to a new assessment by clicking the 'recommend new assessment' button in the 'before you start the Support Plan Review' window.

If not already scheduled earlier, a SPR may be routinely scheduled 12 months from the last assessment for older people with ongoing CHSP services in place. A reassessment is only required for significant changes in care needs or circumstances since the last assessment. The service provider is responsible for reviewing client services at least every 12 months.

- When conducting an assessment, assessors should be considering the current needs of the older person and not recommending services that aren't supported by the assessment.
- An unplanned SPR will replace the scheduled review in the system, and if necessary, can be re-scheduled at the completion of the unplanned review.

- An older person can have multiple reviews of their Support Plan linked to the same assessment.
- If new WHS information is recorded on the Support Plan following a SPR for an existing older person, the assessor should advise the provider of the new information so the provider can make the appropriate risk-based determination of how best to support the older person's service delivery.

Once a support plan review has been commenced, an assessor will be able to make changes to information in the following sections of the older person's Support Plan:

- Assessment summary
- Older person motivations
- Goals & recommendations, including recommendations for linking support & reablement.
- Manage services & referrals
- Associated People
- Review

It is important for the assessor to keep in mind that generated support plans can include goals and concerns from all previous assessments. The assessor should remove and/or update previous goals to ensure the focus remains on the older person's current goals and aspirations as per their most recent assessment and/or SPR.

Prioritising Urgent SPRs

While no priority category for SPRs exists as it does for assessment referrals (outlined in Chapter 4) assessors should prioritise SPRs where there is an identifiable urgent need. In particular, assessors should prioritise:

- **End-of-Life SPRs,** completing them as soon as possible. These will be marked 'urgent' in the system. Team Leaders can locate these in the Assessor Portal by filtering for urgency, then expanding the boxes to locate the EoL clients.
- 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.
- Requests for **a second unit of restorative care,** particularly those where there is a need for continuity of services

Otherwise, all other SPRs should be completed within calendar 15 days from the date the SPR referral is accepted.

10.1.3. Outcome of the SPR

After conducting the SPR, the assessor should consider possible outcomes, including: determining that no changes to the Support Plan are required (as it meets the older person's needs), updating the current plan, or conducting a reassessment.

The assessor can record the outcome to 'complete' the SPR and 'finalise' the SPR when it has been completed. If the SPR outcome is a reassessment, then the assessor is prompted to issue the assessment referral. The SPR referral will appear above the Assessment Summary Information in the older person's Support Plan.

Note:

A SPR should accurately reflect the review details, including date, attendees, mode, assessor name, reason for SPR and the outcome of the review (up to 1000 characters).

Assessors must ensure the older person or active, appointed decision maker (whether or not a registered supporter) agree to the details entered in the outcomes field as these comments will automatically appear on the older person's Support Plan.

The Assessment Summary section of the Support Plan has a 5000-character limit which can also be updated with the SPR. All past versions of the Support Plan are retained on the My Aged Care system and are a record of any deleted content.

After selecting 'complete & finalise support plan review' no further changes can be made. Where applicable (e.g. if new services have been added or if a decision has been made to not approve a specific request), a Notice of Decision will be required to be prepared for Delegate approval and shared with the older person.

The assessor may determine that the older person's needs or circumstances have changed significantly since their original assessment, and a reassessment is required.

10.1.4. Reassessments

An older person may require a reassessment following a SPR in the following instances:

- the older person has multiple new needs or significantly increased needs
- the older person requires a different service group (i.e. client receiving CHSP needs to move to Support at Home) the My Aged Care assessor portal allows a reassessment referral where:
    - the SPR request meets one of the four defined scenarios only (transition care, residential care, residential respite care and older person relocation) or
    - if the request does not meet the defined scenarios and the SPR clearly needs to be converted to a reassessment, the assessor can issue a reassessment referral where they select 'A reassessment required' as the outcome of the SPR or
    - after the full SPR is completed and finalised, the assessor has the option to start a reassessment referral if this is appropriate.

Where the SPR outcome does not indicate a reassessment is necessary, but the person (or their active, appointed decision maker, whether or not a registered supporter) continues to request a reassessment, assessment organisations should be aware that making a decision not to proceed with a reassessment process is a reviewable decision under the Act.

If the triage delegate's clinical opinion (based on guidance materials and evidence) is that a comprehensive assessment is not required, the assessment organisation must ensure the older person:

- is aware of, understands and accepts this decision.

- is provided with the updated support plan which details the outcome of the SPR and if applicable, references the reason/s to the older person why the requested reassessment is not required at this stage; and
- is provided with information on how to request a further SPR should the older person's care needs or circumstances change.

If the older person does not accept the decision, then the assessment should proceed.

Reassessment of a classification level

Depending on the classification type for the service group, an individual or a registered provider acting on behalf of the individual may have the right to apply for a reassessment of a classification level under section 82 of the Aged Care Act 2024. Section 82 outlines who may apply for a classification reassessment for each classification type for a service group and when an application may be made. This is outlined in the table below.

Table 54. Circumstances when a classification reassessment can be sought

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
Ongoing or short-term for home support, assistive technology or home modifications	The individual	If: • the classification type is in effect for the individual; and • the individual considers a different classification level in the classification type for the service group should be approved; and • the funded aged care services are not being delivered under a specialist aged care program; and • it is considered the circumstances (if any) prescribed by the Aged Care Rules 2025 (the Rules) apply.
Ongoing for residential care	The individual A registered provider on behalf of the individual	If: • The registered provider is delivering ongoing funded aged care services to the individual through the service group in an approved residential care home; and • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • the funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply:

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
		• if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(2) of the Act in that time period; • it is considered the circumstances (if any) prescribed by the Rules apply.
Short-term for residential care	The individual The registered provider on behalf of the individual	If: • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • an access approval is in effect for the individual for the classification type for the service group; and • if the application is made by the registered provider: • the registered provider is delivering short-term funded aged care services through the residential care service group to the individual in an approved residential care home; and • those funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply: • if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(3) of the Act in that time period; • it is considered the circumstances (if any) prescribed by the Rules apply.
Hospital transition (for any service group)	A registered provider on behalf of an individual	All of the following apply: the registered provider is delivering hospital transition funded aged care services to the individual through the service group; and • the registered provider or the individual considers that an extension of the period of effect for the classification level that is in effect for the individual for the classification type for the service group should be approved for the individual.

When a reassessment is needed (for all classifications expect those for the residential care service group), Triage Delegates will review the application, considering the individual's current care needs and whether they still meet the requirements for a classification reassessment.

If the application meets the necessary criteria, the assessor will complete a reassessment. The assessment delegate will decide whether to approve a different classification level for the classification type for a service group or an extension of the classification level (if relevant) under section 78 of the Act. All new decisions will be documented in a new Notice of Decision letter.

Note

Individuals who are reassessed and approved for a higher classification level while awaiting funding in the Support at Home Priority System will have their position in the queue for their priority category based on their original approval date. If a new priority category is assigned, the individual's record in the system will be moved to that new priority category and their position in the queue is based on the original approval date.

10.1.5. Criteria for SPRs and reassessments by program

The table below describes the circumstances in which a SPR is required versus a reassessment.

Table 55. Circumstances when an SPR is required versus a reassessment

Program	Support plan review	Reassessment
Ongoing Support at Home 1-8	Approval for additional service types, or for additional services within the prescribed service types that have already been included in the support plan and is within the current SaH classification. This can be submitted by the older person's Support at Home provider.	An older person's circumstances have changed significantly that is likely to mean that they will require a higher classification level, with more frequent or a different type of funded aged care service. e.g. the individual's caring arrangements have ceased, permanently, to provide some or all care to the individual; or the individual has experienced an event, or a decline in their condition.
Restorative care	Approval for additional service types, or for additional services within the prescribed service types that have already been included in the support plan during the restorative care episode, or to provide evidence that a second unit of funding is	To meet changing needs of the older person which may include needing an ongoing service type after an episode of restorative care has finished (or during the period if circumstances change).

Program	Support plan review	Reassessment
	required (may consider availability of units).	
AT-HM	Changes to existing AT and/or HM funding tiers AT funding tier to access repairs or maintenance of an item listed on the AT-HM list. Addition of new AT and/or HM funding tiers for transitioned HCP recipients with insufficient HCP unspent funds (from November 2025).	Where there has been a significant change in needs which may include the individual requiring a higher ongoing Support at Home classification level or a different type of funded aged care service including a new need for AT and/or HM.
End-of-Life Pathway	Request an urgent SPR to be assessed for End-of-Life Pathway if the person already has a Support at Home classification. Request an urgent SPR to move to an ongoing SaH. classification if the person needs services beyond the End-of-Life Pathway funding period.	A person who does not have a Support at Home classification will need a reassessment to be approved for the End-of-Life Pathway.
Residential care- (permanent)	N/A	Clients needing residential care who have not had residential care added as a care type to their support plan.
Residential care- (respite)	N/A	Clients needing residential care who have not had residential care added as a care type to their support plan.
TCP	N/A	If the client receiving other aged care services enters hospital and needs TCP, a reassessment is required.
CHSP	To meet changing needs which may require additional CHSP services. To close off a period of reablement support and/or meet changing needs which may include needing an ongoing service type after episode of reablement has finished.	If a CHSP participant needs access to a different service type that they are not currently approved for. For example, Support at Home or residential respite care, a reassessment is required.

Program	Support plan review	Reassessment
MPSP	If a client is receiving other aged care services and an MPSP service recommendation needs to be added.	New MPSP clients will require an assessment from 1 November 2025. If an existing MPSP client who had not previously been assessed (who were deemed across under transitional arrangements) needs to move to mainstream services, a reassessment should be undertaken.
NATSIFACP	If a client is receiving other services and a NATSIFACP service recommendation needs to be added.	New NATSIFACP clients will require an assessment from 1 November 2025. If an existing NATSIFACP client needs to move to mainstream services and hasn't been assessed before, a reassessment should be undertaken.

10.1.6. SPRs for Aboriginal and Torres Strait Islander assessment organisations

SPRs will usually be reallocated to the assessment organisation that completed the previous assessment. As Aboriginal and Torres Strait Islander assessment organisations commence, an Aboriginal and Torres Strait Islander client may wish to transfer their SPR to one of these organisations. In such case, the current assessment organisation is expected to support a warm transfer of the assessment referral. This approach ensures continuity of care, respects client choice, and supports culturally safe aged care assessment delivery.

10.1.7. SPRs for AT-HM

Participants accessing assistive technology (AT) or home modifications (HM) can request an SPR:

- to seek a higher AT or HM funding tier
- to seek AT funding to meet their assistive technology repair or maintenance needs
- to seek allocation of an AT or HM funding tier if they are a participant with a transitional Support at Home classification (from November 2025).

Note:

If transitional clients don't have unspent funds or have insufficient unspent funds to meet their need for assistive technology and home modifications, they can agree for their providers to supply information indicating any additional funding needs through the AT-HM scheme data collection process.

This is a direct pathway where the department delegate may allocate an AT ongoing and/or AT/ HM low, medium or high short term funding tier.

This process will be available from 1 November 2025 until February 2026, and should be followed in the first instance before seeking an SPR.

The following will require a reassessment:

- to allocate an AT or HM funding tier for the Restorative Care Pathway
- to allocate an AT funding tier for End-of-Life Pathway

If an SPR is requested for a higher AT or HM funding tier or for repair and maintenance of assistive technology providers will be required to submit evidence, along with the SPR request, for the aged care assessor to review:

- a valid prescription (if applicable) and
- a quote indicating costs of AT repairs or maintenance needs

10.1.8. SPRs for Restorative Care Pathway (RCP)

Restorative care partners can submit a SPR for several reasons related to the RCP including:

- Request approval for additional services which were not approved at assessment but are required to meet goals identified in the Goal Plan
- Request approval for additional unit of RCP funding to be accessed concurrently (subject to unit availability)
- Request a reassessment due to changing needs

Like other classifications, a provider can submit a SPR requesting additional services to ensure goals can be met.

Second unit of funding for Restorative Care Pathway

Under subsection 195-3A of the Aged Care Act 2024, an older person may access an additional unit of funding for use during their 16-week episode. Please note this is not a reviewable decision.

Access to a second unit of funding is requested through a SPR. A clinical assessment delegate will need to consider written evidence provided to determine approval (refer to Chapter 6 for information on manual oversight of RCP units/places). Evidence includes written confirmation from a medical practitioner, registered nurse or allied health practitioner, or restorative care partner of the registered provider that the individual requires additional funding to access nursing care and allied health and therapy services to achieve restorative care outcomes as detailed in the goal plan. Further supporting evidence can include the goal plan, clinical assessment tool outcomes, and individualised budget. Where an older person is already receiving ongoing services, information should be provided to demonstrate adjustments to ongoing services is also not sufficient to achieve restorative outcomes in combination with their initial RCP unit of funding. Availability of RCP units may also be considered.

Those with an active Short Term Restorative Care (STRC) approval who did not start STRC before 1 November 2025, had their approvals transferred into an approval for RCP.

Note for this cohort using their STRC approval to access the RCP:

- They can access 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 SPR request.
- The decision to approve a second unit will be informed by evidence submitted by the provider with the SPR request and may be informed by the availability of RCP funding units.
- 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.

Important:

Second units of funding are counted as part of RCP cap management. Assessors and assessment delegates should stay informed of any communications from the Department's Assessment Delivery Section regarding RCP units when recommending and approving a second unit of funding.

For more information on the Restorative Care Pathway please refer to the Support at Home Manual.

Recommending ongoing services after/during a period of Restorative Care Pathway

Assessors should consider any potential needs after exiting from the RCP, it may be necessary to undertake a reassessment for ongoing funding towards the end of the RCP episode.

The intention of Restorative Care Pathway (RCP) is to improve levels of function and delay the need for ongoing or higher levels of ongoing aged care services. This can only be determined after the RCP episode has been completed. The restorative care partner could request a reassessment if it is anticipated ongoing services may be required or there has been a change in circumstances.

10.1.9. SPRs for the End-of-Life Pathway

SPRs are used in the context of the End-of-Life Pathway for the following reasons:

- For existing Support at Home participants, to move from their current ongoing Support at Home classification to the End-of-Life Pathway
- For participants accessing the End-of-Life Pathway who require services beyond the End-of-Life funding period, to move from the End-of-Life Pathway to an ongoing Support at Home classification

In both cases above, the SPR should be marked as an 'urgent' SPR.

Funding under the End-of-Life Pathway can be used for a maximum of 16 weeks. An urgent SPR can be requested any time after 12 weeks if it appears the participant will require services that exceed the End-of-Life funding period. The SPR will enable the participant to:

- Return to their previous ongoing Support at Home classification, if they were already receiving services under Support at Home, or
- Transfer to the ongoing classification that was determined at assessment, in the case of participants who were new to Support at Home when they commenced the End-of-Life Pathway.

It is critical that SPRs to transfer a participant from the End-of-Life Pathway to ongoing services are prioritised in order to ensure there is no break in continuity of service. If a participant is returning to an ongoing Support at Home classification that is considered insufficient for their needs, a reassessment may be needed. However, the SPR to return the participant to their current ongoing classification should be completed first, in order to ensure funding is made available. After this, a reassessment can be requested.

Department of Health, Disability and Ageing website:

My Aged Care – Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews

My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review

11. Chapter 11: Reviewable decisions, revoking eligibility or approval decisions and complaints

What you'll find in this chapter:

This chapter provides information on assessment related reviewable decisions in accordance with the *Aged Care Act 2024 (the Act)*. It also details:

- the reconsiderations process
- the corrections process
- options for reviews and revocations
- the pathways that clients can take to submit complaints and raise concerns about their My Aged Care experience.

The primary audience for this section is assessors, team leaders, delegates and operational managers. Assessors should be aware that they are providing a valuable and trusted public role in the delivery of quality aged care assessment services on behalf of the Commonwealth. A necessary part of a quality assessment is having supporting processes that allow the older person the right to complain without fear of reprisal, while also upholding the statement of rights and principles.

11.1. Reviewable decisions

The Act broadens the scope of reviewable decisions related to the assessment process. It is essential for all delegates to be aware that certain decisions can be reviewed, and to ensure that every decision made is thoroughly documented and supported by evidence.

Section 557 of the Act outlines the decisions made by the System Governor that are subject to review, including those related to assessments and assessment-related activities. This section also identifies the specific entities affected by each reviewable decision.

An affected entity for a reviewable decision is a party that has the right to seek a review of a decision. To find out whether a person is an affected entity in relation to a reviewable decision refer to column 2 of section 557 of the Act.

An older person's registered supporter/s can communicate the decision of an older person to seek a review of a decision. It is not the role of a registered supporter to make decisions for an older person. If an older person has an active, appointed decision maker, that person may make a decision on behalf of an older person to seek a review of a decision. They may only do this if this decision is within the scope of their legal authority and that legal authority is active.

11.1.1. Reviewable decisions related to assessment

Table 56 is an excerpt of the table in Section 557 of the Act relating to decisions made by the System Governor that relate to assessment.

Table 56: Reviewable decisions made by the System Governor that relate to assessment

Item	Decision	Simplified explanation	Entity
7	A decision under subsection 57(1) not to make an eligibility determination for an aged care needs assessment for an individual	Deciding that an individual is not eligible for an aged care needs assessment	The individual (the older person)
8	A decision under subsection 64(1) that a reassessment of an individual's need for funded aged care services is not required	No need for reassessment: Deciding that an older person does not need a support plan review or reassessment of their aged care needs	The individual (the older person)
9	A decision under subsection 65(1) that an individual does not require access to funded aged care services	No need for aged care services: Deciding that an older person does not need funded aged care services	The individual (the older person)
10	A decision under subsection 65(2) not to approve a service group, or a classification type for a service group, a service type, or a funded aged care service, for an individual	Not approving certain services: Deciding not to approve a service group, service types or services, or classification types for an older person	The individual (the older person)
11	A decision under subsection 65(4) that exceptional circumstances do not apply in relation to an individual	No exceptional circumstances: Deciding not to approve access where an older person has not	Each of the following: (a) the individual (the older person);

Item	Decision	Simplified explanation	Entity
		undergone a needs assessment.	(b) the registered provider
12	A decision under subsection 71(2) to not specify an earlier day in a notice of decision under section 70	Not setting an earlier date: Deciding not to backdate the date of approval in the notice of decision for an older person.	The individual
13	A decision under subsection 71(6) to reject an application for a longer period for an individual to make an application	Rejecting a longer application period: Deciding not to give an older person more time to submit an application to have their date of approval backdated	The individual (the older person)
14	A decision under subsection 74(1) to revoke an eligibility determination for an aged care needs assessment for an individual	Revoking eligibility for an assessment: deciding to cancel an older person's eligibility for an assessment	The individual
15	A decision under subsection 74(1) to revoke an access approval for an individual	Revoking eligibility for aged care: Deciding to cancel an older person's eligibility for aged care services	The individual (the older person)
16	A decision under subsection 78(1) to establish a classification level for an individual for a classification type for a service group	Setting a classification level: Deciding on a classification level for an older person for a specific classification type in a service group	Each of the following: (a) the individual; (b) if a copy of the notice of the decision is required to be given to a registered provider

Item	Decision	Simplified explanation	Entity
			under subsection 79(3)—the registered provider
17	A decision under subsection 83(1) to change a classification decision (the original decision) for an individual	Changing a classification decision: Deciding to change a previous classification decision for an older person	Each affected entity for the original decision
18	A decision under subsection 86(1) to assign a priority category for a classification type for a service group	Assigning a priority category: Deciding on a priority level for an older person for a specific service group	The individual
19	A decision under subsection 90(1) to change a decision about an individual's priority category for a classification type for a service group	Changing a priority category: Deciding to change an older person's priority level for a specific classification type for a service group	The individual (the older person)

11.2. Reconsiderations process

If an affected entity is not satisfied with a decision that is reviewable under the Aged Care Act 2024 (the Act), they are encouraged to first contact their assessment organisation to discuss their concerns in the first instance. The affected party may also submit a written **reconsideration request within 28 days** of receiving the decision notice:

By Email:

agedcarereviews@health.gov.au

By Post:

The System Governor
Department of Health, Disability and Ageing
Attn: Review of Decisions Section
GPO Box 9848
ADELAIDE SA 5001

This request must set out reasons why they are seeking a review. The System Governor can allow further time for someone to make a request for reconsideration (see subsection 559(3)(c) of the Act.)

The reconsideration will be conducted by an internal decision reviewer who is different from the original decision-maker, holds equal or higher position and was not involved in the making of the original decision.

The internal decision reviewer will be a departmental delegate of the System Governor and will carry out a comprehensive administrative review of the original assessment organisation's decision.

They will consider all relevant information, including new evidence from third parties before making a determination. They must also, within 14 days of receiving the request, provide the affected entity written notice that the request has been received and when it was received. The notice must also set out that if the internal reviewer has not provided notice of their decision within 90 days of receiving a request, the original decision has been affirmed.

The internal decision reviewer must make a decision within **90 days** after receiving the request. They may:

- Affirm the original reviewable decision.
- Vary the original reviewable decision.
- Set the reviewable decision aside and make a new decision.

After making their decision, the internal decision reviewer must give written notice of the following to each affected entity for the reviewable decision:

- the reconsideration decision;
- the day the reconsideration decision was made;
- the reasons for the reconsideration decision;
- details of the affected entity's right to apply to the Administrative Review Tribunal for review of the reconsideration decision.

If the affected entity is still not satisfied after the reconsideration, they may apply for a further review by the Administrative Review Tribunal.

11.2.1. The role of assessors in reconsiderations

During the reconsideration process, the Departmental delegate may discuss the request with the assessor through the assessment organisation's Operational Manager. This step helps clarify any matters related to the case.

Assessment organisations play a vital role in the reconsideration process. They will be invited to provide additional information in response to the request for review, including the rationale for their decision making. Any additional information will be carefully considered as part of the administrative review.

11.2.2. New point in time assessment

If the Internal Review Officer identifies that there has been a significant change in the older person's circumstances since the original decision, they may discuss with the older person, the option of pursing a reassessment and withdrawing their review request.

If the older person decides to withdraw their review request, the Department will facilitate the reassessment and cease to deal with the matter.

> Important:
>
> The Department cannot discontinue the review process unless the older person chooses to withdraw their application.

If the older person decides to pursue a new point-in-time reassessment, the Internal Review Officer will instruct the assessor to conduct a reassessment.

11.2.3. Supplementary off-line assessment by assessment organisation to inform the reconsideration process

When a review officer determines that a supplementary off-line assessment is required to support a review decision, they may request that it be undertaken. This scenario typically arises when it appears that an incorrect decision may have been made, but the Internal Review Officer requires updated information to determine the most appropriate assessment outcome. The outcome of this assessment will contribute to the body of evidence considered as part of the review process. This process is distinct from a reassessment, because a reassessment stems from a change in circumstances. In the case of a reassessment, the outcome would not be backdated to the time of the original assessment. Requests for off-line supplementary assessments are infrequent and are only made when necessary to support a thorough and fair reconsideration process.

Through the assessment organisation's operational manager, the Internal Review Officer will request the off-line supplementary assessment in writing. It will be necessary to use the paper-based version of the Integrated Assessment Tool (accessible from the My Aged Care assessor portal) or other form as specified by the Internal Review Officer.

The off-line supplementary assessment is usually performed by an assessor who was not involved in the original decision or by a different assessor from the same organisation. To ensure a comprehensive evaluation, the reassessing assessor can collaborate with the original assessors, the original Assessment Delegate, and any other relevant parties as needed.

The assessor must not discuss the supplementary off-line assessment outcome with the older person or any other party in any way after completing the assessment. The outcome of the supplementary off-line assessment is not recorded in My Aged Care by the assessment organisation. Instead, it is shared with the Department through the assessment organisation's operational manager.

11.2.4 Role of Internal Decision Reviewer in relation to Support at Home Reviewable Decisions

Where an older person or their supporter is unhappy with a Support at Home classification or priority decision, they can submit a written request to the Department for the decision to be reviewed. The role of the Internal Decision Reviewer is to, standing in the shoes of the original decision maker, consider whether the correct decision has been made in accordance with the relevant legislation and policy frameworks. The Departmental Delegates conducting the internal review of Assessment Decisions are subject to the same legislative limitations as the original decision maker.

Where a request to review a classification decision is received by the Department, the internal decision reviewer will consider whether any of the inputs into the IAT are incorrect or need amendment, having regard to all the evidence (including new evidence) available. If this process results in the older person receiving a different Support at Home Classification level, then the original decision will be set aside and substituted with the new classification level. This process ensures the integrity of the classification algorithm and ensures that program funding is allocated consistently and equitably to all participants based on their needs, in accordance with the criteria described in section 81-10 of the Rules.

Similarly, where a request to review the decision to assign a priority category is received by the Department, the internal decision reviewer will consider whether there is any evidence to suggest that the criteria set out in subsection 87-5(2) of the Rules was not appropriately applied. Should on review of the evidence and information before the internal reviewer, the individual is determined to be eligible for a different priority category, the original decision will be set aside and substitute the decision with a new priority category.

As part of the internal review process, the internal decision reviewer will seek additional evidence from the Applicant, and other third parties including the AO, any home care provider or medical practitioners.

11.3. Further avenues of review

If affected entities remain dissatisfied with the outcome of the review, they can apply to have their reconsideration decision reviewed by the Administrative Review Tribunal (ART) and the Commonwealth Ombudsman.

If an affected entity has concerns about the way a decision was made or the processes involved, they can make a complaint to the Commonwealth Ombudsman.

11.3.1. Administrative Review Tribunal (ART)

If a person who has requested a reconsideration of a decision is not satisfied with the outcome, they may apply to the ART for a further review. It is important to note that there is a cost to the applicant for initiating this process.

Assessment Delegates must ensure that all information used in making approval decisions, including any data gathered during reviews of reviewable decisions is properly maintained and readily available for review by the ART.

Both the Departmental delegate and the Assessment Delegate who made the original decision may be required to appear before the ART as part of the review process.

11.3.2. Commonwealth Ombudsman

The Commonwealth Ombudsman is responsible for considering the administrative actions and decisions made by Australian Government agencies. The Commonwealth Ombudsman will not make a fresh decision on the matter, rather they will consider the way a decision was made and make recommendations on how the decision or process could be improved.

The Ombudsman's office handles complaints, conducts investigations, performs audits and inspections and carries out specialist oversight tasks to determine whether the actions and decisions of agencies are wrong, unjust, unlawful, discriminatory or unfair.

An older person, or any person supporting them such as their carer, advocate or registered supporter, can contact the Commonwealth Ombudsman through the official website to raise their concerns or file complaints.

11.4. Revocations

Triage and Assessment Delegates are not delegated the power to consider or decide to revoke an older person's eligibility or approval decisions. These delegated powers are exercised by department delegates (delegates employed directly by the department).

11.4.1. Revocations on the initiative of the System Governor

There are specific circumstances where an approval or eligibility decision may be revoked. One scenario is that during the assessment or application process the individual gave information or documents and those information or documents were false or misleading, omitted any matter or thing that without would make the document false or misleading. This can include situations where key facts presented during the assessment process were inaccurate or misleading, resulting in the approval or 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.

Decisions to revoke an eligibility determination for an aged care needs assessment and access approval for an individual are reviewable decisions under Section 557 of the Aged Care Act 2024.

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 the Department at AssessmentRevocations@health.gov.au

Before making a final decision to revoke eligibility or access approval, the Departmental delegate must follow the structured process outlined under the Act. The Departmental delegate must first notify the individual in writing that a decision to make a revocation is being considered. The notice must clearly state the reasons why a revocation is being considered and invite the individual to make written submissions about the matter within 14 days of receiving the letter (or a longer period if specified). Additionally, the notice must inform the individual that the Departmental delegate may proceed with the decision after considering the submissions.

If an individual has made their submission, the Departmental delegate is required to carefully consider them before making a final decision. This ensures that the individual's perspective and any relevant information are taken into account, allowing for a transparent and fair assessment of the situation.

If, after considering the submission, the Departmental delegate deicides to revoke the eligibility determination or access approval, they must notify the individual in writing within 14 days of making the decision. The notification must include the decision itself, the reasons for the decision, and information on how to apply for a reconsideration if the individual wishes to challenge the outcome.

If an eligibility or access approval is revoked, any pending applications related to the individual are automatically withdrawn. This means the individual will need to reapply for access if they wish to receive funded aged care services.

11.4.2. Requests on the initiative of the individual

Approvals can be revoked if the individual themselves requests it. Under section 72 of the Act, an individual has the right to request the revocation of an eligibility determination or an access approval if it is currently in effect. This option to withdraw an eligibility approval is only available if the individual is under the age of 65 at the time of making the request. The request for revocation must be submitted using the approved form to ensure that the process is formally documented and consistent with legislative requirements. Once a valid request for revocation has been made, the System Governor is obligated under section 73 to revoke the eligibility determination or access approval within 28 days of receiving the request. The decision must be communicated to the individual within 14 days of being made in the form of a written notice. This notice should clearly outline the revocation decision, including any relevant reasons and implications.

> Note:
>
> Once an approval or eligibility determination is revoked, any pending applications related to that individual under section 56 or 64 are automatically considered withdrawn.
>
> This means that no further action will be taken on those applications.

Additionally, approvals lapse automatically if they are superseded by a subsequent decision. This occurs when a new eligibility determination or access approval replaces the existing one, rendering the previous approval invalid. In these cases, the revocation happens implicitly because the new decision takes precedence.

11.5. Corrections process

Assessment delegates are responsible for ensuring their decisions are recorded accurately and completely. Diligent quality checks are essential to minimise the need for corrections and maintaining accurate records.

If an administrative or typographical error is identified after submitting a decision, assessment delegates must promptly initiate the corrections process. As an example, errors could include an omission of funded care types from an individual's approval that were recommended in the Support Plan and the delegate intended to approve; or entering an incorrect approval date of effect (delegation date) that does not match the actual approval date of effect.

Where an error has been identified, an assessment delegate must request a 'correction' **within 42 days of the original decision**. Corrections should be requested via the 'Decision History' tab in the My Aged Care Assessor Portal using the 'Request Changes to care approval decisions' button. Additional information that does not fit in the free text field should be forwarded to the department for consideration, via email at the following address: reviewable.decisions@health.gov.au

The reason for the correction must be recorded when lodging the request. For example, "*Ongoing residential care omitted from online approval process, evidence of an ongoing residential care recommendation in Support Plan*". For the department to agree to the correction, the assessment delegate's intention (as at the time the decision was made) should be clearly evident though assessment documentation and/or other supporting documents on My Aged Care.

If the assessment information is not consistent with the correction request, the department will reject the request. In instances where a client's needs change after the original decision, a reassessment should be undertaken.

In situations where the Assessment Delegate has reconsidered their decision and changed their mind after recording the approval (based on additional information they have received), a correction request is not appropriate, and a reassessment is required. Any correction requests received by the department for this reason will be rejected.

A correction cannot be requested where service referrals have been issued for services. Where a correction is required for an assessment and service referrals have been issued,

the assessment organisation must recall all services in an ‘issued’ state before they can request a correction.

If it is identified a correction is required after a service referral has been accepted or services have commenced, the correction should be escalated to the department via email at the following address: reviewable.decisions@health.gov.au

11.6. Complaints

Older people (and/or their carer/advocate/registered supporters) have the right to raise their concerns about the information, service or care they have received from My Aged Care, their assessor or service provider.

There are different ways to make a complaint depending on the part of My Aged Care that the concern relates to, such as:

- the My Aged Care Contact Centre
- aged care assessment with an assessor
- the outcome of an aged care assessment
- the care and services received from a service provider; or
- the conduct of a registered supporter.

11.6.1. Concerns about My Aged Care

An older person or registered supporter should discuss their concerns about the service or information they receive from My Aged Care with the contact centre in the first instance.

If they are unable to resolve the issue, My Aged Care will provide a reference number to track the progress of the complaint. A person can make a complaint by:

Calling My Aged Care on 1800 200 422.

Posting their complaint to:

My Aged Care Complaints
PO Box 1237
Runaway Bay QLD 4216

An assessor can make a complaint or escalate an issue about contact centre services by calling the My Aged Care Service Provider and Assessor Helpline on 1800 836 799.

If an older person, assessor or provider is not satisfied with the response received, they can take further action by sending an email with the detail of their complaint, and their My Aged Care reference number to: myagedcaresupport@health.gov.au

11.6.2. Concerns about the assessment

Assessment organisations are required to have a complaints procedure in place.

If a person has concerns about their assessment, they are advised to contact the assessor or their assessment organisation in the first instance.

If the department receives a complaint through My Aged Care, it will be referred to the relevant assessment organisation for investigation and/or resolution. The assessment organisation will report back to the department on the outcome.

If the person cannot first resolve the issue with their assessor or their organisation, they are advised to call My Aged Care for assistance on 1800 200 422. Complaints relating to assessment organisations are escalated to the department for investigation.

My Aged Care Complaints and

My Aged Care Quality in Aged Care

11.6.3. Complaints about an aged care provider

If an older person (and/or their carer/advocate/registered supporter/appointed decision maker) is unhappy with any aspect of the care or services being received through an aged care provider they can:

- Speak to their service provider about their concerns
- make a complaint to the Aged Care Quality and Safety Commission (ACQSC):
    - By calling 1800 951 822
    - By completing an online form on the commission's website
    - In writing to:

      Aged Care Quality and Safety Commission
      GPO Box 9819, in your capital city

An assessor can also make a complaint with the ACQSC if they have concerns about an aged care provider.

In addition to the above, complaints about care received from Multi-Purpose Service Program (MPSP) providers or Transition Care Program providers can be referred to the relevant state and territory health department complaints bodies.

MPSP providers also have an obligation, under their MPSP agreement with the Commonwealth, to ensure their respective state or territory is advised when complaints have been made by an individual about the aged care or health services being delivered.

ACQSC: Aged Care Service Provider Complaints

ACQSC: Lodge a Complaint

11.6.4. Complaints and concerns about registered supporters

Any person or organisation can raise a complaint or concern with the System Governor relating to a registered supporter's conduct, including alleged non-compliance with the duties of a registered supporter. The System Governor can suspend and/or cancel the registration

of a supporter. This may occur at the request of an older person or registered supporter, or at the initiative of the System Governor.

Complaints or concerns can be raised by anyone. This includes an older person, their other registered supporters, appointed decision makers, aged care providers or workers, medical or allied health practitioners, advocates or any other person who is concerned for the welfare or treatment of themselves or the older person.

Assessors have a role in raising or handling complaints, concerns, or requests to cancel the registration of a supporter by escalating any relevant information to the departmental delegate responsible for supporters. This includes any request from an older person or their registered supporter to cancel the relationship where the circumstances mean the registered supporter may be suspended under the *Aged Care Act 2024* (the Act), or any other complaint or information that suggests a registered supporter is not complying with their duties under the Act. This includes anything an assessor notices at an assessment.

Concerns and complaints can be raised using the online form for making a submission to the System Governor responsible for supporters.

Information about the duties of a registered supporter and the complaints process can be found in the policy library for registered supporters.

Complaints about aged care providers, including their engagement with registered supporters, can be made to the Aged Care Quality and Safety Commission.

11.6.5. Complaints about aged care policies

Complaints related to Australian Government aged care policies, guidelines or decisions should be referred to the Department of Health, Disability and Ageing.

12. Chapter 12: Supporting diverse experiences and needs

What you'll find in this chapter:

This chapter 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.

12.1. Supporting diverse needs during an assessment

The Department of Health, Disability and Ageing, Australian Government agencies, aged care assessment organisations, providers and the aged care workforce must ensure that older people have access to person-centred, culturally safe, trauma aware and healing informed aged care assessments and services. This includes valuing older people, their identities, cultures, abilities, diversity, beliefs and life experiences.

The Aged Care Diversity Framework provides guidance for an accessible aged care system for every older person.

The Statement of Principles in section 25 of the Aged Care Act 2024 (the Act) provides for an aged care system that offers accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed aged care services, based on the needs of the individual, regardless of their location, background and life experiences. This may include individuals who:

- are Aboriginal or Torres Strait Islander persons, including those from stolen generations
- are veterans or war widows
- are from culturally, ethnically and linguistically diverse backgrounds
- are financially or socially disadvantaged
- are experiencing homelessness or at risk of experiencing homelessness
- are parents and children who are separated by forced adoption or removal
- are adult survivors of institutional child sexual abuse
- are care-leavers, including Forgotten Australians and former child migrants placed in out of home care
- are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or are gender diverse or bodily diverse
- are an individual with disability or mental ill-health
- are neurodivergent
- are deaf, deafblind, vision impaired or hard of hearing
- live in rural, remote or very remote areas.

It is important to understand that individuals may identify across more than one group and may have a variety of special and diverse needs that will need to be recognised and taken into consideration.

During the assessment process, assessors must consider how they can create a safe assessment setting and ensure older people have a trusted support person present if needed. This may be a carer, partner, registered supporter, friend or perhaps a member from their 'family of choice' (who may or may not include biological family). This will help to build trust and ensure that an assessor can collect all information necessary to develop an appropriate and tailored Support Plan with the older person that considers their diverse needs.

It is important to recognise that many older people with diverse needs, characteristics and life experiences may have experienced exclusion, discrimination and stigma during their lives and may not feel safe to reveal such potentially sensitive information in an assessment.

Aged Care Diversity Framework

12.2. Understanding cultural safety for older Aboriginal and Torres Strait Islander people

Assessors are required to complete an introduction to cultural safety as part of the induction training through MAC Learning to ensure they understand why cultural safety is important in providing safe aged care experiences for older Aboriginal and Torres Strait Islander people.

The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council's (NATSIAACC) definition of cultural safety (referenced below) was co-designed in 2024 and included in the revised explanatory memorandum accompanying the Aged Care Bill 2024. All workers in the aged care system, including assessment staff, are expected to critically self-reflect and take responsibility for building an understanding of how they can improve their approach to culturally safe care in their daily practice.

It is also required that assessment organisations provide their staff with additional cultural safety and trauma aware, healing informed training relevant to the customs and protocols local to the area in which they operate. Further to this, it is recommended that assessment staff undertake additional training on how to understand and support the Stolen Generations. As at 2022, all Stolen Generations survivors are aged 50 or over and therefore may be eligible to receive aged care services. Many Stolen Generations survivors live in urban and regional locations where there are few, if any Aboriginal and Torres Strait Islander community controlled aged care services and facilities.

When assessing Aboriginal and Torres Strait Islander clients, it is important to be guided by the individual's preferences, and observe body language and respond respectfully. If appropriate, assessors are encouraged to tailor their assessment approach to the specific needs of individuals to ensure that their support requirements are accurately reflected in their support plans. This may include:

- using a trusted cultural broker, or advocate,
- using supplementary assessment components of the IAT that are best suited for assessing the older person's needs, and/or
- developing relationships that support regular interactions and mentorship with existing and trusted health services and specialist providers located within a local community,

- working with existing Aboriginal Community Controlled Organisations (ACCOs) Aboriginal Community Controlled Health Organisations (ACCHOs) affiliates and Indigenous organisations who specialise in providing aged care services where they are available, and
- using the Kimberley Indigenous Cognitive Assessment (KICA) assessment tools and the Good Spirit, Good Life guide in the Integrated Assessment Tool (IAT) for older Aboriginal and Torres Strait Islander people. These have been validated as the most acceptable and reliable instruments for assessing the needs of Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander aged care | Australian Government Department of Health, Disability and Ageing

The KICA and the Good Spirit, Good Life guides are in the IAT User Guide

NATSIAAC definition of cultural safety

'Cultural safety requires understanding of one's own culture and the impact that your culture, thinking, and actions may have on the culture and wellbeing of others through ongoing critical self-reflection.

Only the care recipient themselves can determine whether the service is culturally safe. Ensuring access to a culturally safe, respectful, responsive and racism free aged care system is inherent for the optimal safety, autonomy, dignity, and absolute wellbeing of Aboriginal and Torres Strait Islander Elders, senior and older people, their families and community.

Aged care service providers and workers must take responsibility for building trust and relationships with Aboriginal and Torres Strait Islander service users, and their families, and for creating a new aged care system which centres on their living experience, cultural, and ageing needs, as determined by Aboriginal and Torres Strait Islander service users themselves.

The implementation of a trauma aware, healing informed approach to professional practice, and facilitating a greater understanding and respect for individual and collective cultures, histories, knowledges, traditions, stories, and values of Aboriginal and Torres Strait Islander service users, their families and communities, will greatly support the delivery of a quality and culturally safe aged care system.

Aged care service providers must also firmly commit to continuously measure and improve structures and behaviours necessary for cultural safety and quality support to remain embedded in the Australian aged care system'.

12.3. Cultural safety for other cohorts

Cultural safety is an important consideration for all culturally distinct groups, for example culturally and linguistically diverse and lesbian, gay, bisexual, trans/transgender, intersex+ communities. It's important for assessors to recognise and respect the identities and customs of all older people who are culturally different from themselves, and have different life experiences, to provide equitable outcomes and quality assessment services.

Respecting a person's identity, culture and diversity in aged care should focus around understanding their individual needs and preferences and providing an assessment that is reflective of and responsive to their social, cultural, linguistic, religious, spiritual, psychological, medical and other needs, including cultural safety.

Assessments for all older people, regardless of culture or background, should be conducted in a way that is:

- **Welcoming and open-minded:** an assessor truly listens to the older person and works from the older person's cultural perspective, rather than their own
- **Respectful:** recognises their cultural identities and customs and does not challenge, assault or deny the identity of the older person
- **Safe, inclusive and flexible:** meets the older person's needs, expectations and rights, and is supportive of diverse characteristics and life experiences
- **Collaborative:** shares meaning, knowledge and experience through meaningful dialogue between the older person and the assessor
- **Self-determined:** provides choice, participation and control to the older person, and allows them to make decisions about matters that affect them

Aged Care Diversity Framework action plans | Australian Government Department of Health, Disability and Ageing

Partners in Culturally Appropriate Care (PICAC)

Working with Diverse Groups in Aged Care

Australian Migrant Resource Centres

12.3.1. Aboriginal and Torres Strait Islander assessment organisations

As a part of the Single Assessment System, Aboriginal and Torres Strait Islander assessment organisations began being rolled out from August 2025. These assessment organisations provide a choice for older Aboriginal and Torres Strait Islander people seeking access to a culturally safe aged care assessment. A small number of organisations will commence providing these services initially and over time, these services will extend their reach and progressively cover more areas across Australia.

A culturally safe assessment process will help to improve the experience for older Aboriginal and Torres Strait Islander people and increase their uptake of aged care services. This will support them to maintain their independence at home for longer.

The organisations will help older Aboriginal and Torres Strait Islander people, their families, and carers, to access aged care services across urban, regional, and remote Australia.

Aboriginal and Torres Strait Islander assessment organisations will:

- Take a less formal yarning approach to assessments to make the older Aboriginal and Torres Strait Islander person feel 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.
- In line with the older person's wishes, welcome the presence of the older person's family member, advocate or registered supporters, to be part of the meetings.
- Allow for multiple visits, if required, to build trust and develop a relationship.
- 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 person's preferences and needs.
- Be supported by connection to community to gather information about the older person's health and wellbeing to understand the aged care services they need prior to meeting them. This will limit the amount of information that the assessor needs to draw from the assessment, which will help to limit the number of times that the older person needs to re-tell their story.
- Maintain a connection with the older person for the whole journey to receiving services, through Elder Care Support workers. This will help to manage any uncertainty or questions throughout the process.
- Work with organisations that support Stolen Generation survivors.
- Provide interpreting services when needed.

Until an Aboriginal and Torres Strait Islander service is available in their area, older Aboriginal and Torres Strait Islander people can receive aged care assessments via an existing assessment organisation. Once an Aboriginal and Torres Strait Islander organisation becomes available, older Aboriginal and Torres Strait Islander people will have the choice to be assessed through either assessment pathway.

More information available at - Aboriginal and Torres Strait Islander Aged Care Assessment Organisations.

12.4. People with dementia

Under the Statement of Rights in section 23 of the Aged Care Act 2024 (the Act), an individual has a right to equitable access to an assessment in a manner that is accessible and suitable for individuals living with dementia or other cognitive impairment.

The Australian Government recognises the unique needs of people with dementia and their families, registered supporters or other people who support them. People with dementia can experience communication challenges, which emphasises the need for clear, respectful and effective engagement that is person-centred. As dementia is a progressive condition, people will require reassessment to respond to changing needs and to plan appropriate, personalised, care and support.

Presumption of capacity

The Act establishes a modern rights-based, person-centred approach that prioritises the safety, health and wellbeing of older people. As such, it places older people and their wishes at the centre of the aged care system.

A key change under the Act is that every older person is presumed to have the ability to make their own decisions and to have those decisions respected and recognised by law. This is known as the presumption of capacity. This means that other people, for example assessors, registered supporters, workers, health professionals and carers, should assume

in the first instance that an older person can make their own decisions and do things themselves.

The presumption of capacity applies to every decision to be made. This means that an older person is presumed to be able to make every new decision. If an older person is not able to make a decision on one occasion, it does not mean the older person should be excluded from decision-making on other occasions.

Assessors should implement supported decision-making principles and processes where appropriate, regardless of the presence or absence of a registered supporter, active appointed decision-maker, or other person supporting an older person.

A diagnosis does not necessarily mean that a person no longer has the ability to make some or all decisions for themselves. This includes diagnoses of dementia, mental illness, intellectual or cognitive disability, or acquired brain injury. For example, simply because a person has been diagnosed with dementia, does not mean that they lack decision-making ability for some or all decisions.

Guidance for assessors

Assessors should foster links with dementia-specific services, including Dementia Australia and Dementia Support Australia (DSA), and build awareness of local memory, cognition and dementia services available, including cognitive or dementia reablement where appropriate. Where relevant, include dementia expertise in the assessment process. This knowledge and connection will assist assessors to better understand the specific needs of people living with dementia and their care partners, families, and representatives, and assist to improve linkages, integrated care, and access. Assessors should be particularly alert to concerns about cognitive impairment or people who indicate a previous diagnosis of dementia. Referrals to the National Dementia Helpline or a GP should be considered where concerns about cognitive impairment are raised or where there is a diagnosis of dementia but the person, their registered supporters or other people who support them are not receiving the dementia-specific support they need. Information and appropriate interventions after a diagnosis help people to live well with dementia, and plan for the future. Assessors can request a call back for carers who have concerns about dementia (with their consent) from the National Dementia Helpline through the Assessor Portal and the Aged Care Assessor App. A trained professional from Dementia Australia will then call the carer and speak to them about dementia-specific services and supports that might be of assistance.

Note:

A person does not need to have a formal dementia diagnosis to be referred to the National Dementia Helpline or Dementia Support Australia.

People living with dementia can experience behaviour changes, known as behavioural and psychological changes of dementia (BPSD), which impact their care and quality of life. Personalised support services are available from Dementia Support Australia (DSA) to help carers and service providers anywhere nationally to develop strategies that optimise function and support unmet needs for people impacted by BPSD and assessors can make referrals for support (with appropriate consent of the older person and care network as relevant) via DSA's 24-hour helpline or online.

Assessors must use their professional judgment where an older person has dementia or is cognitively impaired. In these cases, the input of registered supporters or other people who support the older person and/or advocates is particularly important. However, only a person

with active, legal decision-making authority for an older person can make a decision on their behalf.

> Note: assessors should be aware that applying professional judgement might be especially difficult when working with Aboriginal and Torres Strait Islander older people and older people from Culturally and Linguistically Diverse backgrounds living with dementia or cognitive impairment. Factors such as language barriers, different concepts around ageing and dementia, a lack of awareness of dementia among family members and the additional stigma attached to dementia in some cultures can all make assessment more complex. Some culturally appropriate dementia resources are included under further information below.

The IAT User Guide provides assessors with prompts to help evaluate cognition throughout the assessment, including aspects related to an individual's functional capacity.

Assessors are required to complete a Dementia specific training module in MAC Learning as part of their training and additional educational resources are available through Dementia Training Australia.

Assessors may find the *Clinical Practice Guidelines* and *Principles of Care for People with Dementia* (the Guidelines) useful. The Guidelines provide recommendations for the diagnosis and management of dementia and are intended for use by staff working with people living with dementia in the health and aged care sectors, including GPs. Updated Guidelines are currently in development.

Companion documents to the Guidelines include a Health Professional Quick Reference Guide, and for people living with dementia and their carers the *Diagnosis, treatment and care for people with dementia: A consumer companion guide.*

Free accredited training, education, upskilling and continuing professional development for the workforce providing dementia care in the primary, acute, and aged care sectors, also accessible for aged care assessors, is available through Dementia Training Australia and the Wicking Dementia Centre.

Dementia Australia website:

Home | Dementia Australia

Dementia Support Australia website:

Nationwide, 24-hour dementia carer support | Dementia Support Australia

Department of Health, Disability and Ageing website:

My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships

What we're doing about dementia | Australian Government Department of Health, Disability and Ageing

University of Sydney (Cognitive Decline Partnership Centre) website:

Clinical Guidelines for Dementia

The Wicking Dementia Centre

12.5. People who live in remote and very remote areas

A small number of older people live in isolated areas. These locations are classified using the Modified Monash Model (MMM). Whilst recognising face-to-face assessment is good practice and should be the first option, this mode of assessment is not always possible for older people living in remote areas. In these circumstances, assessments may be conducted using non-face-to-face technologies such as telephone or telehealth. Where this occurs, a suitably qualified person from within the local health service or community care provider should be present to support the older person and to facilitate the assessment.

Assessors should develop and maintain good working relationships with health and community workers in rural and remote communities who may be called upon to assist with assessments and provide information and community needs and local services.

12.6. People who are financially or socially disadvantaged

Financial or social disadvantage can often create a significant barrier for people to access a wide range of services in the community. Assessors should ensure that they develop and promote links with organisations in their area which attempt to overcome these barriers and provide assessments to people who may benefit from services regardless of their financial or social circumstances.

People who are financially or socially disadvantaged may also experience difficulties in accessing services after their approval. Assessors should be prepared to engage in a wide range of care coordination activities on behalf of older people to ensure that they receive the care which they need and to which they are entitled.

From 1 November, financial hardship arrangements will continue to be available if an older person can't afford to contribute to the cost of their aged care, both in residential care and in-home care. An older person will be assessed on their specific circumstances. If approved for hardship assistance, the Australian Government will pay some (or all) of their aged care fees. The government will pay any approved amounts to the aged care provider on the older person's behalf. If an older person is required to pay some of their fees, they will continue to pay those to their provider.

To apply for financial hardship assistance, an older person must meet certain requirements and complete the Aged Care Claim for Financial Hardship Assistance form. This form is sent to Services Australia to assess the application, and they will let the older person know in writing of their decision and what assistance they are eligible for. This form should be submitted by an older person once they start accessing aged care services.

Hardship assistance for aged care – Fact sheet

Financial hardship assistance | My Aged Care

12.6.1. Veterans

The Australian Government recognises the aged care needs of the veteran community, in particular, mental health issues including post-traumatic stress. This is creating demand for a wider range of health care and support services in residential and home care services.

Assessors should establish links with relevant veterans' organisations in their communities and develop links between veterans and home care and residential care services. They should aim to facilitate an understanding of veterans' particular needs and to improve integrated care and access.

Assessors should have a good understanding of services provided by the Department of Veterans' Affairs (DVA) including the Veterans' Home Care (VHC) Program, the Coordinated Veterans' Care (CVC) Program and other mental health and rehabilitation programs.

Assessors should advise veterans that if they are an Australian former prisoner of war or Victoria Cross recipient, DVA will pay their basic fee and means tested care fee. They still may need to pay a means tested accommodation payment if their income and assets are above a certain limit. Services Australia will take into consideration DVA compensation payments when assessing a person's income and assets under the Support at Home program.

Optional learning for all assessors called 'Supporting older Australians, people with disability and Veterans' is available through MAClearning.

Department of Veterans' Affairs website

12.7. People who are homeless or at risk of becoming homeless

Assessors have a responsibility to recognise older people who are experiencing, or are at risk of becoming homeless, and to ensure that they can access an assessment and any aged care services approved for them. Liaisons between assessors and support services for homeless people are particularly important for this cohort because of their extreme vulnerability. Assessments for this cohort will require a flexible and unique approach by assessment organisations. For example, assessors may need to travel to outreach locations in order to undertake the assessment, working closely with the providers already linked to the older person, such as community health clinics, hospitals, emergency housing providers or other community services such as those that provide free meals and laundry services.

People aged 50-64 seeking aged care services under the homeless or at risk of homelessness criteria must meet the appropriate definition as described in Chapter 1 and Chapter 5.

Assessors should also be aware that homelessness alone is not grounds to approve an older person as eligible for residential or other forms of aged care. The person must meet the eligibility criteria set out in the *Aged Care Act 2024*.

Where housing assistance services are not available, assessors should make appropriate referrals and work with their state and territory government housing and homeless services.

Learning for all assessors called ‘Homelessness and older people’ is available through MAClearning.

For further detail on the definition of homelessness in aged care, see Chapter 1 ‘Homeless or At Risk of Homelessness Eligibility’.

12.8. Care leavers

The department’s website provides information on care leavers, including a description of the term ‘care-leaver’.

This term refers to children who were in institutional and other out-of-home care prior to the year 2000, including:

- Forgotten Australians - people who spent a period of time as children in children's homes, orphanages, and other forms of out-of-home care prior to the year 1989.
- Former child migrants - children who arrived in Australia through historical child migration schemes and were subsequently placed in homes and orphanages.
- Stolen Generations - children of Aboriginal and Torres Strait Islander descent who were taken from their families and communities by Federal and State government agencies and church missions under the forcible removal policies from the late 1800s until the 1970s.

Assessors should be particularly sensitive to the effects of care-leavers’ childhood experiences with government officials, authorities and institutional care. These individuals may have experienced complex trauma and have general distrust of institutions and Government departments. Assessors should consider how to best support older people in the most sensitive and respectful way with an awareness and understanding of how childhood experiences may influence their concerns, preferences and decisions in relation to aged care, and emphasise that older people can have a support person at the assessment and that they are not obliged to take up any approved care.

In December 2016, the ‘Caring for Forgotten Australians, Former Child Migrants and Stolen Generations resource was launched. This package is designed to enhance aged care services and ensure residential and home care providers provide the best possible care to the care leaver groups. Additionally, the Real Care the Second Time Around Project has developed practical tips to assist aged care providers and staff to engage with Forgotten Australians/Care Leavers.

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.

Department of Health, Disability and Ageing website: Caring for Forgotten Australians, Former Child Migrants and Stolen Generations Information Package

Helping Hands website: Real Care the Second Time Around – Practical Tips

12.9. Parents separated from their children by forced adoption or removal

This term refers to the policies and practices that resulted in forced adoptions and the removal of children throughout Australia, particularly during the mid-twentieth century.

Forced adoption practices impacted a large number of Australians and caused significant ongoing effects for many people, particularly mothers, fathers, and adoptees.

Assessors need to be particularly sensitive to those older people who have been adopted or impacted by past forced adoption practices, including interactions with government officials, authorities, and institutional care, as these experiences can have significant personal and psychological impacts. Assessors should emphasise that older people' wishes are taken into account, they can have a support person at the assessment, and they are not obliged to take up any approved care.

Department of Social Services website: Families and Children; Forced Adoption Practices and Forced Adoption Support Services

12.10. Lesbian, gay, bisexual, trans, intersex and other gender diverse people (LGBTI)

In Australia, the acronym 'LGBTIQA+' is used widely, however, older people often prefer the use of 'LGBTI', as the word 'queer' can trigger past trauma as it has previously been used as

an offensive derogatory term. 'LGBTI' refers collectively to people who are lesbian, gay, bisexual, trans and gender diverse, and/or intersex. LGBTI is often viewed as and referred to as single category that is used to speak about people using broad generalisations. However, LGBTI communities are not homogenous. Within the LGBTI acronym are several distinct, but sometimes overlapping, demographics each with their own histories, experiences and health needs.

Older LGBTI people and elders are likely to have experienced violence, stigma and discrimination throughout their lives. As a result, they may be reluctant to disclose their identities or histories to aged care services and therefore remain isolated or invisible within both the sector and the broader community. Combined with general stigmatisation and invisibility of LGBTI needs at large, this results in a lack of awareness of the unique needs of older LGBTI people, including a lack of targeted services to support them. In addition, the fear of mistreatment or rejection from aged care providers can lead to older LGBTI people delaying seeking care until their health deteriorates or a crisis occurs.

Assessors should ensure they conduct a non-judgmental assessment and the choice to disclose sexual orientation, sex/gender identity or variations of sex characteristics is entirely the older person's decision. Where an older person does disclose this information, the Assessor should emphasise that their information is protected information under the Aged Care Act 2024. In the case of transgender and intersex older people, where specific medical history may need to be communicated to service providers, it is important to discuss the way this information will be communicated or shared with providers.

Assessors should also be aware of service providers who provide LGBTI-specific services and those that are LGBTI inclusive and be prepared to advocate for LGBTI older people with other service providers as necessary as part of their care coordination activities.

In 2019, Actions Plans to Support LGBTI Elders were developed under the Aged Care Diversity Framework to address the unique needs and challenges faced by older LGBTI people. The provider action plan sets out what aged care providers can do to deliver inclusive care that is appropriate and sensitive to the needs of older LGBTI people. The consumer guide helps older LGBTI people to express their needs when speaking with aged care providers. It can also help people working in aged care to better understand the needs of LGBTI people.

Department of Health, Disability and Ageing website:

Actions to Support LGBTI Elders: A Guide for Consumers

Actions to Support LGBTI Elders: A Guide for Aged Care Providers

Working with Diverse Groups in Aged Care

Federal Register of Legislation website: Aged Care Act 2024 - Federal Register of Legislation (see Statement of Principles section 25)

12.11. Other groups

12.11.1. Carers

It is important for assessors to recognise the valuable contribution and informal support that carers provide in the care of older Australians.

Where possible, with the older person's consent, the assessor should involve the older person's carer, family, registered supporters or other people who support the older person in the assessment and support planning process. In assessing the older person's care needs where family and carers are involved, assessors may find there is a need to balance the older person's concerns and preferences with those of their family and/or carers. Assuming the older person has capacity to make their own decisions, only the goals and preferences of the older person should be reflected in their Support Plan. The assessor may need to meet with the older person separately to ascertain the older person's preferences.

Assessors should (with the older person's consent) gain an understanding of the carer's support preferences for the older person and their capacity to continue in the caring role. Assessors need to consider the carer's circumstances and assess if there are any factors that may affect the sustainability of the caring role. An older person may agree to service recommendations that also benefit the carer, for example a type of respite service where there is an identified area of concern regarding strain in the older person/carer relationship and a goal to relieve stress on the carer.

Assessors should provide information to carers regarding specific support services that are available for carers to access in their own right and inform carers how to link with these support services. Assessors can directly refer carers (with their consent) to Carer Gateway and the National Dementia Helpline through the Assessor Portal and Aged Care Assessor App.

Carer Gateway website.

Department of Health, Disability and Ageing website: Our work related to dementia | Australian Government Department of Health, Disability and Ageing

My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships

Dementia Australia **website.**

Dementia Support Australia website.

12.11.2. People living with mental health conditions

When assessing the aged care needs of older people living with a mental health condition assessors are encouraged to liaise with mental health services to assist their understanding of the older person's needs. Assessors can also assist by facilitating links between the older person, providers, and appropriate mental health services.

Aged care services usually do not have the capacity to adequately meet the needs of people with a serious, uncontrolled mental health condition without the support of, and treatment by, mental health services.

Assessment and approval for entry to aged care is only appropriate if the intensity, type, and model of care is the most appropriate to meet the person's care needs. This includes the following considerations:

- The person's mental health is stable. If they have recently received treatment, their mental health should be stable prior to being assessed although it is understood they may still have significant symptoms.

- Community mental health services will continue to provide collaborative care for those elderly people who have significant or unstable psychiatric symptoms.

The assessor must, prior to commencing an assessment, obtain informed consent for the assessment either from the person (if they have the capacity to do so), or an appointed decision maker consistent with state or territory arrangements who is able to make decisions regarding health, accommodation, and daily living care.

Involuntary mental health care is governed by separate mental health legislation in each state and territory. People who are placed under some form of an involuntary order (e.g., to manage their medicines when living in the community) may be eligible for aged care services. Assessors should consider each referral on a case-by-case basis.

In some jurisdictions, under certain circumstances, mental health legislation empowers the treating psychiatrist to make accommodation decisions in the best interests of a person receiving treatment under an involuntary order. This power is only exercised when a particular accommodation setting is required to facilitate the treatment of a person's mental health condition. It does not replace the need for guardianship when a mental health condition is incidental to that person's need for placement in residential care.

A comprehensive assessment is also required to access residential aged care facilities in jurisdictions where residential aged care facilities are part of the aged mental health service system.

All assessment organisations should develop assessment protocols that reflect relevant state or territory legislation and regulations, to ensure that older people living with a mental health condition are directed to the responsible agency to assess and recommend services most appropriate to meet their care and support needs.

12.11.3. People with palliative care needs

Under the Statement of Rights in section 23 of the Aged Care Act 2024 (the Act), an individual has a right to equitable access to palliative care and end-of-life care when required. The strengthened Aged Care Quality Standards also include outcome 5.7 Palliative Care and End-of-Life Care, that provides the intent for providers to follow, including recognising and addressing the needs, goals and preferences of individuals for palliative care and end-of-life care

Palliative care is person and family-centred treatment, care and support for people living with a life-limiting illness. Palliative care aims to improve quality of life and support people to live well for as long as possible.

The Aged Care Quality and Safety Commission stipulate that care recipients are entitled to receive personal and/or clinical care that is appropriate and recognises their needs, goals, and preferences. This is particularly important for care recipients nearing the end of their lives whose preference may be to remain in their home for as long as possible.

Older people with a life-limiting condition can be supported by multiple care systems including, aged care services, mainstream health care services (including specialist care) and state and territory specialist palliative care services.

Where the aged care system is identified as part of the care requirements for a person over the age of 65 years (or over 50 years for Aboriginal and Torres Strait Islander people and people who are homeless or at risk of homelessness) with a life-limiting illness, it is important the aged care assessment is holistic and considers all of the person's needs. An

important part of the aged care assessment will be the identification of palliative care and end of life care needs. Timely provision of appropriate care can support people to be cared for in their home for as long as possible if this is their preference. This is therefore important to consider as part of the assessment and when recommending care options and services.

Assessors should pay particular attention and use their professional judgement to note if an older person has a life limiting illness, they would likely benefit from receiving a palliative approach to care.

Supporting information

Palliative care seeks to prevent and relieve suffering through early identification and correct assessment and treatment of pain and other symptoms, associated with a life-limiting illness, whether physical, psychosocial, or spiritual. The types of supports that may be needed by an individual, their families and carers will vary and may include a range of clinical and non-clinical supports.

Palliative care can occur in almost all settings where health and aged care is provided. It may be provided by a variety of professionals, including specialists, general practitioners, nurses, allied health workers, aged care workers, counsellors, and pastoral carers. The assistance of specialist palliative medicine physicians and nurses may be required when a person's symptoms are complex or difficult to manage.

Palliative care is different to 'end-of-life care'. While palliative care may be provided from the point of diagnosis of a life-limiting illness, end-of-life care is care for a person who is in the last months or weeks of life, including for those whose death is imminent (within weeks or days). The needs of patients are higher at this time and timely access to services is vital. Timely access to aged care services may depend on the services being sought and whether a person is already engaged with an aged care program.

It is therefore important to explore all options for an older person, including whether the Support at Home End-of-Life pathway is appropriate. Eligibility for the End-of-Life Pathway can be found in Chapter 6.

The provision of both palliative care and end-of-life care cuts across systems – care offered through the aged care system should be integrated to facilitate seamless transition, building upon clinical palliative care services offered by primary care professionals, or state-based specialist palliative care services.

For example, where a state or territory provides clinical palliative care services in the home, older people receiving palliative care may also require assistance with basic daily living support and supportive care to ensure they are able to remain at home for as long as possible. These care needs range from assistance with daily chores to personal care, providing meals, transport assistance, respite care, home modifications and social support.

Department of Health, Disability and Ageing website:

AN-ACC Class 1 – admit for palliative care

National Palliative Care Strategy

Training and tools for health and aged care professionals

The Australian Government funds accredited education and training on palliative care for the workforce.

The Palliative Aged Care Outcomes Program (PACOP) aims to systematically improve palliative and end-of-life care outcomes in aged care settings in Australia.

End of Life Directions for Aged Care (ELDAC) provides information, guidance, and resources for all aged care staff to support palliative care and advance care planning.

Information can be found at health.gov.au/palliative-care-education

12.11.4. Older people who are in prison

Usually, aged care assessments will be conducted when the person is released from prison into the community by referral through My Aged Care. Assessments of ex-prisoners in a community setting will depend on the person's needs and the screening and triage outcome. However, in a prison setting, only clinical assessors can undertake such assessments. A triage delegate can only arrange an assessment by a non-clinical assessor to take place after the person is released.

If it is imperative that an assessment occurs in prison, the clinical assessor can conduct an in-prison assessment, provided the prisoner has a release date and the prison is agreeable to the arrangement. By exception, an older person may be assessed in a prison setting by a clinical assessor prior to them securing a release date. This can only occur in cases where a release date is dependent on a needs assessment being undertaken.

In recognition that prisoners can have very complex health and care needs, it is appropriate for a clinical assessor to be supported by another assessor. This is a decision for the assessment organisation to make keeping in mind the health and safety of its assessors. For additional considerations for WHS screen prior to assessment see Chapter 5.

Regardless of whether the assessment occurs in a community or prison setting, Commonwealth subsidised aged care services can only commence after the prisoner is released. It is the responsibility of the relevant state or territory government to provide the appropriate care and services while the person is incarcerated. If the older person is found eligible for Support at Home, the assessor should update the older person's status to 'not seeking services' at the time of assessment. Upon receiving a prison release date, the older person or registered supporter or other person who support the older person will need to contact My Aged Care to indicate they are actively seeking care to be placed on the Support at Home priority system.

If the 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. Providers will be presented with a banner message on My Aged Care where a sensitive note exists prompting them to contact the assessor. The assessor should disclose information where it is applicable to the provider in their provision of care or services to the

older person (see Recording sensitive information in Chapter 5). Where it is recorded the older person has challenging behaviours that may impact the safety and welfare of the older person or staff, the assessor should contact the provider to help ensure they can appropriately manage these behaviours once services commence.

The Support Considerations section of the IAT gives assessors the opportunity to ask the older person if there is any further information providers should be aware of in the delivery of care and services. This will allow (although this is up to the older person to agree to) the older person to advise of parole conditions or any implications of their incarceration that relate to effective and safe aged care provision that have not previously been raised during the assessment. The assessor can record this information as a sensitive note and/or sensitive attachment and should add a note in the Support Considerations section of the IAT (and only if appropriate, the Support Plan) indicating that there is a sensitive note and/or sensitive attachment to view.

Assessors should be mindful that there is an increased likelihood that prisoners or ex-prisoners are at risk of vulnerability and complexity and requiring additional linking support (see Delivering Linking Support / Care Coordination to Vulnerable Older people in Chapter 5).

Note: When assessing an older person in a prison 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. Where a person is not in the setting they plan to reside in, 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.

13. Chapter 13: Operating procedures

What you'll find in this chapter

This chapter includes information on privacy, information management and relevant legislation. Also included in this chapter is information about:

- Applying to be delegate
- Information management
- Clinical governance
- Branding
- Resources for consumers
- Reporting and performance

13.1. Applying to be a delegate

Delegate applications are submitted online within the My Aged Care assessor portal. There are currently three delegate positions:

- Triage delegate,
- Clinical assessment delegate and
- Non-clinical assessment delegate.

13.1.1. Delegate on/off form

To be appointed to a delegate position, such as a triage delegate or assessment delegate and gain the authority to make approval decisions, individuals must complete an application process and be approved by the Department of Health, Disability and Aged Care (the Department). This application is submitted through the My Aged Care assessor portal.

> Note: All non-clinical assessors have a blanket delegation under the Instrument of Delegation to approve CHSP, CHSP AT, CHSP HM. In practice, even though there is a blanket delegation, assessment organisations can instruct their workforce to get someone else to approve a client's home support assessment.
>
> Greater functionality will be introduced from late June 2026 to provide for a non-clinical delegate workflow in the Assessor Portal. All non-clinical assessors who are non-clinical delegates will need to hold a non-clinical delegate role in the Assessor Portal from this period onwards.

Within the portal, the Delegate on/off form can be used to:

- **Add** users to delegate positions.
- **Cease** existing delegates from delegate positions.
- **Replace** existing delegates noting that the replace functionality will cease existing delegate access and add their replacement in a single step.

A number of rules apply:

- Only assessors, team leaders, and delegates can hold delegate positions.
- To apply on behalf of someone else, the applicant must be either a Team Leader or an Assessment Organisation Operational Manager.
- Team Leaders can submit applications for themselves as well as for others.
- Assessment Organisation Operational Managers can only hold a delegate position if they are also an assessor or a Team Leader.

All approved delegates are assigned a unique Delegate ID in the My Aged Care system. This ID consists of a 6-character code, where:

- The first three characters represent the assessment organisation ID
- The fourth character indicates the profession ID
- The final two characters identify the specific position within the organisation.

Delegate ID Position setup

The Delegate Position framework derives the position name (Delegate ID Position) for all delegate roles as the concatenation of: 'Initials of delegate role + delegate team ID + profession code + position number'

Initials of delegate role

Table 57. Initials of Delegate Roles

Delegate Role	Initials of Delegate Role
Triage Delegate	TD
Clinical Assessment Delegate	blank (no value)
Non-Clinical Assessment Delegate	NCAD

Delegate team ID

The delegate team ID is an existing field and is unique to an outlet.

Profession code

Table 58. Profession codes

Profession	Profession Code
Non-Clinical	0
Medical Practitioner	1
Registered Nurse	2

Social Worker	3
Occupational Therapist	4
Physiotherapist	5
Other Health Professional	6
Psychologist	7

Position number

The position number is a counter, automatically incremented.

Example:

A Triage Delegate role for an outlet with:

- Delegate Team ID: "7YC"
- Profession: Social Worker (Profession Code: "3")
- Position Number: "00"

The Delegate Position ID will be TD7YC300.

A Clinical Assessment Delegate position (ID: 6SR315) is located in Southern Tasmania (Aged Care Planning Region) for the Tasmanian Department of Health. This role:

- Can only be occupied by a Social Worker
- Is identified by the Position Number: 15 in that outlet.

Using the My Aged Care assessor portal

The My Aged Care assessor portal allows applicants to manage delegate positions through a structured process.

The delegate application process consists of four main steps:

- Create the application – The applicant initiates and submits the application.
- Verify the application – A verifier, who must hold the Team Leader role in the portal, reviews and confirms the application details.
- Support the application – A supporter, who must hold the Assessment Organisation Operational Manager role in the portal, provides the final approval or endorsement.
- Approve the application – The Department reviews the application and any supporting evidence before deciding to approve or deny it.

Each step in the application process must be completed in order, following the system's established rules and workflows.

Portal processes

A key requirement is that applications progress one step at a time. For instance, if a Team Leader submits an application on behalf of another user, they must first create and submit the application. Only after submission can they return to verify it. This structured approach ensures clarity and organisation throughout the process.

Applicants, verifiers, and supporters have access to the proposed delegate's profile details, including their name, contact information, clinical status, occupation, and qualifications. However, these details cannot be updated during the application process. If any information needs to be changed, the applicant must work with the outlet or organisation administrator to update the details within the portal, separately from the application process.

Access to applications is limited to authorised users

Outlet-level Team Leaders and Outlet Administrators have limited access. For applications involving multiple outlets, only Team Leaders overseeing all included outlets can view them. Outlet Administrators have similar restrictions and, like Organisational Administrators, do not participate in processing delegate applications.

Creating a delegate application

When creating a delegate application, delegate positions can be managed by adding, replacing, or ceasing delegates.

- The **Add** option allows the user to create a new delegate position.
- The **Replace** option lets the user cease an existing delegate and assign their replacement.
- The **Cease** option is used to remove a delegate from their positions without assigning a replacement.

Each application must focus on a single delegate role, which must be selected at the time of submission. The available roles are Triage Delegate, Clinical Assessment Delegate, or Non-Clinical Assessment Delegate.

If someone is required to hold multiple roles, separate applications must be submitted for each role. In replace applications, the new delegate automatically inherits the same role as the ceasing delegate.

Important to note

- For Add and Replace applications, selecting the delegate's profession is a key step. The system uses this information to either assign an existing vacant position for that profession or create a new position if no vacancy exists. For Cease applications, there is no need to select a profession. Simply choose one or more positions the delegate currently holds to proceed with their cessation, regardless of their profession.
- Applicants can include start and end dates in their applications. The Date From field specifies when the delegate will begin their role, while the Date To field is used to automate the delegate's dissociation when their term ends. However, the Date To field is not needed for ceasing a delegate, as both temporary and permanent cessations are treated the same by the system.

- As part of the process, applicants must nominate a Team Leader to verify the application and an Assessment Organisation Operational Manager to support it. The system filters the list of eligible Team Leaders to include only those who cover all outlets involved in the application. If no suitable Team Leader is available, the system will display an error message. The Operational Manager must also be selected from the provided list to ensure their role matches the application's requirements.

- Special rules apply when a Team Leader submits their own application. In such cases, they must nominate another Team Leader to verify it. Once submitted, the nominated verifier will handle the next steps.

- The system automatically checks several details during the application process, including the proposed delegate's clinical status, occupation, and qualifications. If the delegate does not meet the criteria, warning messages will guide the applicant to update the delegate's user profile or adjust their position type or profession. Applicants can still proceed by acknowledging these issues, and this acknowledgment will be visible to the verifier and supporter in the next stages. Some issues, however, are considered hard stops. For example, if the delegate lacks a clinical status or is assigned a role incompatible with their profile, the application cannot proceed until their user profile is updated.

Note:

The department's My Aged Care Capability Section verifies each application to ensure all required training has been completed.

For details on mandatory training requirements for each position, please refer to the My Aged Care Workforce Learning Strategy.

- Supporting documentation to be uploaded with the application could include MAC learning training transcripts, qualifications, AHPRA registration evidence etc.

- Once the application has been submitted, a confirmation banner will appear confirming that the application has been created and submitted to the verifier for action.

My Aged Care Workforce Learning Strategy.

Assessor Portal User Guide 12 – Managing Delegate Roles

13.2. Information management

13.2.1. Privacy and Protected Information under the Aged Care Act 2024 (Cth)

Sections 537 to 541 of the *Aged Care Act 2024* (the Act) specifies the purposes for which information can be used or disclosed in accordance with the Act. The collection of information from an older person, their registered supporter(s) and/or appointed decision maker/s for the purposes of determining an individual's eligibility and assessing their access to funded aged care services is authorised by the Act.

Personal information collected during the assessment process is considered protected information. Protected information is defined under section 21 of the Act, as personal information or information, including commercially sensitive information, where the disclosure of which could reasonably be expected to found an action by an entity (other than the Commonwealth) for breach of a duty of confidence. Personal information has the same meaning as in the Privacy Act 1988 (Privacy Act) and is defined as information or an opinion about an identified individual, or an individual who is reasonably identifiable:

- Whether the information is true or not; and
- Whether the information or opinion is recorded in a material form or not.

Additionally, information collected during the assessment process may also be considered sensitive information as defined by section 6 of the Privacy Act which includes information about an individual's identity and health. Sensitive information within the meaning of the Privacy Act may be personal information (information is not personal information if it is only about a person who has died.) Sensitive information is afforded additional protection under the Australian Privacy Principles (APP) and should only be used for authorised purposes (see information below about assessment organisations who may be APP entities.

The Aged Care Act 2024 (the Act) imposes strict rules on the management of protected information, stating that a person commits an offence if they make a record of, disclose, or otherwise use protected information that was acquired in the course of performing duties or exercising powers or functions under the Act or the *Aged Care (Transitional Provisions) Act 2024,* where the use or disclosure is not authorised under Division 2 of Part 2 of Chapter 7 of the Act. The maximum penalty for such an offence is imprisonment for up to two years or a fine of 120 penalty units, or both.

To comply with these requirements, individuals and entities who handle assessment information must implement stringent confidentiality measures. This includes secure handling, recording, and storage practices to ensure that the information is safeguarded against unauthorised access or disclosure.

To ensure the proper handling and disclosure of protected information in accordance with the law, assessment organisation staff must follow their organisation's standard operating procedures and guidance in this manual.

Assessment organisations who are APP entities under the Privacy Act will also need to comply with the requirements of the Privacy Act in handling personal information. Where personal information is used or disclosed in accordance with an authorisation in Division 2, Part 2, Chapter 7 of the *Aged Care Act 2024* this will be permitted under the *Privacy Act* (see APP 6.2(b)).

Assessment organisations should consult the Privacy Act and APP Guidelines for further information on the definition of APP entities and its applicability to their organisation.

13.2.2. Collection and protection of information

The collection of information about an older person and their support network as part of the assessment process must comply with the legislative requirements under the Aged Care Act 2024 and Privacy Act 1988 (the Privacy Act). Where applicable assessors must seek and gain informed consent using the My Aged Care Assessment Consent Form (the Consent Form) including reading the consent scripts to the older person or their appointed decision maker (whether or not they are a registered supporter).

Any information collected for the purpose of determining an individual's eligibility and need for Commonwealth-subsidised aged care is collected on behalf of the Commonwealth and is therefore Commonwealth property. This includes any notes, documents or other materials created for the purpose of preparing an older person's record.

The Privacy Act contains further provisions to protect information which applies to assessment organisations.

Where the Privacy Act applies, it is critical that assessment organisations have systems, protocols and processes in place to ensure the safety of older people's records from loss, interference, misuse, unauthorised access, modification or disclosure. This requirement relates to Australian Privacy Principle 11. Penalties may apply to agencies and individuals for breaches of the Privacy Act. Assessment organisations may refer to the Office of the Australian Information Commission for further information on the handling of personal information and the consequences of misuse.

If a record of an assessment is a state or territory government as well as being a Commonwealth record, there may be further requirements to retain and store information under state or territory legislation. Assessment organisations should seek advice from their state or territory government on any state or territory requirements. Assessment organisations must meet all requirements at both levels of government.

All assessment organisation staff should exercise caution and care when handling personal information. If an assessment organisation staff member becomes aware of a potential privacy breach, they must discuss this with their assessment organisation manager and follow their organisation's procedures.

13.2.3. Use, storage and retention of information

Records are now created, stored and managed electronically in the My Aged Care portal. In some circumstances, it may be necessary for records to be created in a hard copy paper format (e.g., the Emergency Residential Care - Application for Care form). In these cases, the paper records are to be uploaded to the My Aged Care portal as soon as possible and the paper copy destroyed in accordance with the destruction guidelines (see Destruction below).

Should you require information about the management of legacy records, those records that were created prior to the My Aged Care Gateway please contact your assessment organisation manager who can liaise with the department if necessary for further advice.

13.2.4. Destruction of information

The destruction of new paper records should be undertaken as soon as the record has been captured digitally in the My Aged Care portal, and a true electronic copy has been confirmed. Destruction can be undertaken using class B paper shredders that shred to P-5 security level. Level P-5 provides more security with cross-cut shreds that are only ≤ 30 mm² particles with width ≤ 2 mm.

Alternatively, destruction can also be through a Protective Security Policy Framework endorsed T4 accredited waste management agency.

The destruction of electronic records requires the deletion of all copies of the record from any system in such a way that it is impossible to restore the record. For records that are

destroyed and not uploaded to My Aged Care, assessment organisations must also maintain evidence of identifying what has been destroyed and the means of destruction.

Department of Home Affairs website: Protective Security Policy Framework

13.2.5. Use and disclosure of information

Assessors and other staff must be aware that information they acquire or generate in the course of performing their delegated functions or powers under the Aged Care Act 2024 (the Act) may not be recorded or disclosed or otherwise used unless it is in accordance with the Act. Generally, information can be used or disclosed by assessors and staff in the course of performing their delegated powers or functions under the Act or with the consent of the older person. Written records of 'interesting cases' may not be kept by staff members, and cases may not be referenced in public discussion such as in a Letter to the Editor or in social media. There are explicit authorisations for the use and disclosure of information under the Act. These may generally be categorised as:

- **general authorisations**- including but not limited to functions and powers under the Act, for proceedings, with consent, preventing serious threat to safety, health or wellbeing, for the purposes of worker screening
- **entrusted persons** – disclosure to a minister, disclosure for the purposes of obtaining legal advice or another legal service, for the provision of services to an individual (but only for specific purposes, such as assessing the level of care an individual needs, relative to the needs of others)
- **authorisation by the System Governor or Appointed Commissioner** – disclosure to relevant Commonwealth bodies and agencies, disclosure to a registered supporter of an individual accessing or seeking access to funded aged care, disclosure for continuation of funded aged care services, disclosure for research, disclosure for law enforcement and revenue protection, disclosure for maintenance of professional standards, disclosure for certified purposes
- **authorisation by the System Governor or Appointed Commissioner for certain inquiries**- disclosure to the coroner, disclosure for state or territory complaints
- **Authorisation by the System Governor for grants and quality purposes**- disclosure for grants and disclosure for star ratings

Disclosures made under any of the authorisations must be in accordance with the specific requirements outlined under Division 2 of Part 2 of Chapter 7 of the Aged Care Act 2024 (the Act).

Any systems developed for the collection and analysis of data should incorporate adequate procedures to protect the privacy of people being assessed. If data is to be used for purposes other than assessment, or individual care planning, assessors must have procedures in place to ensure that older person confidentiality is maintained and individuals cannot be identified.

Older people and their registered supporters should be encouraged to access their My Aged Care online account. This gives direct access to the older person's assessment information, which they can disclose to other parties as they wish.

In cases where there is no consent to release information or any doubt about the release of information, the assessor should discuss this situation with the organisation's manager. The manager may further consult the assessment organisation's auspice organisation, the state

or territory government, the department or obtain independent legal advice if any doubt remains, before releasing information.

Australian Security Intelligence Organisation website: ASIO T4 Protective Security

Federal Register of Legislation website: Aged Care Act 2024 - Federal Register of Legislation

Archives Act 1983

Electronic Transaction Act 1999 (see Part2, Division 2, Section 12 – Retention)

Privacy Act 1988 - Federal Register of Legislation

National Archives of Australia website: Records Authority 2011/00396196 Department of Health and Ageing (includes Aged Care)

Office of the Australian Information Commissioner website:

Australian Privacy Principles

13.2.6. Freedom of information

The Commonwealth *Freedom of Information Act 1982* (Freedom of Information Act) gives members of the public the right to request access to government-held information. This includes information the government holds about individuals or about government policies and decisions. The Freedom of Information Act extends, as far as possible, the right of the Australian community to access information (generally documents) in the possession of the Commonwealth, limited only by considerations of the protection of essential public interest and of the private and business affairs of persons in respect of whom information is collected and held by departments and public authorities.

Federal Register of Legislation website: Freedom of Information Act 1982

Office of the Australian Information Commissioner: What is freedom of information? | OAIC

13.2.7. Framework for Governance of Indigenous Data

The Framework for Governance of Indigenous Data provides a stepping stone towards greater awareness and acceptance by Australian Government agencies of the principles of Indigenous Data Sovereignty.

The Indigenous Data Sovereignty Principles are outlined by the Maiam nayri Wingara Indigenous Data Sovereignty Collective. The principles concern the right of Aboriginal and Torres Strait Islander people to exercise ownership and control over Indigenous data at all phases of the data lifecycle. Indigenous data is defined by Maiam nayri Wingara as

'information or knowledge, in any format or medium, which is about and may affect Indigenous peoples both collectively and individually.'

The framework contains the following guidelines for Australian Government agencies to change data governance practices, in alignment with the commitments made in the National Agreement on Closing the Gap:

- **Partner with Aboriginal and Torres Strait Islander people-** establishing formal partnerships and shared decision-making with Aboriginal and Torres Strait Islander people, embedding Indigenous leadership into data governance.
- **Build data-related capabilities-** Supplementing of technical skills with understanding of the ways in which Indigenous data has been collected and the narratives and challenges which arise from current datasets. Supporting Aboriginal and Torres Strait Islander communities and organisations through training and up-skilling Indigenous people.
- **Provide knowledge of data assets-** Supporting Aboriginal and Torres Strait Islander people to locate and access relevant government held data by informing Indigenous people about what data is held by the government, its usage and access permissions.
- **Build an inclusive data system-** The structural transformation of datasets to support the inclusion of Aboriginal and Torres Strait Islander people in data governance.

https://www.oaic.gov.au/privacy/the-privacy-act/Framework for Governance of Indigenous Data

13.3. Clinical governance

Assessment organisations have a responsibility to implement effective clinical governance, made operational through a clinical governance framework. A clinical governance framework is a framework that describes an organisation's approach to clinical governance. It must include the practical, clinical supports that are in place for staff who may need to exercise clinical judgement or undertake elements of an aged care needs assessment that are clinical in nature.

Appendix C provides guidance on how to implement effective clinical governance.

13.4. Separation of assessment services and delivery of aged care services

13.4.1 Conflict of Interest in assessment services delivery

Assessment organisations that deliver Commonwealth-funded aged care services must declare, and are required to outline, to the Commonwealth's satisfaction and approval, how any perceived, potential or real conflicts of interest in the delivery of aged care assessment services will be managed and mitigated. This also applies to any related entities.

It is possible that an older person may be referred to a service provider of a related entity to the assessment organisation for Commonwealth-funded services, particularly when there are no other service providers operating in the same area as the older person.

Strategies and mitigations that the department considers when identifying and determining acceptance of an assessment organisation's conflict of interest includes but is not limited to:

- adequate separation of workforce through separate physical premises;
- separate team and management structure;
- separate IT systems;
- conflict of interest policies and processes and awareness through staff training;
- employee declarations prior to and during employment;
- internal audit programs.

Assessment organisations have an obligation to report any conflict of interest to the department, and must make full disclosure of a conflict and provide the steps it proposes to take to resolve or otherwise deal with the conflict of interest to the satisfaction of the department.

If the department is not satisfied that a conflict is being managed appropriately under the contract, the department has options including:

- withholding or revoking approval of an assessment organisation's approval to provide Commonwealth-funded aged care services in the same Service Area as it is delivering assessment services
- reasonably requiring the assessment organisation to take steps to resolve or otherwise deal with the conflict of interest
- as a last resort, termination of contract.

13.4.2 Separation of assessment services and delivery of aged care services

An assessment organisation delivers the assessment of older person needs independent of provider preferences, and ensures older people are referred only to the services that will fulfil their needs and goals.

It is a requirement for assessment organisations to contractually have operational separation of assessment services from service delivery (where applicable) for all contracted assessment organisations and any relevant sub-contractors (including consortiums).

Assessment organisations that deliver both assessment services and service delivery must ensure there is a clear separation of service, particularly in the facilitation and management of assessments and referrals to aged care services. Assessment organisations must have policies and procedures in place to assure the separation of assessment from service delivery**.**

Assessment organisations must seek prior approval from the Department of Health, Disability and Ageing (the department) before engaging or using assessment organisations and any relevant sub-contractors to provide aged care services.

13.5. Branding

Assessment organisations that are contracted to (or in an agreement with) the Australian Government (under the oversight of the department) are required to comply with branding guidance that is included in the following style guides:

- Ensure all materials produced adhere to the Australian Government Branding Guidelines.

- Ensure all web-based content complies with the relevant Digital Service Standards including Requirements for Australian Government websites and comply with the Web Content Accessibility Guidelines (WCAG) version 2.2 AA for all government websites. http://www.w3.org/TR/WCAG

Subcontractors are required to consult with their primary contractor on branding requests.

- **Department of Prime Minister and Cabinet website:** Australian Government Branding Guidelines | PM&C
- Digital Service Standards Web Content Accessibility Guidelines (WCAG) 2.2

13.6. Aged care resources for older people

Hard copies of My Aged Care resources including booklets, brochures, posters and magnets are available from National Mailing and Marketing by emailing: health@nationalmailing.com.au or calling (02) 6269 1025.

Information and resources about aged care can be found on the My Aged Care website. Recommended information and resources include:

- *Exploring aged care* booklet for older people, their families and carers:
- Signing up to receive the EngAged, our monthly newsletter on aged care and ageing well:
- Following the Council of Elders on Facebook and keep up with the work they are doing. Find out what the Department of Health, Disability and Ageing is doing to help people in Australia age well:
  -

Resources | My Aged Care

Exploring aged care booklet

EngAged newsletter: health.gov.au/aged-care-newsletter-subscribe

facebook.com/groups/AgedCareCouncilOfElders

health.gov.au/topics/positive-ageing-is-ageing-well

13.7. Reporting and performance

Assessment organisations are expected to meet measures on timeliness and performance according to their contractual agreements with the Australian Government.

The department makes available various business intelligence (BI) and management reports which support assessment organisations in monitoring and managing their performance

against agreed KPIs and other measures. These reports will progressively become available during the establishment of the Single Assessment System workforce. Assessment Organisations can access Qlik reports on the Health Data Portal, reports currently available include:

- SAW001: Referral and Assessment Volumes
- SAW 002: Timeliness
- SAW003: Outstanding Assessments
- SAW005: Organisation Performance
- SAW006: Recommended Services
- SAW007: Service Referrals
- SAW008: Home Care Package Approvals
- SAW 009: Referral Data Breakdown
- SAW010: Assessment Data Breakdown

As further reports become available, they will be communicated to Assessment Organisations and listed above. For queries regarding the Single Assessment System Qlik reports, support documentation or assistance with access to the Health Data Portal, please contact AgedCare.Assessment.Reporting@health.gov.au

14. Chapter 14 – Fees and payments

What you'll find in this chapter:

This chapter provides guidance on:

- fees,
- payments, and
- participant contributions for funded aged care services.

14.1. An assessor's role in advising clients about fees and payments

It is important that older people understand the potential costs of care early in their interaction with the aged care system.

Assessors are not responsible for providing detailed financial information about the fees or charges that an older person may be charged to access aged care services, but they do have a role in advising older people about where they can access the information they need and what the process may entail. They should be able to assist clients to access appropriate support should an older person be experiencing financial disadvantage (see section 14.2.4Financial Hardship).

Ideally, clients should be referred to the My Aged Care website and the contact centre for information regarding care costs and fees prior to the face-to-face assessment. This gives the client time to consider the information prior to the assessment.

Note:

After the assessment, rather than the assessor handing out Services Australia hard copy forms to the client (which may lead the client to complete a form unnecessarily), assessors can leave booklets specific to their service recommendations which contain necessary fee information for that program or type of care.

Assessors may wish to point out the section of the booklet which provides information about fees, who to contact about whether they need to complete a form and how to access the forms if required (see Chapter 13).

14.2. Aged care program fees

14.2.1. Fees for Commonwealth Home Support Program (CHSP)

A provider delivering funded aged care services through a service group under the CHSP may charge an individual an amount for or in connection with those services (the CHSP

contribution), in accordance with section 286 of the Aged Care Act 2024. Providers must have a publicly available financial hardship policy that covers how clients can apply for a waiver or reduction of the CHSP contribution.

The CHSP contribution must be agreed with the client in writing, including how and when it is to be paid and outlined in the client's Service Agreement. In agreeing to the amount of CHSP contribution, providers should consider a range of factors including:

- business costs associated with delivering the service
- affordability for CHSP clients
- the socioeconomic circumstances of those receiving services.

There is no formal means testing for CHSP client contributions. The client contribution fee may vary from person to person. This is because the fee can vary depending on the specific services a client receives and their individual capacity to pay. Two clients of a similar age with similar support needs may pay different CHSP contributions for a similar service.

The National CHSP Client Contribution Framework outlines the principles that service providers can adopt in setting their client contribution policies with a view to ensuring that those who can afford to contribute to the cost of their care do so whilst protecting those most vulnerable.

Commonwealth Home Support Program (CHSP) 2025–27 Manual (from 1 November 2025) | Australian Government Department of Health, Disability and Ageing

Commonwealth Home Support Program (CHSP) resources

14.2.2. Fees for Support at Home participants

The introduction of contributions in the Support at Home Program have replaced fee arrangements under the Home Care Package Program.

With the transition from the Home Care Package program to Support at Home, changes have been made to how participant contributions are calculated. This information is applicable for older people accessing services under the Support at Home Program, including through the Restorative Care Pathway, End-of-Life Pathway and Assistive Technology and Home Modifications (AT-HM) scheme.

For Support at Home participants, an income and assets assessment by Services Australia determines participant contributions. Contributions will be different for each participant based on the type of service received, the outcome of their income and assets assessment and their pension status.

- Clinical support services will attract no contribution fees as they are fully funded by the government for all participants.
- Independence services such as personal care will attract moderate contributions.
- Everyday living services such as cleaning and gardening will attract the highest contributions.

For full or part pensioners, Services Australia will use the information on a person's income and assets assessment that has been provided for their pension assessment to determine their Support at Home contributions. Non-pensioners, once approved for Support at Home will need to complete an income and assets assessment if Services Australia does not already have their financial details.

Completing an income and assets assessment is not mandatory, however, Support at Home participants who choose not to complete one can be asked to pay the maximum participant contribution rate.

Providers do not need to wait for an income assessment to be completed before an older person commences Support at Home services. Service providers and participants can agree on a temporary contribution rate while a new participant's income and assets are being assessed by Services Australia. The Support at Home fee estimator, available on the department's website can be used to assist in determining these temporary rates.

A no worse off principle applies for grandfathered Home Care Package care recipients who, on or before 12 September 2024, were either receiving a Home Care Package, on the National Priority System or assessed as eligible for a package. The no worse off principle applies to financial contributions. These participants will make the same contributions, or lower, than they were assessed as having to pay under Home Care Package Program arrangements, even if they are reassessed into a higher Support at Home classification at a later date. The same lifetime cap will also be honoured for this cohort (approximately $85,000).

For Support at Home Participants there are defined circumstances when they may simultaneously access CHSP services. When doing so, a Support at Home participant must pay regular CHSP client contribution fees. These client contribution rates are subject to government subsidisation. The Support at Home participant will need to fund the client contribution fees themselves and cannot use their Support at Home funding allocation. This arrangement is applicable in the following circumstances:

- Pre-existing CHP social support group
- Hoarding and Squalor
- Short-term respite
- Emergency access
- Specialised support (Vision advisory services)

For further information about the circumstances when a Support at Home Participant can simultaneously access CHSP services, refer to Chapter 6.

If required, Support at Home Participants can choose to pay for additional CHSP services out of their Support at Home budget. As the Support at Home participant is already receiving government subsidised aged care services, additional CHSP services will be charged at the full cost and not subject to further subsidisation.

Restorative Care Pathway

Participant contributions apply for services delivered in the independence and everyday living categories. Services in the clinical support category do not require participant contributions and are fully funded by the government.

ATHM Scheme

Support at Home participants may be required to make contributions for AT-HM items and services. AT-HM items attract a contribution rate equivalent to the independence category. Prescriptions and wrap-around services fall under the clinical supports category, requiring no participant contribution.

End-of-Life Pathway

Consistent with ongoing Support at Home, participant contribution arrangements apply for independence and everyday living services accessed under the End-of-Life Pathway. For services in the clinical supports category, no participant contribution is required as these services are fully funded by the government.

Further information is available on the Department of Health, Disability and Ageing website:

- Support at Home Participant contributions
- Support at Home Program Manual
- Schedule of Fees and Charges for Residential and Home Care

My Aged Care Website:

- Aged Care Resources
- Fact Sheet: Support at Home program - participant contributions

Services Australia website:

- Providing home care
- Providing residential care

14.2.3. Older people entering permanent residential care

How much a person pays for their residential aged care is based on their income and assets. Services Australia or the Department of Veterans' Affairs (DVA) assesses income and assets, and this is known as an aged care means assessment. If an older person is a member of a couple, they will be assessed on half of their combined income and assets. Residents who have had their means assessed are required to report changes to their financial circumstances to Services Australia or DVA within 28 days to help keep their fees correct.

People who can't afford to make a higher contribution will only pay the basic daily fee. Those who can afford to will contribute more to their aged care costs.

If an older person chooses not to have their means assessed, they will not be eligible for assistance with care and accommodation costs.

If a person moves into an aged care home for permanent residential care, they will pay fees under one of 2 arrangements:

- **1 July 2014 fee arrangements:** these apply for people who were approved for or accessing a Home Care Package on 12 September 2024, and who are therefore protected by the 'no worse off principle" and will pay fees under the 1 July 2014 arrangements.
- **1 November 2025 fee arrangements:** these apply to people who first enter residential care on or after 1 November 2025.

1 July 2014 fee arrangements

Residents under these arrangements are not affected by the changes to means assessments under the *Aged Care Act 2024*.

Before entering into permanent residential care, an older person should have their means assessed to see if they're eligible for Australian Government assistance with fees and accommodation costs. The fees they pay will depend on the outcome of their means assessment and what they agree on with their aged care provider. Residents can also submit an *Aged care calculation of your cost of care form* after entering aged care.

All fees must be clearly written in the resident or service agreement, accommodation agreement and the optional higher everyday living agreement.

An older person may need to pay some or all of these fees:

- basic daily fee
- means tested care fee
- accommodation costs
- fees for optional services.

Understanding fees for aged care homes – 1 July 2014 fee arrangements | Australian Government Department of Health, Disability and Ageing

Means assessment for residential aged care | Australian Government Department of Health, Disability and Ageing

1 November 2025 fee arrangements

Residents who have entered care after 1 November 2025 are affected by means assessment changes under the Aged Care Act 2024. These include:

- new income and asset limits will determine the new means tested fees
- the hotelling supplement will be means tested rather than paid in full by the government, and some residents will contribute to it with a hotelling contribution
- some residents will pay a new means tested non-clinical care contribution with daily and lifetime caps.

Before entering permanent residential care, an older person should have their means assessed to see if they're eligible for Australian Government assistance with fees and accommodation costs. The fees they pay will depend on the outcome of their means assessment and what they agree on with their aged care provider. Residents can also submit an *Aged care calculation of your cost of care form* after entering aged care.

All fees must be clearly written in the service agreement with the provider, accommodation agreement and the optional higher everyday living agreement. These fees may change over time during the time of an older person's care.

Older people may need to pay some or all of these fees:

- basic daily fee
- hotelling contribution
- non-clinical care contribution
- accommodation costs
- higher everyday living fee.

Understanding fees for aged care homes – 1 November 2025 fee arrangements | Australian Government Department of Health, Disability and Ageing

Means assessment for residential aged care | Australian Government Department of Health, Disability and Ageing

14.2.4. Financial hardship

Financial hardship arrangements available if an older person can't afford to contribute to the cost of their aged care, both in residential care and in-home care. An older person will be assessed on their specific circumstances. If approved for hardship assistance, the Australian Government will pay some (or all) of their aged care fees. The government will pay any approved amounts to the aged care provider on the older person's behalf. If an older person is required to pay some of their fees, they will continue to pay those to their provider.

To apply for financial hardship assistance, an older person must meet certain requirements and complete the Aged Care Claim for Financial Hardship Assistance form. This form is sent to Services Australia to assess the application and they will let the older person know in writing of their decision and what assistance they are eligible for. This form should be submitted by an older person once they start accessing aged care services.

Hardship assistance for aged care – Fact sheet

Financial hardship assistance | My Aged Care

14.2.5. Fees payable by older people receiving transition care

Registered providers may ask individuals to pay a care fee as a contribution to the cost of their care. Any fees must be fully explained to the individual and the amount charged forms part of the service agreement between the individual and registered provider.

The maximum amount that can be charged as per section 286-10 of the *Aged Care Rules 2025* is:

- if Transition Care Program (TCP) is delivered through the residential care service group —the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis); or

- if TCP is delivered in a community/home setting and is delivered through the home support, or assistive technology service groups — the amount obtained by rounding down to the nearest cent the amount equal to 17.5% of the basic age pension amount (worked out on a per day basis).

An individual's access to transition care should not be affected by their ability to pay fees but should be decided based on their need for care and the capacity of the registered provider to meet that need. Decisions on whether to charge fees are entirely at the discretion of each State and Territory. The Australian Government recommends that fees be waived for financially disadvantaged individuals. Information on the cost of transition care for individuals is outlined on the My Aged Care website.

Transition care | My Aged Care

Transition Care Program Guidelines – November 2025 | Australian Government Department of Health, Disability and Ageing

14.2.6. Non-Australian residents

Non-Australian residents are not excluded from entitlements under the *Aged Care 2024* (the Act) and Visa holders do not require a Medicare Card in order to access an assessment.

Under the Act, non-Australian residents may be eligible for Government assistance with their aged care costs, if the person has been approved by an assessor and has had their income (for home care) or means (for residential care) assessed by Services Australia.

While the Australian Government is the majority funder of aged care, beyond this support it is expected that people will use their income and/or assets, depending on their care type, to contribute to the costs of their care, where they can afford to do so. The amount that the person can be asked to contribute will be assessed by Services Australia under the same rules as any other aged care recipient.

In the event that a non-Australian resident client requests advice from an assessor regarding what fees and payments they may be required to contribute towards their home care or residential care services, they should be advised to complete an income or means assessment to determine their contribution. This applies for all clients who wish to receive Government assistance with the cost of their care, regardless of residency status.

Income and means assessment

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APPENDIX A – Glossary

Table 59. Glossary of terms

Term	Acronym/ abbreviation	Definition
Administrative Review Tribunal	ART	The Administrative Review Tribunal (ART) provides independent merit reviews of a wide range of administrative decisions made by the Australian Government. The ART can review decisions made under Commonwealth and Norfolk Island laws. The ART aim to make their review process accessible, fair, just, economical, informal and quick.
Aboriginal and Torres Strait Islander Aged Care Framework		This Framework establishes a 2035 vision for older Aboriginal and Torres Strait Islander people to age well by having their spiritual, physical and mental health needs met through holistic, high-quality and culturally safe aged care. This care should promote wellbeing, deliver trauma aware and healing informed responses and empower connection to culture, family, community and Country or Island Home.
Aged Care Act 2024 (Cth)	The Act	The *Aged Care Act 2024* (Cth) replaces the *Aged Care Act 1997* (Cth) as the primary piece of aged care legislation from 1 November 2025. In response to the first recommendation of the Royal Commission into Aged Care Quality and Safety, the Act was developed to implement fundamental reforms to aged care. It provides a legislative basis for a rights based aged care system focused on the safety, health and wellbeing of older people. The legislative framework provided by the Act sets out the governance of the aged care system and the requirements to access and deliver funded aged care services. It further introduces a new risk-based regulatory model focused on increasing provider accountability and encouraging the delivery of high quality funded aged care services by registered providers.
Aged Care (Consequential and Transitional		The *Aged Care (Consequential and Transitional Provisions) Act 2024* provides for transitional arrangements to support the commencement of the *Aged Care Act 2024*.

Term	Acronym/ abbreviation	Definition
Provisions) Act 2024		
Aged Care Act 1997 (Cth)		From 1 November 2025, the *Aged Care Act 1997* (Cth) will cease as the primary piece of aged care legislation. It will be superseded by the *Aged Care Act 2024* (Cth). From the cessation of the Act on 1 November 2025, Assessment Organisations should consult the *Aged Care Act 2024* (Cth) for information on access, delivery and governance of the aged care system.
Aged Care Assessment Quality Framework	Framework	Assessment organisations are required to use the Aged Care Assessment Quality Framework to maintain a consistent, high quality assessment experience for every older person.
Aged Care Diversity Framework		The Aged Care Diversity Framework is an overarching set of principles designed to ensure an accessible aged care system where people, regardless of their individual social, cultural, linguistic, religious, spiritual, psychological, medical and care needs are able to access respectful and inclusive aged care services.
Aged care needs assessor		A person who conducts aged care assessments, for home support and comprehensive assessments. An aged care needs assessor can be a clinical assessor or a non-clinical assessor.
Aged Care Principles		From 1 November 2025, the *Aged Care Act 2024* (Cth) will replace existing aged care legislation including the Aged Care Principles. Once commenced, Assessment Organisations should consult the *Aged Care Act 2024* (Cth) for information on access, delivery and governance of the aged care system.
AN-ACC Assessment Tool		Assessment tool used by residential aged care funding assessors to conduct residential aged care funding assessments.

Term	Acronym/ abbreviation	Definition
Assessment organisations	N/A	An entity engaged by the Department to provide Aged Care Needs Assessment Services and/or RAC Funding Assessment Services.
Assessor	N/A	An aged care needs assessor.
Aged Care Specialist Officer	ACSO	ACSO, located in some Services Australia service centers, help people with their aged care matters and provide in-depth support including in relation to financial information and means assessment.
Active, appointed Decision Maker	N/A	'Active, appointed decision maker' is the term used for a person who would be considered a 'guardian etc.' under the *Aged Care Act 2024* (Cth). If a person is a registered supporter and is also an active, appointed decision maker for an older person (for example, the person is also an enduring attorney for the older person they are registered to support), they are recorded as a 'supporter guardian' for Information Communications Technology (ICT) purposes. Active, appointed decision makers can only make decisions for an older person within the scope of their legal authority under a Commonwealth, state or territory arrangement.
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.
Assistive Technology and Home Modifications (AT-HM) list	AT-HM list	A list that sets out the defined equipment, products, and home modifications that can be purchased for eligible participants under the AT-HM scheme.
Assistive Technology and Home Modifications scheme	AT-HM scheme	The scheme provides assistive technology and home modifications funding for eligible participants.

Term	Acronym/ abbreviation	Definition
AT-HM scheme guidelines		The AT-HM scheme guidelines provide additional information and processes in relation to the AT-HM scheme.
AT-HM tier guide		A guide created to support assessors in making an AT-HM funding tier recommendation.
Australian National Aged Care Classification	AN-ACC	Funding model for residential aged care, effective from 1 October 2022.
Australian Privacy Principle/s	APP/s	The Privacy Act includes 13 APPs in Schedule 1 that apply to the handling of personal information by most Australian and Norfolk Island Government agencies and some private sector organisations.
Care finder		Care finders assist vulnerable older Australians who do not have someone who is able to help them access aged care services and other relevant supports in the community. Contact information for care finder services in each region is on the My Aged Care website at Help from a care finder | My Aged Care
Classification		Refers to the classification of a Support at Home participant, including: • Ongoing classification (Classifications 1-8) • Short-term classifications (AT-HM scheme, Restorative Care Pathway Classification and End-of-Life Classification). Also refers to residential care classification (ongoing or short-term)
Clinical aged care needs assessor		A clinically trained assessor who meets the qualification and training requirements outlined in the assessment organisation's contractual agreement with the Commonwealth and in the My Aged Care Workforce Learning Strategy 2024 (or subsequent versions). A clinical assessor undertakes complex (comprehensive)